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

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

Analysts’ risk-focused assessment of operational risk should take into consideration the following areas (but not be limited to):

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

# GENERAL GUIDANCE

To assess operational risk, consider the procedures, data elements, metrics and benchmarks in this chapter.

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



**Poor (or Declining) Operating Performance For P/C Insurers**

Determine whether concerns exist regarding the insurer’s operating performance.

In evaluating the insurer’s operating performance, analyze the combined ratio as a key indicator of underwriting profitability. Identify and assess potential concerns such as elevated losses, decreased premiums, or increased underwriting expenses. Delve into the underlying causes of these issues to gain deeper insights. High commission and expense ratios may indicate a high expense structure that may make it difficult for the insurer to attract new business, compete with other insurers and fulfill its strategic plan.

While the combined ratio solely focuses on underwriting performance, the two-year overall operating ratio (Insurance Regulatory Information System (IRIS) ratio #5) and return on surplus offer a broader perspective on overall profitability. The two-year operating ratio reflects the insurer’s financial performance relative to underwriting and investment activities over a two-year period. Conversely, return on surplus measurers net income and unrealized gains (losses) as a percentage of two-year average surplus.

In addition to analyzing the current year results, analysts should also examine trends in these metrics over the past five years. Continued trends in expense ratio, combined ratio and overall profitability may indicate ongoing solvency risks. Additionally, benchmarking certain metrics against industry averages can highlight outliers and potential areas of concern.

Procedures/Data

* Analyze the current year’s performance, changes from the prior year and trends over past five years in the following metrics to assess the insurer’s operating performance:
  + Combined ratio
  + Loss ratio (direct, assumed, gross, ceded, and net)
  + Expense ratio
  + Commissions and brokerage ratios
  + Change in individual income and expense line items (i.e., net premium earned, inclured losses and loss adjustment expenses, expenses and commissions)
  + Net income
  + Return on surplus ratio
  + Two-year operating ratio (IRIS #5)
  + Ratio of other income to net income, when the absolute value of other income is material to surplus

Additional Review Considerations

* Compare the entity’s actual results against projections. Determine any variances and request additional information for those areas where unfavorable variances exist. If material differences exist, request updated projections based on revised assumptions.
* Compare the metrics and data above for operating performance to industry averages to determine any significant deviations.
* Review the components of other income in the Annual Financial Statement, Statement of Income, including write-ins for miscellaneous income, for reasonableness.
* Describe any known trends that have had or that the insurer reasonably expects will have a material favorable or unfavorable impact on net revenues or net income. If the insurer knows of events that will cause a material change in the relationship between benefits, losses, and expenses, the change in the relationship should be disclosed.
* Review the Annual Statement Blank, Insurance Expense Exhibit (IEE), to identify any expense allocation concerns or unusual operating results by line of business. The (IEE) is a supplemental P/C schedule filed by April 1. The IEE includes an interrogatories section and three major parts. Part I shows, for each expense line item included in the Annual Financial Statement, the allocation to five expense groups: 1) loss adjustment expense; 2) acquisition, field supervision, and collection expenses; 3) general expenses; 4) taxes, licenses and fees; and 5) investment expenses. Part II shows major categories of expenses and the allocation to each line of business. Part III is similar to Part II except that premiums are reflected on a direct basis. While the IEE is not a primary source of information for solvency analysis, it does provide meaningful information for evaluating an insurer’s operations and overall profitability. In addition, the IEE may be used in the rate-making process or for evaluating an insurer’s performance by line of business.
  + Investigate unusual items, especially situations where expenses were allocated to lines of business using methods not defined in the Annual Statement Instructions. The Annual Statement Instructions are included in the Supplements section and additional guidance in this regard is included in the *Financial Condition Examiners Handbook*.
* Review IEE, Part 1:
  + Investigate significant fluctuations in expenses by expense groups between years
  + Compare expenses by expense group for the insurer with the industry averages
* Review the IEE , Part II and Part III:
  + Investigate significant fluctuations in expenses by lines of business between years
  + Compare expenses by line of business with industry averages
  + Determine whether the totals agree with financial statement line items included in the Annual Financial Statement
* Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses.
* Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations.
* In conjunction with review of reinsurance program(s) (within Strategic Risk), consider the impact of reinsurance program(s) on the insurer’s operating performance. This could include assessing whether there are any risk limiting features or insufficient ceding commission rates that could be a significant additional drain on operating earnings when insurers utilize reinsurance for RBC or premium leverage considerations.

**Poor (Or Declining) Operating Performance for Life/A&H Insurers**

Determining whether concerns exist regarding the insurer’s Summary of Operations or operating performance.

One of the most common measures of overall profitability and operating performance for an A&H insurer is the IRIS ratio of net income to total income (including realized capital gains and losses). Six principal factors affect the insurer’s net gain, as reflected in this ratio: 1) mortality and morbidity experience; 2) adequacy of investment income; 3) commissions and expenses; 4) reinsurance transactions; 5) the relationship of statutory reserve requirements to prevailing interest and mortality rates; and 6) realized capital gains and losses. This ratio is an indicator of the insurer’s overall profitability and operating performance without consideration of realized gains and losses. Another important measure of the insurer’s operating performance is the return on capital and surplus, which considers net income as a percentage of capital and surplus. All of these metrics are intended to assist analysts in determining whether the operating performance and profitability of the insurer may represent a current or prospective operating risk to be evaluated and assessed.

Additional steps may include reviewing the summary of the individual income and expense items for the past five years for unusual fluctuations or trends between years. In addition, analysts might compare the ratio of return on capital and surplus to industry average results to determine any significant deviation from the industry average. By reviewing the Analysis of Operations by Lines of Business in the Annual Financial Statement, analysts could determine which lines of business had significant surrender activity during the year, which lines of business were profitable, and which lines of business generated a loss, and whether commissions and expenses on any lines of business appear excessive, based on the volume of premiums and deposit-type funds. If the ratio of commissions and expenses to premiums appears high or if the ratio of investment yield appears unusual, analysts should consider: 1) reviewing these ratio results for the past five years for unusual fluctuations or trends between years; and 2) comparing the ratio results to industry averages to determine any significant deviations from the industry averages. If write-ins for miscellaneous income or deductions are significant, analysts should consider reviewing the individual components of these amounts for reasonableness.

Procedures/Data

Determine whether concerns exist regarding the insurer’s income statement or operating performance.

* Review the net income/(loss) and related ratios:
  + Net Loss in the current year, or in two or more of the past three years.
  + Change in net income/(loss) if the value of net income is material to capital and surplus.
  + Ratio of net income to total income (including realized capital gains and losses) (IRIS Ratio 3).
  + Ratio of net gain from operations (before realized capital gains and losses) to total income.
* Ratio of return on capital and surplus.
* Ratio of commissions and administrative expenses to gross premiums for non-life insurers, and five-year trend.
* Accident and health (A&H) loss ratio, and 5-year trend.
* Ratio of aggregate write-ins for miscellaneous income to net income when aggregate write-ins for miscellaneous income is material to capital and surplus.
* Ratio of aggregate write-ins for deductions to net income when aggregate write-ins for deductions are material to capital and surplus.
* Change in material individual income and expense categories, and five-year trend.
* Compare the following measures of operating performance to the industry average to determine any significant deviations:
  + Return on capital and surplus ratio
  + Commissions and administrative expenses to premiums ratio
* Review the lines of business information from the Analysis of Operations by Lines of Business and determine:
  + Income/(Loss) by lines of business in the current year, or negative trend in profitability over the past five years.
  + Whether commissions and expenses on any lines of business appear excessive based on the volume of premiums.

Additional Review Considerations

* Compare the entity’s actual results against projections. Determine any variances and request additional information for those areas where unfavorable variances exist. If material differences exist, request updated projections based on revised assumptions.
* Describe any known trends that have had (or that the insurer reasonably expects will have) a material impact on the net revenues or net income, or a material impact on the relationship between benefits, losses, and expenses.
* Review the components of the aggregate write-ins for miscellaneous income and aggregate write-ins for deductions for reasonableness.
* If concerns exist regarding operating performance, consider the following procedures:
  + Review Exhibit 2 – General Expenses to identify concerns or unusual items to identify any expense allocation concerns or unusual operating results by line of business to assist in identifying areas for follow-up and investigation with the insurer.
  + Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses.
  + Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations.
* Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses. This procedure can assist analysts in further understanding the cause of poor operating performance and assess whether it is likely to continue going forward.
* Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations. This procedure can assist analysts in evaluating the insurer’s plans and mitigation strategies for addressing the poor operating performance.
* If the insurer writes Medicare Part D business, obtain and review supporting documents if concerns are identified related to the operating performance of Medicare Part D business. Supporting documents may include information on contracted benefits, premium and cost sharing with the CMS, and support for reserve, utilization and benefit cost assumptions projected in the development of the contract.

**Poor (or Declining) Operating Performance for Health Insurers**

Determine whether concerns exist regarding the insurer’s Statement of Revenue and Expenses or operating performance.

Each of the ratios provided in this procedure is designed to provide analysts with an overall assessment of the health entity’s profitability. The profit margins in the health insurance industry have traditionally been fairly low. As a result, the threshold for this ratio is established at less than 0% or greater than 10%. A profit margin ratio less than 0% indicates the health entity has experienced a net loss and operating problems may exist. With continued losses, the health entity’s capital cushion to support the business is likely to be diminished. Conversely, a profit margin greater than 10% is unusual in the health insurance industry and should be investigated.

