higher incurred claims can lower the estimate for provider payments under a risk-sharing contract. The health entity's actuary should consider the total liability when doing his or her estimate.

8. Premium deficiency reserves

When future premiums and current reserves are not sufficient to pay future claims and expenses, a premium deficiency reserve is required. HIPAA requires that all individual and small group medical products be issued on a basis that allows termination only of an entire line of business. These requirements may increase the number of instances where premium deficiency reserves will need to be reported for blocks of business. Analysts should be aware that some states have stricter termination rules than those imposed by HIPAA.

If contracts not protected by HIPAA or state termination restrictions are not profitable, they can be canceled. The contracts with many large groups allow them to be canceled. Also, certain lines of business can be canceled in total. In spite of contractual provisions, companies may decide not to cancel and therefore a deficiency reserve may be required. A company may not want to cancel a large group or a line of business in a state either because of the effect on its reputation or because the membership represented gives it bargaining power with providers.

A reserve may even be required for an Administrative Service Only (ASO) or Administrative Services Contract (ASC) agreement if administrative fees are not sufficient to cover administrative expenses. An insufficient administrative fee may be acceptable to the health entity when the importance of writing a large group due to prestige or bargaining power is provided to the health entity. Analysts should refer to *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* for a discussion of the reporting of loss contingencies.

In instances where future premiums can be increased to cover projected claim levels for a block of business, these increases may cause better risks to drop coverage. This will result in even higher claims costs and potentially continuing deficient premiums. It is difficult to predict the effect of this type of selection, but the health entity's actuary should attempt to include the effect of selection in his or her determination of the need for a deficiency reserve.

There is some state variation concerning limits on the assumptions that can be used in calculating premium deficiency reserves. Since these variations are not currently documented, analysts should contact the department actuary for input on any guidance that has been given to health entities in the state.

Areas of confusion and inconsistency include:

- How to define a block of business for calculation of deficiency reserves.
- The time period to use for calculation of deficiency reserves.
- Assumptions to use concerning enrollment changes, premium increases, and marginal versus allocated expenses.
- The level of claim reserves and claim reserve conservatism to be available at the end of the time period and thus included in the deficiency reserve.

For a thorough discussion of deficiency reserves and an up-to-date position on issues surrounding deficiency reserves analysts should refer to SSAP No. 54R and the *Health Reserves Guidance Manual*.

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Long-Term Care Insurance (LTCI) Reserves Overview

"Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital[3]. Historically, insurers that wrote LTCI encountered difficulties accurately projecting claims costs, lapse rates, investment returns and other factors associated with LTCI, and subsequently many writers have experienced unprofitability in older (legacy) blocks of LTCI business. This has led many companies to request significant rate increases, modify product benefits, or exit the product line altogether. Therefore, many insurers continue to experience significant solvency challenges related to this line of business, and state insurance regulators should continue to carefully evaluate and monitor the solvency position of all insurers with a material amount of LTCI business.

These same risks also affect reinsurers, because the reinsurance contract may not arbitrarily allow for ceded premium increases. Additionally, in order to effectuate a true transfer of risk, the reinsurer may not have the ability to require the direct writer to request rate increases[4]. As some insurers look for avenues to minimize or eliminate its risk from the LTCI block, they may look to new reinsurance opportunities or non-traditional buyers.

In addition, periods of economic downturn and low interest rates increase the risk that LTCI writers will be challenged to generate sufficient returns to support this line. In addition, declines in projected investment returns could have a significant impact on LTCI reserve assumptions.

Actuarial Guideline 51—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51)

Effective for reserves reported with the Dec. 31, 2017, financial statement, Actuarial Guideline 51 — The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) now applies. The *Health Insurance Reserves Model Regulation* (#10) and the *Valuation Manual* VM-25, Health Insurance Reserves Minimum Reserve Requirements, contain requirements for the calculation of LTCI reserves. AG 51 requires companies with more than 10,000 LTCI enrollees to submit standalone LTCI asset adequacy analyses to the state. AG 51 is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for the asset adequacy testing applied to a company's LTCI block of contracts. AG 51 requires reporting to the department within the appointed actuary's actuarial memorandum required by VM-30, Actuarial Opinion and Memorandum Requirements, or in a special actuarial memorandum containing LTCI-specific information on the results of the analysis, assumptions on mortality, voluntary lapse, morbidity, investment returns and rate increase assumptions.

Factors Impacting LTCI Reserves and Rates

This following guidance provides additional information that may assist state insurance department staff in understanding the differences in premium rate review and approval, and valuation review of reserve adequacy assumptions in order to maintain or improve state insurance departments' current intra-departmental

[3] Definition per NAIC *Long-term Care Insurance Model Act* (#640) Section 4.A.
[4] Refer to the NAIC *Life and Health Reinsurance Agreements Model Regulation* (#791) with respect to qualifying for risk transfer and reinsurance accounting within life and health reinsurance agreements.

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coordination/communication practices between the states' rate reviewers, valuation actuaries and analysts/examiners.

Reserve Increase Factors

1. Background

Ever since asset adequacy testing became a requirement for life insurers in the 1980s, actuaries have been required to analyze reserve adequacy assumptions on an annual basis and make the assumptions more conservative when experience or expectations become more adverse. If the result of the more conservative assumptions was inadequate reserves, companies have been required to establish higher reserves to ensure future claims could be paid in the more adverse environment.

In some cases, the chain of events is straightforward. For instance, for life insurance, if more people die at earlier ages than expected and the experience is highly credible, then the actuary increases mortality rates in the upcoming year-end filing, leading to higher reserves being established.

In other cases, the chain of events is less straightforward. For instance, it is expected that cash surrenders on deferred annuity products will increase if interest rates rise. However, most deferred annuities have been sold during a period of decreasing interest rates. Actuarial and regulatory practice require reserves to be adequate in moderately adverse conditions, even if those conditions have not been recently experienced. There is typically judgment by the company actuary and another layer of judgment by regulators in play in this type of complex situation. The *Standard Valuation Law #820* (SVL), the Valuation Manual, and the *Actuarial Standards Board's* (ASB's) *Actuarial Standards of Practice* (ASOPs) describe how these complex situations should be handled.

2. Long-Term Care Insurance

For LTCI blocks of business that experience higher morbidity than expected, this experience will likely lead to changes in expectations on future morbidity for both the observed block and other blocks.

With LTCI, some factors are likely to play out in a straightforward manner. A combination of higher life expectancy and lower lapses will lead to more people than expected reaching prime LTCI claims ages of 80 and above, which leads to companies holding higher reserves than originally anticipated. Similarly, all companies have experienced the decreasing interest rate environment, which has led to lower-than-expected investment returns and the need to hold higher reserves, because investment income is relied upon to help pay claims.

Mortality, lapse, and interest rate factors become observable and can develop credibility during the premium-paying years prior to policy years when significant claims tend to occur.

3. Morbidity Assumptions:

Morbidity, however, has tended to fall into the category of a complex factor. The three main aspects of LTCI morbidity are: (1) incidence, the percentage of people at a given age who start a claim; (2) average length of claim; and (3) utilization, which is less than 100% if, e.g., the daily nursing home cost is lower than the maximum daily benefit in the insurance policy.

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There has not been uniform experience development in morbidity, except that length of claim has tended to increase, likely because cognitive (e.g., dementia and Alzheimer's disease) claims tend to be longer than average and incidence has been higher than expected, likely due to more people reaching the age when cognitive claims tend to occur.

Because of divergent experience among companies and because morbidity becomes observable and credible during the later claim-paying years, establishing and regulating LTCI morbidity assumptions has not been straightforward. However, as with other factors and other products, the handling of these situations is addressed in *Model #820, Valuation Manual, and ASOPs*. Examples of these standards include:

- Model #820 12A(3)(a): "Assumptions shall, to the extent that company data is not available, relevant, or statistically credible, be established using other relevant, statistically credible experience."

- Model #820 Section 12A (4): "Provide margins for uncertainty … such that the greater uncertainty the larger the margin and resulting reserve."

- AG 51 (providing guidance on VM-30) Section 4.B.: "The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding identification of key risks. Material assumptions associated with the LTCI business shall be determined testing moderately adverse deviations in actuarial assumptions."

- *Acounting Practices and Procedures Manual (AP&P Manual)*, Appendix A-010 paragraph 48.e (referenced in VM-30): "The total contract reserve established shall incorporate provisions for moderately adverse deviations."

- AP&P Manual, Appendix A-010 paragraph 51 (referenced in VM-30): "Annually, an appropriate review shall be made of the insurer's prospective contract liabilities… and make appropriate increments… if such tests indicate that the basis of such reserves is no longer adequate."

The result is that whether credible experience exists or not, the company actuary needs to set assumptions underlying reserves, and the factors underlying the assumptions are often complex and frequently changing. Company and regulatory actuaries are experienced in working in this complex, changing environment with many life insurer products, such as variable annuities, indexed products, and LTCI having product features and factors underlying reserves that are complex and changing.

4. Rate Increases:

A unique aspect of LTCI products is being a long-term product with rate increases that require review by states. Besides states with the largest insurance departments, the actuaries reviewing LTCI reserves are often the same staff reviewing LTCI rate increases. For larger states, there is typically coordination or training to ensure the reserve and rate teams are on the same page regarding developments in for example, life expectancy and morbidity. State insurance regulator experience in reviews of LTCI reserves and rate increase filings show that reserve increases and requests for rate increases are due to similar factors including higher life expectancy, lower lapses, lower investment returns, and worsened morbidity.

There has been additional regulatory attention on ensuring the companies asking for rate increases based on adversity of certain factors are holding reserves based on at least the same level of adversity in those

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factors. The questions used in many states' rate increase reviews require the company to explain the consistency between the rate increase filing assumptions and reserve adequacy assumptions.

To date, the most common complex, non-straightforward case is the applicability of a company's adverse morbidity experience of an older LTCI block to morbidity assumptions on a newer block. This complex dynamic comes into play when establishing reserve and rate increase assumptions.

The reserve assumption changes can occur with initiation by the company, through formal or informal agreement between regulators or companies, or by relying on Model #820 Section 11.6., which allows a commissioner to require a company to change reserve assumptions and adjust reserves.

Example:

A typical example of a chain of events would first involve a block issued in 1995 to 1998 to policyholders with issue ages ranging from 52 to 62. By 2019, enough policyholders have reached prime LTC claim ages of 80+. This experience is what drives reserve assumption changes. As policyholders enter ages in the upper 80s and 90s, additional experience will be attained that will predict future LTCI costs and result in further changes in reserve assumptions. The development of older-age morbidity experience is expected to generate volatility in LTCI reserves. For some companies, the older-age morbidity experience will likely be unfavorable, with increased reserves needed. For most other companies, the older-age morbidity experience will likely be as expected, leading to no significant, unforeseen reserve increases.

Companies will be expected to apply lessons learned from older blocks of business to their newer blocks. Those lessons will likely differ by situation. For example, to the extent underwriting is different, the newer and older blocks may experience different morbidity trends.

5. Rate Increase Factors

Factors impacting LTC reserves, including higher life expectancy, lower lapses, lower investment returns, and changes in morbidity, also potentially impact LTC rate increases.

If a company's reserve adequacy testing is dependent upon assumption of future LTC rate increases, the state insurance department staff performing reserve valuation should evaluate that assumption for reasonableness. The company's rate increase assumptions and documentation should be consistent with the requirements specified in AG 51 related to rate increase plans. The state insurance department staff performing reserve valuation may wish to coordinate and communicate with the state's rate review staff to help evaluate the appropriateness and reasonableness of the company's future rate increase assumption.

6. Intra-Department Communication and Coordination of Actuarial Review Work

While every state insurance department may be structured differently, many state insurance departments have the same staff members perform work on both LTCI reserve valuation analysis and rate increase reviews, while other have separate staff perform these functions. In the latter instance, department staff should be aware of or coordinate the intra-department review work related to each function.

The following are suggested steps a state may consider to ensure that actuarial assumptions associated with the rate increase request are consistent with the assumptions embedded in the asset adequacy testing.

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- Inquire of the company's actuary or senior management regarding:
    - The relationship of the actuarial assumptions embedded in the rate filing versus those made for annual statement reporting.
    - Explanation if there is inconsistency between assumptions reported.
    - How AG 51 affects the company's rates and reserves.
    - Affirmation that the assumptions underlying the projections are consistent with the assumptions used in asset adequacy analysis.
    - A copy of the company's rate increase plan when rate increase filings disclose that future rate increase filings, beyond what is currently being requested, are planned.
- Consider reviews of different filings for consistency. For example:
    - Compare reserving assumptions to rate increase assumptions,
        - e.g., review the RAAIS and the Actuarial Opinion and Memorandum (AOM) to ensure that assumptions used for pricing and reserving are similar in nature.

Identify assumptions underlying the asset adequacy testing memorandum that appear.

Discussion of Annual Reserving Risk Repository

Using the Repository

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

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

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

The placement of the following data and procedures in the reserving risk repository is based on "best fit." Analysts should use their professional judgement in categorizing risks when documenting results of the analysis. Key insurance operations or lines of business, for example, may have related risks addressed in different repositories.

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

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Quantitative and Qualitative Data and Procedures

Reserve Adequacy and Valuation

PROCEDURE #1 asks analysts to review and incorporates any concerns or issues noted in the review of the Actuarial Opinion into the review of the valuation of the health entity's health reserves. The valuation of these reserves should be in accordance with Appendix A-010 of the AP&P Manual. Issues noted in the review of the Actuarial Opinion may be relevant to aspects of reserve risk identified in other procedures, and risks should be assessed concurrently with those procedures.

PROCEDURE #2 assists analysts in determining whether an understatement of health reserves would be significant to the health entity. The ratios of gross and net health reserves to capital and surplus are leverage ratios that are calculated gross and net of reinsurance ceded. The net health reserves to capital and surplus ratio indicates the margin of error a health entity has in estimating its health reserves. For a health entity with a net health reserves to capital and surplus ratio of 300%, a 33% understatement of its health reserves would eliminate its entire surplus.

The effect of a reduction in capital and surplus of 10% of the net claim reserve on risk-based capital (RBC) indicates if there would be a potential solvency problem if reserves were understated by 10%. A 200% RBC ratio is the Company Action Level of concern according to the NAIC *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315). A ratio below 200% indicates a health entity must file an RBC plan with the domiciliary state.

In evaluating these leverage ratios, analysts should also consider the nature of the health entity's business. For example, a health entity that has written primarily health business for many years and has proven that it can manage the business profitably is probably less risky than a health entity that has just begun writing health business, even if both entities have the same leverage ratio results.

PROCEDURE #3 assists analysts in reviewing reserve development as an indicator in determining whether health policies appear to have been adequately reserved.

Part 2B – Analysis of Claims Unpaid - Prior Year-Net of Reinsurance of the Underwriting and Investment Exhibit provides information that allows analysts to determine if the health entity has had adverse reserve development in the past year. Using this exhibit, a ratio of the paid claims plus reserves for prior periods to the reserves established in the prior year can be calculated. A positive result (ratio > 1) for this ratio represents additional or "adverse" development on the reserves originally established by the health entity (the estimated amount of the original reserves has proven to be understated based on subsequent activity). The amount of reserve deficiency is compared to the reserve to determine if the deficiency was > 10%.

Part 2C – Development of Paid and Incurred Health Claims of the Underwriting and Investment Exhibit shows a history of reserve development. If the health entity's ratio results consistently show additional development, this could be an indication that the health entity is understating its health reserves. Analysts should review this exhibit to determine if there have been any adverse trends or fluctuations and if reserves have been adequate to pay actual claims.

PROCEDURE #4 provides loss ratio and underwriting gain/loss indicators that assist analysts in determining if health policies appear to be adequately reserved.

The loss ratio for each product line should also be reviewed as a part of this procedure. Significant increases in this ratio might be indicative of additional health reserves being established due to prior understatements while significant decreases might be indicative of current health reserve understatements. Analysts should consider the effect of changes in membership on loss ratios. Conventional logic says that significant increases in membership will result in lower loss ratios since first year claims experience is typically lower in the first year. Dropping membership accompanied with increasing loss ratios may indicate that healthier individuals and groups are leaving. This is often the first sign of a potential adverse selection rate spiral where rates force healthier individuals to leave resulting in inadequate rates. Reviewing the per-member per-month medical expense in the prior year or quarter may be further indication of problems, especially if membership is dropping.

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A deficiency reserve is required when future premiums are not sufficient to pay future claims and expenses. If a line of business is showing an underwriting loss there may be a need for a deficiency reserve. It is possible that premium increases have been implemented to correct the deficiency, but the situation should be considered.

PROCEDURE #4D A significant decrease in health reserves to incurred claims may indicate that reserves have been weakened. Note, there are other possible explanations for this type of change such as a shift in provider contracting or product design, however analysts should investigate if material changes occur.

Analysts should review the percentage of claims paid on a capitated basis. If this percentage is decreasing, indicating a shift from capitated to fee-for-service, there should be an increase in health reserves in proportion to incurred claims. A shift in the other directions should have the opposite effect.

PROCEDURE #4E instructs analysts in comparing the health entities medical claims expense per member per month (PMPM) and claims unpaid ratio to similarly situated industry peers. If these claim results are significantly different from industry peers, analysts may need to gain a better understanding of the health entity's claim experience.

PROCEDURE #5: The ratio of claims in process of adjudication to the average incurred non-capitated claims per day measures the average number of days of reported unpaid claims in inventory by reducing annual incurred claims to a daily average. An unusual result may indicate problems with claims administration or cash flow.

To determine the size of the backlog you must first determine the average daily-incurred claim expense less capitation. Once you have determined this amount, then determine the amount of claims in the process of adjudication, excluding capitation, divided by the average daily-incurred claim expense, to determine the average number of days of claims backlog.

Results for a recently licensed or rapidly growing health entity may have a high ratio because the growth of the numerator will be faster than the growth of the denominator. Reporting inventory valuation problems may also skew results for this ratio. Also, any IBNR changes will affect any results of this ratio.

Please note that a similar ratio might be calculated based on average daily paid claims instead of average daily incurred medical expense less capitation.

PROCEDURE #6 provides metrics for assessing unpaid claims adjustment expenses.

PROCEDURE #7 provides procedures analysts may consider in assessing the lines of business written by the health entity and gaining an understanding of the impact differences in the types of plans may have on reserving risk.

PROCEDURE #8 instructs analysts to review the LTC Experience Reporting Form of the Annual Financial Statement and the Actuarial Guidelines 51 reporting filed to the department if the insurer writes LTCI to gain an understanding of the reserve adequacy of the LTC line of business. If concerns exist, consider requesting additional information as necessary to assess actual vs. projected results, legacy vs. newer blocks of business separately, any recent rate increases and capital support. If the insurer has recently filed for rate increases on LTCI blocks, consider intra-departmental discussion with the rate increase analysis and outcome with the rate review staff (if a different person than the analyst/actuary performing the valuation reserve analysis).

PROCEDURE #9 provides for a review of the Annual Financial Statement to determine whether there has been a change in the valuation basis of the health policies during the year. Analysts should consider a review of changes that result in a decrease in health reserves in an amount greater than 5% of capital and surplus.

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 reserving risk issues were discovered during the examination.

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INQUIRE OF THE INSURER directs analysts to consider requesting additional information from the insurer if reserving risk concerns exist in a specific area. The list provided are examples of types of information or explanations to be obtained that may assist in the analysis of reserving risk for specific topics where concerns have been identified, such as reserve methodologies, assumptions and oversight of reserve setting.

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 reserving 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 reserving risks that could impact the insurer.

Example Prospective Risk Considerations

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

Discussion of Quarterly Procedures

The Quarterly Reserving Risk Repository procedures are intended to identify if an understatement in reserves would have a potential impact on the health entity's solvency and if significant changes in health reserves or health benefits have occurred since the prior year Annual Financial Statement.

PROCEDURE #2 assists analysts in determining whether health policies appear to have been adequately reserved. A change in reserves of greater than 10% may indicate reserves should be looked at more closely. Actual claim payments and the current reserve for prior periods are reviewed in relationship to the prior year-end reserves to determine if the year-end reserve was adequate in light of subsequent experience.

Enrollment, premium, and utilization are reviewed to determine if there have been large changes in these key elements. Increasing utilization may lead to increasing loss ratios if premiums are not increased adequately. Large increasing enrollment may require increasing reserves and large decreases in enrollment may result in increasing loss ratios due to the loss of healthier individuals. This particularly happens when there are large rate increases and healthier individuals, families, and groups shop for better rates elsewhere. If healthier individuals are leaving, there may be a need for deficiency reserves on medical policies. Other types of coverage experience a release of contract reserves when enrollment drops resulting in increasing surplus.

Analysts should consider reviewing the Underwriting and Investment Exhibit to determine which lines of business are being written by the health entity and which health lines of business may have been under reserved at the prior year-end. Analysts should also consider reviewing: 1) the health entity's health insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits; 2) the health entity's RBC filing to better understand the types of managed care arrangements being used; and 3) contacting the policy forms section of the insurance department and inquiring as to whether the health entity has filed any new and unusual health policy forms during the past year. In addition, analysts could review the health entity's description of the valuation standards used in calculating the additional contract reserves and consider whether the reserve bases, interest rates, and methods used appear reasonable. (The health entity's description of the valuation standards used is required to be attached to the filed Annual Financial Statement.) Analysts might want to contact the qualified actuary who signed the health entity's actuarial opinion to discuss the nature and scope of the valuation procedures performed and/or request a copy of the qualified actuary's actuarial memorandum to review for comments regarding the analysis of reserves performed and the conclusions reached.

Other steps for analysts to consider include: 1) reviewing the ratio of unpaid claims plus aggregate health reserves to incurred claims by line of business for past years for unusual fluctuations or trends between years;

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and 2) if the ratio appears unusual, analysts should consider comparing it to the average ratio of claim liability plus claim reserve to incurred claims or similar health entities in the industry to determine any significant deviations from the industry average. 3) If the adequacy of claim liabilities is a concern, analysts might want to request information from the health entity regarding claims paid after year-end which were incurred prior to year-end in order to test the reasonableness of the year-end claim liabilities established by the health entity.

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

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Strategic Risk: Inability to implement appropriate business plans, to make decisions, to allocate resources or to adapt to changes in the business environment will adversely affect competitive position and financial condition.

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 strategic risk. For example:

- Changes in officers, directors or organizational structure also is discussed in the Operational Risk Repository.
- Some review of investment strategies also may be performed in the Credit, Market and Liquidity Risk Repositories.

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

News, Press Releases and Industry Reports

1. Determine if concerns exist regarding news, press releases, stock movements or industry reports involving the insurer or insurance group.

	Other Risks
a. Review any insurance, marketplace or economic industry reports, news releases, press releases, and emerging issues to identify if any issues have the potential to negatively impact the insurer's strategy. • Examples: NAIC "Insurance Industry Snapshots" and "Insurance Industry Analysis Reports"; NAIC Capital Markets Bureau reports, rating agency reports, insurance news sources, NAIC Risk Alerts, etc.	RP*, LG
b. Review movements and trends in the insurer's or group's stock price and trading volume to assist in identifying and assessing strategic risk.	RP*
c. If concerns exist regarding a recent industry report, news release, stock movement or emerging issue, determine if the news or industry issue has the potential to impact the insurer's strategy, operations or financial solvency.	RP*, LG
d. Perform additional non-routine procedures where applicable (e.g., survey or questionnaire, stress testing, etc.).	RP*, LG

Risk Management and Governance

2. Determine whether the risk management practices of the insurer are sufficient to provide for the establishment, implementation and oversight of an effective business strategy.

	Other Risks
a. If the insurer or insurance group is subject to Own Risk and Solvency Assessment (ORSA) requirements, review and evaluate the results of the most recent ORSA Summary Report analysis conducted by the lead state as discussed in Section VI.F Own Risk and Solvency Assessment (ORSA) of the Handbook. Document any concerns regarding the insurer's risk management practices and effects on the insurer's ability to establish, implement and oversee an effective business strategy.	OP

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b. If the insurer or insurance group is not subject to ORSA requirements: i. Communicate with the examiner or obtain the recent examination work papers, including Exhibit M and C-Level interview results, to gain an understanding of the insurer's enterprise risk management (ERM) program. ii. Inquire as to whether the company prepares an ERM assessment or similar risk assessment program? If "yes," request a copy. If not, request an explanation or lead a discussion on how the insurer identifies risks.	OP
c. Review information provided on the company's ERM assessment or similar risk assessment program and/or follow-up on the work performed by the examiners regarding assessment of risk management, and evaluate any changes in the following or other areas: • The risk management culture demonstrated throughout the organization. • The importance of risk management to the organization. • How risk tolerances and "appetites" are defined and communicated throughout the organization. • How existing risks are identified, tracked, assessed and mitigated. • How emerging and/or prospective risks are identified, tracked, assessed and managed. • How the organization uses the risk information to determine capital needs. • Whether internal models are utilized and regularly updated to ensure appropriate risk management decisions. • How responsibilities for risk-management functions are delegated and monitored. • The level of involvement of the board of directors in the risk management function. • How risk management processes and results are incorporated into ongoing strategic planning and decision making.	OP

3. Evaluate the effects of changes in officers, directors or organizational structure on the strategic direction of the insurer.

	Other Risks
a. Review the changes in officers, directors or trustees and any concerns noted during a review of biographical affidavits. i. Do new directors and officers have the required knowledge, experience and training to perform their duties? Document any concerns. ii. Are the new board of director members sufficiently independent from management and adequately engaged in performing their duties? iii. Have new directors and officers ever been officers, directors, trustees, key employees or controlling stockholders of an insurance company that, while they occupied any such position or served in any such capacity with respect to it: A. Been placed in supervision, conservation, rehabilitation or liquidation; B. Been enjoined from, or ordered to cease and desist from, violating any securities or insurance law or regulation; C. Suffered the suspension or revocation of their certificate of authority or license to	OP*, RP, LG

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do business in any state? If "yes," explain. iv. Summarize the insurer's policies and procedures regarding performance of background checks on new management.	
b. If a significant amount of turnover and/or changes in key positions (i.e., chairman of the board of directors, chief executive officer [CEO]) are identified, gain an understanding of and evaluate the impact of such changes on the insurer's strategic direction. Consider requesting updated business plans, holding in-person meetings, conducting conference calls, or taking other steps to understand and address significant changes.	OP*, RP
c. Have there been any changes in the organization's structure? If "yes," request the reasons for the changes and the impact on future business plans and strategy.	OP, RP
d. Have there been any significant operational or business changes that have resulted in significant changes to staffing levels, consolidations of operations with affiliates, outsourcing of key functions, or placing blocks of business into run-off (closed) blocks?	OP*

Mergers and Acquisitions

4. Determine how recent and pending merger and acquisition activity affects the current and prospective solvency position of the insurer.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Has the insurer been a party to a merger or consolidation? [Annual Financial Statement, General Interrogatories, Part 1, #5.1]		=YES	[Data]	[Data]
				Other Risks
b. If 4.a is "yes," note any observations or concerns, ensure Form A or additional filings have been approved, and assess if the insurer is meeting the expectations set forth in the Form A business plan, consider the following additional procedures (as necessary): i. If regulatory approval of the merger or acquisition was subject to ongoing conditions or restrictions, verify compliance with those requirements. ii. Compare actual results to pre-transaction projections to determine whether results are meeting expectations. If not, gain an understanding of why projections have not been achieved and the company's planned actions to address issues. iii. Request and review information regarding the integration of the new business into the company's processes and systems (systems transition plan), as well as the steps taken to ensure that adequate cybersecurity precautions are taken during the integration process. iv. Gain an understanding of and consider the impact of planned cost-cutting activities, including the nature and magnitude of cuts and their potential impact on risk exposures.				LG, OP

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Business Plans

5. Evaluate the effectiveness of the insurer's business/strategic planning process and whether the current plan adequately addresses the significant solvency risks facing the insurer.

	Other Risks
a. Review previous business plans and financial projections filed with the state insurance department, and determine the following: i. Have significant changes in business plan or philosophy occurred? If "yes," explain. ii. Assess if initiatives outlined in the business plan have been accomplished. iii. Compare actual with projected financial results. Are actual results consistent with management's expectations? If not, explain. iv. Request an explanation for the variance including an explanation of whether management believes it has achieved its goals for the period and if any noted risks or challenges were not considered in the business plan. v. Request a revised business plan. vi. Describe any events, transactions, market conditions and/or strategic management decisions that have occurred (or are planned) that may cause a significant positive or negative variance from projections, including new product development or enhancements, changes in sales volume, product mix, or geographical locations. vii. Are there internal and/or external prospective risks that have the potential to impact the overall business plan?	OP
b. If necessary, request and review an updated strategic business plan, note any areas of concern and if necessary, request additional explanations from the insurer. i. Does the new business plan reflect significant changes in the strategic goals or philosophies compared to the prior plan? If "yes," explain. ii. Describe the insurer's strategic and annual planning process. iii. Describe the board of directors' involvement in developing and implementing the business plan. iv. Assess the insurer's ability to attain the expectations of the business plan and projections. Does the business plan reflect changes that appear unrealistic for the current market environment, financial position of the insurer or other circumstances? If "yes," explain. • Reasonableness of underwriting assumptions • Current and anticipated interest rate and economic environment • Growth objectives • Stability of capital and ability to access additional capital, if needed • Quality and sources of earnings (trends and stability) • Dividends and dividend payout policy	OP

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c. For startup insurers that project rapid growth and material losses, consider the following: i. Obtain a five-year business plan and assess the insurer's current and projected capital adequacy relative to its growth plans. ii. If future growth is to be funded by capital contributions from the parent, assess the parent's ability to meet future funding expectations. iii. Determine whether growth and capital financing expectations are sustainable until the insurer becomes profitable.	OP

6. Determine whether the insurer's investment strategies and holdings are appropriate to support its ongoing business plan and strategy.

