***Legal Risk: Non-conformance with laws, rules, regulations, prescribed practices or ethical standards in any jurisdiction in which the entity operates will result in a disruption in business and financial loss.***

The Legal Risk Assessment is focused on risks emerging from company activities that might not be in accordance with legal and regulatory requirements. Given the wide range of legal and regulatory requirements that insurers are exposed to, including various jurisdictions and agencies, legal risks can emerge from many different areas. As such, the analyst will need to have a good understanding of the insurer and its operations in order to identify the applicable legal and regulatory requirements that could have a significant impact on the insurer’s financial position and prospective solvency.

The Current Period Analysis section of the Risk Assessment Worksheet includes a procedure step related to Compliance Analysis, which may assist in identifying various risks addressed in the legal risk procedures. In addition, some of the detailed procedures below may be useful in completing your state’s Compliance Analysis. However, if significant compliance issues are identified that represent a risk to the insurer’s financial position or prospective solvency, analysis of such risks should be discussed and documented under Legal Risk in the Risk Assessment section of the worksheet (Section III).

In analyzing legal risk, the analyst may analyze a wide range of risk exposures related to the insurer’s compliance with laws and regulations. An analyst’s risk-focused assessment of legal risk should take into consideration the following areas (but not be limited to):

* Market conduct activities and violations
* Expenses and potential liabilities associated with ongoing litigation
* Fraudulent activities
* Compliance with code of ethics
* Compliance with state laws and reporting requirements
* Compliance with federal agency requirements
* Compliance with federal Affordable Care Act (ACA) provisions (health business only)
* Compliance with audit requirements, including those pertaining to the audit committee

# GENERAL GUIDANCE

To assess legal risk, consider the procedures, including specific data elements, metrics and benchmarks in this chapter. The following is not an all-inclusive list of possible procedures, data, or metrics. Therefore, risks identified for which no procedure is available should be analyzed by the state insurance department based on the nature and scope of the risk.

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

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

Analysts are not expected to document every procedure, data or benchmark result. Rather, analysts and supervisors should use their expertise, knowledge of the insurer and professional judgement to tailor the analysis to address the specific risks of the insurer and document the applicable details within the analysis. Results of legal risk analysis should be documented in Section III: Risk Assessment of the insurer. Documentation of the Risk Assessment analysis should be sufficiently robust to explain the risks and reflect the strengths and weaknesses of the insurer.

Analysts should complete their legal risk assessment in conjunction with:

* A review of the Supervisory Plan and Insurer Profile Summary and the prior period analysis.
* Communication and/or coordination with other internal departments.
* 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.

# ANNUAL LEGAL RISK ASSESSMENT

**Impact of Market Conduct Examination/Material Findings**

Determine if concerns exist regarding Market Conduct, including complaints, market conduct actions, communication with market conduct staff, etc., that could have an impact on financial position and prospective solvency. If concerns exist, communicate risks/issues to the state insurance department’s Market Conduct Unit to investigate further. For example, large fines levied by states, suspensions or revocations of licenses, market conduct exam settlements (whether financial or other), or other regulatory actions taken based on market conduct violations may have a material impact on the financial solvency of the insurer. Additionally, if a recently concluded market conduct examination resulted in regulatory requirement to perform remediation (E.g., reprocessing denied claims) the financial impact may be material to the insurer.

Procedures

* Review any market conduct information available from the NAIC market analysis tools available on iSite+ (Market Analysis Profile (MAP), Examination Tracking System (ETS), Market Analysis Review System (MARS), Regulatory Information Retrieval System (RIRS), Special Activities Database (SAD), Market Initiative Tracking System (MITS), Market Conduct Annual Statement (MCAS) and the Complaints database). Note any unusual items or negative trends for the following items that translate into financial risks or indicate further review is needed:
	+ Count of Regulatory Actions for the current and prior two years
	+ Aggregate of Regulatory Fines for the current and prior two years
	+ Market Conduct Examination Called or Concluded in the current and prior two years
* For Health insurers, determine the average number of days of unpaid claims. If concern is noted, review the Financial Profile Report to identify changes in the average number of days of unpaid claims in past years for unusual fluctuations or negative trends between years and determine if the insurer has met state statutes and regulations regarding timely payment of claims.
* In reviewing the items disclosed in the Market Conduct Examination and other Market Conduct findings, the analyst should assess their potential impact on the insurer’s financial condition and prospective solvency by placing and discussing risk information within the appropriate branded risk classification, if not a legal matter.

Additional Review Considerations

* Review any market conduct information, including information available from the state’s market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee). Note any unusual items that translate into financial risks or indicate further review is needed.
* Review any inter-departmental communication, as well as communication with other state, federal or international insurance regulators and the insurer. Note any unusual items or prospective risks that indicate further analysis or follow-up is necessary.
* If market conduct information is unusual and indicates potential financial risks, analysts can perform the following procedures:
	+ Describe and document the findings of the most recent market conduct examination and analysis and communication with the insurance department’s market conduct staff.
	+ Describe any current or future actions of the insurance department, other state insurance departments or other regulatory bodies against the insurer related to market conduct violations.
	+ Describe the actual or projected financial impact of any settlements, fines, or remediation to operations and surplus.
* Determine if the insurer has met state statutes and regulations regarding timely payment of claims.

**High Litigation, Legal and Government Expenses**

Identify and evaluate risks related to expenses paid for litigation, other legal issues and/or government lobbying. Determine if the insurer has reported high legal, litigation or government expenses that are material to overall operating expenses.

Procedures/Data

* Review General Interrogatories, Part 1, #41.1 and #41.2 and investigate any individual payments for legal expenses that represent a material amount of total legal payments made during the year.
* Review Exhibit 2 of the Annual Financial Statement to determine whether legal expenses of investigation and settlement of policy claims make up the bulk of legal expenses (Life only).
* Review General Interrogatories, Part 1, #42.1 and #42.2 and investigate any individual payments for government expenditures in connection with matters before legislative bodies, officers or government departments that represent a material amount of total legal payments made during the year.