Another ratio that provides an assessment of a health entity’s profitability is the combined ratio. The threshold for the combined ratio is set at greater than 100%. A health entity with a combined ratio of 100% should have investment income for profit. The combined ratio consists of the medical loss and the administrative expense ratios. The administrative expense ratio includes administrative expenses as well as claims adjustment expenses. Claims adjustment expenses are the costs incurred relating to reported and unreported claims and are considered to be administrative in nature. The threshold for the medical loss ratio is set at greater than 85% and the administrative expense ratio is set at greater than 15%. These thresholds are based upon a typical relationship between the combined, medical loss, and administrative expense ratios. Some health entities may have a higher medical loss ratio but a lower administrative expense ratio. Some view this relationship as positive because more benefits are provided to the consumer. Other health entities may have a lower medical loss ratio and a higher administrative expense ratio. In some cases, this relationship may be positive because sometimes this is indicative of a health entity with lower operating leverage. Also, the medical loss ratio measures the direct cost of business as related to premiums earned and should have a consistent trend, while the administrative expense ratio which measures indirect expenses as related to premiums earned should decrease as the company becomes more efficient over a period of time. Typically, premium increases are driven by claim cost trends that exceed general inflation, which drives administrative costs. On the other hand, in situations where general inflation is less than medical cost trends, administrative cost ratios may actually increase since administrative trends will be higher than premium trends. As previously mentioned, analysts should also be familiar with the health entity’s primary lines of business in order to evaluate their operating performance. This includes lines with business risk (ASO/ASC) but no underwriting risk, which report fees as a reduction of expenses, instead of as premium.

In addition to providing information on the current year’s operating performance, this procedure also provides information on changes from the prior year. As previously mentioned an increase in a health entity’s medical loss ratio may indicate a loss of control in the health entity’s underwriting or pricing processes. An increase in the administrative expense ratio may indicate escalating costs or an expense structure that no longer supports the health entity’s premium volume. Changes may also be the result of a change in the health entity’s business mix. As previously mentioned, a health entity’s entrance into new lines of business or sales regions might result in financial problems if the health entity does not have expertise in these new lines of business or regions. All of these items should be further investigated to further assess the risk to the health entity.

All of these metrics are intended to assist analysts in determining whether the operating performance and profitability of the insurer may represent a current or prospective operating risk to be evaluated and assessed. In addition, analysts are encouraged to review data and metrics provided and presented in the Annual Financial Profile Report over a five-year period to identify trends and areas of concern. Analysts are also encouraged to compare results in certain areas against industry averages to identify outliers and areas of concern. Finally, review the Analysis of Operations by Line of Business and the Statement of Revenues and Expenses line item aggregate write-ins to understand results, recognize trends and identify items for follow-up with the insurer.

Procedures/Data

Determine whether concerns exist regarding the insurer’s income statement or operating performance.

* Net income (loss)
  + Current year net loss
  + Change in net income when net income is material to surplus
  + Net loss in two or more of the past five years
* Review the components of the Statement of Revenues and Expenses line item aggregate write-ins for other health care related revenues, other income or expenses for reasonableness.
* Profit margin ratio, change from the prior year and, or negative trend over the past five years.
* Return on capital and surplus ratio
* Combined ratio, change from the prior year and, negative trend over the past five years
* Medical loss ratio, change from the prior year and, negative trend over the past five years
* Administrative expense ratio, change from the prior year and, negative trend over the past five years
* Combined ratio for any line of business
* Determine if combined, medical loss, and administrative expense ratios appear reasonable.
* Losses incurred from ASO/ASC plans [Annual Financial Statement, Notes to Financial Statements, Note #18]
* Review the five-year trend with the Annual Financial Profile Report for the following measures of operating performance, and note any unusual fluctuations or trends between years for each ratio:
* Ratios by line of business
* Change in material individual income and expense categories
* Review the Analysis of Operations by Line of Business to determine which lines of business generated a loss.
* Compare the following measures of operating performance to the industry average to determine any significant deviations
  + Combined ratio
  + Return on capital and surplus

Additional Review Considerations

* Compare the insurer’s actual results against projections. Determine any variances and request additional information for those areas where unfavorable variances exist. If material differences exist, request updated projections based on revised assumptions.
* Describe any known trends that have had or that the insurer reasonably expects will have a material favorable or unfavorable impact on net revenues or net income or a material impact on the relationship between benefits, losses and expenses.
  + Consider if the insurer is dependent upon investment income.
  + If the insurer knows of events that will cause a material change in the relationship between benefits, losses, and expenses, the change in relationship should be disclosed.
* Review the Supplemental Health Care Exhibit (SHCE) to identify concerns or unusual items for further analysis. This procedure can help analysts determine what specific areas of operations or lines of business may be the source of poor operating performance.
  + Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses. This procedure can assist analysts in understanding the cause of poor operating performance and assess whether it is likely to continue going forward.
  + Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations. This procedure can assist analysts in evaluating the insurer’s plans and mitigation strategies for addressing the poor operating performance.
* If the insurer writes Medicare Part D business, obtain and review supporting documents if concerns are identified related to the operating performance of Medicare Part D business. Supporting documents may include information on contracted benefits, premium and cost sharing with the CMS, and support for reserve, utilization and benefit cost assumptions projected in the development of the contract.

**Lack of Effective Corporate Governance/Oversight of Operations**



The lack of an effective governance function to oversee operations may make it difficult for the insurer to fulfill its strategic plan and achieve desired outcomes.

Procedures

Determine whether corporate governance practices of the insurer provide effective oversight of operations.

* + Review the Corporate Governance Annual Disclosure (CGAD) filing (if filed on an insurance entity basis) to identify and assess the governance practices in place at the insurer. If the CGAD is filed on a group basis, rely on the information provided in the GPS or provided by the lead state if material risks are only relevant to specific insurance entities.
    - Identify and follow up on any issues noted that could affect the insurer’s ability to adequately oversee operations.
* If your state is the lead state, document information and risks from the CGAD in the Group Profile Summary (GPS) (Refer to the procedures in chapter VI.D. Corporate Governance Disclosure Procedures of the Handbook.)
  + Identify and follow up on any issues noted that could affect the group’s ability to adequately oversee operations.
  + If material risk relates only to an insurance entity, contact the domestic state in a timely manner.
  + If your state is not the lead state and the CGAD is filed to the lead state, review the corporate governance assessment included in the lead state’s GPS and contact the lead state with any questions, concerns or follow-ups. Upon the receipt of any additional information, the non-lead state should document any material concerns regarding corporate governance that could impact the financial condition (e.g., operations, policyholder surplus or capital position) of the domestic insurer.
  + Review the results of the corporate governance assessment conducted during the last on-site examination, other examination documentation or summaries, communication with the examiner-in-charge, or the most recent communication with the insurer, to identify issues or concerns to be considered or addressed.
  + If concerns are identified, request a copy of recent board minutes to determine if the board of directors has taken any significant actions that may result in changes in operations, business structure, or management that may result in a material financial impact on the insurer.
* Consider reviewing internal resources on file related to the following, and if not on file, request the following information from the insurer:
  + For the board of directors and each committee established by the board of directors request a copy of the charter/policy, the business ethic policy, code of conduct policy, and conflict of interest policy
  + The most recent conflict of interest statement, or its equivalent, for each member of the board of directors and committees established by the board of directors including an explanation of any conflicts reported
  + Financial expertise or statutory accounting principles expertise of the audit committee
  + Reporting structure of the internal audit function
  + Copy of the company’s by-laws currently in effect
  + If part of a holding company system, discussion on the level of oversight the parent company maintains over the insurer
  + Discussion of compliance with corporate governance statutes
  + Discussion of compensation policies, bonus/incentive programs, and management performance and assessment programs
  + Discussion of the board of directors’ and management’s responsibilities and authority
  + Contact the insurer regarding actions taken to address the concerns identified.
  + Based on the above procedures, determine if the board of directors and management provide a sufficient level of oversight and support.

**Risks of Change in Operations/Turnover in Key Board or Sr. Management Positions**

Evaluate the effects of changes in officers or directors on the operations of the insurer. A significant change in operations resulting from turnover or changes in key board of directors and/or senior management positions may increase operational risk and should be evaluated for their potential impact on the current and prospective solvency of the insurer.

Procedures

* + Review any changes in officers, directors or trustees and any concerns noted during a review of biographical affidavits to assess suitability. Determine if:
    - new directors and officers have the required knowledge, experience and training to perform their duties. Document any concerns.
    - new board of directors’ members sufficiently independent from management and adequately engaged in performing their duties.
    - there has been significant turnover in management in the current year or a pattern of turnover in the past five years. If so, document the reasons.
    - new directors and officers have ever been officers, directors, trustees, key employees or controlling stockholders of an insurance company that, while they occupied any such position or served in any such capacity with respect to it:
      * Been placed in supervision, conservation, rehabilitation, or liquidation.
      * Been enjoined from, or ordered to cease and desist from, violating any securities or insurance law regulation.
      * Suffered the suspension or revocation of their certificate of authority or license to do business in any state.
  + If so, request and review the insurer’s policies and procedures regarding performance of background checks on new management.
* If a significant amount of turnover and/or changes in key positions are identified, gain an understanding and evaluate the impact of such changes on the insurer’s operations.
* Request updated business plans, hold in-person meetings, conduct conference calls, and take other steps to understand and address significant changes.
* Determine if there have been significant operational or business changes that have resulted in significant changes in staffing levels, consolidations of operations with affiliates, outsourcing of key functions, or placing blocks of business into run-off (closed) blocks.
* Review and evaluate the insurer’s human capital and succession planning processes and controls.
  + Evaluate the insurer’s management and personnel to identify directors, executives, or key employees that may be approaching retirement and discuss the steps taken by the company to plan for succession for any individuals identified.
  + Determine whether the insurer is overly reliant on any one individual to produce its business or manage its operations and discuss succession plans for any individuals identified.
  + Describe the insurer’s processes to identify, appoint, train, evaluate, and compensate directors, executives, and key members of personnel.