	Other Risks
a. Review the asset section of the Financial Profile Report to identify material shifts in investment percentages between asset categories, which may indicate the insurer has increased its investment risk exposure.	CR, MK, LQ
b. Request a copy of the insurer's investment plan that discusses investment objectives and strategy, with specific guidelines as to quality, maturity, and diversification of investments and: i. Evaluate whether the investment plan appears to result in investments and practices that are appropriate for the insurer, based on the types of business written and its liquidity and cash flow needs. ii. Review the guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity and geographic location. iii. Determine who is authorized to purchase and sell investments and what approvals are required for investment transactions. iv. Evaluate the involvement of the board of directors and senior management in overseeing the investment strategies of the insurer. v. Consider the level of knowledge and expertise of asset managers used by the insurer in making investment decisions, and evaluate the level of oversight provided to any third-party asset managers. vi. Determine whether the insurer appears to be adhering to the investment plan.	CR, MK
c. If the insurer allocates a significant amount of its portfolio to structured securities, request information from the insurer regarding its background and expertise in structured securities of its investment advisers (in-house and/or contractual) and its analytical systems capabilities. Determine whether the advisers and systems are adequate to allow the insurer to continuously monitor its structured securities investments.	CR
d. If the insurer's investment plans and strategies include the use of derivatives for hedging purposes, request and review a comprehensive description of the insurer's hedge program in order to gain an understanding of how derivative instruments are used to hedge against the risk of a change in value, yield, price, cash flow, quantity or degree of exposure with respect to assets, liabilities or future cash flows that the insurer has acquired or incurred or anticipates acquiring or incurring and: i. Evaluate whether the hedge program appears to result in hedges that are appropriate for the insurer based on its assets, liabilities and cash flow risks, and are consistent	MK

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with the insurer's overall strategy. ii. Note anything unusual or any variances from the insurer's current hedging program description. iii. Determine whether the insurer appears to be adhering to the description of the hedge program.	
e. If concerns related to the investment strategy or portfolio are identified, consider requesting and reviewing a preliminary portfolio analysis from the NAIC's Capital Markets Bureau.	CR, MK, LQ

Reinsurance Strategy

7. Determine whether the insurer has established and maintained appropriate levels of reinsurance to support its business plan and strategy, in consideration of its capital and surplus position and risk exposures.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Gross premium leverage ratios: i. P/C: Gross premium written to surplus [IRIS #1] ii. A&H: Gross A&H premium written to capital and surplus	PR/UW*	>900% (P/C) >500% (A&H)	[Data]	[Data]
b. Net premium leverage ratios: i. P/C: Net premium written (NPW) to surplus [IRIS #2] ii. A&H: Net A&H premium to capital and surplus iii. Health: Premium & risk revenue to capital and surplus	PR/UW*	>300% (P/C) >400% (A&H) >10:1 (Health HMO) >8:1 (Health Non-HMO)	[Data]	[Data]
c. Net retention	PR/UW		[Data]	
d. Gross premium written (liability lines) to surplus [P/C]	PR/UW	>300%	[Data]	[Data]
e. Net premium written (liability lines) to surplus [P/C]	PR/UW	>150%	[Data]	[Data]
f. NPW (long-tail) to total NPW [P/C]	PR/UW	>25%	[Data]	[Data]
g. Change in NPW (long-tail) to total NPW from prior year [P/C]	PR/UW	>25 pts	[Data]	[Data]
h. Largest net amount insured in any one risk (excluding WC) to surplus [P/C]	PR/UW	>10%	[Data]	[Data]
i. Ceded loss ratio	PR/UW		[Data]	
j. Did the insurer report they do not have stop-loss		=YES	[Data]	[Data]

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reinsurance? If "yes," provide explanation. [Annual Financial Statement, General Interrogatories, Part 2, #5.1 and #5.2] [Health]				
Procedures Applicable to All Policy Types				*Other Risks*
k. If the insurer or insurance group is subject to ORSA requirements, review and evaluate the results of the most recent ORSA Summary Report analysis conducted by the lead state as discussed in Section VI.F Own Risk and Solvency Assessment (ORSA) of the Handbook. Document any concerns and conclusions reached regarding the insurer's reinsurance strategy and program structure.				OP
l. Obtain a copy of the insurer's A.M. Best Supplemental Ratings Questionnaire and review the reinsurance section to identify any risks or concerns.				CR, PR/UW
m. Review and compare the insurer's ceded loss ratio to its overall loss ratio to evaluate the effectiveness and sufficiency of reinsurance coverage.				PR/UW
n. Briefly scan the individual reinsurers and related financial data provided in the Annual Financial Statement and: i. Identify any significant changes in the primary reinsurers during the year compared to the prior year. ii. Determine if there are any significant new reinsurers known to engage in financial reinsurance or surplus relief transactions that may trigger concerns as to transfer of risk with respect to this specific insurer. iii. Determine if there are specific situations noted or overall trends that involve significant shifts in the mix of reinsurers to lower quality, higher risk companies. iv. Determine if there are any unusual items noted, such as significant amounts of reinsurance with alien reinsurers. v. If concerns are identified, contact the company to discuss and evaluate the effect on the company's business plan and strategy.				CR
P/C Specific Procedures				*Other Risks*
o. After reviewing information on reinsurance included in the business plan and the various regulatory filings available to analysts, request and review additional information as necessary to gain an adequate understanding of the insurer's reinsurance strategy and program structure. Evaluate the impact of any significant changes in program structure (e.g., changes in retention levels, coverage limits, exclusions, etc.) on the insurer's business plan and strategy.				PR/UW
p. Review the Annual Financial Statement and other available information (e.g., actuarial opinion, Management's Discussion and Analysis (MD&A), Form B, business plan, etc.) to gain an understanding and evaluate the insurer's reinsurance program in relation to its risk profile and strategy, including adequate protection for large losses. i. Request the Department Actuary review the available information regarding the reinsurance program to identify any concerns. ii. Consider the following specific procedures related to the Annual Financial Statement, General Interrogatories, Part 2: • #6.1. Do any concerns exist regarding the provision the company has made to protect itself from any excessive loss in the event of a catastrophe under a				PR/UW

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workers' compensation contract issued without limit of loss? • #6.3. Do any concerns exist regarding the provision the company has made to protect itself from an excessive loss arising from the types and concentrations of insured exposures composing its probable maximum property insurance loss? • #13.2. Does any reinsurance contract considered in the calculation of the largest net aggregate risk amount include an aggregate limit of recovery without also including a reinstatement provision? • #13.3. Are the number of reinsurance contracts considered in the calculation of the largest net aggregate risk amount cause for concern?	
q. Review the insurer's gross and net writings leverage positions to assist in evaluating the adequacy of the insurer's reinsurance strategy. Consider the following specific procedures in this area: i. Compare the gross writings leverage ratio and the net premium written to surplus ratio to the industry averages to determine any significant deviations from the industry averages. ii. If the insurer is a member of an affiliated group of insurers, compute the gross premium written to surplus ratio and the net premium written to surplus ratio on a consolidated basis to determine if the affiliated group of insurers appears to be excessively leveraged. iii. Obtain an explanation from the insurer for unusual results for P/C IRIS ratios #1 and #2.	PR/UW
r. Review, for each line of business included in the Annual Financial Statement, Schedule P, the trends in accident year loss ratios, on both a gross and net basis, for indications of deteriorating underwriting results that may warrant reinsurance consideration.	PR/UW
s. Review the Annual Financial Statement, Schedule T and determine whether there appears to be large geographic concentrations of premiums in areas especially prone to catastrophic events. If "yes," consider requesting and reviewing information from the insurer regarding its catastrophic reinsurance coverage to evaluate its sufficiency.	PR/UW
t. Review information provided by the insurer in the RCAT (PR027) section of its risk-based capital (RBC) filing to identify and assess the insurer's current exposure to catastrophic events at modeled worst year in 50, 100, 250, and 500 levels on both a gross (direct and assumed) and net basis (after reinsurance). Evaluate the adequacy of the company's catastrophic reinsurance coverage at various modeled loss levels, including the potential impact on capital and surplus and RBC position.	PR/UW
u. Review information provided in the insurer's response to the NAIC's Climate Risk and Disclosure Survey (if available) on its exposure to physical losses impacted by climate change, as well as its potential impact on reinsurance decision-making. i. Determine whether any of the company's responses require further investigation and inquiry.	PR/UW
v. Review relevant information provided in the Own Risk and Solvency Assessment (ORSA) Summary Report and/or U.S. Securities and Exchange Commission (SEC) 10-K or 10-Q filings (if available) discussing the insurer's exposure to physical losses impacted by climate change, as well as its potential impact on reinsurance decision making.	PR/UW

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w. Utilize the information gathered and/or request additional information as necessary to evaluate and assess the adequacy of the insurer's catastrophic reinsurance coverage to limit its exposure to large loss events and/or the attritional costs of multiple smaller events. i. Gain an understanding of and evaluate the company's process to incorporate catastrophe modeling results into its reinsurance decision-making processes (e.g., retention levels, coverage limits, exclusions, reinstatement provisions, or use of nontraditional reinsurance). ii. Gain an understanding of and evaluate the potential impact of climate change on the company's reinsurance decision-making processes.	PR/UW
Life Specific Procedures	*Other Risks*
x. After reviewing information on reinsurance included in the business plan and the various regulatory filings available to analysts, request and review additional information as necessary to gain an adequate understanding of the insurer's reinsurance strategy and program structure. Evaluate the impact of any significant changes in program structure (e.g., changes in retention levels, coverage limits, exclusions, etc.) on the insurer's business plan and strategy.	PR/UW
y. Review the Annual Financial Statement and other available information (e.g., actuarial opinion, MD&A, Form B, business plan, etc.) to gain an understanding and evaluate the insurer's reinsurance program in relation to its risk profile and strategy. i. Request the Department Actuary review the available information regarding the reinsurance program to identify any concerns. ii. Consider the insurer's surplus level and leverage position in evaluating the adequacy of reinsurance.	PR/UW
z. Review, for each line of business included in the Annual Financial Statement, Analysis of Operations by Lines of Business, the trends in loss ratios for indications of deteriorating underwriting results that may warrant reinsurance consideration.	PR/UW
Health Specific Procedures	*Other Risks*
aa. After reviewing information on reinsurance included in the business plan and the various regulatory filings available to analysts, request and review additional information as necessary to gain an adequate understanding of the insurer's reinsurance strategy and program structure. Evaluate the impact of any significant changes in program structure (e.g., changes in retention levels, coverage limits, exclusions, etc.) on the insurer's business plan and strategy.	PR/UW
bb. Review the Annual Financial Statement and other available information (e.g., actuarial opinion, MD&A, Form B, business plan, etc.) to gain an understanding and evaluate the insurer's reinsurance program in relation to its risk profile. i. Request the Department Actuary review the available information regarding the reinsurance program to identify any concerns. ii. If 7j. is "yes," review the insurer's maximum retained risk in Annual Financial Statement, General Interrogatories, Part 2, #5.3. Do any concerns exist regarding the health entity's level of maximum retained risk?	

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cc. Review, for each line of business included in the Annual Financial Statement, Analysis of Operations by Lines of Business, the trends in loss ratios for indications of deteriorating underwriting results that may warrant reinsurance consideration.	

8. Determine how changes in affiliate reinsurance relationships may affect the insurer's business plans and strategy.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Premiums assumed from affiliates to gross premiums [P/C]	PR/UW	>50%	[Data]	[Data]
i. Change from prior year	PR/UW	>25 pts or <-25 pts	[Data]	[Data]
ii. Change over past five years	PR/UW	>50 pts or <-50 pts	[Data]	[Data]
b. Premiums ceded to affiliates to gross premiums [P/C]	PR/UW	>50%	[Data]	[Data]
i. Change from prior year	PR/UW	>25 pts or <-25 pts	[Data]	[Data]
ii. Change over past five years	PR/UW	>50 pts or <-50 pts	[Data]	[Data]
c. Total reinsurance recoverables from affiliates to surplus [P/C]	PR/UW	>20%	[Data]	[Data]
d. Premiums assumed from affiliates to gross premiums [Life]	PR/UW	>25%	[Data]	[Data]
i. Change from prior year	PR/UW	>25% or <-25%	[Data]	[Data]
ii. Change over past five years	PR/UW	>50% or <-50%	[Data]	[Data]
e. Premiums ceded to affiliates to gross premiums [Life]	PR/UW	>25%	[Data]	[Data]
i. Change from prior year	PR/UW	>25% or <-25%	[Data]	[Data]
ii. Change over past five years	PR/UW	>50% or <-50%	[Data]	[Data]
f. Reinsurance recoverables from affiliates to capital and surplus [Life]	PR/UW	>15%	[Data]	[Data]
i. Change from prior year	PR/UW	>15%	[Data]	[Data]
ii. Change over past five years	PR/UW	>25%	[Data]	[Data]
g. Premiums assumed from affiliates to gross premiums [Health]	PR/UW	>10%	[Data]	[Data]
i. Change from prior year	PR/UW	>15 pts or <-15 pts	[Data]	[Data]

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ii. Change over past five years	PR/UW	>25 pts or <-25 pts	[Data]	[Data]
h. Premiums ceded to affiliates to gross premiums [Health]	PR/UW	>10%	[Data]	[Data]
i. Change from prior year		>15 pts or <-15 pts		
ii. Change over past five years		>25 pts or <-25 pts		
i. Reinsurance recoverables from affiliates to capital and surplus [Health]	PR/UW	>10%	[Data]	[Data]
i. Change from prior year	PR/UW	>15%	[Data]	[Data]
ii. Change over past five years	PR/UW	>25%	[Data]	[Data]
P/C Specific Procedures				*Other Risks*
j. Were there any changes in intercompany pooling agreements during the year? [Annual Financial Statement, Notes to Financial Statements, Note #10 and Note #26]				PR/UW
k. Were there any premium portfolio transfers involving affiliates? [Annual Financial Statement, Schedule F – Part 2]				PR/UW
Life Specific Procedures				*Other Risks*
l. Are any of the reinsurers, listed in Annual Financial Statement, Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the insurer or any representative, officer, trustee, or director of the insurer [Annual Financial Statement, Notes to Financial Statement, Note #23, Schedule S – Part 3 – Section 1]? If "yes," review Annual Financial Statement, Schedule S – Part 2 and Schedule S – Part 3 – Section 2 to determine if any unusual items are noted regarding the nature or magnitude of these non-affiliated relationships.				PR/UW
m. Have any policies issued by the insurer been reinsured with an alien insurer owned or controlled, directly or indirectly, by the insured, a beneficiary, a creditor of the insured, or any other person not primarily engaged in the insurance business [Annual Financial Statement, Notes to Financial Statements, Note #23, Schedule S – Part 3 – Section 1]?				PR/UW
Health Specific Procedures				*Other Risks*
n. Are any of the reinsurers, listed in Annual Financial Statement, Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the insurer or any representative, officer, trustee, or director of the insurer? [Notes to Financial Statements, Note #23; Schedule S – Part 3 – Section 1] If "yes," review Annual Financial Statement, Schedule S - Part 2 and Schedule S – Part 3 – Section 2. Are any unusual items noted regarding the nature or magnitude of non-affiliated relationships?				PR/UW
o. Have any policies issued by the insurer been reinsured with an alien insurer owned or controlled, directly or indirectly, by the insured, a beneficiary, a creditor of the insured, or any other person not primarily engaged in the insurance business? [Notes to Financial Statements, Note #23; Schedule S – Part 3 – Section 1]				PR/UW

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Procedures Applicable to All Policy Types	*Other Risks*
p. Obtain and review the underlying agreements that support the transaction(s) in question. Critically assess the substance of the transaction in terms of the following criteria: • The transaction must be economic-based and at arm's length • The transaction must result in transfer of risk and represent a consummated or permanent act • Any assets transferred to an affiliate must be transferred at fair value in an economic-based transaction • In the case of a portfolio transfer involving an affiliate, the transaction may not be allowable under state law or may require prior regulatory approval	PR/UW

9. Determine how any significant or unusual third-party reinsurance transactions (e.g., loss portfolio transfers, commutations, etc.) and relationships with reinsurance intermediaries may affect the insurer's business plans and strategy.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Surplus aid to policyholders' surplus [P/C IRIS #4]	PR/UW	>15%	[Data]	[Data]
b. Surplus relief [Life IRIS #8]	PR/UW	>10%	[Data]	[Data]
c. Ratio of total assumed premiums written to gross premiums [Life]	PR/UW	>50%	[Data]	[Data]
d. Ratio of total assumed premiums written to gross premiums written for any significant line of business, defined as a line of business where gross premium is greater than 25% of total gross premium written [Life].	PR/UW	>50%	[Data]	[Data]
e. Ratio of assumed premiums written from non-affiliates to total gross premiums written [P/C, Life]	PR/UW	>50%	[Data]	[Data]
f. Assumed loss ratio compared to gross loss ratio where the assumed premiums written are greater than 20% of gross premiums written [P/C]	PR/UW	>25 pts or <-25 pts	[Data]	[Data]
g. Does any agent, general agent, or broker control a substantial part of new or renewal business? [Annual Financial Statement, General Interrogatories, Part 1, #4.11 and #4.12]? [Life]	PR/UW	=YES	[Data]	[Data]
h. Ratio of ceded premiums written to gross premiums written	PR/UW, CR* (Health)	>50% (Life) >75% (P/C) >10% (Health)	[Data]	[Data]
i. Ratio of ceded premiums written to gross premiums written for any significant line of business, defined as a line of business where gross premium is greater than 25% [Life] or 20% [P/C] of total gross premium written	PR/UW	>50% (Life) >90% (P/C)	[Data]	[Data]

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j. Ceded commissions to ceded premiums written as percentage of expense ratio [P/C]	PR/UW	>30%	[Data]	[Data]
k. Has the company reinsured any risk under a quota share reinsurance contract that would limit the reinsurers' losses below the stated quota share percentage? [Annual Financial Statement, General Interrogatories, Part 2, #7.1] [P/C]	OP	=YES		[Data]
l. Has the reporting entity ceded any risk under any reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates) for which, during the period covered by the statement: (1) it recorded a positive or negative underwriting result greater than 5% of current year-end surplus as regards to policyholders, or it reported calendar-year written premium ceded or year-end loss and loss expense reserves ceded greater than 5% of current year-end surplus as regards policyholders, (2) it accounted for the contract as reinsurance and not as a deposit, and (3) the contract(s) contain(s) one or more of the following: • A contract term longer than two years, and the contract is non-cancelable by the reporting entity during the contract term; • A limited or conditional cancellation provision under which cancellation triggers an obligation by the reporting entity, or an affiliate of the reporting entity, to enter into a new reinsurance contract with the reinsurer, or an affiliate of the reinsurer; • Aggregate stop loss reinsurance coverage; • An unconditional or unilateral right by either party (or both parties) to commute the reinsurance contract, whether conditional or not, except for such provisions which are only triggered by a decline in the credit status of the other party; • A provision permitting reporting of losses, or payment of losses, less frequently than on a quarterly basis (unless there is no activity during the period); or • Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity. [Annual Financial Statement, General Interrogatories, Part 2, #9.1] [P/C]	PR/UW, OP	=YES		[Data]

m. Has the reporting entity, during the period covered by the statement, ceded any risk under a reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates) for which it recorded a positive or negative underwriting result greater than 5% of prior year-end surplus as regards policyholders, or for which it reported calendar-year written premium ceded or year-end loss and loss expense reserves ceded greater than 5% of prior year-end surplus as regards policyholders, excluding cessions to approved pooling arrangements or to captive insurance companies that are directly or indirectly controlling, controlled by, or under common control with (1) one or more unaffiliated policyholders of the reporting entity, or (2) an association of which one or more unaffiliated policyholders of the reporting entity is a member where: • The written premium ceded to the reinsurer by the reporting entity or its affiliates represents 50% or more of the entire direct and assumed premium written by the reinsurer based on its most recently available financial statement; or • 25% or more of the written premium ceded to the reinsurer has been retroceded back to the reporting entity or its affiliates in a separate reinsurance contract. [Annual Financial Statement, General Interrogatories, Part 2, #9.2] [P/C]	PR/UW, OP	=YES		[Data]
n. Except for transactions meeting the requirements of paragraph 36 of SSAP No. 62R, Property and Casualty Reinsurance, has the reporting entity ceded any risk under a reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement and either accounted for that contract as reinsurance (either prospective or retroactive) under statutory accounting principles (SAP) and as a deposit under generally accepted accounting principles (GAAP), or accounted for that contract as reinsurance under GAAP and as a deposit under SAP? [Annual Financial Statement, General Interrogatories, Part 2, #9.4] [P/C]	OP, LG	=YES		[Data]
o. Were there any agreements to release reinsurers from liability during the year? If "yes," explain. [Annual Financial Statement, General Interrogatories, Part 2, #8.1] [P/C]	LG, OP	=YES		[Data]
p. If the insurer has assumed risks from another	RV	=YES		[Data]

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company, did the company fail to establish a reserve equal to that which the original company would have been required to establish had it retained the risks? If "yes," explain. [Annual Financial Statement, General Interrogatories, Part 2, #10] [P/C]				
q. Has the insurer guaranteed any policies issued by another company and now in force? If "yes," explain. [Annual Financial Statement, General Interrogatories, Part 2, #11.1] [P/C]		=YES		[Data]
Procedures Applicable to All Policy Types				*Other Risks*
r. Review the Annual Financial Statement, including the reinsurance schedules and related footnotes, as well as other regulatory filings (e.g., actuarial opinion, MD&A, Form B, etc.) to determine whether any significant and/or unusual reinsurance transactions were completed during the year. Such transactions may include portfolio transfer transactions; commutation agreements; surplus relief or financial reinsurance; bulk or assumption reinsurance; or material non-renewal, cancellation or revisions of ceded reinsurance agreements or changes in the primary reinsurers. i. Did the insurer enter into any assumption reinsurance agreements whereby the responsibility for the insurer's policyholder obligations passes to an assuming insurer? ii. Are there any concerns expressed in the actuarial opinion relating to surplus relief reinsurance, loss portfolio transfers or financial reinsurance, etc.?				PR/UW, OP
s. If concerns exist relating to significant and/or unusual reinsurance transactions, consider the following additional procedures: i. Obtain and review significant commutation agreements, portfolio transfer agreements, bulk or assumption reinsurance agreements, surplus relief or financial reinsurance agreements. ii. Obtain and review supporting documentation for material transactions regarding non-renewal, cancellations or revisions of ceded reinsurance agreements. iii. Determine whether transfer of risk criteria have been met. iv. Obtain the Annual Financial Statement of the other insurer that is party to the portfolio transfer agreement (or other type of surplus relief agreement) and determine whether the transaction has been properly "mirrored" v. Determine whether proper policyholder consents received before the assumption reinsurance transfer was consummated. vi. Determine whether the underlying motivation of the insurer to enter into such a transaction involves financial difficulties that warrant additional investigation. vii. For P/C insurers, consider performing additional P/C specific procedures as indicated below				PR/UW, OP
t. Did the insurer report during the year, in accordance with the *NAIC Disclosure of Material Transactions Model Act* (#285), any material non-renewals, cancellations, or revisions of ceded reinsurance agreements? i. If "yes," obtain and review supporting documentation of such material transactions. ii. Determine if, in the analyst's opinion, additional procedures are considered necessary.				PR/UW, OP

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u. Obtain and review underlying documents relating to the use of the reinsurance intermediary or reinsurance assumed. Determine whether agreements are at arm's length and have economic substance.	OP
v. Determine whether the requirements of the *NAIC Reinsurance Intermediary Model Act* (#790) have been met. If not, list the requirements that the insurer has not met.	LG
w. Determine whether the requirements of the *NAIC Managing General Agents Act* (#225) have been met. If not, list the requirements that the insurer has not met.	RP / LG
x. If the insurer is engaged in reinsurance for fronting purposes: i. Determine whether the requirements of the state's statutes and regulations regarding fronting disclosure have been met. ii. Review the types of reinsurance being used and the specific products involved. iii. Perform procedures to evaluate collectability (see Credit Risk Repository)	LG, CR
P/C Specific Procedures	*Other Risks*
y. Were any portfolio transfer transactions consummated that, individually or in the aggregate, resulted in an increase in surplus greater than 5%?	OP
z. Review the Annual Financial Statement, Notes to Financial Statements, Note #23E: i. Were any commutation agreements consummated that, individually or in the aggregate, resulted in a significant change in surplus (+/-5%)? If "yes," list the agreements. ii. Determine whether there is a trend of annual commutations and if a trend is identified, obtain a detailed rationale for the transactions. iii. If annual trending of commutations is noted, determine any favorable/unfavorable financial impact on the insurer.	OP
aa. Review the Annual Financial Statement, Schedule F, Part 3, Note A (footnote disclosure of the five highest commission rates relating to reinsurance treaties). Are any of the commission rates greater than 40%?	OP
bb. If the insurer utilizes financial reinsurance: i. Review a summary of the reinsurance contract terms. ii. Review the discussion of management's principal objectives for entering into the reinsurance contract, as well as the economic purpose achieved. iii. Review the aggregate financial impact gross of all ceded reinsurance contracts on the balance sheet and statement of income. iv. Determine whether the reinsurance contract has been accounted for properly, and note any special accounting treatment, including any difference in treatment between GAAP and SAP.	LG, OP

Life Specific Procedures	*Other Risks*
cc. If the insurer cedes gross premium to captive (non-traditional) reinsurers, utilize the information in Form D for affiliated captive transactions and other annual reporting i.e. annual statement, actuarial reporting, and if necessary, ask the company, to gain an	CR, RV

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understanding of the purpose of the use of captive (non-traditional) reinsurance to better assess the insurer's overall reinsurance strategy.	

Capital Adequacy

10. Evaluate the adequacy of the insurer's risk-based capital (RBC) position in light of its business/strategic plans and risk exposures.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. RBC ratio	OP	<300%	[Data]	[Data]
b. If RBC ratio <350%, has there been a significant change from prior year?	OP	>30 pts or <-30 pts	[Data]	[Data]
c. Change in Total Adjusted Capital from prior year	OP	<-10%	[Data]	[Data]
d. Change in Authorized Control Level from prior year	OP	>10%	[Data]	[Data]
e. RBC trend test triggered	OP	=YES	[Data]	[Data]
f. Decrease in RBC over last two years	OP	=YES	[Data]	[Data]
				Other Risks
g. If there has been a downward trend in RBC over the last two years, document the cause(s) of the decline. If a broader trend (e.g., five or more years decline) has been noted, document how the insurer plans to mitigate this continued decline.				OP
h. If the insurer reported an increase in Total Adjusted Capital due to special surplus or capital infusions, etc., document the source and plan for continued support.				OP
i. Review the RBC risk component(s) and document the underlying causes of any significant changes.				OP
j. If the insurer triggered the RBC Trend Test review and document the reason(s).				OP
k. If the insurer has triggered an RBC Action Level event and if authorized by state statute, obtain and review a copy of the insurer's RBC plan and monitor the overall progress.				OP

11. Evaluate the adequacy of the insurer's total capital and surplus position in light of its business/strategic plans and risk exposures.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Capital and surplus to total admitted assets (excluding separate accounts) [Life]	OP	<5%	[Data]	[Data]
b. Surplus to assets ratio [P/C]	OP	<20%	[Data]	[Data]
c. Change in adjusted policyholders' surplus [P/C IRIS #8]	OP	>25% or <-10%	[Data]	[Data]
d. Gross change in policyholders' surplus [P/C IRIS #7]	OP	>50% or <-10%	[Data]	[Data]
e. Net change in capital and surplus [Life IRIS #1]	OP	> 50% or <-10%	[Data]	[Data]

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f. Gross change in capital and surplus [Life IRIS #2]	OP	>50% or <-10%	[Data]	[Data]
g. Change in capital and surplus [Health]	OP	>40% or <-10%	[Data]	[Data]
h. Decrease in surplus (capital and surplus) from any of the prior four years	OP	>10%	[Data]	[Data]
i. Unassigned funds	OP	<0	[Data]	[Data]
j. Capital/surplus notes to policyholders' surplus	OP	>10%	[Data]	[Data]
k. Change in capital/surplus notes from prior year	OP	<>0	[Data]	[Data]
l. Review footnote (h) in the Annual Financial Statement, Exhibit of Net Investment Income. Did the insurer report interest expense on capital or surplus notes during the year?	OP	<>0	[Data]	[Data]
m. Stockholder dividends to prior year capital and surplus	OP	<=-10%	[Data]	[Data]
n. Write-ins for special surplus funds or other than surplus funds to surplus	OP	>10%	[Data]	[Data]
o. Absolute value of current year change to current year surplus for any of the following: • Net unrealized capital gains/losses • Net unrealized Foreign Exch. capital gains/losses • Net deferred taxes • Non-admitted assets • Provision for reinsurance [P/C] • Liability for unauthorized reinsurance [Life/Health] • Reserve valuation basis [Life/Health] • AVR [Life] • Surplus notes • Change in accounting principle	OP	>3%	[Data]	[Data]
				Other Risks
p. If the insurer or insurance group is subject to ORSA requirements, review and evaluate the results of the most recent ORSA Summary Report analysis conducted by the lead state as discussed in Section VI.F Own Risk Solvency Assessment (ORSA) of the Handbook. Document any concerns or conclusions regarding the insurer's capital modeling and capital position and their effects on the insurer's ability to establish, implement and oversee an effective business strategy.				OP
q. Review the Capital and Surplus section in the Financial Profile Report and/or the Capital and Surplus Analysis (roll forward) in the Annual Financial Statement for unusual fluctuations or trends in the changes in surplus between years. Investigate any significant or unexplained items.				OP
r. Compare the surplus (capital and surplus) to assets ratio to the industry average to determine any significant deviation.				OP

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s. If there has been a change in capital or surplus notes compared to the prior year-end, indicate the current and prior year-end balances and the amount of the change. Also, review any notes issued, principal or interest paid, or any other changes that have been made and whether any necessary approvals were obtained.	OP
t. If a significant portion of policyholders' surplus (capital and surplus) is made up of capital/surplus notes, consider performing the following additional procedures (as necessary): i. Review the Annual Financial Statement, Notes to Financial Statements, Note #13 and Note #11 to identify any unusual terms (e.g., interest rate, date of maturity, assets received, conditions, etc.) and evaluate the impact on the insurer's surplus position. ii. Recalculate important ratios, excluding the amount of surplus notes, to determine the effect of surplus notes on the ratio results.	OP
u. Review the write-ins for special surplus and for other than special surplus funds for reasonableness.	OP
v. Review the detail of unrealized gains or (losses) in Annual Financial Statement, Exhibit of Capital Gains (Losses) for reasonableness.	OP
w. If the insurer declared dividends to stockholders during the year, consider the following procedures: i. Review Annual Financial Statement, Notes to Financial Statements and Extraordinary Dividend approvals to determine what assets were used to pay dividends: • Was the amount of the dividend at a level that required regulatory approval? • Did the insurer fail to obtain proper regulatory approvals? • If the shareholder dividends paid were at a significant amount that required the liquidation of assets to cash, were any liquidity concerns noted? ii. Review the trend of stockholder dividends along with the results of the Holding Company analysis performed by the lead state. Is the insurer relied upon for dividend payments to meet holding company business needs?	OP
x. Review Annual Financial Statement, Notes to Financial Statements, Note #14 to identify any parental/affiliated guarantees, of any form, in place between the company and any member within its holding company system. If guarantees are in place, review and discuss with the company and evaluate the potential effect on the insurer's surplus position.	OP, LG

Financial Impact of Affordable Care Act on Capital & Surplus and RBC

12. Assess the impact of Affordable Care Act (ACA) assessments, Risk-Sharing Provisions and Medical Loss Ratio (MLR) rebates on the financial solvency of the insurer.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Did the insurer write accident and health insurance premium that is subject to the ACA risk-sharing provision?		=YES	[Data]	[Data]
b. Impact of the net receivable/payable effect of the Risk Adjustment, Reinsurance and Risk Corridors			[Data]	

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(3Rs) programs on capital and surplus				
c. MLR rebate liability to capital and surplus		>5%	[Data]	[Data]
				Other Risks
d. Evaluate the impact of ACA fee assessments, risk sharing mechanisms and MLR rebate liabilities on the insurer's current and long-term solvency position.				
e. Review the Annual Financial Statement, Notes to Financial Statements, Supplemental Health Care Exhibit Part 1 and the final rebate reporting to the U.S. Department of Health and Human Services (HHS). If the amount of MLR rebate liability reported is material (12.h above, greater than 5% of capital and surplus), determine whether there are concerns regarding the insurer's liability for rebates.				LG*
f. If risk sharing provisions have an impact on capital and surplus, determine the impact of the risk-sharing provision on RBC.				

Additional Analysis and Follow-Up Procedures

Examination Findings:

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

Inquire of the Insurer:

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

News, Press Releases, Industry Reports

- The financial impact to the insurer and/or group's operations and surplus
- Disclosures of financial impact to the public and agent distribution force
- The insurer's efforts to mitigate any impact of the risk. For ORSA filers, this may be identified in the ORSA Summary Report for certain risks.
- Policies and procedures in place to mitigate adverse publicity
- Revised business plan

Risk Management and Governance

- Risk management policies and procedures
- Risk monitoring and reporting tools
- The impact of significant changes in board and executive leadership on the insurer's strategy and business plans
- Information on significant recent or pending changes to organizational structure or operations

Mergers and Acquisitions

- Information on due diligence processes
- Pre- and post-transaction projections and results
- Information on integration efforts and cost-cutting measures
- Information on the insurer's process and controls over integration

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Future Mergers and Acquisitions

- Inquire as to whether the company is actively investigating or pursuing merger and acquisition opportunities. If "yes," consider the following additional procedures (as necessary):
  - Obtain an understanding of and consider the company's motivation for pursuing acquisition opportunities (e.g., gain market share, increase producer fees/commissions, diversification, etc.) and how that motivation may affect strategic planning and prospective risk exposures.
  - Gain an understanding of and evaluate the company's processes to perform due diligence when investigating mergers and acquisitions.

Business Plans/ Strategies

- Revised/updated business plans and projections
- Information on strategic planning processes and board approval
- Investment policies and strategy documentation
- Derivative use plan and information on hedging strategies
- Investment management agreements
- Information on reinsurance program structure
- Significant reinsurance contracts and agreements
- Reinsurance intermediary agreements
- Strategies for limiting the financial impact of a pandemic event on the company's solvency position (Health)

Capital Adequacy

- RBC action plan (if necessary)
- Information on capital/surplus notes and dividends (if not already received)
- Information on guarantees and other financial obligations

ORSA Summary Report:

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

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

Holding Company Analysis:

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

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Example Prospective Risk Considerations		
Risk Components for IPS		***Explanation of Risk Components***
1	Impact of [industry risk, news report, reorganization, etc.] on company strategy	Various industry risks, economic conditions, company announcements or other events reported through press releases and news articles may threaten or significantly affect the insurer's strategy.
2	Weak or immature risk management practices	Weaknesses or immaturity in the insurer's risk management practices may limit its ability to identify, track, assess and manage significant strategic risks.
3	Change in strategic direction	A change in strategic direction resulting from turnover or change in key board and/or senior management positions may increase strategic risk.
4	Lack of experienced leadership	The lack of experienced leadership at the board and senior management level may make it difficult to set, maintain and achieve strategic goals.
5	Lack of due diligence in mergers or acquisitions	Failure to adequately conduct due diligence in evaluating the financial condition and compatibility of merger and acquisition candidates may lead to strategic difficulties.
6	Integration challenges	The insurer may experience problems in integrating people, culture, systems and business plans as a result of business combinations and merger/ acquisition activity.
7	Lack of strategic business planning	The lack of formalized business planning and strategic development may limit the insurer's ability to adequately identify, address and respond to risks on a timely basis.
8	Overly aggressive/optimistic business strategies	The insurer's business plans and strategies may be overly aggressive or optimistic, leading to challenges in achieving projected results and meeting strategic objectives.
9	Aggressive investment strategy	The insurer's investment portfolio and strategy may not be structured appropriately to support its ongoing business plan.
10	Lack of investment expertise/oversight	The background, experience and oversight of the investment management function (including in-house staff and third-party investment managers/advisors) may not be sufficient to mitigate investment risks assumed by the insurer.
11	Reinsurance adequacy	The insurer's reinsurance program may be inadequate to support the ongoing business plan and mitigate excessive risk exposures.
12	Affiliated reinsurance concerns	Reinsurance transactions and relationships with affiliates may fail to transfer risk, contain inequitable or unprofitable provisions and/or mask true financial performance.
13	Questionable reinsurance contracts	The insurer may participate in significant third-party reinsurance contracts that distort its surplus position, mask true financial performance, or raise questions related to risk-transfer and ongoing obligations.
14	RBC concerns	The insurer's current and/or prospective RBC position may be insufficient to support its ongoing business plan and strategy.
15	Adequacy of surplus	The insurer's overall surplus position may be inadequate to support its ongoing business plan, operations and long-term strategy.
16	Reinsurance cost and availability	The insurer's reinsurance strategy may not be sustainable due to increasing cost and availability concerns on a prospective basis.