Additional Review Considerations

* Compare legal expenses with industry averages (Industry aggregate totals are available in the NAIC publication *Statistical Compilation of Annual Statement Information)*.
* Review Annual Financial Statement, Schedule P – Part 1 for Defense and Cost Containment Expenses, Notes to Financial Statements Note #23 for Reinsurance Recoverable in Dispute and Note #14G for Contingencies and identify any legal concerns.
* Review the Annual Financial Statement including the Notes to Financial Statements, Audited Financial Report, and Examination findings and follow-up monitoring and identify if there were any legal concerns.
* Upon review of the Notes to Financial Statements, determine whether the insurer was a party to any significant litigation not in the normal course of business? If so, review and understand a description of the litigation and any contingent liabilities for accrued legal expenses.
* Inquire of the insurer:
	+ Negative financial impact on the insurer and/or group should the litigation not be ruled in favor of the insurer
	+ Negative reputational impact of litigation to the insurer and/or group
	+ Negative impact of litigation to shareholders and/or policyholders

**Material Fraudulent Activity/Investigation Results**

Identify and evaluate the materiality of any fraudulent activity and the impact on the financial position and prospective solvency of the company. If fraud, allegations of fraud or ongoing investigations are identified, the analyst is encouraged to document his/her understanding and assessment of the ongoing issues and to contact the company regarding its plans to address the situation.

Review Considerations

* Review the Annual Financial Statement (including the Notes), Audited Financial Statement, and examination findings (i.e., Exhibit G) for any disclosures of fraud concerns.
* Contact the state insurance department’s Fraud Unit (if applicable) to see if the state insurance department has concluded any fraud investigations involving the insurer? If so, identify the following:
	+ Nature and scope of the investigation and its findings
	+ Regulatory and/or corrective actions required of the insurer
	+ Insurer’s plan to address the fraudulent activity
	+ Financial impact of the investigation and corrective actions
* Review news/media reports, information from the insurer or other information available to the analyst that may indicate the insurer is under investigation by any regulatory body other than the state insurance department. If so, identify the nature and scope of the investigation and impact on the insurer to determine whether further information should be requested from the other regulatory body.
* Review Regulatory Actions (through RIRS) to identify whether any regulatory actions taken by other states were identified as fraud. If so, and if not communicated to the state insurance department, contact the reporting state insurance department to obtain information regarding the regulatory action.
* Contact other regulatory agencies that have regulatory authority over the business of the insurer (e.g., federal agencies where the insurer is engaged in government contracts) to identify whether any regulatory authorities have concluded any fraud investigations involving the insurer, its management or board of directors. If so, request the following information:
	+ Nature and scope of the investigation and its findings
	+ Regulatory and/or corrective actions required of the insurer
	+ Insurer’s plan to address fraudulent activity
	+ Financial impact of the investigation and corrective actions
* Review the Group Profile Summary (GPS) and any other information provided by the lead state for any legal risks of the group or the insurance entity (e.g., from the Form F - Enterprise Risk Report) for any reported investigations, regulatory activities or litigations that may impact the insurer or holding company.
* If the above analysis indicates concerns related to current or prior fraud, inquire of the insurer regarding its internal processes and controls for preventing fraud.

**Failure to Comply with Code of Ethics Standards**

Identify and evaluate risks related to the insurer’s compliance with code of ethics standards. If concerns regarding an insurer’s failure to implement or abide by a code of ethics are identified, the analyst should correspond with the company to address these concerns and/or identify other compensating controls in place.

Procedures/Data

* Review General Interrogatories, Part 1, #14.1 and #14.11 to identify if senior officers are not subject to code of ethics standards.
* Review General Interrogatories, Part 1, #14.2 and #14.21 to identify if the code of ethics has been amended.
* Review General Interrogatories, Part 1, #14.3 and #14.31 to identify if the code of ethics has been waived.

Additional Review Considerations

* Review the Corporate Governance Annual Disclosure (CGAD) and identify any concerns.
	+ If the CGAD is filed on an insurance entity bases, verify that the information provided in the CGAD filing on ethics policies does not conflict with the information reported in the General Interrogatories.
	+ If the CGAD is filed on a group basis, rely on the information provided in the GPS for group risks or provided by the lead state if risks apply to the insurance entity and verify that the information does not conflict with the information reported in the General Interrogatories.

**Failure to Comply with State Laws and Reporting**

Assess the insurer’s compliance with NAIC reporting practices, internal policy, laws, regulations and prescribed practices. The analyst should determine whether there are any legal or regulatory impediments that could affect the insurer’s operations or result in a significant legal liability. If a compliance violation is found, the analyst should specify the violation and the impact.

Procedures/Data

* Review General Interrogatories, Part 1, #6.1 and #6.2 and identify if any certificates of authority, licenses or registrations have been suspended or revoked.

Additional Review Considerations

* Identify if the insurer is compliant with state statutes and regulations, including those that are new or revised (e.g., hazardous financial condition analysis, investment limitation analysis, etc.).
* Assess whether surplus meets the statutory minimum amount required by state law (varies by state and business type).
* Review the Notes to Financial Statements, Note #1 and the iSite+ Validation Exceptions tool and determine whether the insurer reported significant corrections of errors, validation errors, or other accounting and reporting changes that indicate possible concerns regarding the accuracy of the financial reporting. Potential missing data, data that does not conform with standards, or any crosscheck errors could materially impact the outcome of an analysis and corrective measures may need be taken by the insurer prior to proceeding with an analysis.
	+ Determine whether the insurer is in compliance with permitted or prescribed practices as reported in Note #1.
* If the insurer failed to comply with the state’s statutes and regulations enacted during the period, identify the following and complete a detailed written explanation of the violation to ensure proper documentation should non-compliance issues recur:
	+ Nature of the non-compliance
	+ Impact to the insurer’s financial position and reporting
	+ Outcome of any department communication with the insurer regarding the non-compliance issues
	+ Resolution of any non-compliance issues or resolution plans of the insurer
* If the insurer had any certificates of authority, licenses, or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period, identify the following:
	+ Nature of the suspension or revocation
	+ Reason(s) stated for the revocation or suspension
	+ Outcome of any department communication with the insurer and/or with the other regulatory authority who issued the revocation or suspension
	+ Resolution of any non-compliance issues or resolution plans of the insurer
* If the insurer has been issued any consent orders or agreements by other regulators/jurisdiction, identify or perform the following:
	+ Request a copy of the consent order or agreement from the other regulator/jurisdiction
	+ Reason(s) stated for the consent order or agreement
	+ Outcome of any department communication with the insurer and/or with the other regulatory authority
	+ Resolution of any non-compliance issues or plans of the insurer

**Failure to Comply with State Investment Laws**

Assess the insurer’s compliance with the state’s investment laws.