**Lack of Control over Purchases, Sales, and Investment Operations**

Determine whether concerns exist related to investment operations, including purchases and sales of securities and control of assets. Assets not under the full control of the insurer may not be available to fulfill policyholder obligations. Assets that are not under the insurer's control might not meet the state’s requirements to be considered net admitted assets.

Procedures/Data

* Ratio of payable for securities to total invested assets.
* Ratio of receivable for securities to total invested assets.
* Review Annual Financial Statement, General Interrogatories, Part 1, #16 to determine if the purchase or sale of any investments have not been approved by the board of directors or a subordinate comettee thereof.
* Review the Annual Financial Statement, General Interrogatories, Part 1, #25.01 and #25.02 to determine:
  + if any stocks, bonds and other securities owned, over which the insurer has exclusive control, not in the actual possession of the insurer, other than securities lending programs.
  + the reason the securities are not in the entity’s possession and who holds the securities in order to evaluate whether they qualify as net admitted assets of the entity under the state insurance laws or whether there are concerns regarding the entity’s ability to have access to the securities when needed.
* Review Annual Financial Statement, General Interrogatories, Part 1, #26.1 and #26.21 to determine:
  + if any stocks, bonds or other assets owned by the insurer not exclusively under the control of the insurer.
  + why the assets are not under the entity’s exclusive control (e.g., loaned to others, subject to repurchase or reverse purchase agreements, pledged as collateral, placed under option agreements). .
* Review Annual Financial Statement, General Interrogatories, Part 1, #21.1 and #21.21 to determine
  + if any assets were reported subject to a contractual obligation to transfer to another party without the liability for such obligation being reported.
  + the purpose and the amount.

Additional Review Considerations

* Request a copy of the insurer’s investment plan to determine who is authorized to purchase and sell investments and what approvals are required for investment transactions.

**Questionable Investment Activities**

Analysts should also consider if the insurer’s investment performance or risks in its investment portfolio may be masked due to questionable investment activities (e.g., wash sales, window dressing, etc.).

Procedures

* Review the Annual Financial Statement, Schedule D – Part 3 and Schedule D – Part 5, to determine:
  + if significant amounts of bonds or stocks purchased near the beginning or the end of the year.
  + types of securities purchased and the vendors used for those purchases.
* Review the Annual Financial Statement, Schedule D – Part 4 and Schedule D – Part 5, to determine:
  + if significant amounts of bonds or stocks disposed of near the beginning or the end of the year.
  + types of securities sold and the purchasers of those securities.
* Review Annual Financial Statement, Schedule D – Part 5 to determine
  + if significant amounts of bonds or stocks acquired near the beginning of the year and disposed of near the end of the year
  + types of securities purchased, the vendors used for those purchases and the purchasers of those securities.
* Based on the results of the two previous questions, determine whether the insurer might have engaged in “window dressing” of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring lower quality investments after year-end).

**Concerns with Third-Party Investment Advisors**

Determinewhether any concerns exist regarding third-party investment advisors, associated contractual arrangements, and related party exposure in the investment portfolio. Heavy reliance on unqualified investment advisors or lack of effective oversight may lead to excessive risk taking and increases in fraud and investment reporting risks.

As investments and investment strategies grow in complexity, insurers may consider the use of unaffiliated third-party investment advisers to manage their investment strategy. Investment advisers may operate independently or as part of an investment company. Investment advisers and companies are subject to regulation by the U.S. Securities and Exchange Commission (SEC) and/or by the states in which they operate, generally based on the size of their business. In certain situations insurers may use a broker-dealer for investment advice. Broker dealers are subject to regulation by the Financial Industry Regulatory Authority (FINRA). Regardless, most broker dealers and investment advisers will register with the SEC and annually update a Form ADV-Uniform Application for Investment Adviser Registration and Report Form by Exempt Reporting Advisers which provides extensive information about the nature of the organization’s operations. To locate these forms, analysts can go to [*www.adviserinfo.sec.gov*](http://www.adviserinfo.sec.gov) and perform a search based on the company name.

Key Information provided on a Form ADV includes:

1. Regulatory agencies and states in which the adviser/broker is registered
2. Information about the advisory business including size of operation and types of customers (Item 5)
3. Information about whether the company provides custodial services (Item 9)
4. Information about disciplinary action and/or criminal records (Item 11)
5. A report of the independent public accountant verifying compliance if the investment advisor also acts as custodian

It is important to note that the information provided on Form ADV is self-reported and is subject to limited regulatory oversight. However, the information may be valuable to analysts in assessing the suitability and capability of investment advisers providing advisory services to insurers. Note that t

Procedures

* Review the Annual Financial Statement, General Interrogatories, Part 1, #29.05 to determine if the insurer utilizes third party investment advisors, broker-dealers or individuals acting on behalf of the insurer with access to its investment accounts.
* If yes, consider the following procedures:
  + Verify that all affiliated and unaffiliated investment advisors the analyst is aware of are disclosed in the interrogatory, whether primary or sub-advisors.
    - Verify that Investment Management Agreements required to be filed with the department have been filed and consider requesting copies of agreements that have not been filed with the department for review.
    - Gain an understanding of the types of investments that are being managed by each of the advisors/sub-advisors disclosed in the interrogatory.
  + Review the results of the most recent financial examination work papers, follow-up and prospective risk information and the summary review memorandum provided by the examiners. Determine if the examination identified any issues with regard to investment advisors and associated contractual arrangements that require follow-up analysis or communication with the insurer. If yes, document the follow-up performed.
    - Note:
* Compare Annual Financial Statement, General Interrogatories, Part 1, #29.05 for the current year to the prior year to determine if there have been any changes in advisors that may prospectively impact the insurer’s investment strategy and overall management of the investment portfolio. If yes, consider obtaining:
  + An explanation for the change from the insurer
  + A copy of the new investment advisor agreement and review it for appropriate provisions,
  + Using the information reported in Annual Financial Statement, General Interrogatories, Part 1, #29.05, obtain and review SEC Form ADV (if available), to determine if the investment advisor is in good standing with the SEC. If not, contact the insurer to request an explanation.
    - See additional guidance in V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures for reviewing affiliated investment manager agreements.
* If agreements with third party investment advisors are affiliated, has the appropriate form D-Prior Notice of Transaction been filed and approved by the department? Were any concerns noted or follow-up monitoring recommended?
* Request information from the insurer regarding the background and expertise in any complex or non-traditional assets (such as structured securities, mortgage loans, investment funds) of its investment advisors (in-house and/or contractual) and its analytical systems capabilities. Determine whether the advisors and systems are adequate to allow the entity to continuously monitor its investments.
* If the insurer uses an external asset manager, consider if there are any investments that may represent a potential for conflict. Examples of this are (1) if there are Investments Report on Schedule BA that are funds that are affiliated/related with the asset manager or are managed by that asset manager, (2) Structured Securities in which the asset manager or an affiliate/related party had a role in originating, or (3) direct investments in the asset manager or any of its affiliates/related parties. If the external asset manager qualifies as a related party, utilize guidance provided in the “Related Party Exposure in the Investment Portfolio” section above to assist in this review. Consider the following issues:
* Have any potential conflicts of interest been reviewed and formally approved by the Board or Investment Committee.
* If the investment is appropriate for the insurer’s portfolio and is arm’s-length.
* If the insurer is paying overlapping fees.



**Related Party Exposure in Investment Portfolio**

Determine related party exposure in the investment portfolio and assessi any related market risk.

Related parties are entities that have common interests as a result of ownership, control, affiliation or by contract as definited in *SSAP No. 25—Affiliates and Other Related Parties* (SSAP No. 25). Refer to the *Insurance Holding Company System Model Act* (Model #440) and SSAP No. 25 for a broader definition of "affiliate,” “related party” and “control”.

Related party transactions are subject to abuse because reporting entities may be induced to enter transactions that may not reflect economic realities or may not be fair and reasonable to the reporting entity or its policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny.

