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*2023 Summer National Meeting
Seattle, Washington*

RISK-FOCUSED SURVEILLANCE (E) WORKING GROUP

Monday, August 14, 2023

9:30 – 10:30 a.m.

Hyatt Regency Seattle—Regency Ballroom B—Level 7

ROLL CALL

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

NAIC Support Staff: Bruce Jenson/Jane Koenigsman

AGENDA

1. Discuss and Consider Finalizing the Updated Affiliated Services Guidance for Referral—*Amy Malm (WI)* Attachment A
2. Discuss the Next Steps in Addressing the 2022 Referral from the Macroprudential (E) Working Group—*Amy Malm (WI)* Attachment B
3. Discuss the Status of the 2023 Analyst/Examiner Salary Survey—*Amy Malm (WI)*
4. Receive an Update on 2023 Peer Review Sessions—*Amy Malm (WI)*



5. Discuss Any Other Matters Brought Before the Working Group
—*Amy Malm (WI)*
6. Adjournment

Note: This document includes excerpts from both the NAIC's *Financial Analysis Handbook* and the *Financial Condition Examiners Handbook* to which revisions are being proposed to update guidance around transactions and service agreements with affiliates. The proposed revisions are shown as tracked changes throughout.

Analysis 1 – III.A.5. Risk Assessment (All Statement Types) – IPS Example

**XX DEPARTMENT OF INSURANCE
INSURER PROFILE SUMMARY
COMPANY NAME
As of 12/31/20XX
Updated as of XX/XX/20XX**

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IMPACT OF HOLDING COMPANY ON INSURER

Summarize the evaluation of the impact of the holding company system on the domestic insurer.

The group is highly dependent upon cash flows from the various entities, including ABC, to make payments on the holding company debt used to help finance past transactions associated with the growth of the group. The Form F provides more specific information on necessary cash flows expected in the near term. Others risk from the non-insurers is not significant. See Domestic and/or Non-Lead State Analysis Holding Company Procedures for further discussion.

OVERALL CONCLUSION AND PRIORITY RATING

This section should include an overall conclusion as to the Company’s financial condition, discuss strengths that potentially mitigate the risks assessed above, and highlight weaknesses and any concerns with the Company’s operations going forward. Include any actions that may have been taken (e.g., significant holding company transactions, prior or planned meetings with management, and referrals to/from other divisions, etc.). Recommend the priority that should be assigned to the Company and explain the rationale.

Based on the branded risk assessments provided above as well as the Company’s poor financial results reported in recent periods, the Company appears to be potentially troubled. The Company has triggered more than five of the department’s prioritization criteria and is a multi-state insurer; therefore, the Company has been assigned our highest priority rating of 1, which is unchanged from the prior year. Some of the most significant issues facing the Company include rate adequacy, reserve sufficiency and overall cash flow and liquidity issues. However, these weaknesses are somewhat offset by Company strengths including a conservative investment portfolio, brand recognition and a strong historical reputation. The department has scheduled a meeting with senior management for the 3rd Quarter to discuss the Company’s poor financial performance and ongoing business plan. During the meeting, the department plans to share its concerns and inform the Company of steps planned to more closely monitor the company’s operations, as described below.

SUPERVISORY PLAN

List any specifically identified items that require further monitoring by the analyst or specific testing by the examiner. In addition, indicate if the Company is or should be subject to any enhanced monitoring, such as monthly reporting, a targeted examination, or a more frequent exam cycle.

Analysis Follow Up

- Obtain further detail regarding the impact of proposed rate increases and monitor through monthly financial reporting.
- Obtain further detail regarding the insurer’s liquidity strategy.

- Assess the reasonableness of the Company's business plan as soon as it is received, given the inability to execute the most recent strategy. Consider attending board meetings to reflect the concern regarding the future viability of the Company.
- Include suggested follow-up procedures to address any potentially significant unresolved concerns with cost sharing or service agreements with affiliates or significant reliance on affiliates to provide services.

Examination Follow-Up

- During the next regularly scheduled examination, audit the specific risks associated with the Company's agents balances and uncollected premiums to determine if further concerns exist.
- Follow-up on segregation of duties issues noted in the last examination.
- Perform a targeted examination of the reserves, pricing and claims management. Consider in the reserve study any pricing review, information related to the changing legal environment, as well as the mix of business in states outside of X and Y.

Analysis 2 – III.B.5.a. Operational Risk Repository – P/C Annual

Note: To conserve space, sections III.B.5b and sections III.B.5c which are the Operational Risk Repositories for Life, A&H and Fraternal Annual and for Health Annual, respectively, have not been included in this file. Where marked text is shown in this section for Property and Casualty Annual, the intent is to make the corresponding sections in the repositories for Life/A&H /Fraternal and for Health as well.

III.B.5.a. Operational Risk Repository – P/C Annual

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

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

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

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Exposure to ~~Affiliated / Related Party~~ Transactions with Affiliates/Related Parties

Note: The following procedures for the review of Corporate Structure and ~~Affiliated~~ 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.

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

	Other Risks
a. Review the Annual Financial Statement, Schedule Y – Part 1 and additional information provided in Form B, for the current and prior year: <ul style="list-style-type: none"> i. Were there any significant changes to the corporate structure during the year (e.g., acquisitions, divestitures, mergers)? ii. If 6.a.i is “yes,” and the change involved ownership of the insurer or a transaction with an affiliate, did the insurer fail to receive proper regulatory approval? iii. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company? iv. Does the insurer have an agency of brokerage subsidiary? 	ST

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

	Other Risks	Benchmark	Result	Outside Benchmark
a. Management fees paid to affiliates s to total expenses incurred [Annual Financial Statement, Underwriting and Investment Income Exhibit, Part 3]		>15%	[Data]	[Data]

III.B.5.a. Operational Risk Repository – P/C Annual

	<i>Other Risks</i>
<p>b. Review the Annual Financial Statement, Schedule Y – Part 2, Notes to Financial Statement – Note #10 and Note #13, and additional information provided in Form B and Form D:</p> <ul style="list-style-type: none"> i. Are any unusual items noted, such as significant new affiliated transactions <u>with affiliates</u> or modified intercompany agreements from the prior year or significant increases in transaction amounts? ii. Has the insurer forwarded to any affiliate funds greater than 15% of the insurer’s surplus? iii. Do affiliated undertakings resulting in a contingent liability to the insurer involve financial exposure greater than 25% of surplus? iv. Review the description of management agreements and service contracts. Is an allocation basis involved other than one designed to estimate actual cost? 	ST, LQ
<p>c. After reviewing both the Annual Financial Statement, Schedule Y – Part 2 and Notes to Financial Statements – Note #10, identify any discrepancies in reporting between the two disclosures.</p>	
<p>d. Verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved (e.g., Dividends – Note #13 and Structured Settlements – Note #27).</p>	
<p>e. Risk Retention Groups: Summarize the insurer’s level of reliance on captive managers, TPAs, or MGAs to run its business operations (e.g., underwriting, claims, records, and reporting).</p> <ul style="list-style-type: none"> i. If significant reliance exists, describe the services provides, any additional relationships, whether the expense ratio is in line with industry standards, and whether those parties service other insurers. 	ST

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Additional Analysis and Follow-Up Procedures
<p>Examination Findings:</p> <p>Review the most recent examination report and Summary Review Memorandum (SRM) for any findings regarding operational risks associated with:</p> <ul style="list-style-type: none"> • Operating performance • Information Technology (IT) systems • Cybersecurity • Fraud • Internal controls

III.B.5.a. Operational Risk Repository – P/C Annual

- Disaster recovery

- Transactions and services with affiliates

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

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~~Affiliated~~ **Transactions with Affiliates:**

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

- If the concern relates to the fair value of ~~an affiliated transaction~~ 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 contract
 - 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 context 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)
- 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

III.B.5.a. Operational Risk Repository – P/C Annual

<ul style="list-style-type: none"> ○ Verify that the amount recoverable from the prior year-end has been paid
<p>-----<i>Detail Eliminated to Conserve Space</i>-----</p>

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

Analysis 3 – III.B.5.d. Operational Risk Repository – Analyst Reference Guide

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

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

Exposure to ~~Affiliated~~ Transactions with Affiliates

<i>Property/Casualty #</i>	<i>Life/A&H/Fraternal #</i>	<i>Health #</i>
6, 7, 8	6, 7, 8	6, 7, 8

PROCEDURE #6 assists analysts in determining whether any concerns exist regarding changes in the insurer’s corporate structure. Significant changes in corporate structure may materially impact the entity’s future financial condition and generally require prior regulatory approval. Analysts should closely analyze changes in corporate structure in order to understand the motivation for the change. By understanding the corporate structure in which the ~~health entity~~insurer operates, analysts may be able to foresee future problems and take appropriate action. For example, a common corporate structure analysts may encounter involves a holding company whose only significant asset is the stock of the insurance entity. The holding company may have financed the acquisition of the insurer through bank financing or other debt where the debt service by the holding company is completely dependent upon dividends paid by the insurer. This type of corporate structure warrants close attention by analysts to ensure that dividends are valid and in compliance with your state’s applicable dividend restrictions, and that any other payments by the insurer to the holding company are legitimate, rather than dividends in disguise. Analysts should also be alert to a corporate structure that includes affiliated brokers or intermediaries that may be recording unusual or significant levels of commissions and fees. When a corporate structure is involved that includes multiple tiers of affiliates where significant levels of surplus are comprised of investments in affiliates, analysts should focus on the level of ~~real~~ surplus that exists on a consolidated basis.