Review Considerations

* Using your state’s investment compliance checklist, determine whether the insurer’s investment portfolio is in compliance with the investment limitations and diversification requirements per the state’s insurance laws.
* Determine whether the insurer is reporting its investments (including the related income and expenses) in accordance with NAIC practices, internal policy, Statutory Accounting Principles and the filing requirements set forth in the Purposes and Procedures Manual of the NAIC SVO.
* Determine whether affiliated investments are in violation of state statutes. If so, gain an understanding of the primary business activity of the affiliate and why such an investment does not comply with regulatory requirements.
* If analysis of investment compliance indicates concerns or a pattern of non-compliance, review the most recent examination file for investment compliance and inquire of the insurer about its internal processes and controls for compliance with state investment laws.

**Failure to Comply with Affiliated Management and Service Agreements**

Assess the insurer’s compliance with affiliated management and service agreements.

Review Considerations

* Determine whether management and service agreements between affiliates either submitted and/or approved are in conformity with regulatory requirements and verify that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.
* Determine whether the amount of the shareholder dividend was at a level that required prior regulatory approval or notification. If so, determine whether the insurer obtained proper prior regulatory approvals.

**Failure to Comply with Transactions Involving Other Jurisdictions**

Assess the insurer’s compliance with transactions involving other jurisdictions.

Review Considerations

* If the insurer redomesticated to your state, determine whether the insurer failed to comply with any regulatory requirements or stipulations placed on the insurer that were expected to be met subsequent to approval of the redomestication and identify any legal implications that represent risk to the insurer due to the redomestication.
* If the insurer engaged in a transaction(s) to redomesticate a subsidiary offshore, determine whether the insurer failed to comply with any regulatory requirements or stipulations placed on the insurer that were expected to be met subsequent to approval of the redomestication and identify any legal implications that represent risk to the insurer due to the redomestication.
* If the insurer engaged in any transactions to acquire a subsidiary domiciled in a non-U.S. jurisdiction, determine whether the insurer failed to comply with any regulatory requirements or stipulations expected to be met subsequent to the acquisition and identify any legal implications that represent risk to the insurer due to the acquisition.

**Failure to Comply with Federal Regulatory Agencies**

Identify and assess compliance with other federal regulatory agencies. In addition to the HHS and the CMS oversight of health insurance, insurers may be subject to regulation by the Federal Reserve, U.S. Securities and Exchange Commission (SEC), U.S. Department of the Treasury and other federal regulatory bodies depending upon the nature, scope and extent of the insurer’s or insurance group’s activities.

Review Considerations

* Review General Interrogatories, Part 1, #8 and determine whether the insurer is subject to regulation by a federal regulatory agency. If so, consider contacting the applicable federal regulatory agency to request any information about the results of that agency’s oversight, including any issues identified, federal compliance violations, fraud investigations and regulatory actions.

**Failure to Comply with the Federal Affordable Care Act (Health Business Only)**

Identify and assess compliance with the federal Affordable Care Act (ACA), Medical Loss Ratio (MLR), MLR Rebate calculations and other ACA requirements. If the insurer is not subject to the ACA, it is recommended to skip the following procedures.

For purposes of reviewing the SHCE, the analyst should refer to the Annual Financial Statement Instructions for details on reporting requirements for health entities in run-off or that only have assumed and no direct business, and health entities that have no business that would be reported in the columns for Comprehensive Health Care, Mini-Med Plans, Expatriate Plans, and Medicare Advantage Part C and Medicare Part D Stand-Alone Plans. If the health entity’s SHCE was reviewed or is under review by examination staff, the analyst should contact the examiner-in-charge (EIC) to inquire about any material examination findings.

Review Considerations

* Determine whether the insurer filed the Supplemental Health Care Exhibit (SHCE) and the SHCE Expense Allocation Report filed in accordance with the Annual Statement Instructions.
* Review the Notes to the Financial Statement (primarily Note #24), the SHCE – Part 1, and the final rebate reporting to the U.S. Department of Health and Human Services (HHS). If the amount of MLR rebate liability reported is material, determine whether there are concerns regarding the insurer’s liability for rebates.
* Compare the MLR rebate liability, as provided in the SHCE, and the actual rebate calculation in the HHS Medical Loss Ratio Reporting Form. If any material differences were identified, consider requesting an explanation of the differences from the insurer.
* During the review of the health care business pursuant to the federal Public Health Service Act and all applicable filings, identify any unusual items or areas of concern, not previously noted, that indicate further review is necessary.
* If concerns exist, contact the federal Centers for Medicare & Medicaid Services (CMS) to request information about CMS sanctions or supervision by the CMS and MLR audits.

**Preliminary Medical Loss Ratio Concerns (Health Business Only)**

The following procedures are only applicable to insurers that write insurance premiums subject to the ACA. The ACA requires health entities to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). Concerns in this area should be reviewed in conjunction with the pricing and underwriting risk assessment.

Procedures/Data

* + Determine whether there are concerns regarding the components of the insurer’s Preliminary MLR:
		- Review the Preliminary MLR from the SHCE by line of business (either the national Preliminary MLR or the state-level MLR) (or the thresholds applicable under state law) for individuals or small group employers with a ratio less than 80% or large group employers with a ratio less than 85%. For Medicare plans, determine whether the preliminary MLR is less than 85%.
		- Review the change in Preliminary MLR for a material increase or decrease from the prior year by line of business (either the national Preliminary MLR or the state-level MLR).
		- In the analyst’s review of the components of the Preliminary MLR, review and assess any material differences between the unadjusted and adjusted amounts for premium and claims. Compare Health Premium Earned to Adjusted Premium Earned by line of business.
		- In the analyst’s review of the components of the Preliminary MLR, review and assess any material differences between the unadjusted and adjusted amounts for premium and claims. Compare Incurred Claims excluding prescription drugs to Total Incurred Claims by line of business.
		- Identify any components that appear unusual, or that increased or decreased materially from the prior year that would indicate further review is warranted. If so, request additional information from the insurer.

Additional Review Considerations

* Review the SHCE – Part 3 and the Expense Allocation Report including the expense allocation methodology to determine whether quality improvement (QI) expenses are appropriate and properly accounted for.
* During the review of the health care business pursuant to the Public Health Service Act and all applicable filings, identify any unusual items or areas of concern, not previously noted, that indicate further review is warranted.
* After completing analysis in this area, if specific concerns are identified regarding MLR compliance, the analyst is encouraged to contact the CMS to request information on CMS sanctions and remediation, as well as CMS supervision and regulatory concerns (including MLR audits).