Procedures

* Review the Annual Financial Statement investment schedules B, BA, D, DA, DB, DL, and E (Part 2), as disclosed in the column “Investments Involving Related Parties” and Utilize the tools available in iSite+ to identify if the insurer has a material exposure to investments involving related parties, either on an asset category basis or in aggregate, and by the related party designation noted below. All investments involving related parties must include disclosure to ensure full transparency which is located in the column previously noted. It designates investments by the following roles:
  1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.
  2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.
  3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.
  4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.
  5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.
  6. The investment does not involve a related party.
* If a material exposure exists, further assessment of the [credit, market, liquidity] risk may be warranted to assess the credit quality of those investments by reviewing designations, assessing historical default experience, etc. Also consider the extent to which related parties are involved in securitizing or originating business for the insurer, and what differences may exist in how investments involving related parties are valued. If the role of the related party is that of a third-party advisor, factors to consider may include for example, the expertise of the related party advisor, any potential conflicts of interest, and if related parties are originating investments only for the insurer or also to the public, the latter being subject to SEC requirements.
* Review the insurer’s investment policy guidelines and determine whether the related party investments follow the guidelines and are in compliance with regulatory requirements.
* Review whether the fee structure for asset management is fair, reasonable, and appropriately recognized as investment expenses.
* If the related party assets manager also originates/securitizes investments held by the insurer, consider requesting additional information from the insurer to determine the following:
* Whether the assets manager has adequate experienceand knowledge in originating and manging the types of investments;
* Whether the assets manager follows appropriate underwriting practices and applicable regulatory requirements in originating investments; and
* Whether the fee structures embedded in securities (if applicable) are fair, reasonable, and appropriately account for potential dulpication of fees or conflicts of interest.



**Changes in Corporate Structure**

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

Significant changes in corporate structure may materially impact the entity’s future financial condition and generally require prior regulatory approval. Analyze changes in corporate structure in order to understand the motivation for the change. By understanding the corporate structure in which the insurer operates, future problems may be avoided. For example, a common corporate structure involves a holding company whose only significant asset is the stock of the insurance entity. The holding company may have financed the acquisition of the insurer through bank financing or other debt where the debt service by the holding company is completely dependent upon dividends paid by the insurer. This type of corporate structure warrants close attention to ensure that dividends are valid and in compliance with your state’s applicable dividend restrictions, and that any other payments by the insurer to the holding company are legitimate, rather than dividends in disguise. Analysts should also be alert to a corporate structure that includes affiliated brokers or intermediaries that may be recording unusual or significant levels of commissions and fees. When a corporate structure is involved that includes multiple tiers of affiliates where significant levels of surplus are comprised of investments in affiliates, focus on the level of surplus that exists on a consolidated basis.

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

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

Procedures

* Review the Annual Financial Statement, Schedule Y – Part 1 and additional information provided in Form B, for the current and prior year to determine:
  + if there any significant changes to the corporate structure during the year (e.g., acquisitions, divestitures, mergers).
    - If the answer is yes, and the change involved ownership of the insurer or a transaction with an affiliate, determine if the insurer failed to receive proper regulatory approval.
  + if there are any indications that the corporate structure may include a holding company whose primary asset is the stock of an insurance company.
  + if the insurer has an agency or brokerage subsidiary.

**Risks Associated with Significant and Complex Services and Transactions with Affiliates**

Several types of transactions with affiliates are reported in the Annual Financial Statement, Schedule Y – Part 2, and explanatory comments are provided in the Annual Financial Statement, Notes to Financial Statements, #10. In addition, information is made available in Note #13, as well as in holding company filings (Form B and Form D) that are received from insurance holding company systems throughout the year. Refer to all of these sources of information in order to develop an understanding and assessment of the underlying transactions with affiliates.

**Risks of Affiliated Transactions—Economic-Based and In Compliance**

The primary objective in this area is to understand the substance of the transactions and to determine whether the transactions are economic-based and in compliance with regulatory guidelines. Review the extent of transactions with officers and directors to ensure that the transactions are at arm’s length and are not detrimental to the financial condition of the insurer. Significant services and transactions with affiliates can alter financial performance and increase risks related to cost sharing, contingent liabilities, unauthorized dividends, etc.

**Risk of Unauthorized Dividends, or Risks Related to Capital Contributions**

The following briefly describes the key concerns for several of the major transactions with affiliates. For shareholder dividends, the major concern relates to whether the level of dividends is within the regulatory guidelines and whether the dividends should be considered extraordinary, and therefore requires prior regulatory approval.

For capital contributions from the insurer to another affiliate, analysts should determine that such contributions do not substantially impact the financial condition of the insurer.

For non-cash capital contributions to the insurer, analysts should determine that the infusion is recorded at fair value so as to not arbitrarily inflate surplus. In the case of purchases, sales or exchanges of loans, securities, real estate, mortgage loans, or other investments, the concern to analysts is primarily one of valuation. These types of transfers should be at arm’s length and recorded at fair value.

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

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

Procedures/Data

* Review the ratio of management fees paid to affiliates to total expenses incurred. (P/C Annual Financial Statement, Underwriting and Investment Income Exhibit, Part 3), (L/A&H Annual Financial Statement, Exhibit 2 General Expenses, Footnote (a)), or (Health Annual Financial Statement, Underwriting and Investment Exhibit, Part 3).
* Review the Annual Financial Statement, Schedule Y – Part 2, Notes to Financial Statement – Note #10 and Note #13, and additional information provided in Form B and D:
  + Determine whether any unusual items were noted, such as significant new transactions with affiliates or modified intercompany agreements from the prior year or significant increases in transaction amounts.
  + Determine whether the insurer has forwarded to any affiliate funds greater than 15% of the insurer’s surplus.
  + Determine whether affiliated undertakings resulting in a contingent liability to the insurer involve financial exposure greater than 25% of surplus.
  + Review the description of management agreements and service contracts. Determine if an allocation basis involved other than one designed to estimate actual cost.
* Review the Annual Financial Statement, Schedule Y – Part 2 and the Notes to Financial Statements – Note #10 to identify any discrepancies in reporting between the two disclosures.
* Verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved (e.g., Dividends – Note #13 and Structured Settlements – Note #27).
* Did capital contributions from the insurer to another affiliate substantially impact the financial condition of the insurer?
  + Were non-cash capital contributions into the insurer not recorded at fair value?
  + Were purchases, sales, or exchanges of loans, securities, real-estate, mortgage loans, or other investments, not at arms-length or not recorded at fair value?
  + Did any transfer of assets between insurance affiliates impact the risk-based capital calculation?
* **Risk Retention Groups:** Summarize the insurer’s level of reliance on captive managers, TPAs, or MGAs to run its business operations (e.g., underwriting, claims, records, and reporting).
  + If significant reliance exists, describe the services provided, and additional relationships, whether the expense ratio is in line with indstry standards, and whether those parties service other insurers.

Additional Review Considerations

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

* If there is a concern related to the fair value of a transaction with affiliates:
  + Obtain and review an appraisal of the asset transferred.
  + Consider consulting an independent appraiser.
* If the concern involves a management agreement or service contract:
  + Obtain and review the supporting contract and compare against Form D filing previously submitted to the department (if applicable).
  + Determine whether the amounts involved are reasonable approximations of actual costs.
  + Determine whether the actual amounts paid are in agreement with the supporting contact.
  + For any arrangement based on a cost-plus formula or percent of premiums formula, request justification from the insurer for amounts in excess of the actual costs of providing the service.
  + For those services being performed by/for an affiliate and that are also provided by unrelated third-party vendors (e.g., data processing, actuarial, investment management), contact such vendors or review vendor pricing schedules in order to determine the reasonableness of the intercompany transfer pricing level.
  + Evaluate whether any portion of such fees in substance dividends should be evaluated in the contact of dividend regulations.
  + Determine if agreements received appropriate regulatory approval in conformity with regulatory requirements.
  + Consider whether additional examination procedures should be recommended to verify/validate information regarding transactions and services with affiliates or to further consider whether the expense allocations continue to be fair and reasonable.
  + See additional guidance regarding criteria to be considered in determining whether an agreement with affiliates merits review during an onsite examination at section V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide (Form D - Prior Notice of a Transaction).

**Risk of Affiliated Transactions—Not Legitimate or Not Properly Accounted For**

Determine whether other transactions with affiliates are legitimate and properly accounted for.

**Exposure to Collectability Risk**

Closely monitor other transactions with affiliates to ensure that the insurer is not exposed to significant collectability risk. For example, if the insurer is included in a consolidated federal income tax return and a significant asset for federal income tax recoverable is recorded on the financial statements of the insurer, Closely review the financial statements of the parent to determine the parent’s ability to repay the receivable. Structured settlements acquired from an affiliated life insurance company may also represent a collectability risk to the insurer. When the amounts of structured settlements are significant, analysts should review and understand the financial statements of the life insurance affiliate.

Procedures/Data

* Review the following ratios to determine the level of affiliated transactions:
  + Affiliated receivables to policyholder surplus.
  + Affiliated payables to policyholder surplus.
  + Federal income tax recoverables to policyholder surplus (P&C) or to capital and surplus (Life/A&H, and Health).
  + Health: Non-current balances [Health Annual Financial Statement, Exhibit 6]
  + Health: Ratio of payments made to affiliated providers to total payments
* Determine if any foreign entity controls 10% or more of the insurer, either directly or indirectly, through a holding company system. [Annual Financial Statement, General Interrogatories, Part 1, #7.1 and #7.2.].
  + If so, determine if the insurer properly disclosed the investment in Schedule Y, Part 1.
* Review the Annual Financial Statement, General Interrogatories, Part 1, #20.1 and #20.2 to assess the exposure to loans to directors, officers, and other stakeholders:
  + Ratio of total amount loaned to directors, other officers, or stockholders to net income.
  + Ratio of total amount of loans outstanding at the end of the year to directors, other officers, or stockholders to policyholder surplus.
* Determine if the insurer has failed to establish a conflict-of-interest disclosure policy [Annual Financial Statement, General Interrogatories, Part 1, #18].
  + If so, is there any evidence that activities of directors, officers or shareholders were in violation of state statutes?