Additional steps may be performed if the insurer’s corporate structure elevates concerns about ~~affiliated transactions~~ 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.

PROCEDURE #7 assists analysts in determining whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines. Several types of ~~affiliated~~ 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. Analysts should refer to all of these sources of information in order to develop an understanding and assessment of the underlying ~~affiliated~~ transactions with affiliates.

The following briefly describes the key concerns to analysts for several of the major ~~affiliated~~ 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 into the insurer, analysts should determine that the infusion is recorded at fair value so as to not arbitrarily inflate surplus. In the case of purchases, sales or exchanges of loans, securities, real estate, mortgage loans, or other investments, the concern to

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

analysts is primarily one of valuation. These types of transfers should be at arm’s length and recorded at fair value.

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

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

PROCEDURE #8 assists analysts in determining whether other ~~affiliated~~ transactions with affiliates are legitimate and properly accounted for. Analysts’ primary objective in this area is to understand the substance of the transactions and to determine whether the transactions are economic-based. Analysts should review the extent of transactions with officers and directors to ensure that the transactions are at arm’s length and are not detrimental to the financial condition of the insurer. Analysts should closely monitor other ~~affiliated~~ transactions 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, analysts should closely review the financial statements of the parent to determine the parent’s ability to repay the receivable. Structured settlements acquired from an affiliated life insurance company may also represent a collectability risk to the insurer. When the amounts of structured settlements are significant, analysts should review and understand the financial statements of the life insurance affiliate.

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Additional Analysis and Follow-Up Procedures

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

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

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

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

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

~~AFFILIATED TRANSACTIONS WITH AFFILIATES~~ direct analysts to take additional steps if concerns regarding the economic substance of an affiliated 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, the analyst should 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).

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

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

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

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

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

Example Prospective Risk Considerations

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

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

Discussion of Quarterly Procedures

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

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

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

Analysis 4 – IV.A. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations

IV.A. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations

Table of Contents

Invested Assets	582
Primer on Derivatives	583
Health Receivables	588
Separate Accounts (Life).....	592
Risk Transfer other than Reinsurance (Health)	597
Other Provider Liabilities (Health).....	591
Income Statement and Surplus	598
Risk-Based Capital	600
a. Property & Casualty.....	601
b. Life & A&H, Fraternal	603
c. Health	604
B. Affiliated Transactions <u>with Affiliates</u>	605
Insurers in Run-off	607
C. TPAs and MGAs.....	608
Reinsurance	609
a. Property & Casualty.....	610
b. Life & A&H, Fraternal	611
c. Health	612
Audited Financial Report	615
Management’s Discussion and Analysis	616
Management Considerations	617
d. Corporate Governance	617
e. Risk Management.....	618
f. Communication and Coordination	620
References.....	620

IV.A. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations

A. ~~Affiliated~~ Transactions with Affiliates

SSAP No. 25 - *Affiliates and Other Related Parties* defines an affiliate as an entity that is within the holding company system or a party that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity. According to SSAP No. 25, control is defined as possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person or entity, whether through the a) ownership of voting securities, b) by contract other than a commercial contract for goods or non-management services, c) by contract for goods or non-management services where the volume of activity results in a reliance relationship, d) by common management, or e) otherwise. Control is presumed to exist when an entity or person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities. An analyst may also refer to the NAIC *Insurance Holding Company System Regulatory Act* for additional guidance.

Transactions between affiliates and other companies within the same holding company system shall be fair and reasonable. The accounting for assets transferred between affiliates is generally determined by an analysis of the economic substance of the transaction. An economic transaction is an arm's length transaction that results in the transfer of risks and rewards of ownership and represents a consummated act. An arm's length transaction is defined as one in which a willing buyer and seller, each being reasonably aware of all relevant facts and neither under compulsion to buy, sell or loan, are willing to participate. Such a transaction must represent a bonafide business purpose demonstrable in measurable terms, such as the creation of a tax benefit, an improvement in cash flow position, etc. A transaction that results in the mere inflation of surplus without any other demonstrable and measurable improvement is not an economic transaction.

Determining that the risks and rewards of ownership have been transferred to the buyer requires an examination of the underlying facts and circumstances. The following circumstances may raise questions about the transfer of risks:

- a. A continuing involvement by the seller in the transaction or in the assets transferred, such as through the exercise of managerial authority to a degree usually associated with the ownership, perhaps in the form of a remarketing agreement or a commitment to operate the property.
- b. Absence of significant financial investment by the buyer in the asset transferred as evidenced, for example, by a token down payment or by a concurrent loan to the buyer.
- c. Repayment of debt that constitutes the principal consideration in the transaction dependent on the generation of sufficient funds from the asset transferred.
- d. Limitations or restrictions on the purchaser's use of the asset transferred or on the profits from it.
- e. Retention of effective control of the asset by the seller.

Security swaps of similar issues between or among affiliated companies are considered non-economic transactions. Swaps of dissimilar issues accompanied by exchanges of liabilities between or among affiliates are considered non-economic transactions. The appearance of permanence is also an important criterion in establishing the economic substance of a transaction. If subsequent events or transactions reverse the effect of an earlier transaction, the question is raised as to whether economic substance existed in the case of the original transaction. In order for a transaction to have economic substance and thus warrant revenue (loss) recognition, it must appear unlikely to be reversed.

IV.A. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations

A bonafide business purpose would exist, for example, if an asset were transferred in order to create a specific advantage or benefit. The advantage or benefit must be to the benefit of the insurer. A bonafide business purpose would not exist if the transaction was initiated for the purpose of inflating (deflating) a particular insurer's financial statement, including effects on the balance sheet or income statement.

When accounting for a specific ~~affiliated~~ transaction with affiliates, the following valuation methods should be used, according to SSAP No. 25:

- a. Economic-based transactions between affiliates should be recorded at prevailing fair values at the date of the transaction.
- b. Non-economic-based transaction between affiliated insurers should be recorded at the lower of existing book/adjusted carrying values or prevailing fair values at the date of the transaction.
- c. Non-economic-based transaction between an insurer and an entity that has no significant ongoing operations other than to hold assets that are primarily for the direct or indirect benefit or use of the insurer or its affiliates should be recorded at the prevailing fair value at the date of the transaction. However, to the extent that the transaction results in a gain, that gain should be deferred until such time as permanence can be verified.
- d. Transactions that are designed to avoid statutory accounting practices shall be included as if the insurer continued to own the assets or to be obligated for a liability directly, instead of through a subsidiary.

Assets may be valued on a different basis if held by a life insurer versus a property/casualty insurer. Therefore, the regulator must take this into consideration when using the general guidelines. In the absence of specific guidelines or where doubt exists as to the propriety of a special accounting method, the domiciliary state should be consulted.

Analysis 5 – IV.B. Supplemental Analysis Guidance – Notes to the Financial Statement

IV.B. Supplemental Analysis Guidance – Notes to the Financial Statement

Note 10 – Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

As discussed in SSAP No. 25—*Affiliates and Other Related Parties*, related party transactions are subject to abuse because reporting entities might be induced to enter transactions that might not reflect economic realities or might not be fair and reasonable to the insurer or its policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny. Because of this, the purpose of this Note is to provide detailed information regarding all types of affiliates and ~~affiliated~~ transactions with affiliates. The accounting guidance for affiliates is addressed in SSAP No. 25 which defines an affiliate as an entity that is within the holding company system or a party that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity.