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Strategic Risk: Inability to implement appropriate business plans, to make decisions, to allocate resources or to adapt to changes in the business environment will adversely affect competitive position and financial condition.

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 strategic risk. For example, changes in organizational structure are also discussed in the Operational Risk Repository.

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

News, Press Releases, and Industry Reports

1. Determine if concerns exist regarding news, press release or industry reports involving the insurer or insurance group.

	Other Risks
a. Review any insurance, marketplace or economic industry reports, news releases, press releases and emerging issues to identify if any issues have the potential to negatively impact the insurer's strategy. • Examples: NAIC "Insurance Industry Snapshots" and "Insurance Industry Analysis Reports"; NAIC Capital Markets Bureau reports, rating agency reports, insurance news sources, NAIC risk alerts, etc.	RP*, LG
b. If concerns exist regarding a recent industry report, news release or emerging issue, determine if the news or industry issue has the potential to impact the insurer's strategy, operations or financial solvency.	RP*, LG
c. Perform additional non-routine procedures where applicable (e.g., survey or questionnaire, stress testing, etc.).	RP*, LG

Risk Management and Governance

2. Evaluate the effects of changes in officers, directors or organizational structure on the strategic direction of the insurer.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Have there been any substantial changes in the organizational chart since the prior quarter end? [Quarterly Financial Statement, General Interrogatories, Part 1, #3.2]	OP*	=YES	[Data]	[Data]
				Other Risks
b. Review the changes in officers, directors or trustees and any concerns noted during a review of biographical affidavits. i. Do new directors and officers have the required knowledge, experience and training to perform their duties? Document any concerns.				OP, RP, LG

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ii. Are new board of director members sufficiently independent from management and adequately engaged in performing their duties? iii. Have new directors and officers ever been officers, directors, trustees, key employees or controlling stockholders of an insurance company that, while they occupied any such position or served in any such capacity with respect to it: • Been placed in supervision, conservation, rehabilitation or liquidation; • Been enjoined from, or ordered to cease and desist from, violating any securities or insurance law or regulation; • Suffered the suspension or revocation of its certificate of authority or license to do business in any state? If "yes," explain. iv. Summarize the insurer's policies and procedures regarding performance of background checks on new management.	
c. If a significant amount of turnover and/or changes in key positions (i.e., chairman of the board of directors, chief executive office [CEO]) are identified, gain an understanding of and evaluate the impact of such changes on the insurer's strategic direction. Consider requesting updated business plans, holding in-person meetings, conducting conference calls, or taking other steps to understand and address significant changes.	OP, RP
d. Have there been any changes in the organization's structure? If "yes," request the reasons for the changes and the impact on future business plans and strategy.	OP, RP
e. Have there been any significant operational or business changes that have resulted in significant changes to staffing levels, consolidations of operations with affiliates, outsourcing of key functions, or placing blocks of business into run-off (closed) blocks?	OP

Mergers and Acquisitions

3. Determine how recent and pending merger and acquisition activity affects the current and prospective solvency position of the insurer.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Has the insurer been a party to a merger or consolidation? [Quarterly Financial Statement, General Interrogatories, Part 1, #4.1]		=YES	[Data]	[Data]
				Other Risks
b. If 3.a is "yes," note any observations or concerns, ensure Form A or additional filings have been approved, and assess if the insurer is meeting the expectations set forth in the Form A business plan, consider the following additional procedures (as necessary): i. If regulatory approval of the merger or acquisition was subject to ongoing conditions or restrictions, verify compliance with those requirements. ii. Compare actual results to pre-transaction projections to determine whether results are meeting expectations. If not, gain an understanding of why projections have not been achieved and the company's planned actions to address issues. iii. Request and review information regarding the integration of the new business into the				LG, OP

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company's processes and systems (systems transition plan), as well as the steps taken to ensure that adequate cybersecurity precautions are taken during the integration process. iv. Gain an understanding of and consider the impact of planned cost-cutting activities, including the nature and magnitude of cuts and their potential impact on risk exposures.	

Business Plans

Note: The following does not contemplate repeating analysis of the business plans that may have been performed as part of the annual analysis. However, if timing of the receipt of business plans coincides with quarterly reviews or if business plans contain quarterly financial projections or other mid-year plans, consider including assessment of business plan in the quarterly review.

4. Evaluate the effectiveness of the insurer's business/strategic planning process and whether the current plan adequately addresses the significant solvency risks facing the insurer.

	Other Risks
a. Review previous business plans and financial projections filed with the state insurance department, and determine the following: i. Have significant changes in business plan or philosophy occurred? If "yes," explain. ii. Assess if initiatives outlined in the business plan have been accomplished. iii. Compare actual with projected financial results. Are actual results consistent with management's expectations? If not, explain. iv. Request an explanation for the variance including an explanation of whether management believes it has achieved its goals for the period and if any noted risks or challenges were not considered in the business plan. v. Request a revised business plan. vi. Describe any events, transactions, market conditions and/or strategic management decisions that have occurred (or are planned) that may cause a significant positive or negative variance from projections, including new product development or enhancements, changes in sales volume, product mix, or geographical locations. vii. Are there internal and/or external prospective risks that have the potential to impact the overall business plan?	OP
b. If necessary, request and review an updated strategic business plan, note any areas of concern and if necessary, request additional explanations from the insurer. i. Does the new business plan reflect significant changes in the strategic goals or philosophies compared to the prior plan? If "yes," explain. ii. Describe the insurer's strategic and annual planning process. iii. Describe the board of directors' involvement in developing and implementing the business plan. iv. Assess the insurer's ability to attain the expectations of the business plan and projections. Does the business plan reflect changes that appear unrealistic for the current market environment, financial position of the insurer or other circumstances? If "yes," explain.	OP

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• Reasonableness of underwriting assumptions • Current and anticipated interest rate and economic environment • Growth objectives • Stability of capital and ability to access additional capital, if needed • Quality and sources of earnings (trends and stability) • Dividends and dividend payout policy	

Changes in Reinsurance Program

5. Determine whether any significant changes may have been made to the insurer's reinsurance program.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Change in writings from prior year-to-date • Direct • Assumed • Ceded • Net	PR/UW*	>20% or <-20%	[Data]	[Data]
b. Gross writings leverage (rolling year) [P/C]		>900%	[Data]	[Data]
c. Net writings leverage (rolling year) [P/C]		>300%	[Data]	[Data]
d. Change in leverage ratios from prior year-end [P/C] • Gross writings leverage (rolling year) • Net writings leverage (rolling year) • Paid reinsurance recoverables to surplus • Reserve leverage		>10 pts or <-10 pts	[Data]	[Data]
e. Change in ceded premiums earned from prior year-to-date [P/C]		>20% or <-20%	[Data]	[Data]
f. Change in ceded premiums to gross premiums written [P/C, Life] • From prior quarter • From prior year-end		>10 pts or <-10 pts	[Data]	[Data]
g. Change in assumed premiums earned from prior year-to-date [P/C]		>20% or <-20%	[Data]	[Data]
h. Change in assumed premiums to gross premiums written [P/C, Life] • From prior quarter • From prior year-end		>10 pts or <-10 pts	[Data]	[Data]
i. If the company is a member of a pooling arrangement, was there any change in agreement or the company's participation? [Quarterly Financial Statement, General Interrogatories, Part 2, #1]. [P/C]		=YES	[Data]	[Data]
j. Is there a balance sheet liability for reinsurance in unauthorized and certified companies? [Life]		>0	[Data]	[Data]
k. Change in balance sheet liability, reinsurance in		>10% or	[Data]	[Data]

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unauthorized and certified companies [Life] • From the prior quarter • From prior year-end		<-10% OR >20% or <-20%		
l. Change in capital and surplus account line item relating to the change in liability for reinsurance in unauthorized and certified companies [Life] • From the prior quarter • From the prior year-end		>10% or <-10% OR >20% or <-20%	[Data]	[Data]
m. Were any new reinsurers added since the prior quarter? [Quarterly Financial Statement, Schedule F [P&C] or Quarterly Financial Statement, Schedule S [Life, Health]]	CR*	YES if count >0	[Data]	[Data]
i. If "yes," were any unauthorized?		YES if count >0	[Data]	[Data]
n. Change in provision for reinsurance from prior year-end [P/C]		<>0		
				Other Risks
o. If new reinsurance is reported, obtain a copy of the new reinsurer's A.M. Best Supplemental Ratings Questionnaire, and review the reinsurance section to identify any risks or concerns.				

6. Determine whether any unusual reinsurance transactions were completed during the quarter.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Were there any agreements to release reinsurers from liability during the quarter? [Quarterly Financial Statement, General Interrogatories, Part 2, #2] [P/C]	CR*, OP	=YES		[Data]
b. Were there any cancellations of primary reinsurance contracts during the quarter? [Quarterly Financial Statement, General Interrogatories, Part 2, #3.1 and #3.2] [P/C]	CR*, OP	=YES		[Data]
c. Did the insurer experience any material transactions requiring the filing of Disclosure of Material Transactions with the state of domicile as required by the Model Act? [Quarterly Financial Statement, General Interrogatories, Part 1, #1.1]	CR*, LG*	=YES		[Data]
i. If "yes," did the insurer fail to make the appropriate filing of a Disclosure of Material Transactions with the state of domicile? [Quarterly Financial Statement, General Interrogatories, Part 1, #1.2]	CR*, LG*	=YES		[Data]

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d. Was the change in the ceded pure loss ratio from the prior year-end significantly greater than the change in the gross pure loss ratio? [P/C]		>30 pts or <-30 pts	[Data]	[Data]
e. Was the change in the assumed pure loss ratio from the prior year-end significantly greater than the change in the gross pure loss ratio? [P/C]		>30 pts or <-30 pts	[Data]	[Data]
				Other Risks
f. If the insurer reported material reinsurance transactions [Quarterly Financial Statement, General Interrogatory #1.1] and if concerns exist relating to significant and/or unusual reinsurance transactions during the quarter, consider the following additional procedures: i. Obtain and review significant commutation agreements, portfolio transfer agreements, bulk or assumption reinsurance agreements, surplus relief, or financial reinsurance agreements. ii. Obtain and review supporting documentation for material transactions regarding non-renewal, cancellations or revisions of ceded reinsurance agreements. iii. Determine whether transfer of risk criteria have been met. iv. Obtain the Annual Financial Statement of the other insurer that is party to the portfolio transfer agreement (or other type of surplus relief agreement) and determine whether the transaction has been properly "mirrored." v. Determine whether proper policyholder consents received before the assumption reinsurance transfer were consummated. vi. Determine whether the underlying motivation of the insurer to enter into such a transaction involves financial difficulties that warrant additional investigation.				

Capital Adequacy Management

7. Determine whether concerns exist regarding the insurer's Risk-Based Capital (RBC) position.

	Other Risks
a. Given the current level of RBC and any significant balance sheet or operational changes, consider the impact to RBC. If there are concerns, consider completing and/or requesting an interim RBC projection.	
b. If the insurer triggered an RBC Action Level event in the prior period and if an RBC plan was filed, review the insurer's RBC plan and monitor the overall progress to-date.	

8. Evaluate the adequacy of the insurer's total capital and surplus position in light of its business/strategic plans and risk exposures.

	Other Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Change in capital and surplus from the prior year-end [Life]	OP	>20% or <-20%	[Data]	[Data]
b. Change in surplus from the prior year-end [P/C]	OP	>25% or <-15%	[Data]	[Data]

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c. Change in capital and surplus from the prior year-end [Health]	OP	>40% or <-10%	[Data]	[Data]
d. Absolute value of the current year change to capital and surplus for any of the following items: • Net unrealized capital gains/losses • Net unrealized foreign exchange capital gains/losses • Net deferred taxes • Non-admitted assets • Provision for reinsurance [P/C] • Liability for unauthorized reinsurance [Life, Health] • Reserve valuation basis [Life, Health] • AVR [Life] • Surplus notes • Change in accounting principle	OP	>3%	[Data]	[Data]
e. Capital and surplus to total admitted assets (excluding separate accounts) [Life]	OP	<5%	[Data]	[Data]
f. Surplus to assets ratio [P/C]	OP	<20%	[Data]	[Data]
g. Ratio of capital and/or surplus notes issued during the quarter to capital and surplus	OP	>10%	[Data]	[Data]
h. Write-ins for special surplus funds or other than surplus funds to capital and surplus	OP	>10%	[Data]	[Data]
i. Stockholder dividends declared during the quarter	OP	>0	[Data]	[Data]
j. Unassigned funds [P/C]	OP	<0	[Data]	[Data]
				Other Risks
k. Review the Capital and Surplus section in the Financial Profile Report and/or the Capital and Surplus Analysis (roll forward) in the Annual Financial Statement for unusual fluctuations or trends in the changes in surplus between years. Investigate any significant or unexplained items.				
l. If stockholder dividends were declared during the quarter, was the amount of stockholder dividends at a level that required prior regulatory approval?				
i. If "yes," did the insurer fail to obtain proper prior regulatory approval for stockholder dividends?				
m. Review the Quarterly Financial Statement, Notes to Financial Statements and Extraordinary Dividend approvals to determine what assets were used to pay dividends. If the shareholder dividends paid were at a significant amount that required the liquidation of assets to cash, were any liquidity concerns noted?				
n. Did the insurer repay any principal and/or pay any interest on capital or surplus notes during the quarter?				
o. For any newly issues capital or surplus note, consider reviewing any notes issued, principal or interest paid, or any other changes made, and whether any necessary approvals were obtained.				
p. Review the write-ins for special surplus and other than special surplus funds for reasonableness.				

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Strategic Risk Assessment

Strategic Risk: Inability to implement appropriate business plans, make decisions, allocate resources or adapt to changes in the business environment that will adversely affect competitive position and financial condition.

The objective of Strategic Risk Assessment analysis is to focus on risks inherent in the company's business strategy and plans. As such, risks in this area are often prospective in nature and may require additional investigation and information requests to understand and assess their potential impact. For example, analysts may require an up-to-date business plan from the insurer to assess emerging risk exposures and prospective risks that could prevent the insurer from meeting its strategic goals. In addition, information presented in the Enterprise Risk Report (Form F) and Own Risk and Solvency Assessment (ORSA) Summary Report (if available) which the lead state reviews and documents risks, may assist analysts in identifying and assessing the insurer's exposure to strategic risks.

The following discussion of procedures provides suggested data, benchmarks and procedures analysts can consider in his/her review. In analyzing strategic risk, analysts may analyze a wide range of risk exposures related to the insurer's business plan and overall strategy. An analyst's risk-focused assessment of strategic risk should take into consideration the following areas (but not be limited to):

- Industry and market factors
- Risk management and governance challenges
- Changes in officers and directors
- Recent and pending merger and acquisition activity
- The insurer's strategic planning process
- Significant recent or pending changes in business plan and strategy
- Underwriting strategy and plans
- Investment strategy and use of investment advisors
- Reinsurance strategy, including adequacy of coverage
- Affiliate relationships and transactions
- Capital planning and adequacy

Discussion of Annual Procedures

Using the Repository

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

In using procedures in the repository, analysts should review the results in conjunction with the Supervisory Plan, Insurer Profile Summary and the prior period analysis. Communication and/or coordination with other

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internal departments are a critical step in the overall risk assessment process and are a crucial consideration in the review of certain procedures in the repository.

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

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

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

Quantitative and Qualitative Data and Procedures

News, Press Releases and Industry Reports

PROCEDURE #1 directs analysts to identify and assess concerns from news, press releases or industry reports with the potential to affect the insurer or insurance group. The intent of this procedure is for analysts to identify issues that could affect an insurer's ability to effectively implement its strategy. For example, if the insurer's strategy is focused on a particular line of business that is facing challenging economic conditions, analysts may be able to identify this concern through NAIC Industry Snapshots and Reports or NAIC Risk Alerts. Another example might be a news release or press release from the company indicating shifts or changes in strategy that could affect the insurer's financial condition. If concerns exist with respect to a potentially damaging report issued on the insurer or group, analysts should inquire about the overall financial impact on the insurer and the steps the insurer plans to implement to mitigate the circumstances.

Risk Management and Governance

PROCEDURE #2 directs analysts to determine whether the risk management practices of the insurer are sufficient to provide for the establishment, implementation and oversight of an effective business strategy. In completing this procedure, analysts must first determine whether the insurer is subject to ORSA requirements. If the insurer is subject to ORSA requirements, analysts are directed to obtain and review work performed by the lead state to evaluate the insurer's risk management framework.

For insurers that are not subject to ORSA reporting requirements, analysts may need to gather additional information regarding the insurer's risk management processes in order to assess their impact on strategic risk. Analysts may be able to leverage work recently completed by financial examiners in this area by requesting Exhibit M and/or C-Level interview results to gain an understanding of risk management practices in place. As part of the examination, several key areas are considered when reviewing the risk management function, including those outlined in procedure 2c. Where applicable, analysts should review and follow-up on work performed by the examiner, including any comments or recommendations.

If the information is not available or not sufficient, analysts may need to inquire regarding the insurer's internal risk management practices to obtain an understanding and evaluate the impact of such practices on the insurer's business strategy. A review of the entity's risk-management function should be conducted through discussions with senior management and the board of directors, and through gaining an understanding of the risk-management function including inspection of relevant risk management documentation. An effective risk-management function is essential in providing effective corporate governance over financial solvency.

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PROCEDURE #3 directs analysts to evaluate the effects of changes in officers, directors or organizational structure on the strategic direction of the insurer. This procedure is intended to assist analysts in assessing the potential impact on strategic risk from changes in directors, senior management, and organizational structure or operations. At times it is impossible to avoid director and management turnover. Whether the change is a result of retirement or term limits, performance, promotion, or termination, the end result is a new individual being placed in a position that could affect the strategy of the insurer. For example, new management may institute change in future business plans that could have a significant impact on the insurer or group (e.g., new types of business, new geographic areas of writings, staff changes, or new affiliations). Changes in organizational structure and operations may have a similar impact and should be considered and evaluated for their potential to affect the insurer's ability to achieve its business strategy.

Mergers and Acquisitions

PROCEDURE #4 directs analysts to consider how recent and pending merger and acquisition activity may affect the current and prospective solvency of the insurer. Merger and acquisition activities have the potential to move the company into new lines of business and new geographical areas, and may result in significant staffing turnover and integration activities. All of these elements have the potential to significantly affect the business strategy of the insurer. In addition, analysts should be mindful of the fact that mergers and acquisitions do not always yield the desired results. As such, follow-up procedures comparing projections to actual results and evaluating the effectiveness of system integration and cost-cutting measures may help identify prospective risks and concerns that merit ongoing monitoring.

Business Plans

PROCEDURE #5 directs analysts to evaluate the effectiveness of the insurer's business/strategic planning process and whether the current plan adequately addresses the significant solvency risks facing the insurer. After obtaining and reviewing a current business plan from the insurer, analysts should determine whether any changes have been made in the business goals or philosophies. Analysts should consider the overall planning process (e.g., who is involved, how frequently it occurs, etc.) and how the overall initiatives are determined. In addition, analysts may consider discussing with the insurer any assumptions used in establishing the goals. Analysts should assess whether the current management team has the expertise to attain the goals of the business plan. Through communication with the insurer, analysts should document any detailed explanations regarding variances in projected financial results and the insurer's intended plan to address variances. If analysts determine the goals of the business plan are not attainable and/or projections are unreasonable, a revised business plan may be requested.

Special consideration should be given to startup insurers that project rapid growth and significant underwriting and net losses. In many cases, startups rely heavily on the parent company's capital contributions to finance operations until the insurer can achieve profitability. The analyst should evaluate the reasonableness of the insurer's business plan and projections and determine whether the plan is attainable.

PROCEDURE #6 directs analysts to assess whether the insurer's investment strategies and holdings are appropriate to support its ongoing business plan and strategy. Analysts should review tool results (e.g., financial profile, investment snapshot, etc.) to get a basic understanding of the insurer's investment holdings/strategy and any changes noted. If changes or concerns are noted, analysts may need to request a copy of the insurer's formal adopted investment plan. This should be evaluated to determine if the plan appears to result in investments that are appropriate for the insurer, based on the types of business written and its liquidity and cash flow needs and to determine whether the insurer appears to be adhering to its plan. The plan should also specify investment guidelines for the company to follow in asset allocation addressing quality, maturity/duration and diversification (by issuer, industry, geographic location, etc.). If concerns are identified regarding the insurer's investment plan or strategy, analysts should consider requesting a portfolio analysis from the NAIC's Capital Markets Bureau or use other investment expertise to address the issues.

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Analysts may perform additional procedures if there are concerns regarding the level of investment in derivative instruments. Analysts should consider obtaining a comprehensive description of the insurer's hedge program in order to obtain an understanding of the insurer's use of derivative instruments to hedge against the risk of a change in value, yield, price, cash flow, or quantity or degree of exposure with respect to the insurer's assets, liabilities, or expected cash flows. The hedge program should be evaluated to determine whether it appears to result in hedges that are appropriate for the insurer, based on its assets, liabilities, and cash flow risks and whether the insurer appears to be adhering to the hedge program. For significant derivative instruments that are open at year-end, analysts should consider requesting and reviewing a description of the methodology used by the insurer to verify the continued effectiveness of the hedge provided, a description of the methodology to determine the fair value of the derivative instrument, and a description of the determination of the derivative instrument's book/adjusted carrying value, to determine whether the requirements of the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual) have been met. Analysts might also consider having the insurer's derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.

Reinsurance Strategy

PROCEDURE #7 relates to the reinsurance levels maintained by the insurer and whether they are adequate to support the insurer's business plan and strategy. As risks related to reinsurance strategy may vary somewhat according to business type, the procedures in this area include both considerations applicable to all business types and those specifically associated with Property/Casualty (P/C), Life and Health business.

In general, to assess the adequacy of the reinsurance program in place, analysts should evaluate the insurer's leverage position (on both a gross and net basis), as well as identify risk concentrations that could expose the insurer to significant loss events. An in-depth understanding of the insurer's lines of business and business strategy is most likely to result in the identification of risk concentrations, and a number of tools and reports can be beneficial in supporting and supplementing that understanding. Many of the most relevant tools and metrics are highlighted in the procedure, such as Schedule T premium data, risk-based capital (RBC) RCAT disclosures, disclosures in the Annual Financial Statement and various tool results and ratios (e.g., Largest Net Amount Insured in a One Risk to Surplus). In addition, information provided in ORSA reporting and rating agency reports (i.e., A.M. Best Supplemental Ratings Questionnaire – Reinsurance Section) may provide additional information on risk concentrations and exposures.

If concerns related to the insurer's leverage position and significant risk concentrations/exposures are identified, analysts should evaluate the adequacy of the insurer's reinsurance program to mitigate those exposures. In so doing, analysts should use information in the Annual Financial Statement and other available information (e.g., actuarial opinion, Management's Discussion and Analysis (MD&A), Form B, business plan, reinsurance contracts filed with the department, etc.) to gain an understanding and evaluate the insurer's reinsurance program in relation to its risk profile and strategy, including adequate protection for large losses. After reviewing information on reinsurance included in the business plan and the various regulatory filings available, analysts should request and review additional information as necessary to gain an adequate understanding of the insurer's reinsurance strategy and program structure. In so doing, analysts should evaluate the impact of any significant changes in program structure (e.g., changes in retention levels, coverage limits, exclusions, reinstatement provisions, or use of non-traditional reinsurance etc.) on the insurer's business plan and strategy.

In addition to considerations regarding the insurer's current reinsurance program and its adequacy, analysts may want to evaluate the longer-term sustainability of the insurer's reinsurance strategy. This is particularly true for entities that are subject to significant catastrophic risk exposures with the potential to be impacted by climate change. The analyst may find information provided in the NAIC's Climate Risk Disclosure Survey, ORSA Summary Reports, and/or U.S. Securities and Exchange Commission (SEC) 10-K and 10-Q filings valuable in identifying and assessing risks in this area.

PROCEDURE #8 asks analysts to determine how changes in affiliate relationships may affect the insurer's business plans and strategies. This procedure focuses largely on affiliate reinsurance relationships and

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transactions (both ceded and assumed) and their impact on business strategy. As risks related to affiliated reinsurance may vary somewhat according to business type, the procedures in this area include both considerations applicable to all business types and those specifically associated with P/C, Life and Health business. These procedures are generally included to provide information to analysts on new reinsurance transactions with affiliates or significant shifts in the results of ongoing affiliated reinsurance arrangements.

It is important to note that a group of affiliated insurance companies may use reinsurance as a mechanism to diversify the portfolios of individual companies and to allocate premiums, assets, liabilities, and surplus among affiliates. Intercompany pooling, where each company reinsures a fixed proportion of business written by pool members, is a standard practice among companies under common management. From an economic standpoint, reinsurance transactions between affiliated insurance companies do not reduce risk for the group but instead shift risk among affiliates. Reinsurance between affiliated companies presents opportunities for manipulation and potential abuse. In a group of affiliated insurers, intercompany reinsurance may serve to obscure one insurer's financial condition by shifting loss reserves from one affiliate to another or improperly supporting or subsidizing one affiliate at the expense of another.

As the placement of risks within a group due can have a drastic effect on an insurer's strategy, analysts should identify and assess risks in this area. In addition, as affiliated reinsurance contracts are typically subject to department review and approval, significant concerns over risk concentrations and/or the reasonableness/equity of terms in significant affiliated reinsurance contracts should be identified and addressed with the insurer as necessary. Such discussions may occur during both the initial department review of the contract (Form D filing) and/or on an ongoing basis as necessary, as the results of affiliated reinsurance arrangements indicate a need to reassess the reasonableness of contracts.

PROCEDURE #9 asks analysts to determine how any significant or unusual third-party reinsurance transactions, including loss portfolio transfers and commutations, as well as relationships with reinsurance intermediaries, may affect the insurer's business plan and strategy. As risks related to unusual reinsurance transactions may vary somewhat according to business type, the procedures in this area include both considerations applicable to all business types and those specifically associated with P/C, Life and Health business. Various metrics are provided in procedures #9a – #9j for P/C, Life and Health to assist analysts in identifying risks related to large or unusual reinsurance transactions or reinsurance arrangements that may require additional review and scrutiny.

PROCEDURES #9R AND #9T (ALL BUSINESS TYPES), as well as many of the procedures from #9k – #9q and #9y – #9bb (P/C-specific), are directed at identifying and assessing unusual reinsurance transactions where a review of the transfer of risk criteria may be important. The essential ingredient of a reinsurance contract is the shifting of risk. The reinsurer must indemnify the ceding company in form and in fact, against loss or liability relating to the original policy. Unless the contract contains this essential element of risk transfer, the ceding company may not account for it as a reinsurance recoverable. Determining whether a contract involves true transfer of risk requires a complete understanding of the contract between the ceding company and the reinsurer. All contractual features that limit the amount of insurance risk to the reinsurer (such as through experience refunds, cancellation provisions, adjustable features, or additions of profitable lines of business to the reinsurance contract) or delay the timely reimbursement of claims by the reinsurer (such as through payment schedules or accumulating retentions from multiple years) should be thoroughly understood. Transfer of risk requires that the reinsurer assume significant insurance risk under the reinsured portions of the underlying insurance contracts, and that it is reasonably possible that the reinsurer may realize a significant loss from the transaction.

Analysts should be particularly alert to certain types of unusual reinsurance transactions where risk transfer issues may be more prevalent and/or where the transaction involves the transfer of a large block of business, such as bulk reinsurance (Life/Health), assumption reinsurance (Life/Health), surplus relief transactions (all business types), commutations (P/C) and loss portfolio transfers (P/C).

Bulk reinsurance (Life/Health) is when an insurer cedes all or part of a block of insurance business. Such bulk cessions may or may not be in the ordinary course of business and may or may not require prior regulatory

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approval. Under an indemnity reinsurance arrangement, the ceding insurer remains liable to the policyholders and the reinsurer has no obligations to them. Typically, the ceding insurer will continue to perform all functions in connection with claims and other policyholder services. Under an assumption reinsurance arrangement, the liability to policyholders is assumed by the reinsurer, although in some cases, the ceding insurer retains a contingent liability. Assumption reinsurance requires that the reinsurer issue assumption certificates to the existing policyholders and take over responsibility for policyholder services. On occasion, the reinsurer will contract with the original insurer to continue to provide such services on a fee basis. Regulatory approval of all assumption reinsurance arrangements is normally required. Typically, because a block of in-force business has value, the sale transaction will result in a gain to the ceding insurer. If the policies are somewhat mature and have reasonably large reserves, the transaction probably will result in a transfer of cash or other assets by the ceding insurer. In this case, the reserves released by the ceding insurer will be greater than the value of the assets transferred, with the resulting credit being a gain and an increase in surplus. If the policies are young and have very small reserves, the assuming insurer may pay some amount in the purchase. If the ceding insurer has an obligation to buy back the block of insurance or to repay the reinsurer's losses, the intent of the transaction has usually been to create surplus in the ceding insurer and a transfer of risk has not occurred. In these situations, the accounting for the transaction must look beyond the intent and record the obligation. Therefore, there is no gain or surplus increase to be recognized, but the credit would be recorded as a liability to reflect the obligation to repay the difference to the reinsurer.

Surplus relief, or financial reinsurance, is a method of accelerating future profits on a block of insurance business. With conventional reinsurance agreements, the ceding insurer receives a ceding fee that covers the acquisition costs plus a profit. A transfer of risk is completed and the reinsurer retains all future profits on the block of business reinsured. In surplus relief reinsurance, however, the reinsurer normally returns the majority of the profits, less a fee, to the ceding insurer through an experience refund. Since surplus relief transactions merely represent a financing arrangement, statutory accounting principles do not allow a credit to surplus until the risk has been transferred.

Assumption reinsurance agreements (Life/Health) occur when the insurer transfers, with the consent of the policyholder, responsibility for policyholder obligations to another insurer. These types of transactions are of concern to the policyholder, particularly where the assuming company has a weaker financial position than the ceding insurer. They may also indicate financial difficulties of the ceding insurer and may be motivated by pressure to generate surplus.

A commutation (P/C) is a transaction that results in the complete and final settlement and discharge of all present and future obligations between parties to a reinsurance agreement. With regard to commutation agreements, the present value of the reinsurer's estimated ultimate losses is paid by the reinsurer to the ceding insurer. The ceding insurer immediately establishes the ultimate loss reserve liability and the cash received as a negative paid loss, thus creating a reduction in surplus equal to the difference between the ultimate and present value of the loss reserve. The reasons for commutations differ from insurer to insurer, however, some of the key reasons include:

- Exit of Business**:** The cedant may strategically exit a specific line of business or the reinsurer may withdraw from the reinsurance marketplace.
- Perceived Financial Instability: The cedant or reinsurer may have concerns regarding the other party's solvency. Commutation in this case would reduce credit risk, provide immediate cash infusions to cedant and/or allow the reinsurer to avoid future issues with the assigned liquidator.
- Disputes: The cedant and reinsurer may have significantly different evaluations of ultimate loss costs, claims resolution, or contract provisions and would prefer a single negotiation over commutation than continued disputes over issues.
- Underwriting Risk: The reinsurer may wish to eliminate underwriting and pricing risks relating to the cedants underwriting practices. Or, the reinsurer may determine that the price of the commutation is less than carried reserves and the commutation improves the reinsurer's underwriting results.

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Commutations require a thorough financial and actuarial review of the business being commuted. The cedant will need to have a clear understanding of the book of business to ensure that it receives adequate settlement from the reinsurer to pay all future claims and expenses and not lose the original value of the reinsurance and commutation agreements.