Additional Review Considerations

* Review Annual Financial Statement, Schedule E – Part 1:
  + Determine if any open depositories a parent, subsidiary, or affiliate.
  + Based upon a review of the holding company financial statements (as filed with the Annual Holding Company Registration Statement Form B), determine if any holding company lenders reported that also appear as open depositories of the insurer.
  + If holding company lenders also appear as open depositories of the insurer, verify this is properly disclosed on Schedule Y – Part 1
  + Determine if there is any evidence that activities directors, officers and shareholders were in violation of state statutes
* Review the Annual Financial Statement, Notes to Financial Statements, Note #9:
  + If the insurer is included in a consolidation federal income tax return, note any concerns relating to how taxes are allocated to the insurer.
  + Review the tax-sharing agreement and verify whether the terms are being followed.
  + Obtain and review the financial statements of the parent of affiliate and evaluate any collectability to the insurer.
  + Verify whether the amount recoverable from the prior year-end has been collected/recovered.
  + If federal income tax recoverables are greater material to surplus and if there are federal income tax recoverables due from an affiliate.
  + If the concern relates to federal tax recoverables from a parent or affiliate:
    - Obtain and review the financial statements of the parent or affiliate, and evaluate any collectability risk to the insurer
    - Review the tax-sharing agreement, and verify that terms of the tax-sharing agreement are being followed
    - Verify that the amount recoverable from the prior year-end has been paid
* Review the Annual Financial Statement, Notes to Financial Statements, Note #27:
  + Determine if the insurer has acquired structured settlements from an affiliated life insurance company.
  + If so, determine if the amount of loss reserved eliminated by annuities greater material to surplus.
  + Determine the current rating of the affiliates from the major rating agencies, if available.
  + Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.
  + Obtain and review the Statement of Actuarial Opinion of the affiliate, if available.
  + Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.
* Review the Annual Financial Statement, General Interrogatories, Part 2, #5. In case of reciprocal exchange:
  + Check for any unusual items noted regarding compensation of the attorney-in-fact.
  + If there is an approved agreement on file with the insurance department, review the Articles of Agreement.
* If unusual items were noted, determine if the insurer properly disclosed the investment on the Annual Financial Statement, Schedule Y – Part 2. If not properly disclosed in Schedule Y – Part 2, determine if any evidence exists that activities of directors, other officers, or shareholders were in violation of state statutes.
* Are there any financial guaranties in place, in any form between the insurer and any member of the holding company system?
* Review the Annual Financial Statement, Schedule SIS to determine if there are any unusual items noted regarding transactions with, or compensation to directors and officers.
* Assemble a list of all affiliated and other related parties and summarize the financial impact of each transaction. Identify any other unusual transactions and investigate for reasonableness.

Health Only:

* If concern exists regarding downstream risk with affiliated provider intermediaries:
* Obtain and review the Audited Financial Report and Annual Financial Statement of the affiliate, if available.
* Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups, if available.
* Obtain and review the actuarial opinion of the affiliate, if available.
* Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.
* Review the Annual Financial Statement, Exhibit 5.
* Are there any balances over 90 days, which are admitted?
* Does the exhibit otherwise suggest that the insurer may have collectability issues with its affiliates?
* Are any of the receivable balances from an affiliate which the insurer also reports a payable balance on Exhibit 6 and could therefore net the balances on the face of the balance sheet if the requirements of SSAP 64 were met?
* Is the analyst aware of any receivable balances from an affiliate which has experienced some financial problems?
* Are there any affiliated receivable balances from medical providers or intermediaries included on Exhibit 5?
* Review the Annual Financial Statement, Exhibit 6. Are any of the balances unusually large for the description or are any of the descriptions unusual?
* Review the Annual Financial Statement, Exhibit 7 – Part 1. Has there been any indication that the amount charged by the affiliated provider is non-economic or non-arms-length?



**Significant Reliance on MGAs and TPAs**

**Concerns with MGAs and TPAs**

Determine whether concerns exist due to a significant amount of the insurer’s direct premiums being written through MGAs and TPAs.

While the amount of direct premiums written by MGAs and TPAs is not necessarily an indication of a problem or concern, this procedure provides an indication of the insurer’s exposure to potential abuse by MGAs and TPAs. MGAs and TPAs who had been delegated significant authority without insurer oversight have played a major role in the insolvency of several large insurers.

Perform additional steps if there are concerns regarding the insurer’s use of MGAs and TPAs. Consider reviewing the information in the Annual Financial Statement, Notes to Financial Statements, Note #19 to determine which MGAs and TPAs are being utilized (and whether any of the MGAs or TPAs are affiliated with the insurer), the types and amount of direct premium written by each, and the types of authority granted to each by the insurer.

For the more significant MGAs and TPAs, consider requesting information from the insurer to determine whether the business produced by the MGA or TPA is ceded to a particular reinsurer and, if so, whether the MGA or TPA arranged for that reinsurance. If the MGA or TPA arranged for the reinsurance, consider determining whether the MGA or TPA is affiliated with the reinsurer. In addition, consider reviewing the reinsurance agreements to determine whether the terms are reasonable. For the more significant MGAs and TPAs, consider requesting information from the insurer regarding commission rates and any other amounts paid to the MGAs and TPAs, reviewing that information for reasonableness and comparing the commission rates to those paid by the insurer to other agents. Any arrangement involving sliding-scale commissions based on loss ratios or a sharing of interim profits on business, where the MGA or TPA establishes claim liabilities or controls claim payments, should be reviewed closely to determine if there is potential for abuse by the MGA or TPA. In addition, consider determining whether the MGAs utilized by the insurer are properly licensed and whether the TPAs utilized by the insurer hold valid Certificates of Authority.

The more authority that is delegated to an MGA or TPA, the more important it is for the insurer to provide active, ongoing oversight into the MGA’s or TPA’s operations. To evaluate the insurer’s oversight of significant MGAs and TPAs, consider requesting from the insurer copies of its contracts with the MGAs and TPAs to determine compliance with the minimum contract provisions per the MGA Act and the TPA Guideline and/or the applicable provisions of the insurance code. Also consider requesting from the insurer copies of financial statements for the significant MGAs and TPAs and documentation supporting the insurer’s periodic (at least semi-annual) review of the underwriting and claims processing systems. If there are concerns regarding the business placed with the insurer by an MGA or TPA, analysts should consider determining if other insurers are utilizing the same MGA or TPA and comparing the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether they are similar (i.e., contain the same commission rates).

Procedures/Data

Determine whether concerns exist due to a significant amount of the insurer’s direct premiums being written through managing general agents (MGAs) and third-party administrators (TPAs).

* Determine if any agent, general agent, broker, sales representative, non-affiliated sales/service organization, or any combination thereof under common control (other than salaried employees of the insurer) received credit or commissions for or control a substantial part of either the sale of new business or renewals. [Annual Financial Statement, General Interrogatories, Part 1, #4.1 and #4.2].
* Determine if the aggregate amount of direct premiums written through MGAs and TPAs to total direct premiums written were material. [Annual Financial Statements, Note #19].Health: Ratio of Aggregate direct premiums written through MGAs and TPAs to capital and surplus.
* Health: Ratio of direct medical expense payments made to intermediaries to total medical expense payments.

Additional Review Considerations

* Review the Annual Financial Statement, Notes to Financial Statements, Note #19 (which lists all individual MGAs and TPAs whose direct writings are greater than 5% of surplus), determine the following:
  + Which MGAs and TPAs are being utilized and whether any are affiliated with the insurer.
  + The types and amount of direct business written by MGAs and TPAs.
  + The types of authority granted to the MGAs and TPAs by the insurer.
* Determine whether the MGAs utilized by the insurer are properly licensed and whether the TPAs utilized by the insurer hold valid certificates of authority. In some states, an insurer may utilize an MGA who is not licensed if biographical questionnaires have been submitted for each individual owning more than 10% of the MGA. If this provision is applicable and the MGA is not licensed, verify that the required biographical questionnaires have been submitted.

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

* P&C: The comparability of the incurred loss and LAE ratios on the business written by the MGA and TPA with that written directly by the insurer (for the lines of business in which significant, but not all, direct business is written through the MGA/TPA).
* Whether the business produced by the MGA and TPA is ceded to a particular reinsurer and, if so, whether that reinsurance was arranged by the MGA or TPA. If the MGA or TPA arranged for the reinsurance, determine whether the MGA or TPA is affiliated with the reinsurer, and consider reviewing the reinsurance agreements to determine whether the terms are reasonable.
* Commission rates and any other amounts paid to the MGA and TPA. Review the information for reasonableness and compare the commission rates to those paid by the insurer to other agents.
* Whether the contracts between the insurer and MGA include minimum required provisions per Section 4 of the NAIC *Managing General Agents Act* (#225) and/or the applicable sections of the insurance code.
* Whether the contracts between the insurer and TPA include minimum required provisions per Sections 2,4,6,7 and 8 of the NAIC *Registration and Regulation of Third-Party Administrators* (#1090) and/or the applicable sections of the insurance code.
* The most recent independent CPA audit or annual report of the MGA or TPA (or IPA for Health Entities).
* For P&C: If the MGA establishes loss reserves, the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA.
* Documentation supporting the insurer’s periodic (at least semi-annual) on-site review of the MGA’s underwriting and claims processing operations.
* Documentation supporting the insurer’s periodic (at least semi-annual) review of the underwriting and claims processing operations of the TPA (or IPA for Health Entities). (Model #225 requires at least one of the semi-annual reviews to be an on-site audit of the operations of the TPA.)
* For Health Entities, consider requesting from the insurer:
  + A listing of significant TPAs and IPAs that pre-authorize, or process claims for the insurer, by line of health business (e.g., pharmacy, vision, mental health) and/or provider types (Hospitals, Physicians).
  + Whether the TPAs and IPAs utilized by the insurer are properly licensed to process, preauthorize or otherwise administrator claims.
  + Contracts between the insurer and the TPA or IPA to determine whether the contracts include minimum provisions.
* For Health Entities, review analyst notes or exam reports for the other companies using the same intermediaries if there is reason to believe problems exist with those entities.
* For Health Entities, if, with respect to business produced by the TPA or IPA, the TPA or IPA provides the insurer with claim reserve and/or claim adjustment expense reserve estimates that are incorporated into the insurer’s financial statement, an opinion from an actuary employed or retained by the TPA or IPA attesting to the adequacy of such reserves.
* For Health Entities, if the TPA or IPA provides paid claims data that is used by the insurer in establishing claim reserves, determine whether the insurer or the actuary providing the insurer’s claim reserve certification tested data provided by the TPA or IPA.