Section		Risks
A, B, C, D	<p>The analyst should use the information in this Note to gain an understanding of the effects of the related party transactions on the financial statement and determine whether concerns exist regarding affiliated transactions <u>with affiliates</u>. The analyst should evaluate amounts owed by a related party to determine if there may be a significant collectability risk. The financial statements of the related party should be reviewed to determine the entity’s ability to repay the amounts due. The analyst should understand the terms and manner of settlement of intercompany balances. Large or increasing amounts owed to the insurer from a related party may pose a liquidity risk should the insurer require immediate repayment and may also indicate an inability to repay the amount due to the insurer. Large or increasing amounts owed by the insurer to a related party may also pose a liquidity risk to the insurer because the payable may have resulted from an effort to move available cash to an affiliated entity that is experiencing cash flow problems. The terms and manner of settlement should be reviewed to determine if there are any unusual disclosures that might indicate that the terms and manner of settlement are other than arm’s length. The analyst should check to see if the company disclosed any changes in the method of establishing the terms of the related party transaction from that used in the preceding period.</p> <p>It is critical to determine whether investments in affiliates are material and are properly valued. When investments in affiliates are significant, it is important for the analyst to review and understand the underlying financial statements of the affiliate. It is only through this process that the analyst can detect situations where the investments may be substantially overvalued.</p>	CR, LQ, OP, ST
E	<p>It is important to evaluate the effect of any guarantees or affiliated undertakings <u>with affiliates</u> that may have a substantial impact on the insurer in the future. For example, if the insurer has guaranteed additional capital contributions to a subsidiary to maintain minimal regulatory requirements, the analyst should attempt to assess the probability and timing of future funding and its impact on the insurer.</p>	LQ, OP, ST
F, G	<p>In cases where the insurer and other enterprises are under common ownership or control relationships exist, the analyst should evaluate the risk that the operating results or financial position of the insurer may pose. The risks may be significantly different than those that would have existed if the enterprises were autonomous. Unusual agreements or affiliated transactions <u>with affiliates</u> may not make good business sense in terms of the consequences to the insurer. The analyst should seek to understand the rationale for the agreements or transactions in order to determine any negative impact on the financial condition of the insurer and whether any regulatory action is appropriate.</p>	CR, LQ, OP, ST

Analysis 6 – V. C. Domestic and/or Non-Lead State Analysis – Form D Procedures

Special Notes:

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

Form D – Prior Notice of a Transaction

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

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12. For management and service agreements, does Form D include the following:

- A brief description of the managerial responsibilities or services to be performed
- A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made (compensation bases other than actual cost should be closely evaluated)

13. For cost-sharing arrangements, determine whether the Form D includes the following:

- A brief description of the purpose of the agreement
- A description of the period of time during which the agreement is to be in effect
- A brief description of each party’s expenses or costs covered by the agreement
- A brief description of the accounting basis to be used in calculating each party’s costs under the agreement
- A brief statement as to the effect of the transaction upon the insurer’s surplus
- A statement regarding the cost allocation methods that specifies whether proposed charges are based on ‘cost or ~~market other than cost.~~’ If ~~market based other than cost,~~ include the rationale for not using ~~market instead of~~ cost, including justification for the company’s determination that amounts are fair and reasonable
- A statement regarding compliance with the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual) regarding expense allocation

14. For management, service and cost-sharing agreements, in accordance with the NAIC Insurance Holding Company System Act #440 and NAIC Insurance Holding Company System Model Regulation #450~~holding company act and regulation of the state,~~ does the agreement¹:

- Identify the person providing services and the nature of such services
- Set forth the methods to allocate costs
- Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the AP&P Manual

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

V.C. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

- Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement
- State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance
- Define ~~books and~~ records and data of the insurer to include all ~~books and~~ records and data developed or maintained under or related to the agreement that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate
- Specify that all ~~books and~~ records and data of the insurer are and remain the property of the insurer, and:
 - Are subject to control of the insurer
 - Are identifiable
 - Are segregated from all other persons' records and data or are readily capable of segregation at no additional cost to the insurer²
- State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer
- Include standards for termination of the agreement with and without cause
- Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services and for any actions by the affiliate that violate provisions of the agreement required in Subsections 19B(11), 19B(12), 19B(13), 19B(14) and 19B(15) of this regulation
- Specify that, if the insurer is placed in supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts]~~receivership of seized by the insurance commissioner under the State Receivership Act:~~
 - All of the rights of the insurer under the agreement extend to the receiver or commissioner to the extent permitted by [law of the state]
 - All records and data of the insurer shall be identifiable and segregated from all other persons' records and data or readily capable of segregation at no additional cost to the receiver or the commissioner
 - A complete set of All ~~books and~~ records and data will immediately be made available to the receiver or the insurance commissioner, shall be made available in a usable format and shall be turned over to the receiver or insurance commissioner immediately upon the receiver or the commissioner's request and the cost to transfer data to the receiver or the commissioner shall be fair and reasonable³
 - The affiliated person(s) will make available all employees essential to the operations of the insurer and the services associated therewith for the immediate continued

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

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

V.C. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

performance of the essential services ordered or directed by the receiver or commissioner

- Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to the [supervision and receivership acts]State Receivership Act
- Specify that the affiliate will provide the essential services for a minimum period of time [specified in the agreement] after termination of the agreement, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], as ordered or directed by the receiver or commissioner. Performance of the essential services will continue to be provided without regard to pre-receivership unpaid fees, so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court
- Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts]a seizure by the insurance commissioner under the State Receivership Act, and will make them available to the receiver or commissioner as ordered or directed by the receiver or commissioner for so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court
- Specify that, in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver’s authority over the insurer, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], and portions of the insurer’s policies or contracts are eligible for coverage by one or more guaranty associations, the affiliate’s commitments under Subsections 19B(11), 19B(12), 19B(13) and 19B(14) of this regulation will extend to such guaranty association(s)

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

Assessment of Form D – Prior Notice of a Transaction

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

- a. For reinsurance agreements, are the general terms, settlement provision, and pricing consistent with those of ~~non-affiliated~~ agreements with non-affiliates?
- b. For management, service or cost-sharing agreement, are the charges or fees to be paid by/to the insurer reasonable in relation to the cost of such services?
- c. Are fees paid for related party transactions consistent with the applicable section of the state’s Insurance Holding Company Act? (Note: Insurers should not use related-party transactions as a method for transferring profits of the insurance company to an affiliate or related party.)
- d. Will the insurer have adequate surplus upon completion of the transaction?

V.C. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

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

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

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

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

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

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

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Summary and Conclusion

Following the review of previous procedures, Ddevelop and document an overall summary and conclusion including items for follow up regarding the review of the holding company Form D.

Recommendations for further action, if any, based on the overall conclusion above could consider steps such as the following:

- Contact the insurer seeking explanations or additional information
- Review support provided by management supporting its assessment that the agreement meets the standard of “fair and reasonable”
- Review the insurer’s business plan on file or obtain a more current business plan if applicable
- Require additional interim reporting information from the insurer including forecasted cash flows relating to the agreement (e.g., 1-3 years) to evaluate materiality of changes in year-to-year cash flows to the insurer, particularly if the agreement is other than cost-based or if there are other ongoing concerns noted
- Compare cash flows relating to any prior agreements (if similar in services/scope, and whether those were with affiliates or non-affiliates) to the forecasted cash flows relating to the proposed transaction or amendment. The comparison should consider not just the fees/expenses, but also the impact on cash flows relating to the services provided (e.g., reduced claims cost, etc.)
- Consider the insurer’s aggregate exposure to all agreements with affiliates, current and trending, absolute dollars and relative to base (e.g., capital and surplus, total expenses, etc.) and whether the terms and amounts meet the “fair and reasonable” standard
- Determine if one or more agreements with affiliates trigger or increase concerns regarding related party risks or create financial solvency concerns

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

V.C. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

- Refer concerns to the examination section for targeted examination or follow-up on the next full-scope examination. Consider suggesting specific procedures to be performed by placing them in the supervisory plan section of the IPS.
- ~~Engage~~ Consider the need to engage external resources to assist in the review of complex agreements with affiliates (i.e., an independent actuary or other reinsurance expert to review specific reinsurance contracts, investment expert to review investment management agreements with affiliates)
- Meet with the insurer’s management
- Other (explain)

Notice to Insurer

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

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

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

V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

Analysis 7 – V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

Non-Lead State Holding Company System Analysis Procedures

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

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

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Form D – Prior Notice of a Transaction

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

Best Practices for ~~Affiliated Management and Service~~ Agreements with Affiliates for Management and Services

Charges for Fees for Services

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

Pricing for agreements with affiliates may be negotiated between related parties on a variety of basis including cost and market other than cost-based pricing. Regardless of the method utilized, it is the responsibility of management to appropriately evidence that the terms of the agreement satisfy the “fair and reasonable” standard. It is management’s responsibility to provide documentation demonstrating that this standard has been met using any of a number of methods including but not limited to those described below. The Form D filing should thus include management’s documented support for its assertion that the transaction meets the “fair and reasonable” standard.

Transactions at Cost

This is the simplest method to evaluate the basis on which entities are charged. Transactions between two or more affiliates can be deemed to be fair and reasonable, subject to further evaluation of the allocation basis, if the transactions are entered into at a value that is based on or reflects an allocation of actual costs.

The costs borne by the entity providing the agreed upon services are allocated to the entity receiving those services. As stated in the related SSAPs, cost allocation must be done in a manner that is fair and yields the most accurate results. Theoretically the service provider should not make a profit or incur a loss if the transaction is at cost. Other considerations may include that:

- Costs can be apportioned directly as if the entity incurring the expense had paid for it directly, or
- Allocated using pertinent factors or ratios such as studies of employee activities, salary ratios or similar analysis.