A loss portfolio transfer (P/C), or LPT, is an agreement that is applied retroactively, in which the ceding company transfers a portfolio of losses (i.e., loss reserves) to another company along with consideration for assuming such loss reserves. LPTs are complicated transactions, and it is often difficult to distinguish between those that provide indemnification through transfer of risk and those that are merely financing arrangements. LPT agreements are normally executed because it is the objective of the ceding company to record, as a credit to surplus, the difference between the loss reserves transferred and the consideration paid. However, statutory accounting practices do not allow such a credit to surplus until the risk has been transferred and the liability of the ceding company has been terminated.

Additional procedures assist analysts in evaluating the significant or unusual reinsurance transactions identified. Analysts should analyze these types of transactions closely to determine whether a transfer of risk has been consummated. Even when transfer of risk has been consummated, analysts should evaluate the impact of the transaction on future financial performance of the insurer.

PROCEDURES #9U, #9V AND #9W (ALL BUSINESS TYPES), relate to whether any significant and/or unusual reinsurance intermediary or reinsurance assumed agreements exist. While some major professional reinsurers are direct marketers, intermediaries (e.g., brokers, managers, or managing general agents) may arrange reinsurance agreements between a ceding company and a reinsurer in exchange for commissions or fees. A reinsurance broker negotiates agreements for a ceding company but does not have the authority to bind the insurer to a reinsurance agreement. On the other hand, a reinsurance manager acts as the agent for a reinsurer and has the authority to bind a reinsurer to an agreement. Finally, a managing general agent may have authority both to underwrite primary insurance and to bind reinsurance agreements on that business for the ceding company. An intermediary has an incentive to place reinsurance with sound reinsurers when its commission is tied to the success of the business being reinsured. However, when commissions are based on volume of business, reinsurance placed through an intermediary may be subject to conflicts of interest and potential abuse. To generate more income, a managing general agent may cede business to reinsurers who later are unable or unwilling to pay losses, or a reinsurance manager may assume poor, underpriced risks. The intermediary bears no financial risk in the event of underpriced or poor underwriting or placement with a troubled reinsurer. But poor performance by an intermediary can affect both ceding companies and reinsurers.

PROCEDURE #9X (ALL BUSINESS TYPES) assists analysts in determining whether reinsurance is being used for fronting purposes and, if so whether any potential abuses exist. Fronting also can be subject to potential abuse by either the ceding company or the reinsurer. For example, where fronting commissions received by the ceding company from the reinsurer exceed the ceding company's costs of selling policies, the insurer has incentive to write additional business to generate commissions and profits. An insurer may underwrite poor risks at underpriced rates because it believes it will not have to pay all the resulting losses. In fact, the ceding insurer may not have adequate details about the business being written by its representatives to assess its potential losses. This practice may be used to circumvent state licensing requirements and thus avoid regulatory oversight. Although an insurance company must first be licensed in a state to sell insurance directly to the public, a reinsurer may assume reinsurance without a license in that state. Through a fronting arrangement, a company not licensed in a state may reinsure all or nearly all of the liabilities for policies that it cannot directly write.

PROCEDURE 9cc. While state insurance departments have enacted principals-based reserving laws that are effective Jan. 1, 2020, some life insurers continue to establish reinsurance agreements to cede longevity risks (e.g., fixed annuities with guaranteed lifetime withdrawal benefits (GLWBs) and other products such as variable annuities and long-term care insurance to non-U.S. affiliates or U.S. captive insurance companies. State insurance regulators should review this reinsurance activity through the Form D approval process, if affiliated,

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and through the annual solvency analysis process when new transactions are identified in the annual statement. A potential area of concern would be if such transactions result in an unlevel playing field between insurers, or if the state insurance regulator regime of the captive's jurisdiction results in reduced policyholder protection and regulatory arbitrage. Specifically,

- Where a captive affiliate is domiciled in an international jurisdiction, the regulatory regime of that jurisdiction may not have the same conservatism as the U.S. statutory framework. For example, it may not require asset adequacy analysis which may create material differences in reserves, or it may not require capital charges for longevity risk.
- With regard to appropriate documentation of the agreement, some ceding insurers may not fully document their assessment of the reinsurance within the Actuarial Opinion and Memorandum (i.e., gross reserve cash flow testing) or require a true-up of the reserve credit.
- If transactions are not at arms-length, it may result in questionable invested assets and activities within funds withheld/modified coinsurance (MODCO) trust agreements. For example, assets in the trust agreement may include non-investment grade assets, mortgage loans, complex and non-rated BA assets, securities lending, etc., which may also indirectly impact the ceding insurer's RBC calculation.

Capital Adequacy

PROCEDURE #10 addresses the adequacy of the insurer's risk-based capital (RBC) position in light of its business/strategic plans and risk exposures. The various metrics and considerations outlined under this procedure address the causes of significant changes in the RBC ratio, as well as follow-up procedures that may be necessary to investigate and address the issues identified. Some examples that may cause the RBC ratio to fall into an RBC Action Level include, but are not limited to, increased writings, heightened investment risk, catastrophic loss events, or an unexpected surplus decline. The procedure also identifies insurers with an RBC ratio below 300% that have recorded significant increases or decreases from the prior year. Additionally, the procedure identifies insurers that have recorded RBC ratio declines over two successive years and a broader trend (e.g., five or more years decline) and the insurer's plans to mitigate. If a downward trend is identified, analysts should review the insurer's projections and document its plan to improve the capital position.

PROCEDURE #10C assists analysts in determining if the change in the insurer's RBC ratio was due to Total Adjusted Capital. Total Adjusted Capital is computed by subtracting the value of any reserving discounts from policyholders' surplus and adjusting for asset valuation reserve (AVR) and half of any dividend liability of the insurer's life insurance affiliates in addition to applying credit for capital notes. Procedure #10d assists analysts in determining if the change in the insurer's RBC ratio was due to the Authorized Control Level.

PROCEDURE #10E assists analysts in determining whether the insurer triggered the RBC Trend Test. For P/C insurers, the RBC Trend Test is triggered when an insurer has an RBC ratio between 200% and 300% and a combined ratio greater than 120%. For life insurers, the RBC Trend Test is triggered when an insurer has an RBC ratio between 200% and 250% (or 300%) and the insurer has had a negative RBC trend for three years. The trend test calculates the greater of the decrease in the margin between the current year and the prior year and the average of the past three years. Any insurer that trends below 190% could be place in a Company Action Level if the state has adopted the RBC trend test. For Health insurers, the RBC Trend test is triggered when a health entity has an RBC ratio that falls below 300% (the Trend Test level) and has a combined ratio greater than 105%.

If the insurer has triggered the trend test, procedure #10j recommends reviewing and documenting the reasons. After considering the reasons for triggering the trend test and their potential impact on the solvency of the insurer, analysts should determine whether the state should place the insurer in RBC Company Action Level to deal with the violation and the underlying issues.

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PROCEDURE #10K directs analysts to obtain a copy of the insurer's RBC plan if the insurer has triggered an RBC Action Event. If applicable in your state, analysts may participate in the review and approval process of the RBC plan. The RBC plan is a comprehensive financial plan that:

1) Identifies the conditions in the insurer that contribute to the Company Action Level event;

2) Contains proposals of corrective actions that the insurer intends to take and would be expected to result in the elimination of the Company Action Level event;

3) Provides projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and/or surplus (the projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component);

4) Identifies the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions;

5) Identifies the quality of and problems associated with the insurer's business including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance in each case, if any.

Analysts reviewing the plan should take the following steps:

- Verify the accuracy of all historical information provided
- Review the plan's assumptions for reasonableness
- Estimate the impact of the proposed corrective actions on financial result, and review the projected experience in the plan for reasonableness
- Consider the likelihood of variations in the assumptions and the resulting impact on the future financial results
- Identify any internal or external problems not considered in the plan that may affect future financial results. Examples of such problems include the following: 1) the existence of competitors to limit future sales levels; 2) recent state legislation restricting the company's product designs; or 3) the loss of key marketing personnel.

Analysts should also monitor, on a periodic basis, the insurer's progress in achieving the initiatives included in the RBC plan and the impact of those initiatives on Total Adjusted Capital and the risk factors in the Authorized Control Level RBC. The goal of any RBC plan is the improvement of the underlying causes that led to an RBC Action Level, and an improvement in subsequent RBC ratio results that will remove the insurer from Action Level status.

PROCEDURE #11 addresses the adequacy of the insurer's overall capital and surplus position in light of its business/strategic plans and risk exposures. The RBC ratio is designed to calculate a minimum threshold of capital and surplus based on each insurer's unique mix of asset risk, credit risk, off-balance sheet risk, business risk, and underwriting (premium and loss) risk. A measure of surplus adequacy that is commonly considered is the ratio of surplus to assets. Gross change in surplus and change in adjusted surplus (P/C IRIS ratio #7 and #8) and net/gross change in capital and surplus (Life IRIS ratio #1 and #2), measure the improvement or deterioration in the insurer's financial condition from the prior year. Even insignificant increases in the change in surplus ratio may indicate instability or mask financial problems attributable to fundamental changes in the insurer.

PROCEDURES #11M is designed to assist analysts in identifying dividend payments or declarations to determine if any necessary approvals were obtained. Other metrics (see #11j, #11k, #11n and #11o) are designed to assist

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analysts in identifying significant amounts of capital and surplus notes and write-ins for special and other than special surplus funds, as well as other activities during the year related to capital and surplus notes.

Procedure #11X assists analysts in assessing current and prospective risk related to existing Parental Guarantees and/or Capital Maintenance agreements.

Parental Guarantees and Capital Maintenance Agreements are commitments aimed at providing assurance that the insurer will be able to meet minimum financial obligations if financial or liquidity issues arise. These documents should be carefully reviewed along with the financial background of the entity required to fund the guarantee or agreement. Analysts may also inquire of the insurer if a contingency plan is in place in the event the parental guarantee or capital maintenance agreement is not honored.

Review and assess any parental guarantees, capital maintenance agreements or other commitments in place and determine if concerns exist regarding financial support or failures to act on these commitments. Analysts should thoroughly review the terms related to the agreement to gain a clear understanding of what is covered in the agreement (e.g., limit on lines of business, commitment to pay policyholder claims, commitment to maintain RBC level, etc.) and the impact to the insurer.

Analysts should also consider the following:

- Expected source and form of liquidity should guarantees be called upon.
- If the parental guarantee or capital maintenance agreement specifically address the concerns identified and provide adequate support to the insurer.
    - If concerns exist, consider requesting additional information, as necessary, to understand the level of commitment.
- Whether the document contains detailed requirements or expectations for capital support.
- The financial stability of the parent holding company to determine if the parent is adequately capitalized to support maintenance of capital in the insurer above certain thresholds.

If a holding company analysis group profile summary (GPS) is available, analysts should review the GPS for insight into the parent company or ultimate controlling person (UCP) and its ability to meet the financial demands of the guarantee currently or prospectively. Review pertinent data on the holding company and its organizational structure as well as the operations and financial condition of the holding company or UCP. Determine if there are liquidity or other concerns identified within the GPS that warrant additional information from the company.

ADDITIONAL PROCEDURES, including prospective risks, are also available if the level of concern warrants further review, as determined by analysts: If the insurer is subject to ORSA reporting requirements, there may be a great deal of information on the insurer's capital/surplus position to be reviewed and evaluated in the ORSA Summary Report, as outlined in procedure #11p. Other possible procedures to perform if concerns are identified are outlined in procedures #11q–#11x. For example, the ratio of surplus to assets may be compared to the industry average to determine any significant deviation. If the insurer issued surplus or capital notes, analysts should consider reviewing the information in the Annual Financial Statement, Notes to Financial Statements #11 and Note #13. If either were issued or repaid, or if interest was paid during the year, analysts should consider determining that these transactions were approved by the domiciliary state insurance department. In addition, if surplus notes represent a significant portion of surplus, analysts should consider recalculating important ratios, excluding the surplus notes, to determine their effect on the ratio results. Other steps to consider include the review of the detail of unrealized gains (losses), assessment of any parental guarantees in place and the review of other components of surplus.

Financial Impact of the Federal Affordable Care Act on Capital & Surplus and Risk-Based Capital

PROCEDURE #12 asks analysts to assess the impact of the Federal Patient Protection and Affordable Care Act (ACA) assessments, risk-sharing provisions and medical loss ratio (MLR) rebates on the financial solvency of the

insurer. This procedure is relevant for reporting entities that wrote accident and health insurance premium that is subject to Section 9010-Health Insurance Providers Fee (Section 9010) of the ACA. If so, the insurer is required to provide information in the Annual Financial Statement, Notes to Financial Statements, Note #22.

Analysts should review the net receivable/payable effect of the Risk Adjustment, Reinsurance and Risk Corridors programs (risk sharing provisions) and determine what the impact they would have on capital and surplus (procedure #12g). Also determine what the impact would be on the company's RBC. In conjunction with the review of strategic risk related to ACA business, consider any related Credit Risk for the collectability of admitted assets related to ACA risk sharing payments, including those receivables from the Federal Government. Also consider any cross-over risk impacting pricing and underwriting assumptions in the Pricing & Underwriting Risk Assessment.

Analysts may also consider performing a comparison of the components of the MLR as reported in the Annual Financial Statement Supplement Health Care Exhibit and the U.S. Department of Health and Human Services MLR Annual Reporting Form to identify any material differences in line items. If, in the analyst's judgment, any material differences require explanation, consider requesting such explanation from the health entity.

The MLR rebates are mandated by the Federal Public Health Service Act to be returned to the policyholders if the ratio of medical losses and various other items paid to the ratio premiums paid (with various adjustments) is below specified thresholds (80% for individuals or small group employers or greater than 85% for large group employers, or a threshold established in state law, and 85% for Medicare plans).

As stated above, analysts should be aware that the preliminary MLR is **not** the MLR to be used for federal rebate calculations and payment purposes. For example, for federal rebate purposes issuers that have blocks of business less than a given size can make a credibility adjustment to their MLR on the Federal MLR Annual Reporting Form. A credibility adjustment refers to the adjustment to account for random statistical fluctuations in claims experience for smaller plans. Blocks of business with less than 1,000 life years are considered non-credible and will not be required to pay rebates in most cases. Blocks of business with greater than 1,000 (but less than 75,000) life years may add a credibility adjustment to the calculated MLR. Blocks of business with greater than 75,000 life years are considered fully credible and cannot use a credibility adjustment. For specific details regarding the credibility adjustment calculation see Issuer Use of Premium Revenue: Reporting and Rebate Requirements, 45 C.F.R. §§ 158.230-158.232 (2016).

If concerns are identified related to ACA assessments, risk sharing provisions or MLR rebates, analysts should perform additional procedures as necessary to evaluate the impact of these concerns on the current and long-term solvency position of the insurer. For example, analysts may request an updated business plan or projections from the insurer in light of concerns in this area.

Additional Analysis and Follow-Up Procedures

EXAMINATION FINDINGS directs analysts to review the recent examination report, summary review memorandum and communication with the examination staff to identify if any strategic risk issues were discovered during the examination.

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

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

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

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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 description 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 strategic risk category.

Discussion of Quarterly Procedures

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

1. Concerns with news, press release or industry reports involving the insurer or insurance group;
2. Whether changes in the organizational chart have the potential to affect the insurer's strategic risk;
3. Whether recent merger and acquisition activity will affect the insurer's ability to achieve its business strategy;
4. Whether updated business plans and projections result in new or emerging strategic risks;
5. Whether significant changes in the insurer's reinsurance program or significant new reinsurance transactions may affect strategic risk;
6. Whether any unusual reinsurance transactions were completed during the quarter;
7. Concerns with the insurer's RBC position;
8. Adequacy of the insurer's total capital and surplus position in light of its business/strategic plans and risk exposures

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

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Note: These procedures are designed for insurers filing on a U.S. generally accepted accounting principles (GAAP) (or modified GAAP) basis, to assist in the completion of the traditional Risk Assessment Procedures.

Balance Sheet Assessment

	Risks
a. If risk-based capital is required, reassess the impact of total adjusted capital if the insurer recorded assets typically non-admitted according to the NAIC *Accounting Practices and Procedures Manual* (AP&P Manual). If risk-based capital is not required, consider various methods to assess the capital sufficiency of the insurer.	OP, ST
i. Consider the potential impact differences between GAAP and SAP investments, and/or deferred acquisitions costs could have on the total adjusted capital component of the RBC calculation.	OP, ST
b. Have there been any changes in assets permitted by the state, such as letters of credit compared to the prior period? If "yes," indicate the line item that changed, current and prior period balances, the amount of the change, and any resulting impact on the insurer.	CR, MK, ST
c. Review any new letters of credit, principal or interest paid and whether any necessary approvals were obtained, if required.	LG, ST
d. Review the Annual Financial Statement, Notes to Financial Statements, Note 1 and document any individual asset category that is greater than 5% of total admitted assets that would typically be non-admitted according to the AP&P Manual. Indicate the asset category (e.g., deferred acquisition costs, fixed assets, prepaid expenses, and deferred taxes), current period-end balance, and the percentage change from the prior period-end. In addition, identify any potential impact these balances may have on liquidity.	LQ
e. Under U.S. GAAP, FAS 113 requires insurers to present reinsurance recoverables on unpaid claims as an asset, as opposed to a contra liability. Consider the impact this presentation has while reviewing the balance sheet of the reporting entity and document the components that are presented differently as well as any significant period-to-period changes.	LQ
f. If the insurer has presented its reinsurance recoverables in accordance with FAS 113, consider the impact this presentation may have on liquidity and the ratio of total liabilities to surplus.	LQ
g. Under U.S. GAAP, reserves can be discounted in some instances. i. Determine if the reporting entity has discounted any reserves that would not be discounted under NAIC SAP and consider the impact of such difference on the overall evaluation of the insurer's financial position. ii. Determine whether permission regarding the discount was received from the Department of Insurance and if the rate of the discount was approved.	LG, RV
h. Under U.S. GAAP, insurers are <u>not</u> required to establish a liability for "provision for reinsurance," but instead are required to establish a contra asset for an allowance for doubtful accounts. Consider the impact this may have on liquidity and the ratio of total liabilities to surplus.	LQ

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Operations Assessment

	Risks
a. Under U.S. GAAP, FAS 115 provides that debt and equity securities that are "being traded" (i.e., trading securities) and are reported at fair value with the change presented through the statement of income. Also under U.S. GAAP, in some cases reserves are allowed to be discounted. Document the impact these differences, as well as any other known differences have on the reporting entity's profitability.	MK, OP, RV

Investment Practices

	Risks
a. Under U.S. GAAP, FAS 115 provides that debt and equity securities that are "available for sale" are reported at fair value with the change presented as unrealized gains and losses through equity (capital and surplus). Document any significant impact of "available for sale" or "trading securities" on the capital and surplus or statement of income of the reporting entity.	OP, MK

Review of Disclosures

	Risks
a. Review the Annual Financial Statement, Notes to Financial Statements to assess the adequacy of disclosures regarding the reconciliation from the AP&P Manual to U.S. GAAP, as well as NAIC validation cross/checks to ensure cross checks failures were adequately explained. Document any inconsistencies with disclosures and validation cross/checks and consider follow-up with the company, if necessary.	LG

Assessment of Results from Prioritization and Analytical Tools

	Risks
a. Analysts should be aware that the Financial Analysis Solvency Tools were designed to assess potential risks within statutorily filed financial statements in conformity with the AP&P Manual and not in conformity with GAAP. Based on the reconciliation found in the Annual Financial Statement, Notes to Financial Statements, Note #1 as well as observations made with the aforementioned questions; review any key ratios for factors that may influence the calculation. Provide an explanation for any unusual or significant fluctuations or trends noted. (A few examples include liquidity ratio, investment yield, etc.)	

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XXX/AXXX Captive Reinsurance Transactions

Review the Annual Statement Supplemental Term and Universal Life Insurance Reinsurance Exhibit to determine if the insurer has any in force reinsurance transactions reported. The analyst may wish to refer to the guidance in section V.C. Domestic and/or Non-Lead State Analysis - Form D Procedures, Assessment of Form D Captive Reinsurance Transactions, procedure #17. Although procedure #17 applies only to affiliate transactions filed for review on Form D, the concepts and regulatory review goals are the same.

Although the analyst should perform a general review of Part 1 to obtain an overview of the insurer's use of reinsurance with respect to XXX/AXXX reserves, the analyst's primary focus should be on the transactions identified in Part 2, as those are the transactions that do not qualify for any of the exemptions identified in Part 1. If there are reinsurance transactions reported in Part 2, complete the following:

1. For all transactions listed in Part 2 and entered into prior to Jan. 1, 2015, and exempt from Actuarial Guideline 48, the following analysis should be performed:

	Other Risks
a. Review security standards for reinsurance of "Grandfathered Policies" to ensure that any credit for alternative reinsurance arrangements must be dependent on security that meets reserve valuation and asset quality requirements, as initially approved by the domiciliary regulator, that are at least as protective as those in place at the time the arrangement received its grandfathered status (12/31/14).	RV, ST, OP, CR
b. Obtain information from the insurer to review the actual experience on the ceded business in order to assess how the transaction is tracking relative to the initial or most recently provided projections and underlying assumptions. Although the actual experience data should be updated annually, the analyst should review three to five years of actual experience, if available, as some level of annual deviation is expected and should be viewed in a broader context.	RV, ST, OP, CR
c. If the information contained within item 1.a. above shows material adverse deviations from the initial or most recently provided projections and/or expected experience and the reinsurer is an affiliate of the ceding insurer, require the insurer to submit five years of pro forma financial statements of the affiliate (assets, liabilities, equity and income) including specifically projected statutorily required reserves as well as any capital requirements imposed by the external finance provider on the reinsurer.	RV, ST, OP, CR
d. Review the investments of the reinsurer, as reflected in the statutory financial statements and any additional information filed by the reinsurer with the reinsurer's domestic regulator, and consider the extent to which they comply with the state's investment laws for non-captive insurers and are admitted assets under the NAIC Accounting Practices and Procedures Manual, as well as whether the overall investment portfolio would be disadvantaged if held directly by a domestic insurer. Review any funds held by or on behalf of the ceding insurer as security for the reinsurance contract to determine that, at a minimum, they comply with state's investment laws for non-captive insurers and are admitted assets under the NAIC Accounting Practices and Procedures Manual. Specifically determine that none of the capital requirements imposed by an external financial provider are supported by any type of letter of credit which would not meet the definition of an admitted asset under statutory accounting principles.	LG, ST, CR
e. Involve a department actuary or consulting actuary wherever necessary.	RV

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2. For all transactions listed in Part 2 and entered into on or after Jan. 1, 2015, or otherwise subject to Actuarial Guideline 48 and using the definitions set forth in Actuarial Guideline 48, the following analysis should be performed:

	Other Risks
a. Obtain information from the insurer to review the actual experience on the ceded business in order to assess how the transaction is tracking relative to the initial or most recently provided projections and underlying assumptions. Although the actual experience data should be updated annually, the analyst should review three to five years of actual experience, if available, as some level of annual deviation is expected and should be viewed in a broader context.	RV, ST, OP
b. Review Parts 2 and 3 of the "Supplemental Term and Universal Life Insurance Reinsurance Exhibit" to determine if: i. funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis; and, ii. funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to subsection (1) above, are held by or on behalf of the ceding insurer as security under the reinsurance contract. If not, request a detailed explanation from the insurer.	RV, ST, OP, CR
c. Involve a department actuary or consulting actuary wherever necessary.	RV
d. At least once every five years: i. If the reinsurer is an affiliate of the ceding insurer, require the insurer to submit five years of pro forma financial statements of the affiliate (assets, liabilities, equity and income). ii. Require the insurer to submit current and five-year projected calculations, and support therefore, of (a) the statutory reserves with respect to the cession and (b) the Required Level of Primary Security. iii. Review the funds held by or on behalf of the ceding insurer to determine whether such funds are properly classified as a Primary Security or Other Security. iv. Have a department actuary, or consulting actuary engaged by the department, review the Actuarial Opinion to determine if the insurer has followed the Actuarial Method for this business consistent with the requirements of Actuarial Guideline 48.	RV, ST, OP, CR

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

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Note: The worksheet is not an all-inclusive list of possible procedures. Therefore, analysts may refer to the branded risk repositories as appropriate. Additionally, 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**.**

Analysis Documentation: Risk exposures identified through the use of the title insurer worksheet should be documented in Section III: Risk Assessment of the insurer.

Capital Adequacy

1. Evaluate the adequacy of the insurer's surplus position in light of its business strategy/strategic plans and risk exposures.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Net change in surplus	ST,OP	>25% or <-15%	[Data]	[Data]
b. Change in surplus notes	ST,OP	<>0	[Data]	[Data]
				Other Risks
c. Review the Capital and Surplus Account section in the Annual Financial Statement, Operations and Investment Exhibit for unusual fluctuations or trends in the changes in surplus between years. Investigate any significant or unexplained items.				ST, OP

Liquidity

2. Determine if there are any concerns regarding the liquidity of the insurer's asset portfolio and overall liquidity.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Liquidity ratio	LQ	>105%	[Data]	[Data]
b. Change in liquid assets	LQ	>50% or <-15%	[Data]	[Data]
				Other Risks
c. Review the five-year trend for the liquidity ratio within the Financial Profile Report and document any unusual fluctuations.				LQ
d. If concerns are identified regarding overall liquidity of the asset portfolio, identify and assess other sources of liquidity available to the insurer.				LQ

Cash Flow from Operations

3. Determine whether concerns exist regarding the insurer's cash flow.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Ratio of net cash from operations to surplus	LQ	< -5%	[Data]	[Data]
				Other Risks

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b. Review the Cash from Operations section in the Annual Financial Statement, Cash Flow to determine the underlying cause of the negative cash flow.	LQ
c. Review the trend in net cash from operations within the Financial Profile Report for the past five years and note any unusual fluctuations or negative trends between years.	LQ

Operating Performance

4. Determine whether concerns exist regarding the insurer's Statement of Income or operating performance.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Combined ratio	OP	>105% or <80%	[Data]	[Data]
b. Change in combined ratio	OP	>10 pts or <-25 pts	[Data]	[Data]
i. Change in premiums earned	OP, PR/UW	>25% or <-25%	[Data]	[Data]
ii. Change in losses and loss adjustment expense (LAE) incurred	OP, PR/UW	>25% or <-25%	[Data]	[Data]
iii. Change in operating expenses incurred	OP	>25% or <-25%	[Data]	[Data]
c. Change in net income when net income is greater than 10% or less than -10% of surplus	OP	> 30% or < -15%	[Data]	[Data]
				Other Risks
d. Review the five-year trend with the Financial Profile Report for the following measures of operating performance, and note any unusual fluctuations or trends between years for each ratio: • Combined ratio • Loss and LAE ratio • Expense ratio				OP, PR/UW
e. If concerns exist regarding operating performance, consider the following procedures: i. Review the Annual Statement, Insurance Expense Exhibit, identify any expense allocation concerns or unusual operating results by line of business. ii. Request and review additional information from the insurer on the causes of poor operating performance or unusual variances in expenses. iii. Request, review and evaluate information from the insurer regarding its plans to address poorly performing operations.				OP, PR/UW

Premium Production

5. Determine whether concerns exist regarding changes in the volume of premiums written or changes in the insurer's geographic location.

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	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Change in total direct premiums written (DPW)	PR/UW	>25% or <-25%	[Data]	[Data]
i. Change in DPW through direct operations	PR/UW	>10% or <-10%	[Data]	[Data]
ii. Change in DPW through non-affiliated agency operations	PR/UW	>10% or <-10%	[Data]	[Data]
iii. Change in DPW through affiliated agency operations	PR/UW	>10% or <-10%	[Data]	[Data]
b. Change in DPW in any one state when DPW is greater than 10% of total DPW in either the current or prior year end	PR/UW	>50% or <-50%	[Data]	[Data]
c. DPW in a new state to total DPW	PR/UW	>5%	[Data]	[Data]
				Other Risks
d. If significant changes in premium volume are identified, consider the following procedures: i. Request and review additional information from the insurer (if necessary) to understand and evaluate the source(s) of significant changes in premium volume. ii. Evaluate the impact of the sources of changes on the underwriting/marketing strategy, profitability and solvency position of the insurer.				PR/UW, ST

Investment Practices

6. Determine whether concerns exist related to investment practices, including purchases and sale of securities and control of assets.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Has the purchase or sale of any investments not been approved by the board of directors or a subordinate committee thereof? [Annual Financial Statement, General Interrogatories, Part 1, #16]	OP	=YES	[Data]	[Data]
b. Are any stocks, bonds and other securities owned, over which the insurer has exclusive control, not in the actual possession of the insurer, other than securities lending programs? [Annual Financial Statement, General Interrogatories, Part 1, #25.01 and #25.02]	OP	=YES	[Data]	[Data]
c. Are any stocks, bonds or other assets owned by the insurer not exclusively under the control of the insurer? [Annual Financial Statement, General Interrogatories, Part 1, #26.1 and #26.2]	OP	=YES	[Data]	[Data]
d. Were there any assets reported subject to a contractual obligation to transfer to another party	OP	=YES	[Data]	[Data]

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without the liability for such obligation being reported? If "yes," comment on the purpose and the amount. [Annual Financial Statement, General Interrogatories, Part 1, #21.1 and #21.2]				
e. Book/adjusted carrying value of total special deposits to assets	LQ	>10%	[Data]	[Data]
				Other Risks
f. Review the Annual Financial Statement, Summary Investment Schedule. Note any unusual valuation methods or areas that indicate further review is necessary.				CR, MK
g. Review the Annual Supplemental Investment Risks Interrogatories and assess any unusual items or areas that indicate a non-diversified portfolio.				MK

Affiliated Investments

7. Determine whether investments in affiliates are significant.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Total of all investments in affiliates to surplus. [Annual Financial Statement, Five-Year Historical Data]	LQ, CR, MK	>20%	[Data]	[Data]
b. Change in total of all investments in affiliates from the prior year-end	LQ, CR, MK	>20% or <-20%	[Data]	[Data]
c. Change in any category of affiliated investments from the prior year-end	LQ, CR, MK	>10% or <-10%	[Data]	[Data]
				Other Risks
d. Are affiliated investments in violation of state statutes?				LG
e. Review the results of the Holding Company Analysis completed by the lead state to determine if any concerns exist regarding affiliated entities.				LQ, CR

Unrealized Capital Gains and Losses

8. Assess unrealized capital gains(losses) including other-than-temporary impairments.

	Risks	*Benchmark*	*Result*	*Outside Benchmark*
a. Net unrealized capital gains/(losses) to prior year-end surplus	MK	>10%	[Data]	[Data]
				Other Risks
b. Review the detail of unrealized gains/(losses) in the Annual Financial Statement, Exhibit of Capital Gains/(Losses) for reasonableness.				MK

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IV. Supplemental Analysis Guidance

A. Financial Analysis and Reporting Considerations

B. Analysis of Notes to the Financials

C. Health Insurance Industry

Legend of Abbreviations

Statement Types	
P	Property/Casualty
L	Life/A&H
H	Health
T	Title

Branded Risk Classifications		
Symbol	**Risk**	**Description**
CR	Credit	Amounts actually collected or collectible are less than those contractually due or payments are not remitted on a timely basis.
LG	Legal	Non-conformance with laws, rules and regulations, prescribed practices or ethical standards (in any jurisdiction in which the entity operates) will result in a disruption in business and financial loss.
LQ	Liquidity	Inability to meet contractual obligations as they become due because of an inability to liquidate assets and/or obtain adequate funding without incurring unacceptable losses.
MK	Market	Movement in market rates or prices (such as interest rates, foreign exchange rates or equity prices) adversely affect the reported and/or market value of the investments.
OP	Operational	The risk of financial loss resulting from inadequate or failed internal processes, personnel and systems, as well as unforeseen external events.
PR/UW	Pricing/ Underwriting	Pricing and underwriting practices are inadequate to provide for risks assumed.
RP	Reputation	Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.
RV	Reserving	Actual losses and/or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.
ST	Strategic	Inability to implement appropriate business plan, to make decisions, to allocate resources or to adapt to changes in the business environment will adversely affect competitive position and financial condition.

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A. Overview of Invested Assets

Insurers receive premiums from policyholders today in exchange for a promise to pay covered benefits/losses in the future. These premiums, net of operating expenses paid, along with capital and surplus funds, are invested in a variety of different types of investments until needed to pay benefits/losses. State insurance laws regulate an insurer's investments and prescribe the types of investments which may be acquired by insurers. These laws also generally provide limitations on investments by type and issue. However, in most states, a large amount of the insurer's assets may be invested at the discretion of management or the board of directors within the statutory limits. An insurer may become financially troubled if it invests heavily in speculative or high-risk investments that later result in losses or if it invests in securities with maturities that are inappropriately matched with its liabilities.