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

* Compare the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether the contracts are similar (e.g., contain the same commission rates).
* Compare the insurer’s loss and LAE ratios on the business placed by the MGA or TPA with those of the other insurers utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the insurer may be receiving a disproportionate amount of “bad” business from the MGA or TPA.



**Risks With Management of Separate Accounts (Life/A&H)**

Determine whether concerns exist regarding the appropriateness of business being placed within separate accounts or regarding transactions between the general account and the separate account. Challenges in properly managing and reporting separate account business and transactions with the general account may mask true financial performance and/or understate liabilities due to the separate account.

Criteria for qualifying for separate account classification under GAAP are outlined in *Statement of Statutory Accounting Principles (*SSAP*) No. 56—Separate Accounts*. A separate account product must meet four conditions as defined in Separate Accounts Annual Financial Statement, General Interrogatories, #8.2 in order to receive separate account classification: 1) legal recognition; 2) legal insulation; 3) investment directive; and 4) investment performance. If an insurer reports any products that do not meet these criteria, analysts should review the conditions listed in Separate Accounts Annual Financial Statement, General Interrogatories, #8.3 and further review the details of the separate account disclosures, as this is an indication the insurer includes products in its separate account that are not true separate account products.

Some insurers may include non-variable (non-unit linked) products in the separate account. Separate Accounts Annual Financial Statement, General Interrogatories, #8.3 may assist analysts in determining if such products are included. Analysts should gain an understanding of the reasons why non-variable products are included in the separate account. Analysts may need to contact the policy form unit within the insurance department to obtain information about the policy form application and approval to help gain such understanding of the products included in the separate account. Analysts may need to contact the insurer to request additional information about the policies included in the separate account. Considerations may include: What investment guidelines apply to these products? Outside of product guarantees, does the general account have any responsibilities for funding the reserve liabilities?

If the insurer filed a non-insulated separate accounts statement, *Procedure #10.b.* assists analysts in gaining an understanding of the insurer’s non-insulated products.

All separate accounts activity reaches the Separate Accounts Annual Financial Statement through the General Account Annual Financial Statement. Premiums are recorded in the general account and then “transferred to” the Separate Accounts Annual Financial Statement through the item Net Transfers to or from Separate Accounts (referred to as “above the line” activity). Once the premiums have been moved to the separate accounts, all direct investment activity and reserve changes are recorded on the Separate Accounts Annual Financial Statement. Seed money is “contributed to or withdrawn from” the Separate Accounts Annual Financial Statement through the item Surplus (contributed to) withdrawn from Separate Accounts during the period (referred to as “below the line” activity).

Additional procedures assist analysts in determining that the accounting for activity between the separate accounts and the general accounts is proper. The primary concern here is to properly classify such activity as to “above the line” (i.e., recorded on the Net Transfers to or (from) Separate Accounts line on the general account) or “below the line” activity (i.e., recorded on the Change in Surplus in Separate Accounts Statement on the general account). An additional area analysts should investigate in this regard is the level of investment management fees charged to the separate accounts. The SEC has set maximums for the level of such fees. Common industry practice is for this fee to range between 125 and 140 basis points on separate accounts assets.

Procedures/Data

Determine whether concerns exist regarding the appropriateness of business being placed within separate accounts or regarding transactions between the general account and the separate account.

* Determine if the insurer reported any separate account products that do not meet separate account GAAP classification? If so, review in detail the products and conditions listed. [Separate Accounts Financial Statement, General Interrogatory #8.3]
* Determine if the insurer filed a non-insulated separate accounts statement. Identify and document any concerns regarding the inclusion of non-insulated products in the separate account.
* Portion of capital and surplus funds of the insurer covered by assets in the Separate Accounts Financial Statement greater than capital and surplus
* Portion of capital and surplus not distributable from the separate accounts to the general account for use by the general account. [Annual Financial Statement, General Interrogatories, Part 2, #3.3]
* Compare the amounts recorded on page 4, line 20 of the Separate Accounts Financial Statement, contributed surplus, to Page 4, line 46 of the General Account Financial Statement, surplus (contributed to) withdrawn from separate accounts during period and verify the amounts reconcile.
* Determine if other changes in surplus in the Separate Accounts Financial Statement are greater than capital and surplus.

Additional Review Considerations

* Determine if any non-variable (non-unit linked) products were reported in the Separate Account. If so:
  + Review the specific product information to determine and understand the reasons for including non-variable products in the separate accounts.
  + Identify and document any concerns regarding the non-variable products’ inclusion in the separate accounts.
* Request additional information from the insurer of any unusual or non-variable (non-unit linked) products included in the separate accounts.
* Review the Annual Financial Statement, Notes to Financial Statements, Note #35 – Separate Accounts.
  + Determine if the amounts transferred between the general account and separate accounts statement(s) reconcile.
  + Determine if any recording adjustments are noted.
  + Determine if the net amount of all reconciling items is material to statutory net income.
* Assess and determine if any additional concerns exist regarding separate accounts reporting.
* Review the Separate Accounts Annual Financial Statement and the General Account Annual Financial Statement and:
  + Verify that the separate accounts gain from operations is properly recorded in the capital and surplus section of the General Account Summary of Operations.
  + Verify that all other premium and benefits activity is properly recorded on the net transfers to or (from) separate accounts line of the General Account Summary of Operations.
  + Review the Separate Accounts Summary of Operations and surplus account in order to identify potential misclassifications as to “above the line” and “below the line” classifications.
* Review the level of investment management fees charged to the separate accounts to determine that they are in the generally accepted range of 125 to 140 basis points on separate accounts assets.
* Review the insurer’s response to Annual Financial Statement, General Interrogatories, Part 2, #3.3. Assess if any concerns exist regarding the portion of capital and surplus funds of the insurer covered by assets in the Separate Accounts Financial Statements that are not currently distributable from the separate accounts to the general account for use by the general account.



**Risk Transfer Agreements Other Than Reinsurance (Health)**

Determine whether experience rating arrangements are significant, reasonable and paid on a timely basis.

**Concerns with Experience Rated Arrangements**

The materiality of experience rated arrangements is determined by comparing the amount due from groups (from write-in for other than invested assets) and the amount due to groups (from reserve for rate credits or experience rating refunds on the Annual Financial Statement, Underwriting and Investment Exhibit, Part 2D, Line 4) to total hospital and medical benefits paid. If experience rating arrangements are significant, analysts should determine whether amounts are reasonable and settled on a timely basis by comparing to prior year balances and inquiring of the company, if necessary.

Procedures/Data

* Determine if experience rating arrangements are significant, reasonable, and settled on a timely basis.
* Compare reserve for rate credits or experience rating refunds to total hospital and medical expenses. Determine if the insurer reported reserve for rate credits or experienced rating refunds to be collected from the prior year. If not settled on a timely manner, inquire with the insurer for any balances outstanding. [Annual Financial Statement, Underwriting and Investment Exhibit – Part 2D, Line 4]
* Compare amounts due from experience rating arrangements from the write-in for other than invested assets to total hospital and medical expenses. Determine if the insurer reported amounts due from experience rating arrangements.
* Determine whether the insurer has reported appropriate reserves. Determine if a premium stabilization reserve been included in the reserve for rate credits or experience rating refunds. [Annual Financial Statement, Underwriting and Investment Exhibit – Part 2D, Line 4]

**Concerns with Capitation Agreements and Payments**

Determine whether capitation payments with providers are material and whether risks exist with providers’ or intermediaries’ ability to meet capitation agreement obligations. The significance of capitation payments is determined by comparing their total to hospital and medical benefits paid. Also, the percent of capitation being paid to intermediaries or “other providers” is reviewed to determine if there is a disproportionate amount being paid to these entities and the proportion of bonuses and withhold payments is reviewed for appropriateness. If capitation payments are material, analysts are asked to review whether provider agreements have been filed with the department and if the arrangements are properly reflected in RBC reporting. If an intermediary (TPA or Individual Practice Associations (IPA)) is involved in capitation payments, analysts are encouraged to request audited financial statements for the intermediary (to verify financial position) and to consider obtaining and reviewing an actuarial opinion on the reserves established for claims incurred and outstanding on business produced by the intermediary.

Determine if capitation payments with providers are material and if so, whether risks exist with providers’ or intermediaries’ ability to meet capitation agreement obligations.