V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

If cost is the method used by management to establish “fair and reasonable,” simply identifying a “rate per unit” estimate on the amount of costs and number of units, does not in and of itself make the charge reasonable. This rate per unit should result in a reasonable approximation of the actual, realized costs. Where appropriate, using a rate per unit is a method for easily calculating interim payments that are due to the service provider. If a rate per unit is used to allocate costs, an expense “true-up” may be prepared and settled on a periodic (e.g., annual) basis to reconcile the estimated costs (payments) with the actual costs incurred. The expense “true up” would serve to replace the estimated costs with the actual costs and any difference between these two would be included in a subsequent settlement between the parties.

Note: Transactions with alien parties may require additional deliberation due to potential conflicts between international tax laws and provision of services at cost vs. market other than cost.

Transactions at Other than Cost

Management is responsible for its assertion that transactions at other than cost that are entered into between affiliates meet the standard of fair and reasonable both on the basis of the amount of charges being allocated and on the basis of the allocation. In the case of two or more affiliates, transactions can be deemed to be at arm’s length (and therefore fair and reasonable) if the transactions are entered into at a value consistent with current market value.

Management may use various approaches to demonstrate that this standard has been met, which could be applied in the following manner:

- The entity providing the service performs a substantial portion of its business with non-affiliated entities and can establish a price for a transaction with an affiliate that is similar to the price charged to non-affiliates, since the non-affiliates are assumed to have negotiated at arm’s length.
- The entity receiving the services analyzes and retains up-to-date documentation of localized market rates of services that could be provided to the entity by non-affiliated parties and demonstrate that the price paid to the affiliate for services is comparable to or within the range of prices charged by non-affiliated service providers. As each transaction or service can be unique and the overall terms of service agreements may vary considerably, determining a fair and reasonable charge can be difficult. Judgement is inherently required when constructing a reasonable range of comparable values using non-affiliated party information. The Form D filing should include management’s documented support for its assertion that the transaction meets the “fair and reasonable” standard.
- The entities providing and receiving the service agree to a “cost-plus” arrangement whereby the rate charged under the agreement is based upon the cost to perform the service plus a negotiated fee/profit margin intended to recognize the risk of providing the service. In some cases, the overall “cost-plus” rate or the negotiated fee/profit margin component may be comparable to market rates for similar services as indicated in the bullets above. However, in other situations, the services provided may be unique and not comparable to prevailing market rates. In these situations, it is the responsibility of management to justify the use of a “cost-plus” approach and to provide adequate supporting rationale and documentation demonstrating its analysis supporting the profit margin selected under the approach. Transactions at “cost-plus” should be carefully reviewed to ensure that they meet the “fair and reasonable” standard.
 - These types of agreements should only be entered into as a method of last resort and may not be acceptable in all jurisdictions. As such, the review of a Form D using this method

V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

should confirm that cost-plus is required (i.e., by another regulator or jurisdiction) and/or that there is no acceptable alternative approach.

Transactions entered into at arm's length by-with unaffiliated parties who willingly and freely (not under compulsion) enter into a transaction and arrive by negotiation at an agreed upon price (value) are by definition fair and reasonable. That does not mean that otherwise identical transactions between various unaffiliated parties will all be valued identically because, among other reasons, parties will vary as to their degree of motivation to transact, their relative advantages in terms of scale, their skills in negotiating, their time horizon to complete the transaction, and their available resources. Value also varies among other things depending on whether transactions are more specialized (i.e., involve non-commoditized goods or services) as well as depending upon the liquidity of the market for the goods and services (i.e., many service providers entering into many similar transactions where the terms and pricing of transactions are transparent to the public). Thus, even for seemingly identical transactions, there will be a range of values at which the market will transact and, as such, a range of values that should be viewed as being fair and reasonable. Further, the fair and reasonable range of values will be wider or narrower for different types of transactions.

When considering a particular transaction and the potential range of values that would satisfy the fair and reasonable standard, the following factors may be considered to the extent relevant:

- Whether the subject good or service was previously transacted with a non-affiliate, and if so, the reason or rationale behind the change to transact with an affiliate.
- Whether the service was previously provided internally at the insurer and the rationale and business purpose for moving it to an affiliate.
- Whether the transaction involves an existing affiliate with an established history of performance and involvement in similar transactions with non-affiliates.
- Whether and, if so, to what degree the value at which the parties transact compare with the value at which the prior arrangement with non-affiliates transacted.
- Whether there are other aspects of the prior and proposed transaction (e.g., other agreement terms and conditions) that should be considered in evaluating differences in the value which is being transacted.
- Whether the transaction is the result of a broader strategic corporate restructuring, such that what might appear to be a stand-alone transaction is only one part of the implementation of that restructuring and, if so, whether there are other aspects of the broader restructuring that should be considered.
- If the filing is to amend an existing agreement with an affiliate, the intended business purpose of the proposed change.
- Whether the entity receiving the services in an agreement with an affiliate utilized other observable market factors and/or entity-specific cost or margin information in addition to, or to supplement, internal or external pricing for a similar product or service including industry sales price averages, market conditions, profit objectives, margin achieved on similar products, etc.
- Whether financial information from insurers and their affiliates including operating ratios, profit margins, and similar data can inform what would be considered a fair and reasonable range of profit margins on cost-plus agreements.

V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

Transactions at Market Rate

The entity providing the service performs a substantial portion of its business with non-affiliated entities and can establish a price for affiliates similar to charges to non-affiliates, since the non-affiliates are assumed to have negotiated at arm's length.

- ~~The entity receiving the services analyzes and retains up-to-date documentation of localized market rates of services that could be provided to the entity by non-affiliated parties. Since each transaction of service is unique, determining a fair and reasonable charge is very difficult and time-consuming. This method is the least relevant and reliable, and not efficient in establishing the rate.~~
- ~~Transactions at cost plus mark-up that is equal to market rate should be reviewed carefully and should be deemed fair and reasonable. Transactions at cost plus mark-up that is less than market rate should be reviewed carefully to determine if it is fair and reasonable.~~

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

- ~~Can be apportioned directly as if the entity incurring the expense had paid for it directly, or~~
- ~~Allocated using pertinent factors or ratios such as studies of employee activities, salary ratios or similar analysis.~~
- ~~Transactions at cost less a discount should be reviewed carefully to determine if it is fair and reasonable.~~

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

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

Regulator Considerations

Items for initial filing review—the actual document(s) should be filed, not merely a summary (these apply regardless of the method – cost or other than cost – unless otherwise noted):

- Identify and document:
 - The specific services that will be provided
 - The specific expenses and/or costs that are to be covered by each party (cost)
 - The entity(ies) providing and receiving each of those services
 - Separate affiliate entities from non-affiliates

V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

- Allocation method (~~cost or market~~other than cost) of the agreement
 - The charges or fees for the services indicated
- The accounting basis used to apportion expenses (cost)
- Confirm that contract provisions will be accounted for in accordance with SSAPs
- Invoicing and settlement terms (should allow for admittance under SSAP 96)
- The effective date and termination date
- The records rights and policies of each entity that is a party in the contract
- The governing law
- Any unique and relevant clauses not covered above
- Financial statements of the entity providing the services
- Other Considerations for Review of the Agreement:
 - Determine the reasonableness of the allocation method and the charges or fees, considering such items highlighted in the “Transactions at Cost” and “Transactions at Other than Cost” sections above
 - Assess if cash flows/activities relating to the agreement are in line with forecasted amounts provided in the initial Form D review and, if not, inquire about material or unexpected variations, their cause, and implications
 - Consider if there have been significant changes in the market for the services subject to the agreement, whether management has considered them and, if so, whether changes to the agreement have been made or are anticipated (for ~~market-based~~other than cost-based agreements)
 - Inquire of management if the agreement continues to be fair and reasonable and their supporting rationale and whether it has changed since the initial filing
 - Consider the insurer’s aggregate exposure to all agreements with affiliates, current and trending, both in terms of absolute dollars as well as relative to a base (e.g., capital and surplus; total expenses, etc.)
 - Does the agreement trigger or increase related party transaction or financial /solvency concerns
 - Determine the agreement does not divert funds that could be considered a dividend
 - Determine the agreement does not result in the insurer’s fair share of expenses being retained by or allocated to a parent/affiliate, thereby masking the true performance of insurance operations
 - Summarize the business rationale for purpose and need of the agreement
 - Summarize the financial impact of the agreement on the company’s surplus or financial condition
 - Summarize the impact the agreement would have on the priority status of the company
 - Summarize the reasons to approve/disapprove the agreement

Examination Verification and Validation

V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

Both analysts and examiners are involved in assessing whether an affiliated agreement complies with statutory requirements (financial and non-financial) and is implemented by the parties in a manner that is consistent with representations made in the Form D as approved by, and considering any conditions imposed by, the regulator. Because both the analysis and examination functions are involved, care should be taken by each to leverage the knowledge and capabilities of the other, to share findings and concerns, and to minimize redundant or unnecessary efforts as well as regulatory burden on the parties involved.

Because of the necessity of a regulated entity to file a Form D for approval (or non-disapproval), the analyst generally is the initial and primary point of contact and is involved throughout the Form D review process. The analyst would thus be most knowledgeable about the agreement from its outset, including how it was initially framed and presented in the Form D, what was learned during the review process, whether any changes were made or required for it to be approved (or not disapproved), any conditions or stipulations that may have been imposed by the regulator as part of that approval/non-disapproval process, as well as about any amendments that may have occurred or inquiries or concerns that may have been received from other states relating to the agreement.