Investment income is often a key component in the pricing of insurance products (i.e., life & annuity and other long-tailed lines). In some cases, management may be pressured into strategies to maximize investment yields when policy benefits are higher than was anticipated at the time products were priced. Higher investment yields generally involve higher risk and ownership of investments with questionable quality or value.

Another important investment consideration is the proper matching of assets and liabilities. An insurer must manage its investment portfolio to match investment maturities with its cash flow needs to pay benefits/losses. Poor matching may result in the insurer being forced to liquidate long-term investments at a loss to provide the currently needed cash flows.

Investment risk may also involve a failure to adequately diversify an investment portfolio. A concentration of assets in one type of investment may not adequately spread the investment risk and may result in more volatile investment returns. A high concentration of investments that are not readily marketable may also indicate increased investment risk and may raise concerns as to the value of the investments.

Life insurers have historically invested primarily in long-term bonds and mortgage loans. Property/casualty insurers have invested primarily in bonds and common stocks. While this still holds true, the industry's approach to investments has changed significantly in recent years. In the past, when the principal focus of the products sold was insurance, the primary objective of an insurer's investment strategy was the preservation of capital, and life insurers invested in long-term bonds with stable interest rates and predictable cash flows while property/casualty insurers invested in high quality bonds and stocks.

However, insurers are now focusing more on investment returns. This change in focus has prompted insurers to turn to assets of higher risk and lower quality in exchange for higher investment yields. Therefore, insurers may have significant investments in noninvestment-grade bonds, privately placed bonds, residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS) and other loan-backed and structured securities (LBaSS). Investments today are also much more complex and sophisticated than in the past. This requires that insurers have investment advisors (in-house and/or contractual) with appropriate background and expertise as well as analytical systems which are capable of continuously monitoring the constantly changing marketplace. It is also important that the investment advisors communicate with personnel responsible for liability cash flows to help assure that projected asset and liability cash flows are adequately matched.

As a result, investment analysis is more important today than it was in the past. The principal areas of concern to analysts in reviewing an insurer's investment portfolio are: 1) diversification, 2) liquidity, 3) quality, 4) valuation, and 5) asset/liability matching. First, an insurer's investment portfolio should be adequately diversified to prevent an undue concentration of investments by type or issue. Second, the investment portfolio should be structured in such a way that it is appropriately liquid to allow for the cash flows necessary to cover the insurer's benefit commitments as they become due. Sufficient assets should be readily convertible to cash and the sale of necessary assets should not involve significant losses caused by changes in the market. Third, default or credit risk is a function of investment quality. As the quality of an investment decreases, the probability that principal will be returned and that the expected yield will be realized tends to decrease. Fourth, invested assets are generally valued at cost or amortized cost, except for common stocks and perpetual

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preferred stocks which are valued at fair value. However, analysts should be alert for investments which should be written down to fair value due to other than temporary declines in value. Fifth, analysts should be alert for investment portfolios with cash in-flows which do not match with projected liability cash out-flows.

Health Entities:

Most health entities typically maintain a fairly conservative investment philosophy. Some of this conservatism can be driven by the health entity's need to maintain liquidity in order to match the generally short-term benefits cycle. The liquidity philosophy may be driven by the health entity's size and level of capital and surplus. In some cases, a small or thinly capitalized health entity may need to maintain additional liquidity and therefore hold mostly cash or cash equivalents. Other health entities, such as Hospital, Medical and Dental Services or Indemnities (HMDIs), may be able to maintain sufficient liquidity while holding some long-term investments. A significant portion of most health entities' invested assets is maintained in cash and short-term investments. Most health entities also hold the majority of remaining invested assets in investment grade bonds with somewhat short-term maturities. Although most health entities will maintain a fairly liquid asset mix, analysts should be aware that an improper matching of assets with liabilities can occur with health entities and can lead to forced liquidations of long-term investments. In some of these cases, it is possible that the health entity may not be able to liquidate its portfolio fast enough when benefits obligations come due. In other cases, the liquidation may result in capital losses, leading to deterioration in the financial solvency of the health entity.

Because of the somewhat conservative investment philosophy used by many health entities, investment yields for most health entities are generally low compared to life or property/casualty insurers. However, some health entities may also write small amounts of life insurance, long-term care (LTC), or other long-tail lines of business. For those health entities, investment income can be a key component in the pricing of these longer-tail lines of business.

Property/Casualty:

Although investments have been more of a concern in the past analyses of life insurers than property/casualty insurers, many property/casualty insurers are now investing in riskier investments. Analysts should be alert for property/casualty insurers with concentrations of investments that are riskier and/or less liquid than traditional bonds and common stocks. Analysts should also evaluate whether these investments are appropriate for the insurer based on the lines of business written and the insurer's liquidity and cash flow needs.

B. Primer on Derivatives

Derivative instruments are financial instruments whose value and cash flows are based on other financial instruments, indices or statistics. Based on the current insurance regulatory framework, this definition is too broad. For example, some people call Collateralized Mortgage Obligations (CMOs), "mortgage-backed derivatives," because the value and cash flows of a CMO are based on the value and cash flows of a pool of mortgages. For insurance regulatory purposes, only options, caps, floors, forwards, futures, swaps, collars and similar instruments are considered derivative instruments. The definitions of these instruments are contained in NAIC *Accounting Practices and Procedures Manual* (AP&P Manual).

This primer will concentrate on options, futures and swaps. It will describe the instruments from an operational standpoint and from a use standpoint. It will also discuss how derivative instruments are reported in statutory financial statements. Accounting will be discussed only in general terms. A discussion of accounting details is provided in SSAP No. 86—*Derivative.*

Derivative Instrument Basics

- **Options**

An option is an agreement giving the buyer the right to buy or receive, sell or deliver, enter into, extend or terminate, or effect a cash settlement based on the actual or expected price level, performance or value of, one

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or more underlying interest. Underlying interest is the asset(s), liability(ies), or other interest(s) underlying a derivative instrument, including, but not limited to, any one or more securities, currencies, rates, indices, commodities, derivative instruments, or other financial market instruments.

An insurer can either purchase an option or write (sell) an option. When an insurer buys an option, the insurer pays a premium for a right, but not an obligation, to exercise the option at a strike. When an insurer writes (sells) an option, the insurer receives a premium from the other party to the transaction (counterparty). The counterparty has the right, but not the obligation, to exercise the option at the strike. An example will help to illustrate these concepts.

Consider an insurance company that sells equity indexed annuities. The equity indexed annuity provides a floor guarantee as to interest with an additional guarantee that the policyholder will participate in the upside of an equity index if the growth in the equity index exceeds the guaranteed interest.

An insurer can purchase an option to hedge the equity risk in the annuity contract. The option purchased would be based on the same equity index as the annuity contract. The level of the strike in the option would be based on the amount determined by the guaranteed interest rate, the participation rate in the annuity contract, and any cap on index growth. If the index grew at a rate greater than the guaranteed interest rate in the annuity contract, the insurer would exercise the option to cover the equity index-based obligation in the annuity contract. If the holder of the option does not exercise the option, the holder's downside is limited to the initial premium paid for the option.

- **Futures**

A futures contract is an agreement traded on an exchange, board of trade, or contract market, to make or take delivery of, or effect a cash settlement, based on the actual or expected price, level, performance, or value of one or more underlying interests.

Futures contracts are different from options in that an insurer entering a futures contract will participate in both gains and losses in the underlying financial instrument as measured from the date the futures contract is opened. For example, if an insurer takes a long position in U.S. Treasury futures, the insurer will experience any gains or losses in the U.S. Treasury futures (the underlying instrument) as measured from the date of opening the position. If interest rates increase after the futures contract is opened, the U.S. Treasuries will decrease in value and the insurer will have to make a payment to the counterparty. On the other hand, if interest rates move down, the insurer will receive a payment from the counterparty. Since the insurer shares in both the upside and downside of the futures contract, the insurer does not pay a premium when entering a futures contract. If the futures contract is exchange traded, the insurer will typically put up a deposit in cash or securities. This deposit is to protect the counterparty in the event the insurer cannot make required payments.

Insurers exposed to interest rate risk can take short positions in U.S. Treasury futures contracts. In this case, the insurer receives payments if interest rates increase and makes payments if interest rates decrease. This is opposite of the situation when the insurer takes a long position. However, going short U.S. Treasury futures can hedge the interest rate risk exposure on bonds that the insurer holds in its portfolio. This is especially important for GAAP accounting purposes when bonds are reported on a fair value basis.

In the discussion above, taking a "long" position has the same financial characteristics as buying the underlying instrument (in this case a bond). Taking a "short" position has the financial characteristics of short selling the underlying instrument (in this case a bond).

- **Swaps**

A swap contract is an agreement to exchange or net payments at one or more times based on the actual or expected price, level, performance, or value of one or more underlying interests. A typical example is a fixed or floating swap. An insurer can make payments to a counterparty based on a fixed rate, for example 6%, semi-annually and receive a floating rate SOFR (Secured Overnight Financing Rate), for example, plus a spread. Each six months, the insurer would pay the counterparty 3% times the notional amount, $10,000,000 for example,

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and would receive an amount equal to $10,000,000 times the then current SOFR rate plus a spread. Of course, the amounts are netted so that a single payment is made by one party to the other party. Depending on the SOFR rate at any payment determination date, the insurer may be making or receiving a payment. In swap transactions, the rates and spread are set so that neither party pays an up-front premium to open the transaction. Also, the notional amount is never exchanged.

The floating rate of a swap transaction can be based on a multitude of different financial indices or rates. For example, in a credit swap transaction, the floating rate can be based on the total rate of return of a junk bond portfolio. In effect, the party that is paying the fixed rate can be exposed to junk bond market risk through a transaction of this type.

- **Caps/Floors**

A cap is an agreement obligating the seller to make payments to the buyer. Each payment is based on the amount, if any, that a reference price, level, performance, or value of one or more underlying interests exceed a predetermined number, sometimes called the strike/cap rate or price. A floor is an agreement obligating the seller to make payments to the buyer. Each payment is based on the amount, if any, that a predetermined number, sometimes called the strike/floor rate or price, exceeds a reference price, level, performance, or value of one or more underlying interests. Caps and floors are similar to options in that one party, the purchaser of the instrument, pays a premium and receives a payment from the other party if an index exceeds the "cap" or falls below the "floor", a specified value, or "strike". An insurer might purchase a floor to protect itself against interest rates falling below the guarantees in the annuity contracts it has sold. An insurer can either buy or write (sell) caps or floors.

- **Collars**

A collar is an agreement to receive payments as the buyer of an option, cap, or floor and to make payments as the seller of a different option, cap, or floor. An insurer could buy a collar that includes the purchase of a cap and the sale of a floor. In effect, the insurer is protecting itself against an increase in interest rates and paying for the protection by selling the floor.

- **Forwards**

A forward is an agreement (other than futures) to make or take delivery of or effect a cash settlement based on the actual or expected price, level, performance or value of, one or more underlying interests. It is an over-the-counter transaction as opposed to a trade on an exchange, which makes it less liquid. It is customized to meet the needs of both parties whereas contracts traded on an exchange are standardized.

- **Warrants**

A warrant is an agreement that gives the holder the right to purchase an underlying financial instrument at a given price and time (or at a series of prices and times) according to a schedule or warrant agreement.

Uses of Derivative Instruments

Besides analyzing derivative instruments from an operational standpoint, they can be analyzed by their use. From an insurance regulatory perspective, derivative instruments can be used in four ways: hedging, income generation, replication of other assets, and speculation. Rules concerning hedging and income generation transactions are included in the NAIC *Investments of Insurers Model Act (Defined Limits Version)* (#280) and the AP&P Manual (SSAP No. 86).

- **Hedging**

For a derivative instrument to qualify for hedge accounting the item to be hedged must expose the company to a risk and the designated derivative transaction must reduce that exposure. Examples include the risk of a change in the value, yield, price, cash flow, quantity of, or degree of exposure with respect to assets, liabilities, or future cash flows which an insurer has acquired or incurred or anticipates acquiring or incurring.

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Some insurance companies that sell Guaranteed Investment Contracts (GICs) guarantee to the GIC holders an interest rate on future contributions for a specified period of time. The risk associated with this type of guarantee is that interest rates may drop before the GIC contract holder makes an additional contribution. The insurer can hedge this risk by using futures contracts.

- **Income Generation**

Income generation transactions are defined as derivatives written or sold to generate additional income or return to the insurer. They include covered options, caps, and floors (e.g., an insurer writes an equity call option on stock which it already owns).

Because these transactions require writing derivatives, they expose the insurer to potential future liabilities for which the insurer receives a premium up front. Because of this risk, dollar limitation and additional constraints are imposed requiring that the transactions be "covered" (e.g., offsetting assets can be used to fulfill potential obligations). To this extent, the combination of the derivative and the covering asset works like a reverse hedge where an asset owned by the insurer in essence hedges the derivative risk.

An example is the writing (selling) of call options that are covered. Covering the call option means that the insurer writing (selling) the options owns the financial instruments or the rights to the financial instrument that can be called by the option holder. The insurer writing (selling) the option earns a profit (the premium) if the option is not exercised by the other party. If the option is exercised, the financial instrument subject to call is paid to the holder of the option. From a risk/return standpoint, writing a covered call generates income in the same way that a callable bond does as compared to a non-callable bond. As with derivatives in general, these instruments include a wide variety of terms regarding maturities, range of exercise periods and prices, counterparties, underlying instruments, etc.

- **Replication**

The basic idea behind replication transactions is to combine the cash flows from a derivative instrument and another financial instrument to replicate the cash flows of another financial instrument. The following is a typical example of a replication transaction: the insurer holds a high-quality corporate bond that pays one 7% coupon per year. The insurer can enter into a swap transaction with another party in which the insurer receives 2% of the notional amount of the swap each year and, in turn, pays the counterparty the drop in fair value of a specific junk bond that would result if the junk bond would default. The insurer does not own the junk bond, but the combined cash flows of the high-grade corporate bond and the swap transaction replicate the cash flows of a junk bond.

Reporting of Derivative Instruments

On an annual basis, derivative instruments are reported in the Annual Financial Statement, Schedule DB. Options, caps, floors, collars, swaps and forwards are reported in Part A. Future contracts are reported in Part B, replications are reported in Part C, and counterparty exposure for derivatives instruments are reported in Part D.

Schedule DB – parts A and B contain two sections: 1) Section 1 identifies the contracts open as of the accounting date, and 2) Section 2 identifies contracts terminated during the year.

Schedule DB–Part C – Section 1 contains the underlying detail of replicated assets owned at the end of the year. Schedule DB – Part C – Section 2 is a reconciliation between years of replicated assets.

Schedule DB – Part D – Section 1 of the annual statement is different. It collects information necessary for risk-based capital (RBC) purposes. Currently, the NAIC RBC formula assumes that all derivative instruments are used for hedging purposes and the only risk exposure to the insurer is that the counterparty may not perform according to the terms of the contract. The concepts of Potential Exposure and Off-Balance Sheet Exposure have been defined to quantify the risk of non-performance by the counterparty. The definition of these concepts is contained in the Annual Statement Instructions.

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On a quarterly basis, the insurer only reports derivative instruments that are open as of the current statement date. Schedule DB – Part A – Section 1 lists the insurer's open options, caps, floors, collars, swaps and forwards. Open futures are reported in Schedule DB – Part B – Section 1, replications are reported in Schedule DB – Part C – Section 1, and counterparty exposure for derivatives instruments are reported in Schedule DB – Part D.

Accounting

Statutory accounting guidance for derivative instruments used for hedging and income generation transactions is contained in the AP&P Manual. Derivative transactions follow SSAP No. 86, *Derivatives.* The insurer is to disclose the transition approach that is being used. In order for a derivative instrument to qualify for hedge accounting treatment, the item to be hedged must expose the insurer to a risk and the designated derivative transaction must reduce that exposure.

An insurer should set specific criteria at the inception of the hedge as to what will be considered "effective" in measuring the hedge and then apply those criteria in the ongoing assessment based on actual hedge results. The penalty for failure to meet the effectiveness criteria varies from state to state.

The NAIC accounting guidance includes a discussion of required documentation. One item that is not mentioned is the "term sheet." The term sheet is a document signed by both parties to an over-the-counter derivative transaction such as a swap. The term sheet contains a detailed description of all of the terms and conditions of the swap transaction.

In many cases, an insurer will enter into several over-the-counter transactions with a single party. In this situation, the insurer should have entered into a master netting agreement. The existence of such an agreement has implications for risk-based capital.

Comprehensive Description of a Hedging Program

When an insurer is actively engaged in derivative activity or when concerns exist regarding an insurer's derivative activity it may be necessary to obtain a comprehensive description of the insurer's derivative program.

States may have specific requirements for items to be included in a comprehensive description of an insurer's derivative program. Items may include detailed information on the following:

- Authorization by the insurer's board of directors, or other similar body to engage in derivative activity
- Management oversight standards including risk limits, controls, internal audit, review and monitoring processes
- The adequacy of professional personnel, technical expertise and systems
- The review and legal enforceability of derivative contracts between parties
- Internal controls, documentation and reporting requirements for each derivative transaction
- The purpose and details of the transaction including the assets or liabilities to which the transaction relates, specific derivative instrument used, the name of the counterparty and counterparty exposure amount, or the name of the exchange and the name of the firm handling the trade
- Management's written guidelines for engaging in derivative transactions, for example:
    - Type, maturity, and diversification of derivative instruments
    - Limitations on counterparty exposures
    - Limitations based on credit ratings
    - Limitations on the use of derivatives
    - Asset and liability management practices

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- The liquidity and capital and surplus needs of the insurer as it relates to derivative activity

- The relationship of the hedging strategies to the insurer's operations and risks
- Guidelines for the insurer's determination of acceptable levels of basis risk, credit risk, foreign currency risk, interest rate risk, market risk, operational risk, and option risk
- Guidelines that the board of directors and senior management comply with risk oversight functions and adhere to laws, rules, regulations, prescribed practices, or ethical standards

C. Health Receivables

Health entities are authorized to report a number of assets in the Annual Financial Statement. According to SSAP No. 4, *Assets and Non-admitted Assets* (SSAP No. 4), an asset has the following three essential characteristics: (a) it embodies a probable future benefit that involves a capacity, singly or in combination with other assets, to contribute directly or indirectly to future net cash inflows, (b) a particular entity can obtain the benefit and control others' access to it, and (c) the transaction or other event giving rise to the entity's right to or control of the benefit has already occurred. Other than invested assets, some of the more significant items that meet the above definition are uncollected premiums and agent's balances, health care receivables, health care delivery assets, amounts receivable relating to uninsured accident and health plans, electronic data processing equipment, and software. Each of the above types of other assets is individually unique and can carry its own risks. This can be particularly of concern for health entities, which may require a more liquid balance sheet than other types of insurers. The following discusses each of these other asset classes in greater detail including some of the unique circumstances and risks to the health entity.

Uncollected Premiums and Agent's Balances

The asset for uncollected premiums includes amounts receivable on individual and group policies that have been billed but have not yet been collected. Uncollected premium balances result from transactions conducted directly with the insured. For most health entities, the primary coverage written is comprehensive group business. While assessing a group's credit risk, if permitted by law, is often an important part of the underwriting process, the credit risk on group business can actually be lower than the credit risk on individual business. This is because most comprehensive group business is written on a monthly installment basis billed and paid in advance of the effective date of the coverage. Said differently, the coverage period is usually one month and is usually due or paid before the coverage period begins. Because of this, a health entity's credit risk is theoretically mitigated by its ability to stop coverage in a short period of time. However, from a practical standpoint, the health entity may desire to retain large or influential groups, either because of the prominence associated with writing to these groups or because the health entity may not want to be viewed as an inhibitor to health care services.

The sale of health insurance can differ significantly from the sale of other types of insurance. Although agents are used by health entities, they are generally not used as extensively as with property/casualty insurers or even life insurers. Agent's balances are admitted to the extent that the assets conform to the requirements of SSAP No. 6 *Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts due from Agents and Brokers* (SSAP No. 6), which also requires that premiums owed by agents should be reported net of commissions and are non-admitted under a 90-day rule. Remaining amounts that are determined to be uncollectable must be written off. Generally, if a contract with an agent permits offsetting, amounts payable to an agent may be offset against a receivable from that agent. Agents' balances carry credit risk and can have a material impact on the net income and capital and surplus of a health entity if the balances are significant. Significant or growing balances can also lead to liquidity problems if the health entity is unable to convert the receivables into cash to be used to pay claims.

The collectability of amounts reported for uncollected premiums may also be impacted as a result of retroactive additions and deletions that are made subsequent to the date the group was invoiced. There may be a delay

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(sometimes several months) between the time that a large group adds a new covered employee or deletes an employee that is no longer covered and notice of the change is sent to the health entity. This length of the delay increases since the invoicing of the monthly premium is frequently in advance of the effective date of the coverage. This delay can result in the health entity reporting part of a monthly billing as more than 90 days overdue and ultimately collecting less than what was billed. SSAP No. 6 states that if an installment premium is over 90 days due, the amount over ninety days due plus all future installments that have been recorded on that policy shall be non-admitted. However, for group accident and health contracts, a non-admitted *de minimus* over ninety-day balance would not cause future installments (i.e., monthly billed premiums on group accident & health) that have been recorded on that policy to also be non-admitted. The *de minimus* over 90-day balance itself would be non-admitted and the entire current balance would be subject to a collectability analysis.

The balance for uncollected premium may also result from amounts due from the Centers for Medicare and Medicaid Services or other government plans. Although coverage periods on this type of business are usually the same as comprehensive group business, the payment cycle can be much different due to the longer settlement periods experienced under government contracts. However, collectability of balances associated with government plans is usually not an issue. Because of this, the 90-day rule that is applied to other receivables is not applicable to receivables from these types of government plans.

Irrespective of the type of business written, inadequate systems and controls over the collection process can lead to uncollectable premiums. Uncollected premium balances on non-government business that are over 90 days due are non-admitted under SSAP No. 6. On all business, an evaluation of any remaining asset balance is required to determine any impairment. Amounts deemed uncollectable are required to be written off against income in the period the determination is made. These accounting requirements are designed to limit the total impact that collectability issues can have on a health entity at a given point in time.

Despite the efforts to mitigate the impact of uncollected premiums and agent's balances, write-offs and non-admitted unpaid premium assets can still have a material impact on the net income and capital and surplus of a health entity. These issues can lead to liquidity problems if the health entity is unable to convert the receivable into cash to be used to pay claims. Analysts should monitor the level of this asset as well as the change in the balance to help identify potential collection problems that can ultimately lead to significant decreases in capital and surplus. Since the asset includes agent's balances as well as premiums, an analyst may refer to the Exhibit for Accident and Health Premiums Due and Unpaid to determine if the balance of the asset is primarily due to premiums or due to agent's balances. See SSAP No. 6 for further discussion of uncollectable premiums and SSAP No. 54R, *Individual and Group Accident and Health Contracts* (SSAP No. 54R).

Health Care Receivables

Health care receivables can include pharmaceutical rebate receivables, claim overpayment receivables, loans and advances to providers, capitation arrangement receivables, risk-sharing receivables and government insured plan receivables. Similar to other assets in general, each of the above types of health care receivables is individually unique and can carry its own risks to the health entity. Some of them carry a higher degree of risk because of the use of estimates in establishing them. Others carry a low level of risk because the accounting requirements only allow the receivable to be established in certain circumstances. However, ultimately each of the health care receivables can present the same kind of financial risks as uncollected premiums. Like uncollected premiums, the collectability of health care receivables should be monitored by the health entity, as it could become a source of future problems if write-offs of uncollectable receivables become material.

- **Pharmaceutical Rebate Receivables**

According to SSAP No. 84, *Health Care and Government Insured Plan Receivables* (SSAP No. 84), pharmaceutical rebates are arrangements between pharmaceutical companies and a health entity in which the health entity receives rebates based upon the drug utilization of its subscribers at participating pharmacies. Generally, this receivable can consist of amounts that have actually been billed but usually a significant portion of the receivable is based upon estimates of the health entity or a pharmacy benefits manager (PBM). Because the

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amounts can be material, SSAP No. 84 does allow these receivables to be admitted to the extent that they conform to certain requirements. Health entities are required to disclose certain information regarding the receivable in Annual Note to Financial Statements #27, Health Care Receivables. Analysts should use the information from the note, along with other knowledge of the health entity's business, to assess whether the balance and the changes in the balance from period to period appear reasonable. See SSAP No. 84 for more specific information related to the determination of the admitted asset.

It should be noted that the disclosures to be included in Note #28 for pharmaceutical rebate receivables should include pharmaceutical rebates of insured and uninsured business. If there are rebates collected pursuant to these uninsured ASO/ASC arrangements, a liability for any payable must be established. Refer to Section IV.B. Notes to Financial Statements, for guidance on reviewing Note #28.

- **Claim Overpayments**

Due to the volume of transactions processed by health entities, the various coverages provided to different employer groups, and the use of deductibles, co-payments and coinsurance, it is not uncommon that claim overpayments may occur as a result of an error or miscalculation. Although the certainty of collection cannot always be estimated or determined, health entities are allowed to admit claim overpayments if certain requirements are met as set forth in SSAP No. 84. The most significant requirement is that the receivable must have been invoiced and specifically identifiable to a claim, and not just an estimate. Although claim overpayments are common, they are generally not material. To the extent they are material, analysts should obtain a better understanding of how the receivable has become so significant and may consider the need to perform more specific procedures to address any collection issues. In addition, analysts may consider the need to understand the processes and procedures the health entity is taking to minimize the balances.

- **Loans and Advances to Providers**

A health entity may make loans or advances to hospitals or other providers. Unlike claim overpayments, these assets can be very material. Although SSAP No. 84 provides that these loans and advances can only be reported as admitted assets in certain circumstances, analysts should obtain a clear understanding of these assets in order to effectively assess the overall financial condition of the health entity. Loans or advances to providers are generally made at the request of the provider to alleviate or prevent cash flow problems or in some cases, to serve as a semi-permanent component of the providers' capital structure. In many cases, these loans or advances are actually paid monthly and are intended to cover one month of fee-for-service claims activity with the respective provider. For large hospitals with many sources of cash flow, these loans and advances can be offset with the reported and unreported claims liability and claims reserve. However, to be admitted assets under SSAP No. 84, loans to hospitals must be reconciled quarterly against actual claim utilization pursuant to contractual terms and is admitted up to the amount payable to the provider for reported claims. The quarterly reconciliation allows for more adequate run-out of claims but is required to avoid potentially material uncollectable balances. Clearly, the longer the balance builds without being reconciled the greater potential for material adverse adjustment.

Loans or advances by a health entity to related parties must constitute arm's-length transactions. Loans or advances made by a health entity to related parties (other than its parent or principal owner) that are economic transactions are admissible under SSAP No. 25, *Affiliates and Other Related Parties* (SSAP No. 25). This includes financing arrangements with providers of health care services with whom the health entity periodically contracts. Again, analysts should obtain as good of an understanding as possible of the health entity's loans or advances to providers. This may include communication with the health entity or an examiner.

- **Capitation Arrangement and Risk Sharing Receivables**

A health entity may also admit advances to providers under capitation arrangements under certain circumstances. Under SSAP No. 84, a capitation arrangement is defined as a compensation plan used in connection with some managed care contracts in which a physician or other medical provider is paid a flat amount, usually on a monthly basis, for each subscriber who has elected to use that physician or medical

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provider. To qualify as admitted assets under SSAP No. 84, among other things, the advances must be made under the terms of an approved provider services contract in anticipation of future services and must not exceed one month's average capitation payments.

SSAP No. 84 defines risk-sharing agreements as contracts between health entities and providers with a risk-sharing element based upon utilization. The compensation payments for risk-sharing agreements are typically estimated monthly and settled annually. These agreements can result in receivables due from the providers if annual utilization is different than that used in estimating the monthly compensation. Consistent with pharmaceutical rebate receivables, although this asset is generally determined based upon estimates, it is allowed to be admitted to the extent it conforms to certain requirements of SSAP No. 84.

Despite these requirements, and the requirement that the collection of risk-sharing receivables be made quarterly, analysts should closely monitor the balance of this asset. Analysts should use the information from Note #28, along with other knowledge of the health entity's business, to assess whether the balance and the change in the balance from period to period appears reasonable. Refer to IV.B. Analysis of Notes to Financial Statements for guidance on reviewing Note #28.

- **Government Insured Plan Receivables**

Government plan receivables may be included in either uncollected premiums or under health care receivables. Analysts should determine their state's method of accounting. However, in some cases, the receivables are not specifically for premiums but arise from coordination of benefits with the government contract (Medicaid carve-out). Amounts receivable under government insured plans that qualify as accident and health contracts in accordance with SSAP No. 50, *Classifications and Definitions of Insurance or Managed Care Contracts,* are admitted assets. However, the collectability of these amounts must be periodically evaluated even though the 90-day past due rule does not apply. Any amounts deemed uncollectable must be written off and charged to income in the period the determination is made. See SSAP No. 84 for further discussion.

Amounts Receivable Relating to Uninsured Accident and Health Plans

SSAP No. 47, *Uninsured Plans* (SSAP No. 47) defines uninsured accident and health plans, including HMO administered plans, as plans for which a health entity, as an administrator, performs administrative services such as claims processing for an at risk third party. Accordingly, the administrator does not issue an insurance policy. Two of the more common types of uninsured accident and health plans include an Administrative Services Only (ASO) plan or an Administrative Services Contract (ASC) plan.

Under uninsured plans, there is no underwriting risk to the health entity. The plan bears all of the utilization risk, and there is no possibility of loss or liability to the administrator caused by claims incurred related to the plan. Because of this, accounting for income and disbursements resulting from such uninsured plans, or the uninsured components of a combination plan should not be reported as insurance premiums and claims. As discussed in SSAP No. 47, amounts received on behalf of uninsured plans or the uninsured portion of partially insured plans are not reported as premium income. Administrative fees for servicing the uninsured plans are deducted from general expenses. Conversely, income relating to the insured portion of any plan is reported as premium income. It should be noted that plans that include a capitated payment method are automatically considered an insured plan.

Although there is no underwriting risk on these types of plans, credit risk can still be an issue. Under these types of agreements, it is common for a receivable to be established for services performed by the health entity, and/or amounts due to the health entity for claims paid by the health entity on behalf of the uninsured plan. The credit risk varies on these types of plans because under an ASC plan, the health entity pays the claims directly from its own bank account and would seek reimbursement at a later date. In contrast, under an ASO plan, the claims are paid from a bank account owned and funded directly by the uninsured plan sponsor or are paid by the health entity but only after receiving funds to cover the amount paid. Combination plans may also be administered which contain elements of both an uninsured and an insured plan. If the funds held for

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disbursement under the uninsured plans are inadequate to meet disbursement needs, the insurer may advance funds to cover such disbursements.

As a result of such advances, the receivable should be recorded as an asset. Liabilities can also result from administering this type of business. This type of liability would result from funds of the uninsured plans being held by the health entity for making plan disbursements. Generally, the asset for the receivable and the liability for funds held should not be netted unless individual receivables and payments meet the requirements of SSAP No. 64, *Offsetting and Netting of Assets and Liabilities* (SSAP No. 64).

Expense risk can also result from uninsured plans. This risk results primarily from the health entity incurring more expenses to administer the business than reimbursed from the uninsured plan. Analysts should use the information in Note #18, Uninsured Plans, to better assess the business risk to which the health entity is exposed under its uninsured plans. Refer to Section IV.B. Notes to Financial Statements, for guidance on reviewing Note #18.

D. Separate Accounts

Separate accounts are segregated pools of assets owned by a life/health insurer in which the investment experience is credited directly to the participating policies. Separate accounts are not a separate legal entity, but rather a segregated line of business where the assets and related investment gains and losses are insulated from general account creditors and liquidation claims. The insurer is not a trustee by reason of the separate accounts and state statutes provide that separate account assets may be invested and reinvested without regard to any requirements or limitations imposed upon an insurer by the investment statutes, which apply to insurers. Separate accounts were historically used for pension accounts. More recently they have been used to market unique investment options and guaranteed investment returns. The flexibility they offer policyholders has been the driving force behind their greatly expanded use. Separate accounts may be used to fund a variety of products including individual and group, fixed and variable, guaranteed and non-guaranteed, life insurance and annuities.

Accounting for separate account business involves both the general account of the insurer and the separate accounts. The Separate Accounts Annual Financial Statement is concerned primarily with the investment activities of the separate accounts and with the flow of funds from and to the general account. Only direct investment transactions (purchase, sale including profit and loss thereon, income, and direct expenses and taxes relative to specific investments) are recorded as direct transactions in the Separate Accounts Annual Financial Statement. All other transactions are reported as transfers between the general account of the insurer and the separate accounts statements. In general, the separate accounts do not maintain surplus since gain or loss from separate accounts is transferred to the general account each year.