The ACA requires health entities to spend at least 80% of premium for individual and small group policies or 85% of premium for large group policies on medical care, with review provisions imposing tighter limits on health insurance rate increases. When reviewing the results of the preliminary MLR, by state, by line of business, the analyst should be aware that individual states can and may require a higher MLR pursuant to state law. If the health entity fails to meet these standards, the health entity will be required to provide a rebate to policyholders. The purpose of the SHCE is to assist state and federal regulators in identifying and defining elements that make up the MLR as described in Section 2718(b) of the Public Health Service Act (PHSA) and for purposes of submitting a report to the HHS Secretary required by Section 2718(a) of the PHSA. During the review of the Preliminary MLR, the analyst should also consider how the individual state’s Preliminary MLR compares to the grand total (refer to the Financial Profile Report).

Beginning in 2014, a similar MLR requirement applies to Medicare Advantage Plans and Medicare Part D Stand-Alone Plans. The health entity must spend at least 85% of premium (with certain adjustments) on clinical services and quality improvement, or rebate premium to the HHS.

In some cases, it may be more useful to use the Preliminary MLR that is calculated by totaling the data from all SCHEs submitted by a company to the states where it has business. This national Preliminary MLR will reduce the impact of potential issues with statistical credibility of claims experience and allocation of various expenses over states and lines of business.

For lines of business in a given state with exposures of less than 1,000 life-years looking at a 5-year trend is of very limited usefulness since in such cases, claims experience is not considered credible and is subject to greater variability. More than 1,000 life years, the experience is considered credible, but still subject to large variations until exposures are well above 1,000 life years.

The MLR is not calculated in the traditional sense where medical expenses are simply divided by premiums. Premiums are adjusted for certain taxes and expenses. The numerator in the calculation will include health improvement expenses and fraud and abuse detection and recovery expenses in addition to medical expenses. The expenses for fraud and abuse detection and recovery are limited by the amount actually recovered.

The MLR calculated on the SHCE is a preliminary calculation and will not be used in determining rebates. Health entities will report information concerning rebate calculations directly to the HHS. The numbers that will be utilized for rebate purposes include revisions for claim reserve run-off subsequent to year end, statistical credibility concerns and other defined adjustments.

The analyst should review completeness or consistency validation exceptions on iSite+ that may indicate if the SHCE has not been prepared and submitted for each jurisdiction in which the company has written direct comprehensive major medical business in accordance with the *Annual Statement Instructions*.

The aggregation of data reported on the SHCE is by state, by market (individual, small group, large group) and by licensed entity. In other words, each health insurance issuer needs to meet the minimum loss ratio targets in each state, and market.

The NAIC iSite+ Financial Profile Report for the SHCE should be reviewed and significant fluctuations investigated. For example, how does the percentage change from the prior year in incurred claims compare to total incurred claims?

In addition, the analyst should ensure that the Supplemental filing was made providing a description of the methods utilized to allocate “Improving Healthcare Quality Expenses” to each state and to each line and column on the SHCE Part 3. When reviewing this Supplemental filing the analyst should consider whether the detailed descriptions of the Quality Improvement expenses were included and whether such descriptions conform to the definitions provided in the Annual Statement Instructions.

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

Despite the differences, the validity and reasonableness of the ACA MLR calculation, and therefore of the rebate calculation can be assessed using the data from the SHCE. The following elements from the SHCE and the rebate calculation can be used for such an assessment. For the following items there should be little or no difference between the amounts in the SHCE and the rebate calculation:

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

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

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

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

**Failure to Comply with Audit Committee Requirements**

Assess compliance with audit committee requirements. As mandated by the *Annual Financial Reporting Model Regulation*, every insurer required to file an audited financial report is also required to have an audit committee that is directly responsible for the appointment, oversight and compensation of the auditor. Insurers with less than $500 million in direct and assumed premium may apply for a waiver from this requirement based on hardship. Based on various premium thresholds, a certain percentage of the audit committee members must be independent from the insurer. However, if domiciliary law requires board participation by otherwise non-independent members, such law shall prevail, and such members may participate in the audit committee.

Procedure/Data

* Review General Interrogatories, Part 1, #10.5 and #10.6 to determine whether the insurer failed to establish an Audit Committee in compliance with the domiciliary state insurance laws and any explanation.
* Review General Interrogatories, Part 1, #10.1, #10.2, #10.3 and #10.4 to determine whether the insurer has been granted any exemptions under Sections 7H, or 18A of the NAIC *Annual Financial Reporting Model Regulation* and if so, review any information about the exemption.

Additional Review Considerations

* Determine whether the Audit Committee membership meets independence requirements of the domiciliary state insurance laws.
* Review the Corporate Governance Annual Disclosure (CGAD):
	+ If filed on an insurance entity basis, determine whether the information provided in the CGAD on auditor independence identified any concerns or conflict with information reported in the Annual Financial Statement, General Interrogatories, Part 1, #10.
	+ If filed on a group basis, determine whether the information provided in the GPS or provided by the lead state identified any auditor independence concerns or conflict with information reported in the Annual Financial Statement General Interrogatories, Part 1, #10.

**Management’s Discussion and Analysis Report**

Assess the insurer’s compliance with the Management’s Discussion and Analysis (MD&A) report requirements and identify any legal risks noted in the report. To assist the analyst in conducting the review, an optional MD&A review workpaper is included in the Handbook and available to download from iSite+. The MD&A workpaper breaks down analysis of the MD&A into two distinct steps: 1) Compliance Analysis; and 2) Assessment. For purposes of simplifying the review of the MD&A, guidance for consideration in performing both of these steps has been included within this reference guide.

Procedures (Compliance and Assessment)