Also, as part of the Form D review process the analyst may have identified issues for which, after implementation of the agreement and in the next examination, it would be appropriate for examiners to follow-up and provide feedback to the analyst. These follow-up procedures could be aimed at determining whether the agreement was implemented consistent with its own terms and its compliance with regulatory requirements, financial or risk impacts to the insurer, and whether the underlying economics of the transactions pursuant to the agreement are consistent with representations in the Form D as approved (or non-disapproved).

In determining which agreements with affiliates or aspects of such agreements are to be reviewed during an onsite examination, the analyst should consider the following criteria:

- Is the agreement new or significantly modified since the prior examination?
- What is the nature and extent of services provided under the agreement?
- What is the basis for pricing/consideration paid under the agreement and what support is provided for that basis (i.e., market other than cost-based allocations with limited support would be of highest concern)?
- Does the ongoing performance of the agreement raise concerns (i.e., excessive profitability of affiliated service provider and/or high expense structure of insurer)?
- Is there a change in business plan or operations that has, or could significantly impact risks or obligations of the parties or the cashflows between the parties to the agreement as compared to what was represented in the Form D or most recent amendment or since the prior examination?
- Whether there are any other concerns that the analyst might have related to the agreement, e.g., impact on rate filings, company compliance with filing requirements, the Company's financial performance, etc. Note that the financial aspects of an affiliated agreement may cause or exacerbate overall financial or even solvency concerns of a company on the one hand, and on the other hand, emerging financial or solvency concerns triggered by other causes unrelated to the affiliated agreement may impact the relative significance of transactions which are subject to the agreement.

Considering the potential significance of concerns noted based on these criteria, the analyst should consider recommending specific follow-up procedures to be performed during an onsite examination, as appropriate. For example, the examination team may be able to verify and validate assertions made by

V.F. Domestic and/or Non-Lead State Analysis – Analyst Reference Guide

management in the Form D filing, as well as verify that the agreement has been implemented and is functioning as approved by the department. In addition, the examination team may be in a better position to assess the fairness and reasonableness of expense allocations after the agreement has been in place for a period of time. Suggested follow-up procedures can be included in the Supervisory Plan section of the IPS and/or covered in the examination planning meeting between the assigned analyst and the examination team.

Exam 1 – Section 1.III – General Examination Considerations

III. GENERAL EXAMINATION CONSIDERATIONS

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

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

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F. Outsourcing of Critical Services

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Affiliated Service Providers

Specific requirements related to an insurance company’s utilization of cost sharing services and management services with affiliates are included in the NAIC’s *Insurance Holding Company System Model Regulation* (Model # 450). Prior to entering into one of these agreements, an insurer must first give notice to the State Insurance Department of the proposed transaction via the Form D filing. As the receipt and review of the Form D filing is typically the responsibility of the Department Analyst, the examiner should leverage that review to the extent possible. If the agreement has not been obtained and reviewed by the analyst, or if significant agreements have not been modified since 12/31/~~14~~21 (date that new provisions were effective in Model #450), the examiner should obtain and evaluate whether the agreement includes the provisions listed below:

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

1. Identify the person providing services and the nature of such services;
2. Set forth the methods to allocate costs;
3. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;
4. Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;
5. State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;
6. Define ~~books and~~ records and data of the insurer to include all ~~books and~~ records and data developed or maintained under or related to the agreement that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate;

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

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

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

Affiliated Service Agreements

Both analysts and examiners are involved in assessing whether an affiliated agreement complies with statutory requirements (financial and non-financial) and is implemented by the parties in a manner that is consistent with representations made in the Form D as approved by, and considering any conditions imposed by, the regulator. Because both the analysis and examination functions are involved, care should be taken by each to leverage the knowledge and capabilities of the other, to share findings and concerns, and to minimize redundant or unnecessary efforts as well as regulatory burdens on the parties involved.

Because of the necessity of a regulated entity to file a Form D for approval (or non-disapproval), the analyst generally is the initial and primary point of contact and is involved throughout the Form D review process. The analyst would thus be most knowledgeable about the agreement from its outset, including how it was initially framed and presented in the Form D, what was learned during the review process, whether any changes were made or required for it to be approved (or not disapproved), any conditions or stipulations that may have been imposed by the regulator as part of that approval/non-disapproval process, as well as about any amendments that may have occurred or inquiries or concerns that may have been received from other states relating to the agreement.

Also, as part of the Form D review process the analyst may have identified issues for which, after implementation of the agreement and in the next examination, it would be appropriate for examiners to follow-up and provide feedback to the analyst. These follow-up procedures could be aimed at determining whether the agreement was implemented consistent with its own terms and its compliance with regulatory requirements, financial or risk impacts to the insurer, and whether the underlying economics of the transactions pursuant to the agreement are consistent with representations in the Form D as approved (or non-disapproved). For example, it may be appropriate to review significant affiliated transactions that utilize ~~market~~ other than cost-based expense structures for in-depth examination review (see Related Party Repository for possible procedures). If several years have elapsed since entering into the affiliated service agreement, the examiner can review whether and to what extent the service provider profited due to the terms of the agreement or if the insurer is trending towards being deemed in a hazardous financial condition as a result of the charges. However, any requested follow-up procedures suggested by the analyst may be more tailored to a particular agreement than the sample procedures that are included in the examination repositories and should thus be a primary consideration by the examiner in developing the examination plan with respect to agreements with affiliates. Any findings from the examination review should be reported back to the analyst via the Summary Review Memorandum (SRM), exit conference, etc.

Cost or Other than Cost Considerations

An affiliated service agreement should specify whether the charges are based on ‘cost or ~~market~~ other than cost’. Agreements with a cost-based structure utilize the actual cost to the service provider, requiring less judgment in setting the price charged by the affiliate. As such, there is no profit or loss to the service provider with the transaction. Within cost-based expense

agreements, ensuring proper allocation of costs is essential so the insurance company is not being charged for additional or inappropriate costs.

Agreements utilizing an other than cost approach, however, require more judgment when setting the price charged by the affiliate. If a market-based structure is utilized, the rationale for using market instead of cost, as well as the justification for the company’s determination that amounts are fair and reasonable, should be thoroughly documented by management and demonstrate that the price charged by the affiliate does not result in the transfer of excessive profits from the insurance company to the affiliate. Similar expectations also apply to ‘cost-plus’ arrangements whereby the rate charged under the agreement is based upon the cost to perform the service plus a negotiated fee/profit margin intended to recognize the risk of providing the service.

Typically, the department analyst (or other assigned regulator) conducts the initial assessment of such agreements through its review and approval of Form D filings. As such, the examiner should meet with the analysts and obtain their input as to which agreements, or aspects of agreements, they would prioritize for review during the examination.

For example, the analyst may suggest that the exam team confirm the regulatory approval by performing additional procedures to evaluate the ongoing fairness/reasonableness of the pricing used in an other than cost-based agreement after it has been placed in service. Based upon recommendations from the department analyst during examination planning and/or the examination’s risk assessment procedures, it may be appropriate to review significant affiliated transactions that utilize other than cost-based expense structures for in-depth review (see Related Party Repository for possible procedures). For example, if several years have elapsed since entering into the affiliated service agreement, the examiner can review whether and to what extent the service provider profited due to the terms of the agreement or if the insurer is trending towards being deemed in a hazardous financial condition. Any findings from this review should be reported back to the analyst via the Summary Review Memorandum (SRM), exit conference, etc.

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Exam 2 – Section 2 – Phase 1 - Understand the Company

PHASE 1 – UNDERSTAND THE COMPANY AND IDENTIFY KEY FUNCTIONAL ACTIVITIES TO BE REVIEWED

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Consideration of Related Parties

A consideration of related parties should begin in Phase 1 of the examination. Related parties are defined as entities that have common interests as a result of ownership, control, affiliation or by contract. 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. The examiner’s review of the company in Phase 1 includes gaining an understanding of the insurer’s significant related party agreements and/or transactions (e.g., pooling agreements, reinsurance contracts, intercompany management and service agreements, tax-sharing agreements, etc.). Special consideration should be given to evaluating the nature and terms of the service/management agreements with affiliates (e.g., cost, other than cost, etc.) and whether the analyst has noted any concerns or follow-up for examination (see Section 1, Part III F in this Handbook for more information). In gaining this understanding, the examiner should leverage information already obtained by the financial analyst to the extent possible. If necessary, the examiner may confirm directly with the insurer under examination to determine the completeness and accuracy of such information. For additional guidance regarding the consideration of related parties, refer to Section 1, Part IV D in this Handbook.

Exam 3 – Section 3 – Examination Repositories - Related Party Considerations

Note: Although not included here for purposes of conserving space, the introductory note cross-referencing to Section 1, Part III, F – Outsourcing of Critical Functions is also proposed for inclusion in the Reinsurance Ceding and Reinsurance Assuming repositories, due to their inclusion of affiliated reinsurance contract considerations.