The following focuses primarily on the impact on the general account of separate accounts activities. With many of the separate accounts' products, the entire investment risk is absorbed by the policyholder. However, other types of separate accounts products include guarantees in the form of minimum death benefits, minimum interest rates and bailout surrender charge provisions. Any minimum guaranteed obligation must be recorded on the general account of the insurer since, by definition, the entire asset transferred to the separate accounts is at risk. The following is a brief summary of the types of separate accounts products that may create contingent liabilities to the general account:

NOTE: Refer to the risk repository procedures for additional guidance and considerations related to separate account risks in Operational Risk, Reserving Risk and Liquidity Risk.

Variable Annuities

These products may have implications for the general account by virtue of transfer rights, enhanced death benefits, and minimum interest rate guarantees. Excess reserves required by these provisions are normally carried in the general account of the insurer.

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Modified Guaranteed Annuities

Modified Guaranteed Annuities were developed in the 1980s and are a hybrid between a book/adjusted carrying value deferred annuity and a variable annuity. This product provides interest rate guarantees for a period of time and is patterned after the group Guaranteed Interest Contract. If the policy is surrendered before maturity, then appropriate adjustments are made to the value. However, the insurer bears default risk and additional risk if the insurer's investment return does not match product guarantees.

Modified guaranteed annuities in general are not insulated or "walled off" from the general account. These liabilities are, in effect, guaranteed by the general account. The general account must fund any shortfalls in the separate account related to these products. Whether this product is insulated from the general account is determined by the product's contract wording. If not specifically addressed in the contract, certain states have taken the position that the product is not insulated. The lack of insulation would result in the assets and liabilities associated with the product being transferred to the general account in the event of liquidation.

Indexed Products

With an indexed product, an insurer guarantees that the portfolio will show returns, which will exceed a certain index by a specified number of basis points. An insurer generally requires a large commitment of deposits before issuing such a product, so that the portfolio can achieve the diversification necessary to support the product structure. The risk to the insurer is a mismatch risk between the index and the rate of return recognized. In addition, the product may also contain expense guarantees.

There are generally restrictions upon withdrawals for the accounts. Certain states have required excess reserves for these products based on the remaining guaranty period. However, there is not consistency within the industry as to whether excess reserves are required, how they are calculated, or where they are recorded.

Experience Rated Guaranteed Interest Contracts

These products are true group products, with three-party involvement. This is a fully guaranteed product from the plan participant's point of view. Interest rate guarantees are generally for interest credited to date. Future interest guarantees typically are 0%. Termination of the contract is generally at true fair value or paid out over time.

Fully Guaranteed Interest Contracts

These are traditional guaranteed interest contracts written in a separate account. Although many insurers carry non-par guaranteed interest contracts in the general account, insurers will write them in the separate account to better control duration matching. Assets and liabilities are generally valued at book, so reserve accounting and asset valuation is the same as for the general account. The product may or may not be insulated from the general account.

Funded, Experienced Rated Group Annuity

These products tend to be immediate annuities, where the plan sponsor participates in the earnings of a segregated investment portfolio. The plan sponsor provides a "margin" in order to participate in the preferred investment portfolio. Nearly all reserves are carried at fair value. If asset value falls below total liabilities plus a margin, then additional deposits are required, or a company has the right to invest the assets more conservatively to better hedge its risk. Reserves may be placed in either the general account or the separate account.

Synthetic Guaranteed Interest Contracts

This product creates an investment management vehicle for a benefit plan that does not require the plan to transfer ownership of plan assets. Therefore, the insurer selling these products provides investment management services but does not own the assets. The assets and liabilities from these products are not carried

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on the insurer's financial statements. These products were developed to provide an extra layer of insulation from general account liabilities. There are two types of synthetic guaranteed interest contracts: 1) participating and 2) non-participating. Non-participating products generally have a portfolio of high-quality assets that is not actively traded. The issuer (insurer) agrees to purchase plan assets at book value if needed to make plan benefit payments. If any plan assets associated with the product go into default, the insurer's purchase obligation is terminated to those securities. The insurer receives a fee for these services.

In participating products, plan assets are normally set aside in a separate custodial account and are actively managed, under agreed upon diversity and credit rating requirements. The portfolio is managed to provide for a return of principal plus a crediting rate. Generally, a floor is established which sets a minimum crediting rate. At the end of the contract term, the insurer is obligated to pay the plan the excess, if any, of the book value of the investment portfolio over its fair value (i.e., the insurer bears the risk of default). Current practices aimed at financial statement disclosure appear to include no disclosure, disclosure through footnotes, or disclosure through inclusion of liabilities on the Exhibit of Deposit-Type Contracts of the general account Annual Financial Statement as both a liability and a negative liability. Some insurers may carry excess reserves for the guaranty of performance, although current practices vary widely.

E. Risk Transfer Other Than Reinsurance (Health)

Risk to health entities comes primarily from underwriting risk, which is the risk that health care costs are higher than those anticipated in premium rate development. Health care costs can be higher than anticipated because of higher than forecasted cost per service or because of a higher level of utilization of those services. Any methodology that controls the cost or utilization of services decreases the risk of incorrectly estimating health care costs. Arrangements that control costs of services may not be as effective in reducing risk, if providers increase utilization to make up for lower costs. For example, controlling the cost of a day in the hospital by contracting for fixed per diems is not effective if lengths of stay increase. Contracting for reduced inpatient care cost or changing benefit designs to reduce the use of inpatient care is not effective if providers shift to outpatient facilities and increase the cost of outpatient care.

Health entities use many types of risk transfer arrangements with outside entities to help control costs. Risk can be transferred to:

- Reinsurers
- Groups
- Insured members
- Providers/provider intermediaries

Risk can be retained by the employer, trade association or other groups using administrative services only (ASO) or administrative service contract (ASC) self-insurance arrangements. In both arrangements, the group bears the underwriting risk that claim payments will exceed a predetermined level, except for any risk that is reinsured through stop-loss contracts, while the health entity bears the business risk in administration. The difference between ASO and ASC arrangements is the amount of business risk that the health entity has if the group becomes insolvent. In ASO arrangements, the health entity is exposed to minimal business risk, but with ASC arrangements, one or more possible situations may result in the health entity being exposed to the business risk for claims, if the group does not pay the claims that it is contractually obligated to pay. First, identification cards given to the member are often indistinguishable from insured member cards. (This may also be the case with ASO arrangements, which would increase their business risk.) This can create an impression on the part of the provider or member that the health entity is responsible for the claims and result in litigation. Very few group members are aware or understand that their insurance is actually self-insured by their employer or association group and is not the responsibility of the health entity indicated on their insurance card. Second, in ASC arrangements where the health entity pays claims first and then bills the group or uses electronic funds transfer to be reimbursed for claims, they may have difficulty obtaining reimbursement if the group becomes insolvent.

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In addition, such risk can exist for both ASO and ASC contracts for claims in the course of settlement or claims incurred but not reported. Statutory accounting was changed under Codification to require premium income and claims expense for self-insured plans to be excluded from revenues and expenses, but rather to be included as a component of administrative expenses. SSAP No. 47, *Uninsured Plans*, describes the accounting for ASO and ASC arrangements. ASO and ASC administrative expenses and ASC medical expenses are included in worksheet XR019 of the Risk-Based Capital (RBC) filing.

Minimum premium arrangements, which are hybrids between insured and self-insured plans, can be used to transfer claim cost risk to groups using an alternative funding mechanism. In these arrangements, a fund is established (e.g., a bank account) and used by the health entity for the purpose of paying claims, up to a pre-determined level (stop-loss threshold). These claims are self-insured, and the associated funding is excluded from premium revenue. In addition, the policyholder remits a minimum premium to the health entity to cover claims in excess of the stop-loss threshold. This portion of the policyholder payment is considered premium revenue to the health entity. Typically, there are two types of stop-loss provisions attached to this arrangement to control the claim cost risk for the policyholder. Individual specific stop-loss limits the risk of the policyholder to a pre-determined amount per covered individual or claim, (e.g., $50,000) and an aggregate stop-loss cover limits the risk of the policyholder to a pre-determined amount on an overall basis for all claims, (e.g., 120% of expected paid claims). The minimum premium remitted to the health entity covers claims in excess of the stop-loss threshold, both individual and aggregate, and for the administrative expenses of the policy. The amounts remitted in the deposit fund vary according to the pre-determined amounts in the individual and aggregate stop-loss provisions, and the benefit provisions of the underlying medical care plan. If claims experience is more favorable than expected, the policyholder may reduce its payments to the deposit fund. Unused amounts in the deposit fund at the end of the policy year revert to the policyholder.

An advantage of these arrangements to the policyholder is that they reduce the up-front cash flow in its first year of operation, as there is no reserve funding required for self-insured claims below the stop-loss threshold. Another advantage is that premium tax is usually not paid in the amounts paid into the deposit funds. At cancellation of this arrangement, the policy may call for the payment by the policyholder to the health entity of a supplemental premium for the handling of the claims incurred and not yet paid.

Another experience rating arrangement, which transfers some risk to the policyholder, is called the Retrospective Premium Arrangement. Under such arrangement, the health entity and policyholder agree to set premiums at a lower level than determined by the health entity, (e.g., 80% level, with a provision that an additional retrospective premium may be required, up to the 100% level, if claims experience is unfavorable). An individual stop-loss arrangement is typically included in these plans, to control the claim cost risk for the policy. These arrangements typically arise when there is some disagreement between the health entity and the policyholder on the magnitude of a premium rate increase. Agreement is reached on a lower level of premiums, with an arrangement for a potential retrospective premium if required. These arrangements also can incorporate a premium stabilization reserve where margins arising from favorable claims experience is deposited and which may be used to pay the additional retrospective premium when claims experience is unfavorable. A premium stabilization reserve reduces the health entity's risk of having to absorb experience deficits in addition to rate increases.

One advantage to the policyholder of these arrangements is that they reduce the up-front cash flow as premiums are remitted at a reduced level during the policy year. One disadvantage to the health entity is that it may be difficult to collect the retrospective premium, if required, at the end of the policy year, possibly leading to questions by the policyholder as to the size of the claim reserves established by the health entity. Once a retrospective premium is billed, any amounts due more than 90 days after the due date are treated as a non-admitted asset. At any time, if it is probable that the additional retrospective premium is uncollectable, it must be written-off against operations in the period such a determination is made. At termination, any fund remaining in the premium stabilization reserve is refunded to the policyholder. However, the health entity will normally hold the rate stabilization reserve for a one-year runoff period before refunding the balance.

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A modification to the retrospective premium arrangement is where the full 100% premium is billed during the policy year, with margins arising from favorable claims experience being deposited in the premium stabilization reserve or remitted to the policyholder. Deficits arising from unfavorable claims experience may be recouped from available funds in the premium stabilization reserves. Unrecouped deficits are carried forward to the next policy year and may be recouped from future years' favorable claims experience. The health entity is not totally protected from unfavorable claims experience, as the policyholder may move the policy to another health entity, leaving the prior health entity with an unrecouped deficit. At termination, any fund remaining in the premium stabilization reserve is refunded to the policyholder after a one-year runoff period as described above.

Premium stabilization reserves are included in the reserve for rate credits or experience rating refunds on Underwriting and Investment Exhibit Part 2D - Aggregate Reserve for Accident and Health Contracts Only line 4, with a corresponding entry to premiums. Accounting guidance for retrospectively rated contracts with return of premium provisions can be found in SSAP No. 66, *Retrospectively Rated Contracts*.

Risk transfer to insured members is accomplished through the use of deductibles, coinsurance, and co-payments (copays), which transfers some of the risk of increased cost and utilization to members.

Although providers are more resistant to taking risk from health entities, there are still many types of arrangements found that transfer risk from health entities to providers. Capitation is the most common method of transferring risk. There are several types of arrangements that fall under the term capitation:

- Paid on a PMPM or percent of premium basis to a provider or provider group that covers only the services of that provider or group.
- Paid on a PMPM or percent of premium basis directly to a provider intermediary such as an Independent Practice Association (IPA) or provider group covering only the services of the providers that have a contract with the intermediary (participating providers or provider network) or provider group.
- Paid on a PMPM or percent of premium basis, covering the services of participating providers and the services of other providers (e.g., specialists and inpatient facilities).

Monthly capitations are paid for all members enrolled with the provider intermediary. Capitations can be deposited to a separate bank account that the provider intermediary then writes checks against to pay for provider services. Capitations can also be accounted for internally by the health entity, but not actually paid; rather a deduction is made from the internal account when claims are paid to providers contracting with the provider intermediary for enrolled member services.

Other arrangements include withholds, bonuses and special payment arrangements. Bonus and withhold arrangements can be structured to take the risk off the provider when there is a capitation arrangement.

If capitation arrangements are significant, Analysts may consider getting more information on the structure of the capitation contract and if there are any associated bonuses and withholds. In the Annual Financial Statement, capitations are broken out in Exhibit 7 – Part 1- Summary of Transactions with Providers. Since intermediaries do not provide services directly, they may be more vulnerable to financial problems if the demand for medical services is higher than anticipated. Intermediaries may pass on some risk through capitating participating providers, but they may also pay some participating providers on a fee-for-service basis. If the total of the intermediary's incurred claims exceed the capitations that they receive from the health entity, the intermediary experiences financial losses. If this continues the intermediary may become insolvent, which can impact the ability of the health entity to maintain its network and ultimately to provide services to its members. Medical groups on the other hand provide more of the services directly and when the demand for services is more than anticipated, they can either work longer hours (called sweat equity) or delay services until their schedule allows.

Capitations have the effect of reducing the amount of unpaid claim liability as a portion of the incurred claims, since payments are made at the beginning of the month to cover services provided in the month.

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Receivables from provider contracts are subject to the analysis and reporting requirements of SSAP No. 84, *Health Care and Government Insured Plan Receivables*. In the situation where the provider contract requires payments from, as well as, to the provider, the health entity should separate ultimate results into the liability entry and the receivable entry.

These amounts do not include the health entity's liability if a contracting provider becomes insolvent. Provision for the effect of provider insolvencies should be included in the claim liability and/or premium deficiency reserve as appropriate.

Special payment arrangements to provider groups can include fee schedules, discounts, and DRG payments to hospitals. See the Reserving Risk Repository guidance for a discussion of how these arrangements affect risk transfer, liabilities, and reserves.

F. Other Provider Liabilities (Health)

Health entities can use many types of risk-sharing arrangements with a provider that transfers part of the financial risk to the provider. Although the type and form of these arrangements may differ, all will ultimately result in the settlement of the risk transfer arrangement. The most frequent arrangements are capitation arrangements where the provider is paid a per-member-per-month amount for providing specified medical services to the members that are enrolled with the provider. Other types of contracting arrangements may contain provisions for bonuses or withholds dependent on the provider meeting specific financial, utilization, and/or quality goals. Financial goals under these types of arrangements may include targets for loss ratios, total claims per-member-per-month, or average prescription drug costs per-member-per-month. Utilization or operational goals may include target hospital inpatient days per 1,000 members or goals for provision of a target number of preventative services per 1,000 members covered. Bonus payments and withhold payments are both dependent on performance over a period of time and are not based on any particular provider service.

Under bonus arrangements, bonuses are paid based on criteria defined in the provider contract. Under withhold arrangements, part of each payment, either fee-for-service or capitation, is retained until a specified point in time when a contractual formula determines the amount of the withholding that is to be paid to the provider. Bonus and withhold arrangements can be very complicated with separate pools being established for specific types of medical costs. For example, a pool can be established for prescription drug costs, another for inpatient days, and another for specialist referrals. Separate pools can be established for hospital services and for physician services.

If provider contract liabilities are percentage withholds from provider payments, they are included in Page 3 Line 1, claims unpaid, otherwise they are included in Page 3 Line 2, accrued medical incentive pool and bonus payments. The amounts included in Page 3 Line 1 are detailed in the Underwriting and Investment Exhibit - Part 2A Line 3, amounts withheld from paid claims and capitations. The current year's accrued medical incentive pool and bonus payments is also entered in the Underwriting and Investment Exhibit – Part 2 on Line 5, while last year's accrued medical incentive pool and bonus payments is entered on Line 10 of that exhibit. The liability is determined according to a formula contained in the provider contract describing the amount to be paid based on specific performance. For further accounting guidance, see SSAP No. 55, *Unpaid Claims, Losses, and Loss Adjustment Expenses* (SSAP No. 55).

A provider contract liability should be established for all contracts that have outstanding amounts due. This includes estimated liabilities prior to the contract settlement date, as well as finalized liabilities that have not been paid as of the valuation date. For contracts prior to the settlement date, the actuary should have estimated the amount accrued based on the contract provisions and performance from the beginning of the contract period to the valuation date.

Methods used to estimate provider liabilities are discussed in detail in the NAIC *Health Reserve Guidance Manual*. The health entity can estimate the liability by reviewing each provider contract separately or by estimating groups of like contracts together. Historical information may be used as a basis for estimating the

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provider's liability using ratios of the provider liability to incurred claims or of the provider liability to member months. Because provider liabilities are based on claims experience, the lower the PMPM claims experience, the higher the provider liability will be. Consequently, in order to ensure that the estimated provider liability is appropriately conservative, the estimate of the unpaid claim liability used by the actuary in calculating the provider liability may contain fewer margins for adverse deviation than the estimate of the unpaid claim liability used in the financial statement. In any case, the actuary should have ensured that the unpaid claim liability and the provider liabilities, in total, make allowance for adverse circumstances.

Receivables from provider contracts are subject to the analysis and reporting requirements of SSAP No. 84, *Health Care and Government Insured Plan Receivables*. In the situation where the provider contract requires payments from, as well as, to the provider, the health entity should separate ultimate results into the liability entry and the receivable entry.

These amounts do not include the company's liability if a contracting provider becomes insolvent. Provision for the effect of provider insolvencies should be included in the claim liability and/or premium deficiency reserve as appropriate.

If the contract period has not ended as of the valuation date or if the settlement has not been paid, there will be expenses associated with the determination and payment of the settlement of the risk-sharing arrangement. A prorated share of this expense should be included on Page 3 Line 3, unpaid claims adjustment expenses.

When withholds and bonuses are paid, they are included in Underwriting and Investment Exhibit – Part 2 Line 2, paid medical incentive pools and bonuses, and are split between claims incurred during the year and claims incurred in prior years in Underwriting and Investment Exhibit – Part 2B Line 12, medical incentive pools, accruals and disbursements.

Withhold and bonus information is also included in the Risk-Based Capital (RBC) filing and is used in the determination of the managed care credit in the RBC calculation. Worksheets XR015 and XR016 contain claim payments subject to withholds, withholds and bonuses available, and withholds and bonuses paid. Some of the information used in the RBC filing corresponds to Exhibit 7 – Part 1, while other information is from company records. Since bonuses and withholds paid in conjunction with capitation arrangements are not itemized in Exhibit 7 or in the RBC filing, they do not provide a total breakout of bonuses and withholds paid.

G. Income Statement and Surplus

Statutory accounting principles emphasize the balance sheet because statutory accounting is primarily directed toward the determination of an insurer's financial condition on a specific date. However, the income statement is also important and should be reviewed as a part of the financial analysis process. Income statement analysis primarily focuses on the operating performance of an insurer.

a. **Property/Casualty**: The most common measure of an insurer's underwriting profitability for a property/casualty insurer is the combined ratio, which is a combination of the loss ratio, expense ratio, and the policyholder dividend ratio. The combined ratio is sometimes thought of as the amount of each dollar an insurer pays out for every dollar of premium received. For example, if an insurer has a combined ratio of 105%, it pays out roughly $1.05 in claims, expenses, and policyholder dividends for every dollar of premiums received. However, such an insurer may still be profitable because it will be earning investment income on the premium dollars held until claims and expenses are paid. The two-year overall operating ratio (P&C IRIS ratio #5) and the return on surplus are two measures of overall operating performance that include investment income.

b. **Life/A&H**: One of the most common measures of an insurer's overall profitability and operating performance for a life/health insurer is the IRIS ratio of net income to total income (including realized capital gains and losses). This ratio considers the six principal factors which affect the insurer's net gain: 1) mortality and morbidity experience; 2) adequacy of investment income; 3) commissions and expenses; 4) reinsurance transactions; 5) the relationship of statutory reserve requirements to prevailing interest and mortality rates;

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and 6) realized capital gains and losses. The return on capital and surplus, which considers net income as a percentage of capital and surplus, is another important measure of overall operating performance.

c. **Health**: One of the most common measures of a health entity's overall profitability and operating performance is its profit margin. This ratio considers the four principal factors which affect the health entity's net gain or loss 1) morbidity (claims) experience, 2) expense and commission structure, 3) investment income, and 4) realized capital gains or losses. The return on capital and surplus, which considers net income as a percentage of capital and surplus, is another important measure of overall operating performance.

   Measures such as the combined ratio, the medical loss ratio and administrative expense ratio provide analysts with more specific measures of the health entity's source of profits or losses. The health entity's management as well as external analysts generally use these more precise ratios. However, even these ratios are somewhat limited in their ability to target the sources of a health entity's profitability. There may be different loss or risk characteristics by product type, or even by region within the same product that the ratios do not reveal. The thresholds for medical loss ratio, the administrative expense ratio and investment yields, 85%, 15%, and between 2% and 6%, respectively, are based upon health entities that write only "comprehensive health products." Fluctuations in operating ratios are also important indicators of potential financial problems and concerns. For example, even if the health entity's medical loss ratio was considered good, an increase may indicate a loss of control in the health entity's underwriting or pricing standards. An increase in the administrative expense ratio may indicate escalating costs or an expense structure that no longer supports the health entity's premium volume.

   Health insurance is provided to consumers through various means and products. Some products provide very specific coverage (e.g., medical only, dental, vision and stop loss) while others provide much broader coverage (e.g., comprehensive, federal employees health benefit plan, Medicare and Medicaid). As previously mentioned, each of these products contains different loss and risk characteristics. Different mixes of these products can significantly impact the profitability of a health entity.

Fluctuations and trends in the individual line items shown in the income statement are also important indicators of potential financial problems and concerns. For example, significant increases in premiums written may be an indication of an insurer's entrance into new lines of business or sales territories that might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums may also indicate that an insurer is engaging in cash flow underwriting to cover current losses. Significant increases in incurred loss ratios may indicate premium pricing errors or reserve strengthening due to prior reserve understatements, whereas significant decreases in incurred loss ratios may be indicative of current reserve redundancies.

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

In assessing the financial condition, considerable emphasis is placed on the adequacy of an insurer's capital and surplus. Surplus provides a cushion for policyholders against adverse underwriting results, catastrophe (P&C), reserve deficiency, insolvency of reinsurers, and fluctuations in the value of investments. In addition, surplus

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provides underwriting capacity and allows an insurer to expand its premium writings. The gross and net writings leverage ratios (P&C, A&H) measure the extent to which an insurer utilizes its underwriting capacity. High ratio results may indicate that an insurer is excessively leveraged and lacks sufficient surplus to finance the business currently being written.

The components of surplus can include common capital stock, preferred capital stock, gross paid-in and contributed surplus, surplus notes, unassigned funds (or retained earnings), and special surplus funds (usually established through an appropriation of unassigned funds). Each state has, by statute, established a minimum required amount of surplus for insurers. In some states, these minimum amounts are based on the lines of business written, while in other states the minimum amounts are based on the type of insurer. In addition, the RBC requirements must also be met.

Insurers may issue capital or surplus notes as a source of financing growth opportunities or to support current operations. Surplus notes (sometimes referred to as "surplus debentures" or "contribution certificates") have the characteristics of both debt and equity. Surplus notes resemble debt in that they are repayable with interest and sometimes, depending on the requirements of the domiciliary state insurance department, include maturity dates and/or repayment schedules. However, key provisions of the surplus notes make them tantamount to equity. These provisions include approval requirements as to form and content and the requirement that interest may be paid, and principal may be repaid only with the prior approval of the domiciliary state insurance department. SSAP No. 41R - *Surplus Notes* requires that interest on surplus notes is to be reported as an expense and a liability only after payment has been approved. Accrued interest that has not been approved for payment should be reflected in the Notes to Financial Statements. Provided that the domiciliary state insurance department has approved the form and content of the surplus notes and has approval authority over the payment of interest and repayment of principal, surplus notes are considered to be surplus and not debt. The proceeds from the issuance of surplus notes must be in the form of cash, cash equivalents, or other assets having a readily determinable value satisfactory to the domiciliary state insurance department. Information regarding surplus notes must be reported in the Annual Financial Statement, Notes to Financial Statements #13.

Insurers may also issue capital notes, which are reported as a liability by the insurer, and are therefore treated as debt instruments (although in liquidation rank with surplus notes) and are subordinate to the claims of policyholders, claimants, and general creditors. Capital notes are included in the insurer's total adjusted capital for RBC calculations. Like surplus notes, capital notes are repayable with interest and include maturity dates and/or repayment schedules. However, payment of interest and repayment of principal generally do not require regulatory approval. When total adjusted capital falls below certain levels or if other adverse conditions exist, capital note payments may be required to be deferred. While deferred, any interest on the capital note should not be reported as an expense or the accrual as a liability, but instead should be reflected in the Annual Financial Statement, Notes to Financial Statements #11, similar to surplus note interest payments that have not been approved.

Capital and surplus notes may have the effect of enhancing surplus or providing funds only on a temporary basis. The person or entity that holds the capital or surplus note may expect repayment on a scheduled basis and may exert pressure on the insurer to generate cash in order to be able to make the payments. As a result, analysts should be cautious when reviewing insurers that rely heavily on these notes. Capital and surplus notes are not inherently bad. They have provided regulators with flexibility in dealing with problem situations to attract capital to insurers whose surplus levels are deemed inadequate to support current operations. They provide a source of capital to mutual and other types of non-stock entities who do not have access to traditional equity markets and provide an alternative source of capital to stock reporting entities.

H. Risk-Based Capital

An insurer's Risk-Based Capital (RBC) requirement is calculated by applying risk factors to various assets, credits, premiums, reserves, and off-balance sheet items, where the factor is higher for those items with greater underlying risk and lower for those items with lower underlying risk. The RBC ratio is defined as the ratio of Total

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Adjusted Capital divided by Authorized Control Level RBC. States that enact the *Risk-Based Capital for Insurers Model Act* (#312) and *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315) can take regulatory action based upon this ratio. Historically, minimal capital requirements were imposed on insurers by various state laws. Those minimums frequently were arbitrary, generally low, varied widely from state to state, and typically did not consider the risk profile of the insurer. Models #312 and #315 supplements the system of absolute minimums and considers the risk profile of each individual insurer.

The Model Acts require a comparison between Total Adjusted Capital and Authorized Control Level RBC. The Model Acts then defines several levels of RBC. The description of each level includes a brief summary of what happens if an insurer's Total Adjusted Capital is below that level. The various levels are related to one another by fixed percentages as follows:

Action Levels Based on RBC Ratio:	
> 200%	No Action Level
≥ 150 to ≤ 200%	Company Action Level
≥ 100 to < 150%	Regulatory Action Level
≥ 70 to < 100%	Authorized Control Level
< 70%	Mandatory Control Level
Company Action Level based on Trend Test:	
> 200 to < 300% and a Combined Ratio of > 120%	P&C Trend Test
> 200% to < 250% (or 300%)	Life/A&H Trend Test Level
> 200 to < 300% and a Combined Ratio of > 105%	Health Trend Test

Most insurers are required to file an RBC report. The report shows the calculation of the Total Adjusted Capital and the calculation of the RBC levels. An insurer whose Total Adjusted Capital is greater than 200% of the Authorized Control Level is not within an action level. Other than filing the RBC report, no further action is required by the insurer. An insurer may trigger a Company Action Level event if the RBC Trend Test is triggered and the domiciliary state has adopted the trend test. An insurer that falls within or below the Company Action Level is required to file an RBC plan with the domiciliary state. The plan must include proposals for corrective steps by the insurer. Models #312 and #315 provide that the plan is confidential. If an insurer's Total Adjusted Capital is within the Regulatory Action Level, the insurance commissioner must perform an examination, as deemed necessary, of the company and issue an order specifying the corrective steps to be taken by the insurer. If an insurer's Total Adjusted Capital is within the Authorized Control Level, the commissioner may seize the company if deemed to be in the best interests of the policyholders and creditors of the insurer and of the public. If an insurer's Total Adjusted Capital is within the Mandatory Control Level, the commissioner must seize the company. However, that step may be forgone if there is a reasonable expectation that the circumstances causing the company to be within that level will be eliminated within 90 days.

Property & Casualty

The components of the Authorized Control Level are factored to apply the level of risk. There are eight major categories of risk including business risk as detailed below:

Asset Risk - Subsidiary Insurance Companies:

This risk focuses on the default of certain affiliated investments. This represents the RBC requirement of the downstream insurance subsidiaries owned by the insurer. To the extent that an affiliate is an insurance

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subsidiary, the capital requirement is the lesser of the RBC requirement of that subsidiary or the carrying value. There are several categories of subsidiary and affiliated investments that are subject to an RBC requirement for common and preferred stock. Off-balance sheet items (e.g., non-controlled assets, guarantees for affiliates, contingent liabilities, etc.) are included in this risk component,

Asset Risk - Fixed Income:

This risk focuses on the default of debt assets. Fixed income assets include bonds, mortgages, short-term investments, etc. For property/casualty insurers, the risk associated with fixed income assets and equity assets is not correlated, so there are two separate components of risk. Each category of assets is assigned a risk factor that increases with the perceived risk (quality) of the asset. For example, high-quality bond investments are assigned a low factor, and non-investment grade bonds are assigned a high factor. An asset concentration factor also exists to reflect the additional risk of high concentrations in single exposures represented, for example, by an issuer of a bond or a holder of a mortgage.

Asset Risk – Equity:

This risk focuses on the loss in fair value for equity assets. Equity assets include common and preferred stock, real estate, long-term assets, etc. Each category of assets is assigned a risk factor that increases with the perceived risk (quality) of the asset.

Asset Risk - Credit Risk:

Credit risk attempts to measure the risk of defaults by agents, reinsurers, and other creditors. Ceded reinsurance balances, including recoverable from paid losses, case and incurred but not reported losses, and unearned premiums, are all assigned a risk factor. Some ceded reinsurance balances, such as recoverable from affiliates and from mandatory pools and associations, are exempt.

Underwriting Risk - Reserves and Premiums:

There are two components to underwriting risk: reserve risk and premium risk.

Reserve risk attempts to measure the risk of adverse development in excess of expected investment income from loss reserves. Because reserves for the various types of business possess different frequency and severity characteristics, there are separate factors for each major line of business. The loss reserve calculation depends significantly on the development of overall industry loss reserves modified for the insurer's actual experience. The resulting insurer's loss reserve factor is adjusted for expected investment income and applied to its unpaid loss and LAE reserves.

Premium or pricing risk attempts to measure the risk of inadequate rates on business to be written over the coming year (premiums charged are not sufficient to pay future losses). Medium to long-tail lines of coverage are generally more volatile and, therefore, carry higher risk factors than short-tail lines. Similar to the loss reserve component, the pricing risk calculation depends significantly on the industry's loss experience as modified for an insurer's experience. The resulting company loss ratio is then adjusted for expected investment income and the insurer's overall expense ratio on a line of business basis. The factor is applied to the previous year's written premium. Thus, the formula establishes a minimum capital standard that requires for the industry as a whole to have sufficient capital to survive a repeat of historically poor underwriting experience. The factors for reserves and premiums are modified to increase the RBC required for lines with relatively favorable historical experience and lower the RBC required for lines with relatively adverse historical experience. This recognizes that particularly favorable or unfavorable historical experience will not necessarily repeat itself in the future.

Business Risk:

Business risk represents other potential risks that are not effectively covered by the previous five categories.

Business risk also includes administrative expense risk which is associated with the fluctuation of administrative expenses relative to the premium needed to pay those expenses; and guaranty fund assessment risk for property insurers who write direct earned premium in any state that is subject to guaranty fund assessments.

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Rcat – Catastrophe Risk:

The catastrophe risk is for earthquake and hurricane risks in certain prone areas of the U.S.

Life/A&H, Fraternal

The components of the Authorized Control Level are factored to apply the level of risk. There are nine major categories of risk including business risk as detailed below:

Asset Risk – Affiliates:

This is the risk of assets' default for certain affiliated investments. This represents the RBC requirement of the downstream insurance subsidiaries owned by the insurer. To the extent that an affiliate is an insurance subsidiary, the capital requirement is the lesser of the RBC requirement of that subsidiary or the carrying value. There are fourteen categories of subsidiary and affiliated investments that are subject to an RBC requirement for common and preferred stock. Off-balance sheet items (e.g., non-controlled assets, guarantees for affiliates, contingent liabilities, etc.) are included in this risk component, such as non-controlled assets, guarantees for affiliates, contingent liabilities, etc.