* In considering compliance, the analyst should determine whether the MD&A addresses the two-year period covered in the insurer’s Annual Financial Statement and discusses any material changes.
* In addition, the analyst should determine whether the insurer prepared the MD&A on a non-consolidated basis, which is required unless one of the following conditions were met: 1) the insurer is part of a consolidated group of insurers that utilizes a pooling arrangement or a 100% reinsurance agreement that affects the solvency and integrity of the insurer’s reserves, and the insurer ceded substantially all of its direct and assumed business to the pool (an insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if it has less than $1 million total direct plus assumed written premiums during a calendar year that is not subject to a pooling arrangement, and the net income of the business not subject to the pooling arrangement represents less than 5% of the company’s capital and surplus); or 2) the insurer’s state of domicile permits audited consolidated financial statements.
* Additional compliance requirements apply to the overall completeness of the MD&A, including elements as described below:
* Overall material historical and prospective disclosure – Insurers should supply information necessary to assess the insurer’s financial condition, including a short and long-tailed analysis of the business of the insurer.
* Results of operations – Insurers should provide a description of any unusual or infrequent events or transactions or any significant economic changes that materially affected the amount of reported net income or other gains/losses in surplus. Insurers should also describe any known trends or uncertainties that have had or are reasonably probable to have a material favorable or unfavorable impact on premiums, net income, or other gains/losses in surplus. If the insurer knows of events that will cause a material change in the relationship between expenses and premium, the change in the relationship shall be disclosed. To the extent that the Annual Financial Statement discloses material increases in premium, reporting entities should provide a narrative discussion of the extent to which such increases are attributable to increases in prices, increases in the volume or number of existing products being sold, or the introduction of new products.
* Prospective information – Insurers are encouraged to supply forward-looking information. The MD&A may include discussions of known trends or any known demands, commitments, events, or uncertainties that will result in or that are reasonably likely to result in the reporting entity's liquidity improving or deteriorating in any material way. Further, descriptions of known material trends in the insurer’s capital resources and expected changes in the mix and cost of such resources should be included. Disclosure of known trends or uncertainties that the insurer reasonably expects will have a material impact on premium, net income, or other gains/losses in surplus is also encouraged.
* Material changes – Insurers are required to provide adequate disclosure of the reasons for material year-to-year changes in line items, or discussion and quantification of the contribution of two or more factors to such material changes. An analysis of changes in line items is required:
* Where material
* Where the changes diverge from modifications in related line items of the Annual Financial Statement
* Where identification and quantification of the extent of contribution of each of two or more factors is necessary to an understanding of a material change
* Where there are material increases or decreases in net premium
* Liquidity, asset/liability matching and capital resources – Insurers are required to discuss both short-term and long-term liquidity and capital resources. Short-term liquidity shall include a discussion of the nature and extent of restrictions on the ability of subsidiaries to transfer funds to the reporting entity in the form of cash dividends, loans, or advances, and the impact, if any, such restrictions may have on the ability of the reporting entity to meet its cash obligations. The discussion of long-term liquidity and long-term capital resources must address material expenditures, significant balloon payments or other payments due on long-term obligations, and other demands or commitments, including any off-balance sheet items, to be incurred beyond the next 12 months, as well as the proposed sources of funding required to satisfy such obligations. Also, identify and separately describe internal and external sources of liquidity, and briefly discuss any material unused sources of liquid assets. Insurers should describe any known material trends, favorable or unfavorable, in their capital resources, and indicate any expected material changes in the mix and relative cost of such resources.
* Loss reserves – The MD&A should include a discussion of those items that affect the insurer’s volatility of loss reserves, including a description of those risks that contribute to the volatility.
* Off-balance sheet arrangements – Insurers should consider the need to provide disclosures concerning transactions, arrangements, and other relationships with entities or other persons that are reasonably likely to materially impact liquidity or the availability of or requirements for capital resources. Material sources of liquidity and financing, including off-balance sheet arrangements and transactions with limited purpose entities, should be discussed.
* Participation high-risk transactions and investments – The insurer should disclose and discuss participation in high-yield financing, highly leveraged transactions, or non-investment grade loans and investments, if such participation or involvement has had or is reasonably likely to have a material effect on financial condition or results of operations. For each such participation or involvement or grouping thereof, there shall be identification consistent with the Annual Financial Statement schedules or detail, description of the risks added to the reporting entity, associated fees recognized or deferred, amount (if any) of loss recognized, the insurer’s judgment whether there has been material negative effects on the insurer’s financial condition, and the insurer’s judgment whether there will be a material negative effect on the financial condition in subsequent reporting periods.
* Preliminary merger/acquisition negotiation – The insurer should disclose and discuss its involvement in any merger/acquisition negotiations, to the extent they are likely to have a material effect on financial condition or operations.
* In reviewing the items disclosed in the MD&A filing, the analyst should assess their potential impact on the insurer’s financial condition and prospective solvency by placing and discussing risk information within the appropriate branded risk classification.

**Audited Financial Report**

Assess the insurer’s compliance with Audited Financial Report requirements and identify any legal risks noted in the report.

Risks identified in the Audited Financial Report may include:

* Audited Financial Opinion other than unmodified
	+ E.g., Going Concern
* Material differences or material audit adjustments
	+ E.g., material differences to the filed Annual Financial Statement and/or resulted in material audit adjustments that will be made to the current or next financial filing
* Material internal control weakness, and the impact of a corrective action plan
* Potential impact of items in the report on the insurer’s financial condition and prospective solvency
	+ Consider placing and discussing specific risk information within the appropriate branded risk classification.

To assist the analyst in conducting the review, an optional Audited Financial Report review workpaper is included in the Handbook and available to download from iSite+. This workpaper highlights both compliance and assessment considerations, as discussed below:

**Audited Financial Report Compliance** – The financial statements are required to be prepared in conformity with statutory accounting practices prescribed or otherwise permitted by the domiciliary state insurance department. In addition, the financial statements should be prepared on a stand-alone basis, unless the insurer has made written application to the domiciliary commissioner to file audited consolidated or combined financial statements if the insurer is a part of a group of insurance companies that utilizes a pooling or 100% reinsurance agreement.

Procedure

* If the insurer is filing financial statements on a consolidated or combined basis, the analyst should determine whether the domiciliary commissioner approved the insurer’s application to file on a consolidated or combined basis, and whether a consolidating or combining worksheet has been included with the financial statements. This worksheet should show amounts for each insurer separately, including explanations for consolidating and eliminating entries, and reconciliations for any differences between the amounts shown for an individual insurer and the amounts per the insurer’s Annual Financial Statement.

**Audited Financial Report Detailed Assessment** – In addition to reviewing for compliance, the analyst should review information provided in the financial statements to assist in risk identification and detailed assessment. One key step in this area is to determine the type of audit opinion that was issued by the independent certified public accountant (CPA). The opinion may be an unmodified or a modified opinion; however, there are three types of modified opinions: qualified, adverse and disclaimer of opinion.

* + Unmodified Opinion – The auditor should express an unmodified opinion when the auditor concludes that the financial statements are presented fairly, in all material respects, in accordance with the applicable financial reporting framework.
	+ Modified Opinion – The auditor should modify the opinion in the auditor’s report, if the auditor concludes that, based on the audit evidence obtained, the financial statements as a whole are materially misstated or is unable to obtain sufficient appropriate audit evidence to conclude that the financial statements as a whole are free from material misstatement. There are three types of modified opinions: qualified, adverse and disclaimer of opinion, as explained below:
		- The auditor should express a qualified opinion when:
1. The auditor, having obtained sufficient appropriate audit evidence, concludes that misstatements, individually or in the aggregate, are material but not pervasive to the financial statements; or
2. The auditor is unable to obtain sufficient appropriate audit evidence on which to base the opinion, but the auditor concludes that the possible effects on the financial statements of undetected misstatements, if any, could be material but not pervasive.
	* + The auditor should express an adverse opinion when the auditor, having obtained sufficient appropriate audit evidence, concludes that misstatements, individually or in the aggregate, are both material and pervasive to the financial statements.
		+ The auditor should disclaim an opinion when the auditor is unable to obtain sufficient appropriate audit evidence on which to base the opinion, and the auditor concludes that the possible effects on the financial statements of undetected misstatements, if any, could be both material and pervasive.