EXAMINATION REPOSITORY – RELATED PARTY

Identification of Risks:

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

Annual Statement Blank Line Items

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

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

Please Note:

- Transactions resulting from related party tax sharing and reinsurance agreements are typically reported on the appropriate tax and reinsurance financial statement line items, which are not listed above.
- The examiner should consider the company’s compliance with the state statutory guidelines when reviewing affiliate and other related-party contracts.
- Before considering the scope of examination work involving agreements with affiliates, examiners are advised to refer to Section 1, Part III, F – Outsourcing of Critical Functions herein with regard to the need to consult with the departmental analysts so as to benefit from their experience with approved agreements in place at the company and their knowledge of factors that they have considered in suggesting follow-up work that may be necessary during the examination, which may vary from one agreement to the other.
- For additional guidance on related party and intercompany transactions, see Section 1, Part IV, D - Related Party/Holding Company Considerations.

Relevant Statements of Statutory Accounting Principles (SSAPs)

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

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

Financial Reporting Risks						
<p>The insurer is not properly recording and disclosing related-party activities.</p>	<p>OP ST</p>	<p>AC VA PD CM CO</p>	<p>RPHCC</p>	<p>For identified related parties, the insurer maintains records (e.g. consolidated schedule of intercompany allocations, balances, etc.) so that individual allocations and balances are easily identifiable and amounts that have been offset are identifiable.</p> <p>The insurer has procedures, including supervisory review, in place to ensure that all related-party activities are properly disclosed and reported.</p> <p>Management reviews contract terms periodically to ensure that they are reasonable and properly reflect current operations..</p> <p>The insurer has a process that identifies transactions that are subject to regulator approval and ensures that transactions are approved as appropriate.</p> <p>The insurer has a policy in place that requires written</p>	<p>Verify that a review of intercompany balances is performed.</p> <p>Consider whether service transactions are occurring but are not being given accounting recognition, such as receiving or providing accounting, management or other services at no charge to a related party. Determine the materiality of such transactions and the impact on the insurer.</p> <p>Review the procedures to ensure that related party activities are properly disclosed, reported and reviewed by supervisory personnel.</p> <p>Verify that contracts are periodically reviewed and updated for changes in operations.</p> <p>Review a sample of past transactions to confirm management’s process was executed, as appropriate.</p> <p>Review meeting minutes of the board of directors</p>	<p>For a sample of identified related parties, review transactions to ensure they are being properly reported and disclosed. Review all other related-party disclosures for reasonableness.*</p> <p>Confirm whether the related-party relationship is disclosed in the insurer’s holding company registration statement. Review the insurer’s transactions with the suspected related party and determine whether the transactions are subject to any prior approval requirements in the domiciliary state’s insurance code <u>and have been filed with the department in a timely manner.</u></p> <p>Review the contracted transactions with affiliates and determine whether they are at arm’s length and properly reported as economic or non-economic, in accordance with SSAP No. 25.</p> <p>Obtain the loan document(s) or written guarantee and verify that the terms of the contract are equitable and</p>

				approval from the board of directors (or committee thereof) prior to entering into any loan transaction (lending or borrowing), or guarantees (parental/affiliated surplus support or loan repayment/collateralization) to ensure that transactions meet “fair and reasonable” and “arm’s-length” standards.	(or committee thereof) for evidence of written approval of related-party loans or guarantees.	reasonable. Verify the guarantee or loan was properly disclosed in the annual financial statement and filed with the domiciliary state insurance department, if applicable.
The insurer engages in transactions <u>and service agreements</u> with affiliates that have inequitable terms.	OP ST	CM AC VA	RPHCC	<p>Management reviews related-party <u>transactions</u> agreements to ensure they that all <u>agreements</u> are at arm’s length and properly reported as economic or non-economic.</p> <p><u>Management reviews affiliated service agreements to ensure the terms of the agreement are fair and reasonable.</u></p> <p>The insurer maintains written contracts for significant transactions (expense allocations, tax-sharing agreements, etc.) with related parties that are reviewed to ensure fair and reasonable terms and are approved by the board of directors (or committee thereof) or other appropriate personnel.</p>	<p>Obtain evidence of management’s review of related-party <u>transactions and/or service agreements with affiliates, as applicable.</u></p> <p>Obtain and review the significant contracts between the insurer and its affiliates. Verify that the insurer reviews the agreements to ensure fair and reasonable terms and approval by the board of directors (or committee thereof) or other appropriate personnel.</p> <p>Verify that contracts are periodically reviewed and updated for changes in operations <u>and filed with domiciliary regulator(s) as required.</u></p>	<p>Select a sample of agreements and transactions for review to verify they agreements are consummated at arm’s length and the transactions are in accordance with the <u>approved</u> agreements. <u>If the related party transaction is not at arm’s length, verify that the transaction is appropriately accounted for as non-economic.</u></p> <p><u>Select a sample of affiliated service agreements and perform procedures to ensure the terms are fair and reasonable, such as:</u></p> <ul style="list-style-type: none"> <u>Obtain and review financial information from insurers and their affiliates to evaluate the impact of the contract terms on</u>

				<p>Management reviews contract terms and actual transactions periodically to ensure that they are reasonable and properly reflect current operations and are in compliance with related party agreements <u>and filed and/or approved as required by the state.</u></p> <p><u>Management is subject to specific authority limits regarding the ability to execute affiliated agreements</u></p> <p><u>Management documents its rationale and maintains supporting documentation (i.e., a third-party quote, third-party opinion, etc.) for the rate utilized in the affiliated agreement.</u></p>	<p><u>Test the controls in place to ensure that affiliated agreements are executed in accordance with documented authority limits.</u></p> <p><u>Obtain the company’s supporting documentation and evaluate the appropriateness of the rate used.</u></p>	<p><u>the entities’ ongoing financial results.</u></p> <ul style="list-style-type: none"> ○ <u>For example, obtain support from the affiliated service provider to evaluate the reasonableness of the service provider’s profit margin on services rendered.</u> ● <u>Obtain a sample of related party /affiliated contracts and compare the terms to unaffiliated contracts. Inquire about any material differences.</u> ● <u>Obtain a third-party quote or access benchmarking data (if available) for similar services and compare to the rate utilized in the affiliated service agreement.</u> ● <u>If a third-party quote or benchmarking to comparable services is not available, consider reviewing the Company’s internal analysis of fair and reasonable compensation, which could include but is not limited to, other observable market factors and/or entity-specific cost or</u>
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						<p><u>margin information for a similar product or service including industry sales price averages, market conditions, profit objectives, margin achieved on similar products, etc.</u></p> <ul style="list-style-type: none"> • <u>If available, obtain and evaluate the analysis supporting the review and approval of contract terms by another regulator (e.g., other state department, IRS, CCIO)</u>
<p>Intercompany allocation of general and administrative expenses among affiliates is inappropriate <u>or is not in accordance with approved agreements.</u></p>	OP	VA PD CO	RPHCC	<p>Management reviews cost-allocation contracts <u>with affiliates</u> to ensure that the basis for expense allocation is fair and reasonable. Expenses to be allocated are identified and reasonable metrics are defined, developed and used for each type of expense.</p> <p>Management also reviews the basis of allocation periodically to ensure that it is still reasonable and properly reflects current operations.</p>	<p>Review the insurer’s expense allocation worksheets and <u>supporting documentation to</u> determine whether the method of allocation follows the contract and is reasonable.</p> <p>Inquire with management regarding changes in operations that might affect expense allocation and verify that those changes are properly reflected.</p>	<p>Test the insurer’s calculation of material expense allocation for compliance with the terms of the contract. Reconcile amounts to the general ledger and Underwriting & Investment Exhibit, Part 3, and trace to receipt or payment documentation as applicable.</p>

Exam 4 – Section 4 – Examination Exhibits – Exhibit A: Examination Planning Procedures Checklist

EXHIBIT A
EXAMINATION PLANNING PROCEDURES CHECKLIST

COMPANY _____ NAME _____

PERIOD _____ OF _____ EXAMINATION _____

The following checklist details the components of Phase 1 and Phase 2, as well as other information that should be considered during the planning process. Narrative guidance is provided within Section 2 of this Handbook to aid examiners in understanding the risk-focused surveillance process.

Pre-planning Procedures

1. At least six months prior to the as-of date, notify the company and its external auditors, with company personnel’s assistance, that an examination will take place and that the auditor workpapers will be requested when the exam begins.
2. If the examination is to be performed on a company that is part of a holding company group, send an informal notification at least six months prior to the as-of date to other states that have domestics in the group.
3. Call the examination in the Financial Exam Electronic Tracking System (FEETS) at least 90 days prior to the exam start date.
 - a. If the examination is to be performed on a company that is part of a holding company group, document your attempts to coordinate the exam with the Lead State and other domestic state(s) within your group. Utilize Exhibit Z – Examination Coordination to assist with this process.
4. Send preliminary information requests to the company with sufficient lead-time to allow information to be provided prior to the start of examination fieldwork. Exhibit B – Examination Planning Questionnaire and Exhibit C, Part One – Information Technology Planning Questionnaire can be utilized to assist in developing pre-planning requests. **Note:** The examiner is encouraged, with input from the financial analyst when possible, to customize Exhibit B to the insurer being examined prior to submitting the information request.