Asset Risk – Other:

Asset risk attempts to measure the risk that an insurer's assets will default or will decline in fair value. Each category of assets is assigned a risk requirement factor that increases with the perceived risk level of the asset. For example, high quality bond investments are assigned a low factor and noninvestment-grade bonds are assigned a high factor. Similar factors are assigned to other asset categories.

Insurance Risk:

Insurance risk represents the risk associated with unfavorable and/or improper assumptions used by an insurer in the mortality, morbidity, persistency and investment income components of insurance underwriting. The risk factors target the net amount of insurance at risk, net of reinsurance. The higher the level of insurance in-force, the lower the relative factor. Health insurance premiums and reserves are also targeted in the insurance risk factor.

Interest Rate Risk:

Interest rate risk represents the risk that may arise under changing interest rate environments associated with asset and liability mismatches. This area especially impacts annuity writers. Annuity products that are not subject to discretionary withdrawal or are subject to discretionary withdrawal with a market value adjustment, are assigned a lower risk factor. Annuity products subject to discretionary withdrawal with nominal surrender charges receive a higher risk factor. Thus, those insurers that have written large volumes of high yielding annuities, and invested in high-risk assets to earn a spread, are required by both the asset risk and interest rate risk formula to maintain higher capital levels to reflect the increased risk.

Market Risk:

Market risk addresses risk for variable annuities and similar products.

Health Credit Risk:

Health credit risk is the risk that health benefits prepaid to providers become the obligation of the health insurer once again.

Business Risk:

Business risk represents other potential risks that are not effectively covered by the previous six categories. General business risk is based on premium income, annuity considerations and separate account liabilities.

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Business risk also includes administrative expense risk which is associated with the fluctuation of administrative expenses relative to the premium needed to pay those expenses; and guaranty fund assessment risk for life insurers who write direct earned premium in any state that is subject to guaranty fund assessments.

Growth Operational Risk:

This is based on the increase in gross direct premium (direct + assumed) from the prior year to the current year.

Health

The components of the Authorized Control level are factored to apply the level of risk. There are five major categories as detailed below.

Asset Risk-Affiliates:

This is the risk of default for certain affiliated investments. To the extent that an affiliate is an insurance subsidiary, the capital requirement is the lesser of the RBC requirement of that subsidiary or the subsidiary's statutory surplus, multiplied in either case by the percentage of the subsidiary owned by the health entity. There are 10 categories of subsidiary and affiliated investments that are subject to an RBC requirement for common and preferred stock. Off-balance sheet items (e.g., non-controlled assets, guarantees for affiliates, and contingent liabilities, etc.) are included in this risk component.

Generally, HMOs have a low affiliated asset risk of less than 5% of the total RBC (before covariance); however, more complex health organizations, such as HMDIs, will carry a higher affiliated asset risk of between 14% and 20% of RBC (before covariance).

Asset Risk-Other:

Asset risk attempts to measure the risk that a health entity's assets will default or will decline in fair value. Each category of assets is assigned a factor that increases with the perceived riskiness of the asset. For example, high quality bond investments are assigned a low factor and non-investment grade bonds are assigned a high factor. Similar factors are assigned to other asset categories. An asset concentration factor adds RBC for holdings of a single issuer that represent a substantial proportion of the health entity's assets.

The Asset Risk – Other component of RBC is usually low for HMOs, between 5% and 10% (before covariance), while HMDIs are generally higher, between 20% and 24% (before covariance). The difference between HMOs and HMDIs is reflected primarily in unaffiliated common stock with less than 2% for HMOs and up to 10% for many HMDIs. Fixed income and property and equipment can account for up to 4% of RBC for HMOs and HMDIs.

Underwriting Risk:

Underwriting risk represents the risk associated with the unexpected fluctuation of incurred claims, typically resulting from variations in such factors as mortality, morbidity, and persistency. The risk factors are applied to the previous year's incurred claims or earned premiums for different categories of health insurance.

The factors are smaller for large volumes of business, because less fluctuation is expected than for small volumes. Similarly, the factors are reduced by a credit for managed care arrangements, which generally reduces the fluctuation of incurred claims relative to fee-for-service arrangements. Note: The factors are larger for coverage that can fluctuate more in claim experience, such as comprehensive medical, which can have individual claims of $1 million or more, compared to the smaller factors for less volatile coverage, such as dental.

The underwriting risk calculation does not directly reflect the risk of underpricing or other poor management decisions by the health entity, although these risks were implicitly reflected in the studies of needed capital on which the formula is based, to the extent they existed in the general population of health entities.

A minimum RBC requirement is applied for each category for small companies, equal to the dollar amount of two unusually large claims, which are assumed to be no less than $750,000 each. For companies that have

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purchased stop-loss reinsurance and are liable for less than $750,000 per claim, the minimum requirement is reduced to reflect their lower liability.

As previously mentioned, net underwriting risk accounts for the largest percentage of RBC for both organization types. HMOs typically have a higher percentage of RBC in net underwriting risk, between 70% and 75% (before covariance), while HMDIs have less net underwriting risk, but still have between 45% and 55% of RBC (before covariance) in net underwriting risk.

Credit Risk:

Health credit risk is the risk that health benefits (or other receivables) that are due from health care providers or other creditors will become an obligation of the health entity as a result of a default by the providers or other creditors.

Health organizations typically have low credit risk, less than 7% of RBC (before covariance) for HMOs and less than 4% of RBC (before covariance) for HMDIs. The higher credit risk on HMOs tends to be driven by the risk with intermediaries.

Business Risk:

Business risk includes the risk of loss on the health entity's non-insurance business such as Administrative Services Only (ASO) and Administrative Service Contract (ASC) plans and agreements, and the risk associated with growth in the RBC that exceeds growth levels of the health entity's premiums.

Business risk also includes administrative expense risk which is associated with the fluctuation of administrative expenses relative to the premium needed to pay those expenses; and guaranty fund assessment risk for health entities who write direct earned premium in any state that is subject to guaranty fund assessments.

The business risk component of RBC is generally low for health organizations, between 7% and 13% (before covariance). HMOs typically have 7% or less in administrative expenses base and 5% or less in excessive growth risk. Business risk for HMDIs is distributed somewhat differently, with 4% or less in administrative expenses base and 6% or less in non-underwritten and limited risk business.

I. 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.

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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.

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 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.

Health Entities:

Affiliated relationships that are unique to health entities include not-for-profit corporations (e.g. hospitals) and other providers of medical care. Not-for-profit health entities are membership corporations that can be affiliated with other entities via common management (members or boards of directors) with other business

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corporations or not-for-profit corporations. Entities related in this way are often deemed to be affiliates. Further, reliance on a particular provider or provider intermediary to provide medical services to members can create an affiliate relationship pursuant to SSAP No. 25. Relationships such as the above can have a material impact on the way a health entity operates. In a corporate structure that includes a hospital, the health entity may exist for the primary purpose of providing a health care delivery system to a community or region. As a result, the operations and financial condition of the health entity may be secondary to other missions of the corporate structure. Also, providers that are affiliated with a health entity may be used by the health entity to mask poor underwriting results of the health entity and/or manipulate Risk-Based Capital (RBC) results. Continual losses of a provider affiliate may be the result of the health entity transferring those losses to the affiliate. Such losses may ultimately impact the health entity. RBC levels of the health entity may not reflect the true nature of the underwriting risk being borne. Conversely, where the provider affiliate is periodically transferring capital to the health entity in order to keep the health entity solvent or to keep from triggering RBC events, the provider may not be able to continue making sufficient contributions. This may result in the health entity becoming financially distressed. The continuing obligations of a health entity, as in the case where capitated or other risk transfer payments are made to an affiliated provider or intermediary, but the health entity retains the ultimate obligation to provide or pay for medical services, may raise questions about the transfer of risks.

Compared to commercial accident and health insurers, some states require health entities, particularly Health Maintenance Organizations (HMOs) and not-for-profit health plans (HMDI or Blue Cross Blue Shield type plans) to be licensed or otherwise authorized to operate in a single state. HMOs can operate regionally or even nationally via a holding company system with an ultimate parent controlling multiple single state affiliated HMOs. In these instances, there are generally administrative services provided by the parent and medical services provided by the affiliated HMOs within a geographic region. Blue Cross Blue Shield Plans may also operate in multiple states via a holding company system. Some services such as administrative services, investment management, and actuarial support may be centralized, while other services, such as marketing, may be decentralized. It is essential for analysts to be satisfied that the identity of, and asset control by, the individual health entities are maintained. Since much of the overall financial strength can be concentrated at the holding company level rather than remaining in the health entity, understanding the consolidated financial condition of the holding company system is important.

J. Insurers in Run-Off

Run-off may be either a voluntary or state mandated course of action where the insurer ceases writing new policies on a portion of business or all business written. During run-off, the insurer typically continues collecting premiums on mandatory policies for a statutorily mandated period and to policy expiration dates. The degree and timing of the reduction in premiums should be closely monitored through the projections provided within the run-off plan. The specific content of the run-off plan may vary depending upon the line and nature of business in run-off and the financial condition of the insurer. The run-off of claims becomes the focus of attention until the last dollar of exposure is paid. The risk exposures for insurers in run-off are likely to be different than that of an insurer writing new business; therefore it may be necessary for an analyst to narrow the focus of the annual analysis and ongoing oversight of the insurer. The focus of the analysis of a run-off insurer may include, but not be limited to, the following:

- **Run-Off Plan** (ST, OP). Analysts should evaluate the effectiveness of the insurer's run-off plan and determine whether the plan is determined to be reasonable. While reviewing the plan, analysts should:
    - Consider the overall planning process and related assumptions built into the run-off projections.
    - Assess the management team and its retention of staff to determine if they possess the expertise to achieve a successful run-off. Analyze and document any variances in projected exposures, claims counts, and cash flow needs.

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- Consider expense reduction, reinsurance, plans for collection of outstanding premium and reinsurance recoverables, potential recovery of statutory deposits, policy buy-back, novation, and claim settlements.
- The insurer's investment portfolio should reflect a conservative strategy to preserve invested assets to meet runoff obligations. Any aggressive strategies may require analysts to discuss the insurer's investment philosophy to ensure that the matching of assets and liabilities are maximized given available capital.

- **Capital and Liquidity Management** (LQ, ST, OP). An objective of an insurer in run-off is to manage its assets and liabilities and maintain sufficient cash flow to ensure claim payments are met. Ideally, the insurer will reduce liabilities over time while ensuring its balance sheet maintains liquid assets to pay claims. To assess liquidity and surplus adequacy, analysts should evaluate the insurer's liquidity ratio and surplus to asset ratio. Analysts should document any material fluctuations in the liquidity and surplus to asset ratio and apply stress testing to assess the capital needs of the insurer. Analysts should also consider the allocation of long v. short tail lines of business in run-off in order to gain a sense of the length of tail in order to assess future cash flow needs.
- **Loss and Loss Adjustment Expense (LAE) Reserves** (RV, ST). Loss reserves are the largest liability reported by an insurer and one of the most critical pieces of data in assessing an insurer that has entered run-off. Many run-off insurers are thinly capitalized. Given the materiality of this liability, a slight variance in reserves can have a significant impact on the insurer's ability to continue as a going concern. As a result, there is increased importance placed on highly accurate reserve estimations as well as close monitoring of loss reserves. For property/casualty (P/C) insurers, much of the analytical work is done by a review of Schedule P. Loss reserve accuracy can be assessed by analyzing reserve development by line of business and accident year. In addition, it's critical to review claims counts and assess the trending and severity by reviewing this data within Schedule P. Life insurers at times enter run-off, however, more frequently a block of business will enter run-off. Typically, with regard to Life run-off blocks, another life insurer will manage that run-off while managing other active blocks of business, closely monitoring asset adequacy.

K. TPAs, MGAs, and IPAs

The NAIC *Managing General Agents Act* (#225) (MGA Act) defines an MGA as any person who (1) manages all or part of the insurance business of an insurer (including the management of a separate division, department, or underwriting office), and (2) acts as an agent for such insurer who, with or without the authority, produces directly or indirectly and underwrites an amount of gross direct written premiums equal to or more than 5% of the insurer's surplus in any one quarter or year and either adjusts or pays claims or negotiates reinsurance on behalf of the insurer. However, the MGA Act exempts certain persons from being considered MGAs, including employees of the insurer, underwriting managers under common control with the insurer whose compensation is not based on the volume of premiums written, and attorneys-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney. MGAs produce or solicit business for insurers and can also provide one or more of the following services: underwriting, premium collection, enrollment changes, claims adjustment, claims payment and reinsurance negotiation. Although this may help to gain critical mass, it can also lead to rapid growth and becoming over leveraged. A written contract should be executed with each MGA and should set forth the specific responsibilities of each party.

The NAIC *Registration and Regulation of Third-Party Administrators* (#1090) (TPA Statute) defines a TPA as any person who, directly or indirectly, solicits or effects coverage of; underwrites; collects charges, collateral or premiums from; or adjusts or settles claims in connection with life or health insurance coverage, annuities, employee benefit stop-loss, or workers' compensation insurance. However, the TPA Statute exempts certain persons from being considered TPAs including, among others, insurers (or health entities), licensed agents whose activities are limited exclusively to the sale of insurance and licensed adjusters whose activities are limited to the adjustment of claims and MGAs. TPAs can serve the same function as MGAs as well, but are more typically used in the processing or preauthorization of claims, or the administration of particular types of

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business. For example, for health entities this includes benefits for prescription drugs (pharmacy benefit managers), dental, mental health and chiropractic service for health entities that underwrite comprehensive medical coverage. In these cases, it is critical that the insurer is able to obtain timely and accurate data from the TPA in order to adjust its reserving and pricing assumptions accordingly. It should be noted that TPAs might contribute to net income of the insurer via reduced claims expenses (e.g., pharmaceutical rebates from manufacturers).

TPAs are also often used to administer uninsured business (ASO/ASC) that is solicited by a health entity when such entity is either precluded by statute or regulation from acting as a TPA, or where it desires to separate this function from its insurance operations. In these cases, the TPA is often affiliated with the health entity. A health entity may also provide stop loss insurance to groups administered by TPAs. Individual Practice Associations (IPAs), which include other provider-based organizations, can act like TPAs but also add the element of risk transfer.

Managing general agents (MGAs) and third-party administrators (TPAs) produce or solicit business for an insurer and also provide one or more of the following services: underwriting, premium collection, claims adjustment, claims payment, and reinsurance negotiation. In addition, IPAs or other provider-based organizations are utilized by health entities to perform similar services, and also can add the element of risk transfer. Insurers are required to have written contracts with MGAs, TPAs and IPAs that set forth the specific responsibilities of each party. MGAs, TPAs and IPAs have been used by insurers to increase the volume of business written without having to expand internal staffing and to facilitate entry into new lines of business or geographical locations. However, the more authority delegated to MGAs, TPAs and IPAs, the greater the opportunity for abuse. If the insurer relinquishes too much control, management may not be able to effectively guide and monitor the insurer's operations. MGAs and TPAs may have priorities or needs that conflict with those of the insurer. For example, there is an inherent conflict for MGAs, TPAs and IPAs between writing quality business and being compensated by commissions based on the volume of business written. When MGAs, TPAs and IPAs are compensated based on the volume of business written, their incentive is to write as much business as possible, which may compromise underwriting controls. TPAs are also often compensated on the basis of claim volume processed, which may lead to lack of adherence to claims adjudication rules and procedures. Alternatively, when TPAs or IPAs preauthorize or process claims, they can cause problems for insurers that must meet regulatory requirements for claims processing. Also, if customer service is delegated to the MGA or TPA as part of the claims payment process, the insurer retains the responsibility if regulatory requirements are not met. In some cases, these problems can result in sizable penalties imposed on the insurer. Furthermore, TPAs, IPAs and MGAs can be responsible for establishing reserves for unpaid claims, or for providing paid claims data that is used by the insurer in estimating reserves for unpaid claims. Note, in some states, IPAs need to be licensed as TPAs or claims adjusters to perform certain functions in a state.

These types of conflicts have played a significant part in the failure of several insurers. The more authority that is delegated to TPAs, IPAs and MGAs, the greater the potential impact of mismanagement making it more important for the insurer to provide active ongoing oversight into the MGAs or TPAs operations. It is important that the insurer actively supervise, control, and monitor the performance of MGAs and TPAs on an ongoing basis to help avoid these conflicts.

To effectively monitor MGAs, TPAs and IPAs, insurers should obtain and review the MGAs', TPAs' and IPAs' annual independent financial examinations and financial reports. In addition, the NAIC model acts regarding MGAs, TPAs and IPAs require insurers to periodically perform on-site reviews of the underwriting and claims processing operations of each MGAs, TPAs and IPAs utilized. If an MGA establishes loss reserves, the insurer must also obtain the opinion of an actuary regarding the adequacy of loss reserves established on the business produced by the MGA.

L. Reinsurance

Reinsurance is a form of insurance for an insurance company. Under a reinsurance contract, the insurer transfers or cedes to the reinsurer all or part of the financial risk of loss for claims incurred under insurance

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policies sold to the policyholder. The reinsurer, for a premium, agrees to indemnify or reimburse the ceding company for all or part of the loss that the ceding company may sustain from claims. Reinsurers may, in turn, transfer or retrocede some of the risk assumed under reinsurance contracts. This form of reinsurance is known as retrocession, and the reinsurer of reinsurance is known as the retrocessionaire. Retrocessions are simply reinsurance for reinsurers.

Property & Casualty

One of the basic functions of reinsurance is to spread the risk of loss throughout the property/casualty industry and increase the amount of coverage insurers can provide. Through reinsurance, an insurer can share its risk with another insurer or insurers and limit its losses on claims incurred under policies written. An insurance company generally limits the amount of coverage it is willing to underwrite relative to its surplus. Through reinsurance, an insurer can reduce its loss reserves by the amount of risk transferred to the reinsurer and, as a result, increase its capacity to write more business.

Reinsurance does not modify in any way the obligation of the primary insurer to pay policyholder claims. Only after loss claims have been paid can the primary company seek reimbursement from a reinsurer for its share of paid losses. Generally, a reinsurer has no direct relationship or responsibility to policyholders.

Insurers operating in the U.S. may obtain reinsurance from insurance companies that specialize in assuming reinsurance, referred to as professional reinsurers, reinsurance departments of primary insurers, and alien reinsurers (i.e., a reinsurer domiciled in another country). Generally, any primary insurer may assume reinsurance for those lines of business in which it is licensed. Reinsurance is also available from pools, which are groups of insurers organized to jointly underwrite reinsurance. According to the booklet *Offshore Reinsurance in the U.S. Market: 2013 Data*, which was produced by the Reinsurance Association of America (RAA), total U.S. premiums ceded to offshore insurers in 2013, affiliated and unaffiliated, totaled $65.7 billion, and net recoverables totaled $111.2 billion.

The basic objective of reinsurance is to spread the risk of loss. Through reinsurance, an insurer can limit its losses under policies issued, as the reinsurer assumes the obligation to indemnify the insurer. There are four primary reasons why an insurer enters into reinsurance transactions:

- Increase Underwriting Capacity

  Reinsurance increases an insurer's capacity to write greater amounts of policy coverage than it could cover on its own. Some risks (e.g., commercial risks) would be too large for any company to insure alone. Prudent management and certain insurance regulations demand limits on any one potential loss proportionate to the size of the insurer's surplus. By transferring risks in excess of this prudent retention, an insurer can write policies with greater amounts of coverage without having to bear the full impact of potential losses under such policies. This function is crucial for small and medium size insurers to compete with larger insurers in meeting policyholders' coverage needs.

- Stabilize Underwriting Results

  Reinsurance can serve to stabilize an insurer's overall underwriting results by allowing an insurer to pass along losses to reinsurers that occurred during bad years in exchange for sharing profits that occurred during good years. Like other businesses, an insurance company tries to avoid wide fluctuations in profits and losses from year to year. As discussed above, an insurer limits exposure to an individual risk by retaining a portion of the original risk and reinsuring the balance. To some extent, an insurer may also limit aggregate losses sustained over a specific period, such as a year, by reinsuring losses in excess of a predetermined cap.

  Reinsurance also stabilizes underwriting results by reducing the possible impact of any one line of business or geographic area on overall results. To adjust its mix of business or geographic spread of risk, an insurer may reinsure certain (e.g., more hazardous or unprofitable) lines of business or policies concentrated in a particular geographic region. Also, insurers may rely on reinsurers for underwriting assistance when entering new lines of business.

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- Protect Against Catastrophic Losses

  Reinsurance protects insurers against large aggregate losses due to natural or man-made catastrophes, such as hurricanes or riots. While individual losses may be small, an insurer may not be able to absorb the accumulation of multiple losses due to a single event or occurrence. Protecting against catastrophic losses is related to stabilizing underwriting results because catastrophes are major causes of loss instability.

- Increase Financial Strength

  Reinsurance provides a form of financing for insurance companies. Generally, an insurance company limits the amount of insurance it is willing to underwrite relative to its surplus. Upon issuing a policy, an insurer must recognize the unearned portion of premiums as a liability. However, the insurer must also pay its expenses at the beginning of the policy. Since premium income is deferred over the policy period and expenses are charged-off immediately, an insurer's surplus shrinks, thus reducing its capital base to finance new growth. Reinsurance can relieve the impact of this accounting allocation. When reinsuring its policies, an insurer transfers a portion of its unearned premiums to the reinsurer and receives a ceding commission from the reinsurer. As a result, the ceding company's surplus rises by an amount equal to the ceding commission. This function of reinsurance is referred to as surplus aid.

Life/A&H, Fraternal

Reinsurance commonly is undertaken in ordinary life insurance (with accompanying disability and accidental death benefits), in credit insurance, in individual health insurance, in annuities, and in group insurance in its various forms. In most ways, reinsurance is in the same position as direct insurance, with several exceptions. There is no direct relationship between the reinsurer and the ceding company's policyholder. In the event of the ceding insurer's insolvency, the policyholder or beneficiary under a contract that is reinsured has the same status as a policyholder or beneficiary with a policy that was not reinsured. Insurers may be required to file copies and receive approval of reinsurance treaties. An insurer may not need to be licensed in a state in order to act as a reinsurer of a domestic insurer. The domestic insurer may not receive full reinsurance credit on business ceded to such reinsurers. Some states require that, to be "authorized," a reinsurer must meet certain criteria, but these may not be the same as those demanded of companies doing direct business in the state. Reinsurance premiums usually are not subject to premium taxes. Frequently, the reinsurer reimburses the ceding insurer for the premium taxes paid on that portion of the direct premium equal to the reinsurance premiums.

In formulating its rules for accepting applications for insurance, an insurer must decide upon three areas of action: retaining, reinsuring or declining the risks presented. Insurers of various sizes have different capacities to write insurance on a single life. An insurer must determine the maximum exposure it is able to accept and retain as its own insurance business. Having made this determination, the insurer must then decide what to do with any risks that exceed the maximum amount it is willing to retain. It has two choices: 1) accept the additional risk and reinsure it or 2) decline the extra risk. Once an insurer has decided to reinsure amounts in excess of its desired retention, it may proceed on one of several basic modes.

- Coinsurance

  Under this mode, the excess face amount is reinsured on the same plan as that of the original policy. The direct writer and the reinsurer share in the risk in the same manner. The ceding insurer pays the reinsurer a proportional part of the premiums collected from the insured. In return, the reinsurer reimburses the ceding insurer for the proportional part of the death claim payments and other benefits provided by the policy, including nonforfeiture values, policy dividends, commissions, premium taxes, and other direct expense agreed to in the contract. The reinsurer must also establish the required reserves for the portion of the policy it has assumed. In coinsurance of participating policies, the reinsurer reimburses the ceding insurer for its portion of the dividends paid to the policyholder. In determining its schedule of dividends, the ceding insurer takes into account the experience on the business as written and the reinsurer generally is required to accept or match this schedule. Coinsurance is also used for nonparticipating policies, particularly in

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situations where a severe strain is on the direct writing insurer's surplus in the first policy year. For example, the premium received by the direct writer during the first policy year usually is insufficient to pay the high first-year commissions and other costs of issue, to establish the initial reserve, and to avoid a surplus loss. In such an example, coinsurance relieves some of the surplus strain of adding large amounts of new insurance and commissions, and expense allowances on the reinsurance provide direct surplus relief to the ceding insurer.

- Modified Coinsurance

  A number of companies reinsure on the "modified coinsurance" mode, which is a variation of coinsurance whereby the reserves for the original policies may be maintained by the ceding insurer instead of the reinsurer. Under modified coinsurance, the assuming company transfers to the ceding insurer, usually on an annual basis as of Dec. 31, the increase in the mean reserve on the reinsured portion. From this is deducted interest at a rate stated in the reinsurance contract on the prior year's total mean reserves. The resulting net transfer is called the modified coinsurance reserve adjustment. The modified coinsurance agreement may provide surplus relief through reinsurance commissions and allowances. In some cases, a policy may be reinsured partially on a coinsurance mode and partially on a modified coinsurance mode.

- Yearly Renewable Term (YRT)

  Under this mode of reinsurance, the primary insurer transfers the net amount at risk to the reinsurer and pays a one-year term premium. The "net amount at risk," as defined in the treaty, is usually the amount of insurance provided by the policy in excess of the reserve on it. In certain term insurance, reserves generally are disregarded. The ceding insurer's liability is the reserve held in the event of death and the cash value held in the event of withdrawal.

- Other

  Other forms of reinsurance are also available, such as catastrophe and stop loss coverage. The terms of such reinsurance vary considerably, so no general rules can be made.

Health

Although reinsurance is not uncommon among health entities, its use is generally more limited compared to traditional life/health and property/casualty insurers. Approximately 40% of health entities have no ceded reinsurance premiums. Health entities that are not licensed as insurers are often not authorized to assume reinsurance. More than 95% of health entities have no assumed reinsurance premiums.

Reinsurance is a form of insurance for an insurance company. Under a reinsurance contract, the primary health entity transfers or "cedes" to another insurer (the reinsurer) all or part of the financial risk of loss for claims incurred under insurance policies sold to the policyholder or subscriber. The reinsurer, for a premium, agrees to indemnify or reimburse the ceding company for all or part of the claims that the ceding company may sustain.

One of the basic functions of reinsurance is to spread the risk of loss and increase the amount of coverage health entities can provide. Through reinsurance, a health entity can share its risk with another insurer or insurers and limit its claims incurred under policies written. An insurance company generally limits the amount of coverage it is willing to underwrite relative to its surplus. Through reinsurance, a health entity can reduce its incurred claims by the amount of risk transferred to the reinsurer and, as a result, increase its capacity to write more business.

Health entities operating in the United States may obtain reinsurance from insurance companies that specialize in assuming reinsurance, referred to as professional reinsurers; reinsurance departments of primary insurers; and alien reinsurers (i.e., a reinsurer domiciled in another country). Generally, any health entity licensed to write accident and health insurance may assume reinsurance for that line of business unless prohibited by Statute or Regulation. Reinsurance is also available from pools, which are groups of insurers organized to jointly underwrite reinsurance. Although voluntary and intercompany pooling is somewhat uncommon among health

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entities, involuntary pools are used by many states to provide coverage to individuals or small groups in order to mitigate the risk of anti-selection or high-cost claims. See SSAP No. 63, *Underwriting Pools*, for further discussion.

Reinsurance does not modify in any way the obligation of the primary health entity to pay policyholder or subscriber claims. Only after claims have been paid can the primary health entity seek reimbursement from a reinsurer for its share of paid claims. Generally, a reinsurer has no direct relationship or responsibility to policyholders. In the event of the ceding company's insolvency, the policyholder or beneficiary under a contract that is reinsured has the same status as a policyholder or beneficiary with a policy that was not reinsured. Health entities may be required to file copies and receive approval of reinsurance treaties. A company may not need to be licensed in a state in order to act as a reinsurer of a domestic health entity. The domestic company may not receive full reinsurance credit on business ceded to such reinsurers. Some states require that, to be "authorized," a reinsurer must meet certain criteria, but these may not be the same as those demanded of companies doing direct business in the state. An analyst should review their state's criteria for licensing of reinsurers and approval of reinsurance treaties or any special exceptions the state has made specific to the health entity. Reinsurance premiums usually are not subject to premium taxes. Frequently, the reinsurer reimburses the ceding company for the premium taxes paid on that portion of the direct premium equal to the reinsurance premiums.

Health entities of various sizes have different capacities to write insurance. A health entity must determine the maximum exposure it is able to accept and retain as its own insurance business. Having made this determination, the health entity must then decide what to do with any risks that exceed the maximum amount it is willing to retain. It has two choices - accept the additional risk and reinsure it, or decline the extra risk.

The two most commonly used types of reinsurance for health entities are excess-of-loss (also referred to as stop-loss) and coinsurance. Excess-of-loss is the most common type of reinsurance arrangement used by managed care health entities. HMDIs also use excess-of-loss coverage and are more likely than other health entities to use coinsurance.

Excess-of-loss

Many managed care health entities use excess-of-loss coverage to provide for day-to-day operations. Other types of companies may use this type of coverage to provide catastrophe coverage. Excess-of-loss reinsurance is often referred to as non-proportional reinsurance or stop-loss reinsurance. Health entity's reinsurance contracts generally operate on a per risk excess-of-loss basis with an aggregate limit per year on each risk and aggregate limit on the life of the member covered. Generally, the excess-of-loss reinsurance agreement reimburses an agreed upon percentage of claims once the ceding company reaches its retention for claims. Excess-of-loss reinsurance may reimburse on the basis of an individual claim or accumulation of claims for a particular member, occurrence or accident, or an aggregate. On a per claim basis, the ceding company recovers claims in excess of a retention that applies to each claim or series of claims for a given member. On an occurrence or accident basis, the company recovers claims in excess of a retention applied to each occurrence or accident resulting in multiple claims, regardless of the number of members involved. The aggregate basis allows the ceding company to recover claims that in the aggregate exceed retention, usually a flat amount for aggregate excess covers and a percentage of net premiums for stop-loss covers. The terms of excess-of-loss reinsurance vary considerably, so no general rules can be made.

Excess-of-loss reinsurance pays benefits to the ceding company after a claim(s) has exceeded a predetermined amount, often referred to as a deductible or retention. This predetermined amount can be either a specific dollar amount or some other amount such as a percentage. An example of a specific dollar amount would be where a contract states that if an individual claim exceeds $100,000, the reinsurance contract becomes effective and the reinsurer will reimburse the ceding company for the amount or part of the amount exceeding the established retention. Contracts that use a percentage to establish retention might state that a reinsurer shall reimburse the ceding company when a financial ratio, such as the loss ratio, exceeds a certain percentage.

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Excess-of-loss premiums are typically based upon the number of members reinsured and generally paid on a per member per month basis. Unlike many other types of reinsurance, in this contract, there is no proportional relationship to the original premiums and claim. Generally, the contract reimburses an agreed upon percentage of claims in excess of the ceding company's retention. Often times the retention amounts, or the reimbursement amounts vary for in-network claims, vs. out-of-network claims or for hospital claims vs. physician claims. Hospital excess-of-loss coverage is the most common excess-of-loss coverage for managed care health entities.

Catastrophe reinsurance is also non-proportional reinsurance. Under this type of reinsurance the ceding company receives payment from the reinsurer when the ceding company's total net retained claims that result from a single accidental event exceed the ceding company's retention or a specified loss ratio.

Coinsurance

Under this mode, the direct writer and the reinsurer share in the risk of claims and expenses on a proportionate basis. The ceding company pays the reinsurer a proportional part of the premiums collected from the insured. In return, the reinsurer reimburses the ceding company for the proportional part of the claim payment and other benefits provided by the policy. The reinsurer may also reimburse the ceding company for its commissions and out-of-pocket expenses incurred in writing the business. This is referred to as an expense allowance.

The reinsurer must also establish the required reserves for the portion of the policy it has assumed. Coinsurance and most excess-of-loss reinsurance contracts are automatic. An automatic contract covers risks meeting the contract criteria at the set premium without specific review of individual claims by the reinsurer. Some coinsurance contracts may be facultative. A facultative contract requires the ceding company to submit the underwriting file on each individual application to the reinsurer for review. Then the reinsurer individually accepts or declines to participate in the reinsurance of that individual. Facultative reinsurance is rarely encountered in the health market.

The basic objective of reinsurance is to spread the risk of loss. Through reinsurance, a health entity can limit its claims under policies issued, as the reinsurer assumes the obligation to indemnify the health entity. There are four primary reasons why a health entity enters into reinsurance transactions.