Procedures

* If a modified opinion is issued, the analyst should document the reasons for the modification and assess the impact of the modification on the insurer’s financial position and prospective solvency.
* In addition to reviewing and assessing the opinion, the analyst should also determine whether total assets, net income, and surplus per the Audited Financial Report agree with the amounts per the insurer’s Annual Financial Statement.
	+ If differences exist, the independent CPA is required to include in the Notes to Financial Statements a reconciliation of the differences between the Audited Financial Report and the Annual Financial Statement along with a written description of the nature of these differences.
	+ If differences are identified, the analyst should document these differences and the reasons for the differences based on a review of the independent CPA’s reconciliation in the Notes to Financial Statements.
	+ The analyst should also consider the impact of the audit adjustments made by the independent CPA on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (i.e., complete additional procedures for items impacted by the audit adjustments) on the Annual Financial Statement information.

Additional Review Considerations

* If further concerns exist, the analyst should consider performing one or more of the following procedures:
* Obtain and review a copy of the signed management representation letter, which acknowledges that management is responsible for the presentation of the financial statements and has considered all uncorrected misstatements and concluded that any uncorrected misstatements are immaterial. The analyst should review the entire management representation letter to determine whether there are representations that would impact the insurer’s solvency.
* Obtain and review all recorded and unrecorded audit adjustments along with supporting documentation regarding the adjustments or explanations from the external auditor. The analyst may use the information regarding audit adjustments to identify risk or internal control weaknesses to determine what the impact of significant audit adjustments might be on the insurer’s solvency.
* Obtain and review the internal control-related matters presentation materials, including the Management Letter, prepared by the external auditor for the audit committee’s review. Note the external auditor is required to provide written communication to the audit committee of all significant deficiencies or material weaknesses known. The comments from the external auditors may be used as guidance as to areas that may require additional investigation and the analyst’s view of this documentation.
* Obtain and review any other audit work papers deemed appropriate or necessary (e.g., Statement on Auditing Standards (SAS) No. 99 Consideration of Fraud in a Financial Statement Audit). This documentation should impact the analysts’ consideration of risk inherent within the entity and impact the overall risk assessment and analysis procedures completed by the analyst. Further, obtain copies of all legal letters and determine the status of all pending litigation and the impact that potential settlements might have on the insurer’s solvency.

**CPA Letter of Qualifications** – The analyst should perform procedures in this area whenever there has been a change in the independent CPA from the prior year, although it may be completed annually whether or not there has been a change in independent CPA. The analyst should determine if the independent CPA furnished to the insurer, in connection with and for inclusion in the filing of the Audited Financial Report, a Letter of Qualifications which includes all of the statements listed in the procedure.

Procedures

* If any of the statements are missing from the letter, the analyst should contact the CPA firm to discuss and address.
* In addition, the analyst should determine whether the CPA retained for review by the domiciliary state insurance department all audit work papers prepared during the audit, unadjusted journal entries, letter of representation, management’s letter and any communications between the CPA and the insurer related to the audit.

**Change in CPA** – The insurer is required to notify the domiciliary state insurance department within five business days when the insurer’s independent CPA is dismissed or resigns. The insurer is also required to furnish a separate letter within 10 business days of the previous notification stating whether, in the 24 months preceding such event, there were any disagreements with the former independent CPA on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, and which disagreements, if not resolved to the satisfaction of the former independent CPA, would have caused the CPA to make reference to the disagreement in connection with the opinion. In addition, the insurer is further required to furnish a letter from the former independent CPA stating whether the independent CPA agrees with the statements contained in the insurer’s letter and, if not, stating the reasons for which he or she does not agree.

Procedure

* The analyst should determine whether the CPA who issued an opinion on the insurer’s financial statements in the current period is the same CPA who issued the opinion in the prior year. If not, the analyst should determine whether all required reports were filed with the state insurance department as outlined above and assess the impact of the change in CPA on the insurer.

Reports on Internal Controls – In addition to the Audited Financial Report, insurers are required to furnish the domiciliary state insurance department with a written Management’s Report of Internal Control Over Financial Reporting by the independent CPA describing material weaknesses in the insurer’s internal control structure as noted by the independent CPA during the audit, if applicable. Such a report is required regardless of whether material weaknesses have been identified. In those instances where material weaknesses are noted, the insurer is also required to provide a description of remedial actions taken or proposed to correct the material weaknesses if such actions are not described in the CPA’s report.

Effective for audits as of December 31, 2021, and thereafter, the NAIC’s Model Audit Rule Implementation Guide requests that the name of the current lead audit partner and the year at which he or she began serving in that capacity be included in the internal control report, so it can be provided to regulators but kept confidential. Such information may be useful in verifying compliance with audit partner qualification and rotation requirements.

Management of insurance companies with more than $500 million in direct and assumed premiums are also required to file with the state insurance department an assessment of internal control over financial reporting. This report states whether or not management is confident the internal controls are effective in providing accurate statutory financial statements.

Procedures

* If material weaknesses are identified or management cannot attest to effective internal controls over financial reporting, the analyst should consider performing additional procedures as highlighted in the worksheet.
* The analyst should consider the financial impact of any corrective actions the insurer is undertaking to correct those weaknesses.

Additional Review Considerations

* Upon review of the Audited Financial Report and Management’s Report of Internal Control Over Financial Reporting, if material risks were noted or weaknesses in internal controls were reported, identify what corrective actions are planned to resolve the issues.
* Inquire of the insurer:
	+ Letter of Representation
	+ Schedule of all recorded and unrecorded audit adjustments
	+ Internal control related presentation materials including Management’s Comment Letter
	+ Any other audit work papers deemed appropriate or necessary (i.e., Statement of Auditing Standards (SAS) 99 Fraud and Legal Representations Letters)
	+ If internal control weaknesses are noted and no corrective action plan is proposed, contact the insurer and request detailed information regarding the insurer’s remediation and corrective action plan to resolve the weaknesses.