Examiner	Date

Phase 1 – Understand the Company and Identify Key Functional Activities to be Reviewed

Part 1: Understanding the Company

Step 1. Gather Necessary Planning Information

Meet with the Financial Analyst

1. Meet (in person or via conference call) with the assigned financial analyst (and/or analyst supervisor) to gain an understanding of company information available to the department. In addition, discuss risks and concerns highlighted in the Insurer Profile Summary as well as the company’s financial condition and operating results since the last examination. Ascertain the reasons for unusual trends, abnormal ratios and transactions that are not easily discernible. Document a summary of significant risks identified by the analyst for further review on the examination. **Note:** An email exchange, in and of itself, is not deemed sufficient to achieve the expectation of a planning meeting with the assigned analyst.
 - a. If deemed necessary, obtain supporting documentation from the most recent annual financial statement analysis to aid in the identification of significant risks and facilitate ongoing discussion with the analyst.
 - ~~a.~~b. Consider utilizing Exhibit D to develop a meeting agenda for the discussion with the analyst

Exam 5 – Section 4 – Examination Exhibits - Exhibit CC: Issue/Risk
Tracking Template

EXHIBIT CC
Issue/Risk Tracking Template

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

Example risks have been included below to demonstrate the level of documentation expected to be included in a tracking template.

Issue/Risk Tracking Template

Issue/Risk Identified	Source(s) of Issue/Risk	Where Addressed	Additional Information
<i>Example 1 – Company plans to begin writing a new line of business next year.</i>	<i>Issue referred from rates and forms unit (A.1.6) and brought up in C-Level interviews (A.3.5, A.3.7).</i>	<i>See Exhibit V (Risk 3).</i>	<i>N/A</i>
<i>Example 2 – The percentage of the company’s invested assets held in equities has increased significantly over the past two years.</i>	<i>Issue referred by the financial analyst (see A.1.5) and discussed in the department planning meeting (see A.1.12).</i>	<i>See risk 1.1 on the Investment Risk Matrix (C.2.3).</i>	<i>N/A</i>
<i>Example 3 – The company’s expense ratio is significantly higher than the industry average.</i>	<i>Issue noted during examiner’s review of the AM Best report (see A.1.7).</i>	<i>Not deemed necessary.</i>	<i>After further discussion, it was noted that the company’s historical expense ratios are higher than the industry average due to the unique coverage written by the company. As ratios have been relatively flat and the company remains profitable, no additional review is deemed necessary.</i>
<u><i>Example 4 – The Company has service agreements with affiliates which may have a material impact to the insurer.</i></u>	<u><i>Issue noted during planning meeting with analyst.</i></u>	<u><i>See risk 1.1 on the Related Party Matrix (C.3.3).</i></u>	<u><i>N/A</i></u>

Exam 6 – Section 4 – Examination Exhibits – Exhibit H: Insurer Profile Summary Template

EXHIBIT H INSURER PROFILE SUMMARY TEMPLATE

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SUPERVISORY PLAN

List any specifically identified items that require further monitoring by the analyst or specific testing by the examiner. In addition, indicate if the Company is or should be subject to any enhanced monitoring, such as monthly reporting, a targeted examination or a more frequent exam cycle.

Analysis Follow-Up

- Obtain further detail regarding the impact of proposed rate increases and monitor through monthly financial reporting
- Obtain further detail regarding the insurers liquidity strategy.
- Assess the reasonableness of the Company's business plan as soon as it is received, given the inability to execute the most recent strategy. Consider attending board meetings to reflect the concern regarding the future viability of the Company.
- Include any unresolved concerns with cost sharing or management service agreements with affiliates or overall reliance on affiliates to provide services.

Examination Follow-Up

- During the next regularly scheduled examination, audit the specific risks associated with the Company's agents balances and uncollected premiums to determine if further concerns exist.
- Follow-up on segregation of duties issues noted in the last examination.
- Perform a targeted examination of the reserves, pricing and claims management. Consider in the reserve study any pricing review, information related to the changing legal environment as well as the mix of business in states outside of X and Y.

To: Amy Malm, Risk-Focused Surveillance (E) Working Group Chair and
Justin Schrader, Risk-Focused Surveillance (E) Working Group Vice Chair

From: Marlene Caride, Commissioner, Financial Stability (E) Task Force Chair and
Justin Schrader, Macprudential (E) Working Group Chair

CC: NAIC Support Staff: Bruce Jenson/Jane Koenigsman

Date: July 21, 2022

Re: Referral from the Plan for the List of MWG Considerations

The NAIC Macprudential (E) Working Group (MWG) of the Financial Stability (E) Task Force (FSTF) was charged with coordinating the various NAIC activities related to private equity (PE) owned insurers. As an initial step, the MWG developed a list of 13 regulatory considerations. These considerations are frequently referenced as private equity (PE) concerns, but the Working Group developed the list with an activities-based frame of mind, recognizing that any ownership type and/or corporate structure could participate in these activities, including but not limited to PE owned insurers. The MWG members discussed detailed elements of the considerations and potential regulatory work, including explicit reference to the 2013 guidance added to the NAIC Financial Analysis Handbook for Form A reviews when a private equity owner was involved, and interested parties added useful comments to these during an exposure period. The MWG and FSTF adopted a final plan for addressing each of the 13 considerations, including many referrals to other NAIC committee groups.

The Financial Condition E Committee adopted this plan with no changes made during its virtual meeting on July 21, 2022. NAIC staff support drafted this referral letter to accomplish the actions captured in the adopted plan. It is unlikely any further modifications will occur to the adopted plan when it is considered for adoption by the full Plenary, but it is a possibility. Please begin work to address these referrals, recognizing the adoption by Plenary is still outstanding.

Each MWG consideration referred to your group is listed below. The summarized notes from the MWG regulator-only discussions follow the consideration in blue font and any interested party comments are also provided in purple font. Please consider these

discussion points and comments in addition to your own discussion ideas when developing proposals to address the MWG consideration.

NAIC staff support for the MWG will follow the work your group performs and summarize your activities for reporting up to the FSTF. If you have any questions or need further direction, please contact Todd Sells (tsells@naic.org).

MWG Consideration Items Referred:

3. The material terms of the IMA and whether they are arm's length or include conflicts of interest—including the amount and types of investment management fees paid by the insurer, the termination provisions (how difficult or costly it would be for the insurer to terminate the IMA) and the degree of discretion or control of the investment manager over investment guidelines, allocation, and decisions.

Regulator discussion results:

- Refer this item to the NAIC Risk-Focused Surveillance (E) Working Group. Regulators recognized similar dynamics to the first two considerations, but this Working Group was selected because it is already currently focused on a project involving affiliated agreements and Form D filings. Items discussed:
 - o Consider training and examples, such as unique termination clauses and use of sub-advisors with the potential for additive fees, and strategies to address these.
 - This included addressing pushback on obtaining sub-advisor agreements as Form D disclosures and some optional disclosures for the Form A.
 - o Given the increasing prevalence of bespoke agreements, does it make sense to tie this work in to the work of the NAIC Valuation of Securities (E) Task Force and/or the NAIC Securities Valuation Office? If yes, how best to do so?
 - o Surplus Notes and appropriate interest rates given their special regulatory treatment, including whether floating rates are appropriate; follow any Statutory Accounting Principles (E) Working Group projects related to this topic and provide comments needed.

Risk & Regulatory Consulting (RRC) Comment: “With respect to an Investment Management Agreement, RRC encourages an approach that includes a thorough review of the IMA to ensure it is fair and reasonable to the insurer. In addition to the specific items noted for consideration:

- ♣ Are there detailed and reasonable investment guidelines?
- ♣ Is there sufficient expertise at the insurer and on the insurer's Board to properly assess the performance and compliance of the investment manager?
- ♣ Is the investment manager registered as such under the Investment Advisers Act of 1940, and recognizes the standard of care as a fiduciary?

AIC Comments on “Conflict of Interest, Fees, and Termination” (3 individual comments):

Conflict of Interest

As a general matter, the terms of a contractual agreement should not be viewed as giving rise to a conflict of interest when the agreement is negotiated on an arm's length basis. Notwithstanding the foregoing, current law provides an established process to address potential conflicts (for example, requirements to appoint independent directors and traditional corporate law processes to ensure fairness and, under certain circumstances, review of transactions by regulators pursuant to Form D filings). Accordingly, investments sourced and allocated by alternative asset managers on behalf of insurance company clients should not, absent other factors, be viewed as presenting a potential conflict of interest, particularly where insurers retain full control over asset allocation (for example, insurers retain control over the asset classes in which they invest, as well as the amounts and periods of time over which such asset exposure is achieved).