Procedures/Data

* Compare total capitation payments to intermediaries to total hospital and medical expenses [Annual Financial Statement, Exhibit 7 – Part 1]
* Health care receivables to capital and surplus.
* Percentage of members covered by capitated arrangements based on capitation payments to total payments.

Additional Review Considerations

* Determine if the insurer has completed Annual Financial Statement, Exhibit 7 – Part 1.
* Determine if the insurer has capitation agreements with providers.
  + Determine if there are copies of provider agreements with domiciliary jurisdiction.
  + If the insurer has capitation arrangements with providers, ensure the appropriate information has been entered in the RBC filing (worksheet XR017).
* Determine if capitation to groups or intermediaries reported in Annual Financial Statement, Exhibit 7 is actually disbursed or withheld by the insurer for future payment of claims as they are submitted.
* Determine if the insurer pays or processes claims for the participating providers of a capitated intermediary.
* Request the most recent independent audited report of the intermediary (TPA or IPA). If not available, request the most recent annual report.
* Obtain the opinion of an actuary attesting to the adequacy of claim reserves and claim adjustment expenses established for claims incurred and outstanding on business produced by the intermediaries, if available.
* Review analyst notes or exam reports for the other companies using the same intermediaries if there is reason to believe problems exist with those entities.

**Concerns with Special Payment Arrangments**

Determine whether special payment arrangements (i.e., bonuses and withholds) with providers are material, reasonable and reported correctly. The significance of special payment arrangements is determined by comparing their total to hospital and medical benefits paid. Also, the percent of bonus/withhold to intermediaries or “other providers” is reviewed to determine if there is a disproportionate amount being paid to these entities and/or if the level paid is appropriate.

Determine if the health entity’s use of bonus and withhold arrangements are significant. Since health entities use these arrangements to different degrees, it is important to determine the significance of their use by the health entity under review. These procedures determine if the amount of bonus and withhold liabilities and expenses compared to the total hospital and medical expense is significant.

Determine the significance of the liabilities outstanding for bonuses and withholds. While these procedures focus on materiality, there are very few tests that can be made to verify that provider liabilities are appropriate. Provider contracts often change dramatically from year to year, limiting the value of year-over-year comparisons. These liabilities build up over the contract period and then are paid, decreasing the liability to zero. Contract periods for different providers may cover different periods so that wide fluctuations can be seen from period to period. Therefore, analysts are encouraged to perform other qualitative procedures to evaluate provider liabilities such as reviewing the Statement of Actuarial Opinion, reviewing provisions in provider contracts and obtaining the detailed calculation supporting the liabilities.

Verify that information that is reported in the financial statement for the health entity is consistent with what is reported in the health entity’s RBC filing. Since withholds and bonuses are reported both in the Annual Financial Statementand in the RBC filing, they should not appear in one and not the other. This procedure also assists analysts in determining if a significant amount of the prior year’s withholds and bonuses available were not paid during that reporting year. Withholds and Bonuses Available represent the total amount that could have been paid in withholds and bonuses. (This information is provided in the RBC filing on page XR016.) The amount paid compared to the amount available provides analysts with a rough indication of how well provider groups were able to meet their contract goals. Further analysis may be necessary in order to determine whether the provider group is able to meet its financial or operational goals in its contracts with the health entity, currently and going forward. Provider groups not being able to meet their financial and operational goals and thus not earning all of their withholds in one year can result in higher claims costs than anticipated and/or less favorable contracts in the next contracting cycle.

Additional procedures may be performed if there are concerns regarding the amount of prior year withholds and if bonuses available not paid were significant. If the level of these arrangements is significant, it is important to determine if any actual risk is being transferred. Potentially, these arrangements could be used to create the appearance of capitated risk transfer when in fact the bonus and withholds result in no actual risk transfer. Since these arrangements reduce RBC, capital requirements could be understated. Some health entities have many types of contracts with providers, but it is possible to request that a health entity provide the primary contracts with its largest contracting providers.

It is also important to determine if these arrangements are concentrated within a few providers. If there is a concentration, any financial weakness of the providers could result in them not being able to fulfill their part of the risk transfer contract. Standards published by the Actuarial Standards Board of the American Academy of Actuaries (Actuarial Standard of Practice 16) requires that the actuarial opinion disclose the actuary’s knowledge of the health entity’s capitated risk contracts indicating if the actuary evaluated the financial position of the contracting providers. The actuarial opinion should be reviewed to determine if the capitated risk contracts, as well as the financial strength of the contracting providers were or were not reviewed by the opining actuary. It may be necessary to contact the qualified actuary to discuss his or her review and potential concerns.

It is possible that the contracting provider is actually an affiliate of the health entity. This can be the case where hospitals own HMOs that then contract back to the parent hospital. These arrangements should be understood for potential impact of the financial weakness of any of the participants.

Determine whether the insurer’s special payment arrangements (i.e., bonus and withold arrangements) with providers are material, reasonable, and reported correctly.

Procedures/Data

* Compare total bonus/withhold arrangement payments to total hospital and medical benefits.
* Compare pool/withhold arrangement payments to total bonus/withhold accrual.
* Bonus/withhold payments and prior year underwriting losses.
* Liability for accrued medical incentive pool and bonus payments to total hospital and medical expense.
* Liability for amounts withheld from paid claims and capitations to total hospital and medical expense.
* Incentive pool and withhold adjustments expense to total hospital and medical expense.
* Change in bonus/withhold accrual from prior year to current year.

Additional Review Considerations

* Review the Annual Financial Statement, General Interrogatories, Part 2. Determine if the insurer reported bonus/withhold arrangements with providers.
* Determine if risk transfer arrangements with providers have had a negative impact on utilization. Review the Exhibit of Premiums, Enrollment, and Utilization in the Annual Financial Statement and compare to prior years. Determine if utilization compared to membership increased.
* Determine if the insurer failed to comply with state-specific laws, regulations, or guidelines regarding arrangements for risk transfer other than reinsurance.
* Request a listing of provider groups contracting with the insurer.
* Review the Statement of Actuarial Opinion to determine if capitation arrangements were reviewed.
* Review the Statement of Actuarial Opinion to determine if:
  + The financial strength of contracting provider groups was or was not reviewed or excluded by the opining actuary.
  + Provider insolvencies were considered when determining the reserves and liabilities.
* Evaluate the financial condition of the largest contracting provider groups.
* Contact the qualified actuary who signed the insurer’s actuarial opinion to discuss the nature and scope of the review of the provider contracts.
* Review bonus/withhold provisions of the provider contracts.
* Obtain detailed calculation of direct bonus and withhold payments, and accruals and those covering capitated arrangements.
* Request information concerning the specific contract provisions of the primary bonuses and withhold arrangements that the insurer is using.
* Request withheld and bonus liability amounts (included in “Accrued medical incentive pool and bonus payments” from Page 3, Column 3, Line 2) for the top five provider groups.
* Evaluate the appropriateness of withhold distributions or bonus payments made to providers relative to contract provisions and the insurer’s underwriting results.
* Determine whether the insurer is compliant with RBC filing requirements and verify that amounts reported for bonuses and withholds in the insurer’s Risk-Based Capital (RBC) filing are consistent with what is reported in the Annual Financial Statement filing.
  + Determine if there is an amount entered in accrued medical incentive pool and bonus Payments on Page 3, Column 3, Line 2, even though the RBC filing on worksheet XR017.
  + Column 2, Lines 3 and 4, indicates that no business is subject to withholds or bonuses
  + Determine if there is no amount entered in accrued medical incentive pool and bonus payments on Page 3, Column 3, Line 2, even though the RBC filing on worksheet XR017 Column 2, Lines 3 and 4, indicates that some business is subject to withholds or bonuses.
  + Determine if the prior year withholds and bonuses paid differed by more than 40% from prior year withholds and bonuses available from RBC worksheet XR017 in the RBC filing. (XR018: ABS (Line 18 - Line 19)/(Line 18)).
  + If amounts reported for bonuses and withholds in the insurer’s RBC filing appear to be potentially inconsistent with what is reported in the annual statement filing, request that the insurer provide an explanation. If further analysis indicates that there is a disconnect between the two filings, request that the insurer amend whichever filing is incorrect.



**Exposure to Cybersecurity Risk**

**Ineffective Mitigation of Cybersecurity Risk**

Determine whether concerns exist regarding the insurer’s exposure to and mitigation of cybersecurity risk.

Cybersecurity is defined as a set of technologies and processes that protect a company’s information system as well as information stored on the system. An insurer’s exposure to cybersecurity risk may be influenced by its size and complexity, the nature and scope of its activities, and the sensitivity of non-public information used by the insurer or in the insurer’s possession, custody or control. These potential cyber risks may directly lead to financial loss and/or reputational risk. As cybersecurity events become more prevalent, there are additional pressures for insurers to enhance their information security program to protect personal and sensitive information. Therefore, the NAIC adopted the *Insurance Data Security Model Law* (#668) in October 2017 to outline requirements for insurers in addressing cybersecurity risks. States are expected to adopt the model in the coming years, which should result in more consistency and authority for state insurance regulators in this area. However, in the meantime, analysts may consider discussing, reviewing and assessing risks in this area on a more frequent basis than the routine examination schedule. As cybersecurity activities and controls are commonly conducted at the group level, efforts may need to be coordinated with the lead state.