# Additional Procedures Applicable to Legal Risk

**Examination Findings**

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

**Inquire of the Insurer**

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

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

* **Policies and Strategies for Compliance with State, Federal and International Laws and Regulations:**
	+ Information on how the legal/compliance function ensures compliance with relevant laws and regulations
* **News, Press Releases and Industry Reports:**
	+ The financial impact of any legal issues on the insurer and/or group’s operations and surplus
	+ Disclosures of financial impact to the public and agent distribution force
	+ The insurer’s efforts to mitigate any impact of the risk. For ORSA filers, this may be identified in the ORSA Summary Report for certain risks.
	+ Policies and procedures in place to mitigate adverse publicity
	+ Revised business plan
* **Legal Risk Assessment by Management:**
	+ How the insurer assesses its legal risk and reports it to senior management
	+ The involvement of legal counsel in changes to existing products and development of new products
	+ The degree to which compliance programs are utilized to control, monitor and report legal risk

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

If the insurer is required to file ORSA or part of a group that is required to file ORSA, determine whether the ORSA Summary Report analysis conducted by the lead state indicated any of the following:

* Legal risks that require further monitoring or follow-up
* Mitigating strategies for existing or prospective legal risks

**Holding Company Analysis**

Determine whether the Holding Company analysis conducted by the lead state indicated any of the following:

* Legal risks impacting the insurer that require further monitoring or follow-up
* Mitigating strategies for existing or prospective legal risks impacting the insurer

# Quarterly Legal Risk Assessment

The quarterly legal risk procedures are designed to identify the following.

**Market Conduct Examination/Material Findings**

Determine if concerns exist regarding Market Conduct, including complaints, market conduct actions, communication with market conduct staff, etc., that could have an impact on financial position and prospective solvency. If concerns exist, communicate risks/issues to the state insurance department’s Market Conduct Unit to investigate further. For example, large fines levied by states, suspensions or revocations of licenses, market conduct exam settlements (whether financial or other), or other regulatory actions taken based on market conduct violations may have a material impact on the financial solvency of the insurer. Additionally, if a recently concluded market conduct examination resulted in regulatory requirement to perform remediation (E.g., reprocessing denied claims) the financial impact may be material to the insurer.

Procedures/Data

* Review any market conduct information available from the NAIC market analysis tools available on iSite+ (Market Analysis Profile (MAP), Examination Tracking System (ETS), Market Analysis Review System (MARS), Regulatory Information Retrieval System (RIRS), Special Activities Database (SAD), Market Initiative Tracking System (MITS), Market Conduct Annual Statement (MCAS) and the Complaints database). Note any unusual items or negative trends for the following items that translate into financial risks or indicate further review is needed:
	+ Count of Regulatory Actions
	+ Aggregate of Regulatory Fines
	+ Market Conduct Examination Called or Concluded
* In reviewing the items disclosed in the Market Conduct Examination and other Market Conduct findings, the analyst should assess their potential impact on the insurer’s financial condition and prospective solvency by placing and discussing risk information within the appropriate branded risk classification, if not a legal matter.

Additional Procedures

* Review any market conduct information, including information available from the state’s market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee). Note any unusual items that translate into financial risks or indicate further review is needed.
* Review any inter-departmental communication, as well as communication with other state, federal or international insurance regulators and the insurer. Note any unusual items or prospective risks that indicate further analysis or follow-up is necessary.
* If market conduct information is unusual and indicates potential financial risks, analysts can perform the following procedures:
	+ Describe and document the findings of the most recent market conduct examination and analysis and communication with the insurance department’s market conduct staff.
	+ Describe any current or future actions of the insurance department, other state insurance departments or other regulatory bodies against the insurer related to market conduct violations.
	+ Describe the actual or projected financial impact of any settlements, fines, or remediation to operations and surplus.
* Determine if the insurer has met state statutes and regulations regarding timely payment of claims.

**High Litigation, Legal and Government Expenses**

Identify and evaluate risks related to expenses paid for litigation, other legal issues and/or government lobbying. Determine if the insurer has reported high legal, litigation or government expenses that are material to overall operating expenses.

Procedures

* Review the Quarterly Financial Statement including the Notes to Financial Statements, and Examination findings and follow-up monitoring to determine whether any legal concerns were identified.
* Upon review of the Notes to Financial Statements, determine whether the insurer was a party to any significant litigation not in the normal course of business. If so, review and understand a description of the litigation and any contingent liabilities for accrued legal expenses.

**Material Fraudulent Activity/Investigation Results**

Identify and evaluate the materiality of any fraudulent activity and the impact on the financial position and prospective solvency of the company. If fraud, allegations of fraud or ongoing investigations are identified, the analyst is encouraged to document his/her understanding and assessment of the ongoing issues and to contact the company regarding its plans to address the situation.

Procedures

* Review the Quarterly Financial Statement, including the Notes to Financial Statements, Examination findings (i.e., Exhibit G – Consideration of Fraud) to identify if any fraud concerns were disclosed.
* Contact the state insurance department’s Fraud Unit (if applicable) to see if the state insurance department has concluded any fraud investigations involving the insurer? If so, identify the following:
	+ Nature and scope of the investigation and its findings
	+ Regulatory and/or corrective actions required of the insurer
	+ Insurer’s plan to address the fraudulent activity
	+ Financial impact of the investigation and corrective actions
* Review news/media reports, information from the insurer or other information available to the analyst that may indicate the insurer is under investigation by any regulatory body other than the state insurance department. If so, identify the nature and scope of the investigation and impact on the insurer to determine whether further information should be requested from the other regulatory body.
* Review Regulatory Actions (through RIRS) to identify whether any regulatory actions taken by other states were identified as fraud. If so, and if not communicated to the state insurance department, contact the reporting state insurance department to obtain information regarding the regulatory action.
* Contact other regulatory agencies that have regulatory authority over the business of the insurer (e.g., federal agencies where the insurer is engaged in government contracts) to identify whether any regulatory authorities have concluded any fraud investigations involving the insurer, its management or board of directors. If so, request the following information:
	+ Nature and scope of the investigation and its findings
	+ Regulatory and/or corrective actions required of the insurer
	+ Insurer’s plan to address fraudulent activity
	+ Financial impact of the investigation and corrective actions
* If the above analysis indicates concerns related to current or prior fraud, inquire of the insurer regarding its internal processes and controls for preventing fraud.

**Failure to Comply with Code of Ethics Standards**

Identify and evaluate risks related to the insurer’s compliance with code of ethics standards. If concerns regarding an insurer’s failure to implement or abide by a code of ethics are identified, the analyst should correspond with the company to address these concerns and/or identify other compensating controls in place.