Fees

Importantly, as an initial consideration, any fees paid to investment managers cannot be considered in isolation, rather they should be considered on a "net" basis – i.e., on the basis of total return (after fees are taken into account). Sophisticated institutional investors (including insurers) have a successful history of investing in a range of strategies despite certain investment products generally having higher fees than other available investment opportunities. On a net basis, private equity has consistently outperformed more traditional asset classes such as publicly traded stocks and public mutual funds⁸ Net-of-fees private debt funds have also consistently outperformed bond and equity market benchmarks.⁹ Insurers continue to recognize the value of investment opportunities that outperform when considered on a net basis.¹⁰ This approach has enabled the consistent delivery of industry leading investment results, which ultimately leads to a high level of financial strength.

Termination

Asset managers often dedicate extensive resources at the outset of a new arrangement in support of managing an insurer's general account assets (e.g., dedicating or reassigning existing personnel, hiring new employees, investing in information technology systems, expanding office space, further enhancing compliance and regulatory processes). As such, and because, in our experience, insurers have the right to terminate their investment management agreements (e.g., upon 30 days' notice), the desire for external asset managers to seek contractual protections (subject to arms' length negotiations) should an insurer decide to terminate the arrangement earlier than was originally anticipated by the parties is entirely appropriate.

4. Owners of insurers, regardless of type and structure, may be focused on short-term results which may not be in alignment with the long-term nature of liabilities in life products. For example, investment management fees, when not fair and reasonable, paid to an affiliate of the owner of an insurer may effectively act as a form of unauthorized dividend in addition to reducing the insurer's overall investment returns. Similarly, owners of insurers may not be willing to transfer capital to a troubled insurer.

- a. Life Actuarial (A) Task Force (LATF) work addresses this –helping to ensure the long-term life liabilities (reserves) and future fees to be paid out of the insurer are supported by appropriately modeled assets.

Regulator discussion results:

- In addition to LATF’s work, refer this item to the NAIC Risk-Focused Surveillance (E) Working Group, as it is already looking at some of this work related to affiliated agreements and fees. Items discussed:
 - o Capital maintenance agreements, suggesting guidance for the appropriate entities to provide them and considering ways to make them stronger.

For Considerations 3 and 4 above (and for the FYI Consideration 5 below):

RRC Comment: In a Form A transaction, whether the owner of the insurer is a PE fund or another type of investor, expectations and structures behind insurer ownership may have changed. Because of that, RRC believes that the stipulations, either limited time or continuing, should protect against adverse policyholder outcomes resulting from that change in dynamic.

- ♣ The regulatory expectation is that owners of insurers should have a long, if not indefinite, time horizon. It is not uncommon for PE funds in general and other similar investment vehicles to have a limited time frame because they are specifically structured investment vehicles such as limited partnerships. For example, requiring that limited partnerships should not have a specific end date would bring that ownership vehicle into line with regulatory expectations.
- ♣ While there are typically no guarantees of additional funding in any ownership situation, having a structure that allows for backstop capital in the event that a need arises should be considered. This could be achieved through a parental guarantee or a capital maintenance agreement.
- ♣ With regards to dividends, even if dividends are permitted, it may be advisable to Memo 2 structure a claw back period. This could be effectuated with allowing dividends to the limited partnership structure but requiring that the funds not be paid out to the partners for some period of time to ensure that the availability is not short-lived.
- ♣ In a limited partnership structure, the limited partners may be considered passive investors and arguably should not be subject to the typical expectations of owners. However, additional understanding and restrictions on the interest of the general partner would be appropriate.
- ♣ In the event that the Form A includes transfer of business to offshore entities, requiring continued maintenance of capital levels similar to those in place prior to the transaction, and ongoing reporting to the U.S. regulator that is in line with the Statutory reporting framework, to ensure that there are no adverse implications to policyholders.
- ♣ Ensuring that corporate governance appropriately balances the desire for strong returns with the need to protect policyholders. For example, the Board and senior management should include members with appropriate background and knowledge of insurance laws and operations. In addition, risk and compliance functions should have appropriate reporting and communication lines to the Board.

- ❖ Policyholder non-guaranteed elements, such as credited rates and dividends, should not be inappropriately reduced from existing levels.

The following MWG Considerations were not referred to the Risk-Focused Surveillance (E) Working Group, but the regulator discussions either considered such a referral or mentioned work already underway at and/or assigned to the Risk-Focused Surveillance (E) Working Group in the above referrals.

5. Operational, governance and market conduct practices being impacted by the different priorities and level of insurance experience possessed by entrants into the insurance market without prior insurance experience, including, but not limited to, PE owners. For example, a reliance on TPAs due to the acquiring firm's lack of expertise may not be sufficient to administer the business. Such practices could lead to lapse, early surrender, and/or exchanges of contracts with in-the-money guarantees and other important policyholder coverage and benefits.
 - a. The NAIC Financial Analysis Handbook includes guidance specific to Form A consideration and post approval analysis processes regarding PE owners of insurers (developed previously by the Private Equity Issues (E) Working Group).

Regulator discussion results:

- Regulators considered referring this consideration to the NAIC Risk-Focused Surveillance (E) Working Group but opted to keep developing more specific suggestions for now. Items discussed:
 - o Consider optional Form A disclosures and guidance for less experienced states; review EU conduct of business language and consider if similar concepts would help target the optional use.
 - o Consider more detailed guidance for financial examinations.
 - o Besides just inexperience, the consideration also includes intentional actions that ignore known concerns to achieve owner's results; might need to consider Market Conduct group(s).
7. The lack of identification of related party-originated investments (including structured securities). This may create potential conflicts of interests and excessive and/or hidden fees in the portfolio structure, as assets created and managed by affiliates may include fees at different levels of the value chain. For example, a CLO which is managed or structured by a related party.
 - a. An agenda item and blanks proposal are being re-exposed by SAPWG. Desire for 2022 year-end reporting to include disclosures identifying related-party issuance/acquisition.

Regulator discussion results:

- Regulators are comfortable the SAPWG's work is sufficient as a first step since it involves code disclosures to identify various related party issues. They also recognize that existing and/or referred work at the Risk-Focused Surveillance (E) Working Group may address some items in this consideration. Once regulators work with these SAPWG disclosures and

other regulatory enhancement, further regulatory guidance may be considered as needed.)

9. Broader considerations exist around asset manager affiliates (not just PE owners) and disclaimers of affiliation avoiding current affiliate investment disclosures. A new Schedule Y, Pt 3, has been adopted and is in effect for year-end 2021. This schedule will identify all entities with greater than 10% ownership – regardless of any disclaimer of affiliation - and whether there is a disclaimer of control/disclaimer of affiliation. It will also identify the ultimate controlling party.
 - a. Additionally, SAPWG is developing a proposal to revamp Schedule D reporting, with primary concepts to use principles to determine what reflects a qualifying bond and to identify different types of investments more clearly. For example, D1 may include issuer credits and traditional ABS, while a sub-schedule of D1 could be used for additional disclosures for equity-based issues, balloon payment issues, etc. This is a much longer-term project, 2024 or beyond.

Regulator discussion results:

- Regulators recognize the new Schedule Y, Part 3, will give them more insights for owners of greater than 10%, but it does not provide insights for owners of less than 10%. However, regulators also recognize that existing and/or referral work of the Risk-Focused Surveillance (E) Working Group may help with some of this dynamic. Additionally, since the SAPWG 2022 code project and its longer-term Schedule D revamp project will help provide further disclosures that will assist with this consideration, regulators are comfortable waiting to see if further regulatory guidance is needed after using the resulting disclosures and other enhancements from these projects.
 - o Specific to owners of less than 10%, regulators discussed the April 19, 2022, Insurance Circular Letter No. 5 (2022) sent by the New York Department of Financial Services to all New York domiciled insurers and other interested parties. This letter highlights that avoiding the levels deemed presumption of control, e.g., greater than 10% ownership, does not create a safe harbor from a control determination and the related regulatory requirements. The circular letter was distributed to all MWG members and interested regulators.

As an FYI for Considerations 7 and 9 above:

RRC Comments on “collateralized loan obligations (CLOs) as a source of concern and therefore a focus for additional disclosure. “While there has been a continuing level of concern about CLOs in general, RRC encourages the working group to take a broader view as well. As a general matter, investments in CLOs are at least subject to disclosure and conflicts of interest standards under various securities laws and regulations. On the other hand, there are other potentially problematic investments that do not benefit from that regulatory oversight.

- ♣ Private funds – Some of the issues noted with respect to concerns about overlapping interests in CLOs may also be prevalent in various kinds of funds, especially privately placed funds that are reported on Schedule BA. Such investment vehicles may have significant areas that have the potential for a conflict of interest that would not be captured by securities laws. Such investment vehicles may also include substantial management fees for management of the fund.

- ♣ Collateral Loans – The U.S. insurance industry’s reported exposure to Collateral Loans that are reported on Schedule BA has grown substantially in the last ten years. In addition to the same potential conflicts, it may be appropriate to revisit valuation and reporting guidance.