Procedures

* Gain an understanding of and evaluate the company’s exposure to and mitigation of cybersecurity risk by reviewing recent exam results and findings, company documentation, and other relevant information. Considerations may include whether the company’s information security program appropriately identifies, prevents, detects and responds/recovers from cybersecurity events. Concern may be heightened in the event of companies with planned mergers or acquisitions (and the resulting system integration), system updates, and/or significant unresolved findings from financial exam or other third-party security audits. If the analyst’s level of concern merits additional analysis, consider performing the following procedures:
  + Obtain and review information on the cybersecurity insurance coverage maintained by the insurer to limit exposure to cybersecurity events.
  + Inquire on recent adjustments made to the company’s information security program to address emerging threats and vulnerabilities.
* If material risk warrants further investigation, or more technical analysis, the analyst should consider seeking the expertise of a cybersecurity expert (e.g., internal examination staff or external consultants) to conduct additional risk analysis and/or target examination in this area. If the cybersecurity expert’s level of concern merits additional analysis, consider performing the following procedures in the scope of the work to be performed by the expert:
  + Obtain and review results of recent vulnerability assessments and/or penetration tests to identify weaknesses in the existing security framework.
  + Obtain and review results of external/internal security audits, including those performed by other regulatory agencies–e.g., Office of Management and Budget (OMB) or Federal Reserve (FRB)–and corresponding changes to the company’s security techniques (e.g., firewalls or intrusion detections, logical access controls (e.g., user access rights or authentication mechanisms) and disaster recovery processes).
* If the state has passed the NAIC’s *Insurance Data Security Model Law* (#668), consider:
  + Obtaining and reviewing any changes to the company’s information security program to ensure compliance with the law’s provisions, which notably include sections on oversight by board of directors and oversight of third-party service provider arrangements.
  + Ensuring the company has submitted an “Annual Certification to Commissioner of Domiciliary State,” which is a new requirement under the Model #668 whereby an insurance company asserts compliance with Section 4 of the model law (i.e., risk assessment, risk management, oversight by board of directors, etc.).
  + Reviewing any recent notifications of a cybersecurity event provided by the company in accordance with Section 6 of Model #668.
    - Gain an understanding of the nature and extent of any cybersecurity event and its expected impact on the company’s reputation and financial standing.
    - For each cybersecurity event, determine whether the company took appropriate steps to remediate, including timely reporting to impacted stakeholders, protection of policyholders against identity theft and/or corrective actions to address identified weaknesses in IT security.
* If the state has not passed Model #668, consider obtaining and reviewing information regarding any cybersecurity events the company has detected over the past 12 months.
  + Gain an understanding of the nature and extent of any cybersecurity event and its expected impact on the company’s reputation and financial standing.
  + For each cybersecurity event, determine whether the company took appropriate steps to remediate, including timely reporting to impacted stakeholders, protection of policyholders against identity theft and/or corrective actions to address identified weaknesses in IT security.

# Additional Procedures Applicable to Operational Risk

**Examination Findings**

Consider a review of the recent examination report, summary review memorandum and communication with the examination staff to identify if any operational risk issues were discovered during the examination with any of the following:

* Operating Performance
* Information Technology (IT) Systems
* Cybersecurity
* Fraud
* Internal Controls
* Disaster Recovery
* Transactions and services with affiliates

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

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

Obtain and review the latest ORSA Summary Report for the insurer or insurance group (if available) to assist in identifying, assessing and addressing risks faced by the insurer.

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

* Determine if the ORSA Summary Report analysis conducted by the lead state indicates any operational risks that require further monitoring or follow-up.
* Determine if the ORSA Summary Report analysis conducted by the lead state indicates any mitigating strategies for existing or prospective operational risks.

**Holding Company Analysis**

Obtain and review the holding company analysis work completed by the lead state to assist in identifying, assessing and addressing operational risks that could impact the insurer.

* Determine if the Holding Company analysis conducted by the lead state indicates any operational risks impacting the insurer that require further monitoring or follow-up.
* Determine if the Holding Company analysis conducted by the lead state indicates any mitigating strategies for existing or prospective operational risks impacting the insurer.

**Enterprise risk management - Pandemic (Health)**

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

# Quarterly Operational Risk Assessment

The quarterly operational risk procedures are designed to identify the following:

**Poor (or Declining) Operating Performance**

Analyze the currant year-to-date performance and trends in the following items to determine whether concerns exist regarding the insurer’s operating performance.

Procedures/Data

* Review the Statement of Income and operating performance.
  + Net Loss (current year-to-date, and five-year trend).
  + Change in net income (loss) from prior year-to-date when absolute value of net income (loss) is material to surplus.
  + P/C: Profitability Ratios (current quarter, change from prior year-to-date, and five-year trend).
    - Combined ratio and its components.
      * Change in net premiums earned from prior year-to-date.
      * Change in net incurred losses from prior year-to-date.
    - Net loss ratio (direct, assumed, gross, ceded, and net).
    - Pure loss ratio.
    - Pure loss adjustment expense (LAE) ratio.
    - Expense ratio.
    - Dividend ratio.
    - Ratio of other income to net income when the absolute value of other income is material to surplus.
  + Life/A&H: Profitability Ratios (current quarter, change from prior year-to-date, and five-year trend)
    - Net income/total revenue (ROR).
    - Annualized net income/total assets (ROA).
    - Annualized net income/capital & surplus (ROE).
    - Ratio of commissions and administrative expenses to premiums and deposits.
    - Ratio of aggregate write-ins for miscellaneous income to net income when aggregate write-ins for miscellaneous income are materials to capital and surplus.
    - Ratio of aggregate write-ins for deductions to net income when aggregate write-ins for deductions are material to capital and surplus.
  + Health: Profitability Ratios (current quarter, change from prior year-to-date or year-end, and five-year trend)
    - Profit margin ratio.
    - Combined ratio.
    - Medical loss ratio (MLR).
    - Administrative expense ratio.

Additional Review Considerations

* Review the components of other income in the Quarterly Financial Statement, Statement of Income, including write-ins for miscellaneous income, for reasonableness.
* Describe any known trends that have had or that the insurer reasonably expects will have a material favorable or unfavorable impact on net revenues or net income. If the insurer knows of events that will cause a material change in the relationship between benefits, losses and expenses, the change in the relationship should be disclosed.
* If concerns exist regarding operating performance, consider the following procedures:
  + Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses.
  + Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations.

**Risks with Investment Operations**

Determine whether all securities owned are under the control of the insurer and in the insurer’s possession.

Procedures/Data

* Determine if any of the assets of the insurer loaned, placed under option agreements, or otherwise made available for use by another person (excluding securities under securities lending agreements)? If so, determine if there any concerns regarding these assets. [Quarterly Financial Statement, General Interrogatories, Part 1, #11.1 and #11.2]

**Exposure to Affiliated/Related Party Transactions**

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

Procedures/Data

Determine whether the insurer is a member of a holding company group and whether the corporate structure elevates concerns about affiliated transactions.

* Determine if the insurer is part of a holding company system. [Quarterly Financial Statement, General Interrogatories, Part 1, #3.1]
* Determine if there have been substantial changes in the organizational chart since the prior quarter end. [Quarterly Financial Statement, General Interrogatories, Part 1, #3.2]

Additional Review Considerations

* If there have been substantial changes and the change involved ownership of the insurer or a transaction with an affiliate, determine if the insurer received proper regulatory approvals.
* Determine if there any indications that the corporate structure may include a holding company whose primary asset is the stock of the insurance company.
* Determine if the insurer has an agency or brokerage subsidiary.

Procedures/Data

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

* Determine if there have been changes to any management agreement, including third-party administrators (TPAs) and managing general agents (MGAs) in terms of the agreement or principals involved. [Quarterly Financial Statement, General Interrogatories, Part 1, #5].

Additional Review Considerations

* Review Quarterly Financial Statement, Schedule A – Part 2 and Part 3 and Schedule BA – Part 2 and Part 3:
  + Determine if any such acquisitions or disposition involve an affiliate or other related party.
  + Determine if the amount of the transaction was material to surplus?
  + Determine if there is any reason to believe that the acquisition was recorded on a basis other than fair value.

**Concerns with Separate Accounts (Life/A&H)**

Determine whether concerns exist regarding the insurer’s separate accounts.

Procedures/Data

* Determine whether the insurer maintains Separate Accounts. Review the Quarterly Financial Statement, Balance Sheet asset and liability items relating to separate accounts business. Determine if there balances in either of these categories

*If not, do not proceed with the remaining Separate Accounts procedures.*

* Change in separate account assets or liabilities from the prior year-end.
* Review the Quarterly Financial Statement, Capital and Surplus Account Statement page.
  + Determine if the line item, “Other changes in surplus in the Separate Accounts Statement,” is greater than capital and surplus.
  + Change in line item, “Other changes in surplus in the Separate Accounts Statement,” from the prior year, same quarter.
* Review the Quarterly Financial Statement, Summary of Operations page.
  + Change in line item, “Net transfers to or (from) separate accounts,” from the prior year, same quarter.
  + Determine if the insurer reported a net loss in the line item, “Separate accounts net gain from operations excluding unrealized gains or losses,” whose absolute value material to the general account capital and surplus.

**Significant Bonus and Withholding Arrangements (Health)**

Determine whether the insurer’s use of bonus and withhold arrangements are significant.

Procedures/Data

* Ratio of Liability for accrued medical incentive pool and bonus payments to annualized total hospital and medical expenses.
* Ratio of Incentive pool and withhold adjustments to total hospital and medical expense.

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