Procedures/Data

* Review the following and identify any concerns with the insurer’s compliance with the code of ethics.
	+ General Interrogatories, Part 1, #9.1 to identify if senior officers are subject to code of ethics standards.
	+ General Interrogatories, Part 1, #9.2 to identify if the code of ethics has been amended.
	+ General Interrogatories, Part 1, #9.3 to identify if the code of ethics has been waived.

Additional Procedures

* Review the Corporate Governance Annual Disclosure (CGAD) and identify any concerns.
	+ If the CGAD is filed on an insurance entity bases, verify that the information provided in the CGAD filing on ethics policies does not conflict with the information reported in the General Interrogatories.
	+ If the CGAD is filed on a group basis, rely on the information provided in the GPS for group risks or provided by the lead state if risks apply to the insurance entity and verify that the information does not conflict with the information reported in the General Interrogatories.

**Failure to Comply with State Laws and Reporting**

Assess the insurer’s compliance with NAIC reporting practices, internal policy, laws, regulations and prescribed practices. The analyst should determine whether there are any legal or regulatory impediments that could affect the insurer’s operations or result in a significant legal liability. If a compliance violation is found, the analyst should specify the violation and the impact.

Procedures/Data

* Review General Interrogatories, Part 1, #7.1 and #7.2 and identify if any certificates of authority, licenses or registrations have been suspended or revoked.

Additional Procedures

* Identify if the insurer is compliant with state statutes and regulations, including those that are new or revised (e.g., hazardous financial condition analysis, investment limitation analysis, etc.).
* Assess whether surplus meets the statutory minimum amount required by state law (varies by state and business type).
* Review the Notes to Financial Statements, Note #1 and the iSite+ Validation Exceptions tool and determine whether the insurer reported significant corrections of errors, validation errors, or other accounting and reporting changes that indicate possible concerns regarding the accuracy of the financial reporting. Potential missing data, data that does not conform with standards, or any crosscheck errors could materially impact the outcome of an analysis and corrective measures may need be taken by the insurer prior to proceeding with an analysis.
	+ Determine whether the insurer is in compliance with permitted or prescribed practices as reported in Note #1.
* If the insurer failed to comply with the state’s statutes and regulations enacted during the period, identify the following and complete a detailed written explanation of the violation to ensure proper documentation should non-compliance issues recur:
	+ Nature of the non-compliance
	+ Impact to the insurer’s financial position and reporting
	+ Outcome of any department communication with the insurer regarding the non-compliance issues
	+ Resolution of any non-compliance issues or resolution plans of the insurer
* If the insurer had any certificates of authority, licenses, or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period, identify the following:
	+ Nature of the suspension or revocation
	+ Reason(s) stated for the revocation or suspension
	+ Outcome of any department communication with the insurer and/or with the other regulatory authority who issued the revocation or suspension
	+ Resolution of any non-compliance issues or resolution plans of the insurer
* If the insurer has been issued any consent orders or agreements by other regulators/jurisdiction, identify or perform the following:
	+ Request a copy of the consent order or agreement from the other regulator/jurisdiction
	+ Reason(s) stated for the consent order or agreement
	+ Outcome of any department communication with the insurer and/or with the other regulatory authority
	+ Resolution of any non-compliance issues or plans of the insurer

**Failure to Comply with State Investment Laws**

Assess the insurer’s compliance with the state’s investment laws.

Procedures

* Using your state’s investment compliance checklist, determine whether the insurer’s investment portfolio is in compliance with the investment limitations and diversification requirements per the state’s insurance laws.
* Determine whether the insurer is reporting its investments (including the related income and expenses) in accordance with NAIC practices, internal policy, Statutory Accounting Principles and the filing requirements set forth in the Purposes and Procedures Manual of the NAIC SVO.
* Determine whether affiliated investments are in violation of state statutes. If so, gain an understanding of the primary business activity of the affiliate and why such an investment does not comply with regulatory requirements.
* If analysis of investment compliance indicates concerns or a pattern of non-compliance, review the most recent examination file for investment compliance and inquire of the insurer about its internal processes and controls for compliance with state investment laws.

**Failure to Comply with Affiliated Management and Service Agreements**

Assess the insurer’s compliance with affiliated management and service agreements.

Procedures/Data

* Review General Interrogatories, Part 1, #1.1 to determine whether the insurer experienced any material transactions requiring the filing of Disclosure of Material Transactions with the state of domicile as required by the Model Act. If so, determine whether the insurer made the appropriate filing of a Disclosure of Material Transactions with the state of domicile.

Additional Procedures

* Determine whether management and service agreements between affiliates either submitted and/or approved are in conformity with regulatory requirements and verify that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.
* Determine whether the amount of the shareholder dividend was at a level that required prior regulatory approval or notification. If so, determine whether the insurer obtained proper prior regulatory approvals.

**Failure to Comply with Transactions Involving Other Jurisdictions**

 Assess the insurer’s compliance with transactions involving other jurisdictions.

Procedures

* If the insurer redomesticated to your state, determine whether the insurer failed to comply with any regulatory requirements or stipulations placed on the insurer that were expected to be met subsequent to approval of the redomestication and identify any legal implications that represent risk to the insurer due to the redomestication.
* If the insurer engaged in a transaction(s) to redomesticate a subsidiary offshore, determine whether the insurer failed to comply with any regulatory requirements or stipulations placed on the insurer that were expected to be met subsequent to approval of the redomestication and identify any legal implications that represent risk to the insurer due to the redomestication.
* If the insurer engaged in any transactions to acquire a subsidiary domiciled in a non-U.S. jurisdiction, determine whether the insurer failed to comply with any regulatory requirements or stipulations expected to be met subsequent to the acquisition and identify any legal implications that represent risk to the insurer due to the acquisition.

**Failure to Comply with Federal Regulatory Agencies**

Identify and assess compliance with other federal regulatory agencies. In addition to the HHS and the CMS oversight of health insurance, insurers may be subject to regulation by the Federal Reserve, U.S. Securities and Exchange Commission (SEC), U.S. Department of the Treasury and other federal regulatory bodies depending upon the nature, scope and extent of the insurer’s or insurance group’s activities.

Procedures

* Review General Interrogatories, Part 1, #8 and determine whether the insurer is subject to regulation by a federal regulatory agency. If so, consider contacting the applicable federal regulatory agency to request any information about the results of that agency’s oversight, including any issues identified, federal compliance violations, fraud investigations and regulatory actions.