Stabilize Underwriting Results

Reinsurance can serve to stabilize a health entity's overall underwriting results by allowing a health entity to pass along claims to reinsurers in bad years in exchange for sharing profits in good years. Like other businesses, health entities try to avoid wide fluctuations in profits and losses from year to year. As discussed above, a health entity limits exposure to an individual risk by retaining a portion of the original risk and reinsuring the balance. To some extent, a health entity may also limit aggregate claims sustained over a specific period, such as a year, by reinsuring claims in excess of a predetermined cap.

Increase Underwriting Capacity

Reinsurance increases a health entity's capacity to write greater amounts of policy coverage than it could cover on its own. Some risks may be too large for any health entity to insure alone. Prudent management and certain insurance regulations demand limits on any one potential claim proportionate to the size of the health entity's surplus. For example, a health entity may issue a policy to its members with a maximum annual coverage of up to $1,000,000 per year with a lifetime limit of $2,000,000. The health entity's retention on any one risk is based upon the total surplus, the number of members covered and how long the company has written this business. By transferring risks in excess of this prudent retention, a health entity can write policies with greater amounts of coverage without having to bear the full impact of potential claims under such policies. This function is crucial for small and medium size health entities to compete with larger health entities in meeting policyholders'/subscribers' coverage needs.

Support Point of Service Operations

The use of reinsurance to stabilize underwriting results and increase underwriting capacity is common to all types of insurance. However, one purpose of reinsurance that is specific to health entities is driven by how a

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particular health entity provides a point of service product. Depending upon state preferences, a health entity may provide a point of service type of product by providing the coverage through the health entity, but only if parts of the coverage are pick up or reinsured by an indemnity company.

Provide Continuation of Coverage and Benefits in the Event of Insolvency

Most health contracts have termination language that allows for automatic termination in the event of insolvency or cessation of operations. This feature is a critical distinction among health contracts since the health entity is presumed to be acting as the primary mechanism to deliver care to its subscribers. In the event of insolvency, a continuation of the benefits clause within the reinsurance agreement will require the reinsurer to be liable for all claims incurred from the date of insolvency for a specified period of time. In addition, continuation of benefits clauses typically require that the reinsurer pay claims from the date of insolvency through the earlier of the date of discharge for a member who is confined to an impatient facility, or the date the member becomes eligible for health coverage under another plan. Continuation of benefits clauses may also contain other limitations as well. The coverage may also provide that the reinsurance company continues benefits for any member for medical services incurred for a service date subsequent to the date of insolvency provided that premium for the members are current. Historically, continuation of benefits clauses has not contained maximum limits. However, more recently, reinsurers have attempted to insert dollar limits to avoid large exposure under the provision resulting from the insolvency of a large health entity.

M. Audited Financial Report

The Annual Financial Statement filed by an insurer is the primary source of the financial information used by a financial analyst during the analysis process. Therefore, it is important that the financial information included in the Annual Financial Statement be accurate if the analysis process is to be beneficial in monitoring the financial solvency of the insurer. However, most state insurance departments perform financial condition examinations of its domestic insurers to verify the accuracy of the financial information reported in the Annual Financial Statement only once every three to five years. The Audited Financial Report can provide comfort to analysts regarding the accuracy of the financial information in the Annual Financial Statement.

Per the NAIC *Annual Financial Reporting Model Regulation* (#205), insurers are required to file an audited statutory financial report by June 1 of each year, which includes an opinion by an independent certified public accountant or accounting firm (hereinafter referred to as CPA) regarding the audited financial statements. For guidance regarding this model, see Appendix G of the NAIC's *Accounting Practices and Procedures Manual*. The independent CPA's opinion may be an unmodified or a modified opinion; however, there are three types of modified opinions: qualified, adverse and disclaimer of opinion. The decision regarding which type of modified opinion is appropriate depends upon the nature of the matter giving rise to the modification and the auditor's professional judgment about the pervasiveness of the effects (or possible effects) of the matter on the financial statements. If the Audited Financial Report differs from the Annual Financial Statement, reconciliation is required, along with a description of the difference(s) in the Notes to Financial Statements in the Audited Financial Report.

The text of the Audited Financial Report should be reviewed carefully. Although an independent CPA's opinion on an insurer's financial statements might, at first glance, appear to be a standard unmodified opinion, additional explanatory language included in the opinion may flag a potential problem. For example, the CPA might issue an unmodified opinion on the financial statements while also including additional language in the auditor's report emphasizing uncertainties, such as contingencies concerning future events that could impact the insurer's financial position or substantial doubt regarding the insurer's ability to continue as a going concern. In addition, the notes to the audited financial statements should be thoroughly reviewed, especially for information concerning investments, reserves, reinsurance, affiliated transactions, contingent liabilities, and if applicable, the amount and nature of differences between the Audited Financial Report and the Annual Financial Statement that was filed by the insurer.

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In addition to and for filing with the Audited Financial Report, the independent CPA is required to prepare a Letter of Qualifications each year. The letter includes a statement regarding the CPA's awareness of the domiciliary commissioner's reliance on the Audited Financial Report and opinion thereon in the monitoring and regulation of the financial position of the insurer. The Annual Financial Reporting Model Regulation requires that the lead audit partner not serve in that capacity for more than five consecutive years and may not rejoin in that capacity of a period for more than five consecutive years. The auditor may not provide various non-audit services that, if performed, would impair the auditor's independence in relation to that company. Insurers with less than $100 million in direct and assumed premium may request a waiver from this requirement based on financial or organizational hardship. Partners and senior managers of the audit committee may not serve as a member of the board of directors, or as president, chief executive officer, controller, chief financial officer, or some other similar position of the insurer if employed by the independent public accounting firm that audited the firm during a one-year period preceding the most current statutory opinion. The letter further states that the CPA will agree to make all work papers prepared during the audit available for review by the domiciliary state insurance department examiners.

If the insurer is an SEC registrant, or significant deficiencies in an insurer's internal control structure are noted during the audit, the independent CPA is required to prepare a report that describes the deficiencies. This report, along with a description of the improvements made or proposed by the insurer to correct the deficiencies noted, must be filed with the domiciliary state insurance department. Insurance company management is required to file an assessment of internal controls over financial reporting with the state insurance department. This report should include a statement by management explaining whether these controls are effective in providing reasonable assurance that the statutory financial statements and disclosure of any unremediated material weaknesses in internal control over financial reporting is reliable. No CPA opinion is required of management's assessment.

The independent CPA is required to notify an insured's board of directors or its audit committee within five business days of any determination that the insurer has materially misstated its financial condition as reported to the domiciliary state insurance department or that the insurer does not meet the minimum surplus/capital and surplus (based on business type) requirement of the domiciliary state. Once notified, the insurer is required to send a copy of the notice to the domiciliary state insurance department within the next five business days. If the CPA does not receive evidence that the insurer has sent a copy to the domiciliary state insurance department, the CPA must then forward a copy of the notice directly to the insurance department within five business days.

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

The Audited Financial Report Worksheet is designed to assist analysts in reviewing the Audited Financial Report and assist in identifying significant information and explanatory language regarding the insurer, which has been emphasized by the independent CPA. Additionally, a review of the independent CPA's Letter of Qualifications and, if applicable, the report of significant deficiencies in the insurer's internal control structure is included within the legal risk repository.

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N. Management's Discussion & Analysis

The Management's Discussion and Analysis (MD&A) is a material historical and prospective textual disclosure enabling regulators to assess the financial condition and results of operations of the reporting entity. The MD&A is intended to give analysts an opportunity to look at the reporting entity through the eyes of management by providing both a short and long-term analysis of the business of the reporting entity. The information provided pursuant to this MD&A need only include that which is available to the insurer without undue effort or expense and that which does not clearly appear in the insurer's Annual Financial Statement.

Generally, the MD&A shall cover the two-year period covered by the Annual Financial Statement and shall use year-to-year comparisons or any other formats that, in the insurer's judgment, will enhance analysts' understanding. However, where trend information is relevant, reference to the Annual Financial Statement, Five-Year Historical Data pages in the Annual Financial Statement may be necessary.

The MD&A shall focus specifically on material events and uncertainties known to management that would cause reported financial information not to be necessarily indicative of future operating results or of future financial conditions. This would include descriptions and amounts of matters that would have an impact on future operations and have not had an impact in the past and matters that have had an impact on reported operations and are not expected to have an impact upon future operations.

O. Management Considerations

Although many insurers have boards of directors, some insurers may have other forms of governing bodies that perform similar roles as a board of directors. In this handbook, any reference to the board of directors refers to the governing body of the insurer.

In order to get a complete picture of insurance operations, it is important to understand who is driving operations within the business enterprise (e.g., chairman of the board, board of directors, president or chief executive officer, operations vice presidents, etc.). Management not only performs the primary role in daily decisions related to operations, but also makes decisions related to the overall mission of the company. However, another factor can be the board of directors' role in this decision-making process. Once analysts determine the players in the decision process, it is necessary to understand management's philosophies as well as the overall process in initiating a business decision. It is also important to assess management or board of directors' changes and determine if the changes appear to indicate a shift in management philosophy or whether management has made any changes in its business plan.

Assessment of management and the board of directors might include:

- Face-to-face interviews
- Review of biographical affidavits
- Review of board of directors' meeting minutes
- Review of Insurer Profile Summary
- Review of examination work papers
- Review of supplemental reports (e.g., S&P and A.M. Best)

Corporate Governance

Corporate governance can be defined as a framework of rules and practices by which a board of directors ensures accountability, fairness, and transparency in an insurer's relationship with its stakeholders. It is important that a fully functional, well-qualified, and independent board of directors be established to ensure that corporate governance principles are effectively implemented. Corporate governance is viewed as a company responsibility defined by corporate law, which may be defined by state law. However, as a result of

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changes in the economic environment and the move toward principle-based regulation, it may be necessary for a greater regulatory focus on corporate governance.

Components of effective corporate governance programs include:

- Adequate competency (industry experience, knowledge, skills) of members of the board of directors;
- Independent and adequate involvement of the board of directors;
- Multiple, informal channels of communication between board of directors, management, and internal and external auditors to create a culture of openness;
- A code of conduct established in cooperation between the board of directors and management, which is reviewed for compliance and is formally approved by senior management;
- Identification and fulfillment of sound strategic and financial objectives, giving adequate attention to risks;
- Support from relevant business planning and proactive resource allocation;
- Support by reliable risk-management processes across business, operations, and control functions;
- Reinforcement of corporate adherence to sound principles of conduct and segregation of authorities;
- Independence in assessment of programs and assurance as to its reliability;
- Objective and independent reporting of findings to the board of directors or appropriate committees thereof;
- Adoption of federal Sarbanes-Oxley Act provisions, whether or not mandated, including, but not limited to, auditor independence and whistle-blower provisions; and
- Board oversight and approval of executive compensation and performance evaluations.

The board of directors should:

- Be composed of a sufficient number of knowledgeable, independent, and active members to properly fulfill its governance and oversight responsibilities.
- Be governed by formal bylaws and charters and to ensure that duties and responsibilities are effectively documented and communicated.
- Possess the appropriate professional qualifications, knowledge, and experience to ensure sound and prudent management.
- Be guided by the basic principles of duty of care and loyalty.

Many insurers, based on premium volume and public company status among other factors, are required to comply with the NAIC *Annual Financial Reporting Model Regulation* (#205), the federal Sarbanes-Oxley Act of 2002, and various other corporate governance standards that require a certain amount of board oversight and risk management.

Risk Management

Broadly defined, risk management can be defined as a process implemented by a company's board of directors and management that is applied through strategy setting throughout the enterprise. It is designed to identify potential events that may affect the company's ability to manage risk within its risk appetite. It is also intended to provide reasonable assurance regarding the achievement of the company's objectives. An insurer's risk management function should limit the risks acceptable to the group to ensure continued operations following an extreme loss event. It is important to note that the risk management principles and processes may be applied at a legal entity level or at the group level, depending on the organizational structure. Risk management should be applied at every level within the group, including an entity-level view of risk.

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Risk management should be composed of (1) setting objectives; (2) identifying significant risks and events affecting the group's objectives; (3) assessing risk, the group environment, the group's response to risks, control policies and procedures, information, and communication; and (4) monitoring of ongoing activities.

An effective risk management function is essential in providing effective corporate governance over financial solvency. Under the risk-focused surveillance approach, analysts and examiners must consider and evaluate the insurer's corporate governance and established risk management processes. By understanding the corporate governance structure and by assessing the risk management processes and the "tone at the top," analysts will obtain information on the quality of guidance and oversight provided by the board of directors and the effectiveness of management.

It is critical for both analysts and examiners to understand and leverage the company's risk management program; that is how the company identifies, controls, monitors, evaluates, and responds to its risks. The discipline and structure of risk management programs vary dramatically from company to company. "Best practices" are emerging for risk management programs and more companies are appointing chief risk managers whose responsibilities go well beyond the traditional risk management function (i.e. the buying of insurance or reinsurance). The most commonly accepted standards relating to internal controls are the Committee of Sponsoring Organization's (COSO) Integrated Framework of Internal Control and the IT Governance Institute's Control Objectives for Information and Related Technology (COBIT). As these standards are widely accepted by many companies, it may be useful for analysts to become familiar with the concepts included in the COSO Integrated Framework of Internal Control and the COSO Enterprise Risk Management Integrated Framework, as well as other COBIT tools, to utilize as sources when identifying and assessing an insurer's risk mitigation strategies/controls. Although companies are not required to utilize the COSO or COBIT standards, the key components within these standards are likely to be incorporated.

Following are five basic elements that contribute to a sound risk management environment:

- Active board and senior management oversight
- Adequate risk identification, monitoring and management processes
- Adequate and clear policies, authorization limits and procedures
- Comprehensive and effective internal controls
- Processes to ensure compliance with laws and regulations

Regardless of the complexity of an entity, certain aspects of a risk control environment facilitate effective oversight of inherent business risks, which include the following:

- Processes that accurately monitor compliance with internal policies and limits on a timely basis
- Effective management oversight and internal controls of day-to-day business activities, including cohesive, effective internal communication mechanisms and appropriate lines of reporting
- Sufficient independence between the risk control functions and the business line functions, so that the adequate segregation of duties and the avoidance of conflicts of interest are ensured
- An effective internal audit function (or effective external audit program for operations) that comprehensively identifies and assesses key areas of risk

Sources of Risk Management Information:

- Descriptions of the internal auditor's role in development of the entity's risk management methodology and in risk monitoring and control
- Recent external and internal auditor reports and management responses

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- Summary of the company's overall risk profile, including significant areas of regulatory concern. *(Review the Insurer Profile Summary)*
- Recent risk-management reports detailing pricing/underwriting, market, credit, liquidity and reserving risk exposures (including those identified as Enterprise Risk Management reports) and other key management reports
- Assessments of the presence and effectiveness of internal control measures across primary business lines; and current year-to-date and prior-year comparisons of financial results to plan*. (This could include assessments made by the company, i.e., internal audit reports, or by the examiner as a result of prior-year examinations)*

Communication and Coordination

In performing an analysis of management considerations, analysts should utilize the risk-focused surveillance examination work that has been most recently completed related to these risk areas. Where applicable, analysts should follow-up on the work performed by the examiners.

In an insurance holding company system, the domestic insurer may share common management and/or a common board of directors with other insurers within the group. Similarly, depending on the nature of the risk, multiple insurers within an insurance holding company system may experience similar risks or be impacted similarly by events or management decisions. For example,

- A board of directors' decision to alter strategic business plans for the group may have similar operational changes to multiple insurers within the group.
- A management decision to implement new IT claim handling systems utilized by multiple affiliated insurers that results in improper claims payments may result in market conduct violations or have a financial impact for more than one insurer within the group.
- Insurers that share common financial reporting staff may experience similar accounting errors that could have a financial impact on more than one insurer within the group.
- News reports about the parent company may result in reputational risk that has a negative impact on multiple insurers' ratings or writings.

The department should utilize the lead state to communicate and coordinate any material analysis findings regarding management and corporate governance risks with other interested regulators.

P. References

Publications

- *Accounting Practices and Procedures Manual*, NAIC
- *Annual Statement Instructions*, NAIC
- *Financial Condition Examiners Handbook*, NAIC
- *Health Reserve Guidance Manual,* NAIC
- *Market Regulation Handbook,* NAIC
- *Own Risk Solvency Assessment Guidance Manual*, NAIC
- *Purposes and Procedures Manual of the NAIC Investment Analysis Office*, NAIC
- *Troubled Insurance Company Handbook*, NAIC

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Model Laws

- *Actuarial Opinion and Memorandum Regulation (#822), NAIC*
- *Annual Financial Reporting Model Regulation (#205), NAIC*
- *Corporate Governance Annual Disclosure Model Act (#305), NAIC*
- *Corporate Governance Annual Disclosure Model Regulation (#306), NAIC*
- *Credit for Reinsurance Model Act, (#785), NAIC*
- *Credit for Reinsurance Model Regulation (#786), NAIC*
- *Disclosure of Material Transactions Model Act (#285), NAIC*
- *Health Insurance Reserves Model Regulation (#10), NAIC*
- *Insurance Holding Company System Regulatory Act (#440), NAIC*
- *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450), NAIC*
- *Investments in Medium Grade and Lower Grade Obligations Model Regulations (#340), NAIC*
- *Investment of Insurers Model Act (Defined Limits Version) (#280), NAIC*
- *Life and Health Reinsurance Agreements Model Regulation (#791), NAIC*
- *Managing General Agents Model Act (#225), NAIC*
- *Model Law on Examinations (#390), NAIC*
- *Model Regulation to Define Standards and Commissioners Authority for Companies Deemed to be in Hazardous Financial Condition (#385), NAIC*
- *Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio for Plan Years 2011, 2010 and 2013 per Section 2718(b) of the Public Health Service Act (#190), NAIC*
- *Reinsurance Intermediary Model Act (#790), NAIC*
- *Risk-Based Capital (RBC) for Health Organizations Model Act, (#315), NAIC*
- *Risk-Based Capital for Insurers Model Act (#312), NAIC*
- *Risk Management and Own Risk and Solvency Assessment Model Act (#505), NAIC*
- *Registration and Regulation of Third-Party Administrators (#1090), NAIC*

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Note 1 – Summary of Significant Accounting Policies and Going Concern

This Note is required as a result of *Statement of Statutory Accounting Principles (SSAP) No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures* and focuses on:

- The insurer's accounting policies compared to the NAIC *Accounting Practices and Procedure Manual* (AP&P Manual).
- The insurer's compliance with the *Annual Statement Instructions,* the AP&P Manual and the insurer's use of estimates.
- Disclosure of all accounting policies that materially affect the assets, liabilities, capital and surplus, or results of operations.
- Going concern disclosures.

Section, Part		*Risks*
A, 1	The first part of Section (A) addresses accounting policies that differ from the AP&P Manual. The analyst should use this information to determine if an insurer's financial position would be different if all the accounting rules of the NAIC were followed. The disclosure requires reporting on permitted practices that have been allowed by the state of domicile, as well as prescribed differences. Prescribed differences represent differences in the accounting methods that the state requires for all of its companies and the accounting methods of the AP&P Manual. This disclosure primarily assists regulators in reviewing the financial statements of foreign (non-domestic) companies because permitted and prescribed practices are approved by the domestic state and should already be known to the analyst. The analyst should consider the dollar amount of differences that exist in this disclosure in determining the priority given to an insurer. The analyst should gain an understanding of the differences if the insurer's capital and surplus is reduced by, for example, 5% or greater, as a result of applying the NAIC methods to illustrate the magnitude of the impact on the insurer's financial position.	LG, OP, ST
A, 2	The analyst should use the information to gain an understanding of any unusual transaction(s) for which the NAIC has not developed any standard accounting rules and which are not discussed in the AP&P Manual. Generally speaking, the AP&P Manual contains accounting guidance for most transactions common to insurers. However, transactions that are unusual within the industry are not documented within the manual. The materiality of the transaction on the financial statements should be considered, but the analyst should examine the accounting to determine if it is consistent with the NAIC statutory concepts of conservatism, consistency, and recognition. These concepts are discussed in the Preamble of the AP&P Manual. The analyst should determine if risk-based capital (RBC) would have triggered a regulatory event had the permitted practice not been used. By reviewing these issues, the analyst can determine if additional information is needed from the insurer and its state of domicile.	LG, OP, ST
B	The *Annual Statement Instructions* are required to be followed by most insurance departments, and generally, there are very few companies that disclose any differences in this section. Because of this, the analyst should carefully review any items that the insurer has disclosed in this section in order to more clearly understand the accounting principles used by the insurer.	LG
C	Insurers are generally required to follow the AP&P Manual for invested assets. Any differences in accounting principles used must be disclosed by an insurer on an annual basis in the Summary Investment Schedule that is required under SSAP No. 1 and Appendix	LG

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	A-001, *Investments of Reporting Entities*. This section of this Note highlights the importance of the accounting methods used by an insurer for each of its invested assets. Although any material differences between the insurer's accounting methods and the AP&P Manual should be highlighted in the first section of this Note, the individual sections of this invested asset section should be reviewed for their consistency with the above disclosure and to determine if the insurer has used any unusual accounting methods.	
D	The analyst should review the auditor's report and the information provided in Section (D) to gain an understanding of the principal conditions and events about the insurer's ability to continue as a going concern; managements evaluation of the significance of those conditions or events; and management's plan that alleviate substantial doubt about the insurer's ability to continue as a going concern as prescribed in the going concern evaluation and going concern disclosures discussed in SSAP No. 1. Going concern conditions or events are potentially significant to the financial solvency of the insurer and should be investigated by the analyst thoroughly to understand the underlying issues, assess the impact of the condition or event and determine what steps the insurer is taking to mitigate the issue. The analyst may need to contact the insurer if information in the annual statement is not sufficient to complete the analysis.	ST

Note 2 – Accounting Changes and Corrections of Errors

This Note includes four sections focused on general changes in accounting principles and/or corrections of errors and is required as a result of *SSAP No. 3—Accounting Changes and Corrections of Errors*. The information provided in this Note can be helpful in assessing the continuing operations of the insurer.

Section		*Risks*
1	The analyst should use the information provided in this Note to determine the initial impact that any change in accounting principle or correction of an error had on the insurer's financial position and determine if further changes are expected based on the knowledge of the insurer and its business. In cases where the insurer's total capital and surplus decreased by 5% or greater, special attention should be given. The NAIC prescribes specific accounting rules to maintain consistency among insurers, thereby increasing comparability. New accounting rules are generally designed to highlight issues that previously were not addressed, but also may highlight a general concern within the accounting profession or the industry. As a result, the change in accounting principles may highlight the exposure that an insurer has to a particular issue or risk.	LG, OP
2	The analyst should use the information provided in this Note to understand any errors the insurer has corrected and determine the financial impact of the correction. Special attention should be given in cases where the insurer's total capital and surplus decreased by 5% or greater as a result of the correction. SSAP No. 3 allows corrections of errors to be reported as direct charges to surplus. SSAP No. 3 and *SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items* should be reviewed in greater detail to understand what type of unusual items are direct charges to surplus. Because the classification of an item as a correction of an error is recorded directly to capital and surplus, the analyst should consider the reporting of the item and the effect that it could have on the insurer's ability to pay dividends. Even though the focus within the industry is on the capital and surplus of an insurer and not its earnings, a transaction that is recorded directly to capital and surplus and identified as a correction of an error should be reviewed carefully.	LG, OP
3	The analyst should use the information provided in this Note to understand any change in	OP

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	accounting estimates, which are also required by SSAP No. 3. The most important concept in reviewing this part of the Note is to determine the effect that the change will have on the insurer in the future. The Note does not require that the insurer disclose the impact of the change on future periods. However, the analyst should use the information provided to determine if the likely future effect is material.	
4	If amended financial statements are filed, the reporting entity should disclose that the prior period was restated, as well as the reason for the restatement.	OP

Note 3 – Business Combinations and Goodwill

This Note has three primary sections focused on: 1) statutory purchases; 2) statutory mergers and assumption reinsurance transactions; and 3) impairment losses. For this disclosure, the analyst should consider the overall purpose and strategic intent of the transactions and the prospective impact on operations.

Section (Statement Type)		*Risks*
A	The statutory purchase method is probably the most common. The accounting guidance for the statutory purchase method is discussed in *SSAP No. 68—Business Combinations and Goodwill* and *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities.* Under the statutory purchase method, the insurer records goodwill when the purchase price paid for the investment exceeds the statutory book value of that investment. Section (A) of this Note focuses on the goodwill and requires the insurer to disclose all pertinent information on the business combination, as long as the insurer reports unamortized goodwill as a component of the investment. This section of the Note does not require any information to be reported if the insurer has no remaining unamortized goodwill because any balance sheet risk would be minimized once the goodwill was fully amortized. The analyst should use this Note to gain a better understanding of the asset recorded on this investment. The analyst should also use the information, along with his or her understanding of the underlying investment, to determine if the value of the unamortized goodwill appears to be reasonable. SSAP No. 68 provides specific guidance on determining if an impairment in the asset has occurred.	OP, ST
B	The accounting guidance for statutory merger is also discussed in SSAP No. 68. SSAP No. 68 references SSAP No. 3, which requires that the statement of operations for the two years presented be restated as if the merger had occurred on January 1 of the year the merger occurred. Section (B) of this Note focuses on the transaction that occurred and requires the insurer to disclose all pertinent information related to the merger. This includes financial information on each of the companies before the companies were merged. The restated numbers, along with the information in the Note, allow the analyst to better understand the true financial impact of the merger and the expected continuing operations of the surviving insurer.	OP, ST
C (L, H)	Assumption reinsurance transactions are unique for Life, Health and Fraternal insurers. Accounting guidance is discussed in *SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance*. Through assumption reinsurance, the transaction effectuates a novation and thereby extinguishes the ceding company's liability. Regulatory approval of such transactions is generally required, so the analyst should first confirm that transactions reported have been submitted and approved based on the requirements of the state. The analyst should review the transaction filing to determine if any issues were identified. Similar to other business combinations, the analyst should use the	OP, ST

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	information to gain an understanding of the goodwill, amortization of goodwill, and the financial and strategic impact of the transaction.	
C (P,T) or D (L, H)	As described above, the analyst should use the information in the first two parts of this Note to obtain a greater understanding of the business combinations into which the insurer has entered. The analyst should use the information in those parts to determine if the value of any unamortized goodwill appears reasonable, but should also use the information in Section (C) and of this Note to obtain a greater understanding of any impairments that have actually been recorded by the insurer. The analyst should use this information together to determine if the value of the unamortized goodwill appears to be reasonable.	OP, ST

Note 4 – Discontinued Operations

This Note provides certain information on discontinued operations. It should be noted that SSAP No. 24 requires that an insurer report its results from discontinued operations consistent with its reporting of continuing operations. The following should be disclosed in the period in which a discontinued operation either has been disposed of or is classified as held for sale under SSAP No. 24.

Section		*Risks*
A–D	The analyst should use the information disclosed in the Note to obtain an understanding of circumstances that lead to the disposal or expected disposal of operations of a business segment. Sometimes, the insurer's decision to dispose of a segment of business is voluntary and may either allow the insurer to generate a significant amount of cash or might allow the insurer to focus on other segments of business. Other times, the insurer's decision to dispose of a segment of business may be involuntary and might be needed to generate cash to support the other lines of business or to reduce the amount of future losses to which the insurer is exposed. Generally, an involuntary decision such as this is needed in order to alleviate the poor underwriting performance of the segment and can be positive for the insurer but may not always be in the best interests of all policyholders. The analyst should consider if the disposal was approved by the domiciliary state and if a plan of run-off was also approved.	OP, ST

Note 5 – Investments

This Note focuses on:

A. Accounting for mortgage loans, including mezzanine real estate loans and the allowance for credit losses as required as a result of *SSAP No. 37—Mortgage Loans*.

B. Recording of the investment in loans that have been recognized as impaired as required by *SSAP No. 36—Troubled Debt Restructuring*.

C. Information regarding the credit risk for the reporting entity and the methods and assumptions used in calculating the reserve for reverse mortgages as a result of *SSAP No. 39—Reverse Mortgages*.

D. Sources of prepayment assumptions for yield calculations and the risk exposure in loan-backed securities as required by *SSAP No. 43R—Loan-Backed and Structured Securities*.

E. Insurer's policy on collateral requirements for repurchase agreements and/or securities lending transactions and accounting for the asset and income associated with it, as required by *SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*.

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F. Information regarding the insurer's policy or strategies for repurchase agreements, accounted for as secured borrowings transactions and collateral requirements associated with it, as required by *SSAP No. 103R*.

G. Information regarding the terms of the reverse repurchase agreements and collateral requirements for any repurchase agreements accounted for as secured borrowings transactions the insurer has, as required by *SSAP No. 103R*.

H. Information regarding the insurer's policy or strategies for repurchase agreements, accounted for as sale transactions and collateral requirements associated with it, as required by *SSAP No. 103R*.

I. Information regarding the terms of the reverse repurchase agreements and collateral requirements for any repurchase agreements accounted for as sale transactions the insurer has, as required by *SSAP No. 103R*.

J. Recording of real estate investments that have been recognized as impaired and the reporting of receivables and improvements associated with retail land sale operations as required by *SSAP No. 40R—Real Estate Investments*.

K. Information regarding the investment in low-income housing tax credit (LIHTC) properties and the accounting for the asset and income associated with it as required by *SSAP No. 93—Low-Income Housing Tax Credit Property Investments*.

L. Recording of restricted assets, which are assets pledged to others as collateral or otherwise restricted by the insurer.

M. Recording of the book/adjusted carrying value (BACV) of working capital finance investments in aggregate, as required by *SSAP No. 105R—Working Capital Finance Investments*.

N. Disclosures regarding the offsetting and netting of assets and liabilities as required by *SSAP No. 64—Offsetting and Netting of Assests and Liabilities*.

O. Disclosure regarding structured notes as defined in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual).

P. Disclosure regarding 5* securities as defined in the P&P Manual.

Q. Disclosures regarding short sales within the reporting period, including settled and unsettled, as required by *SSAP No. 103R*.

R. Disclosures regarding prepayment penalties and acceleration fees.

The information provided in this Note is helpful to the analyst in reviewing the financial statements and related investment schedules for income, and gains and losses.

Section, Part		*Risks*
A, 1–3	The analyst should use the information provided in section (A) of this Note to help quantify the insurer's investment in mortgage loans, including mezzanine real estate loans, and assess the impact of impaired loans; determine whether the insurer followed the guidelines as prescribed by SSAP No. 37 to record the carrying value of the loan; and what allowances for credit losses on impaired loans have been made by the insurer.	CR, MK
A, 4–5	The analyst should pay particular attention to the amount of mortgage loans deemed to be impaired. Under SSAP No. 37, a mortgage loan is considered to be impaired when, based on current information and events; it is probable that an insurer will be unable to collect all amounts due as stated in the contractual terms of the mortgage agreement. The analyst should note information the insurer provided for impaired loans (aggregated by type—Farm, Residential Insured, Residential All Other, Commercial Insured, Commercial All Other, Mezzanine), including the total investment in impaired loans at the end of each period and the allowance for credit losses. The insurer should have also disclosed the amount of	CR, MK

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	investment in impaired mortgage loans for which there is no related allowance for credit losses.	
A, 6	The insurer should have calculated the average investment in impaired loans during the period and the amount of interest income recognized during the time when the loans were impaired. The analyst should compare the amount of investment income incurred on mortgage loans for the year and compare to the amount of cash received on mortgage loans for the same time period. The analyst should verify the reasonableness of the average balance of impaired loans for the period in question.	CR, MK
A, 7	The analyst should review the activity in the allowance for credit losses account, including the balance in the allowance for credit losses account at the beginning and end of each period, additions charged to operations, direct write-downs charged against the allowance, and recoveries of amounts previously charged off.	CR, MK
A, 8–9	The analyst should use the information provided for mortgage loans derecognized as a result of foreclosure to evaluate the impact on assets and the collateral recognized on the foreclosed mortgage loans.	CR, MK
B	The analyst should use the information provided in Section (B) of this Note to determine whether the insurer has recorded the investment in loans recognized as impaired as prescribed by SSAP No. 36. The analyst should evaluate the insurer's investment in loans impaired and the terms agreed upon for debt restructuring. The analyst should review the amount of commitments, if any, to lend additional funds to debtors owing receivables whose terms have been modified in troubled debt restructuring. The insurer may accept cash, other assets, or an equity interest in the debtor in satisfaction of the debt even though the value received is less than the amount of the debt, if the insurer concludes that the recovery of the loan can be maximized.	CR, MK
C	The analyst should review the information provided in Section (C) to determine whether the insurer followed the guidelines as prescribed by SSAP No. 39 in accounting for reverse mortgages. The statement requires that the individual reverse mortgages be combined into groups for purposes of providing an actuarially and statistically credible basis for estimating life expectancy to project future cash flows. The analyst should review the methods and assumptions the insurer uses in calculating the reserve to offset the risk associated with the mortgage loan. Since the reverse mortgages are non-recourse obligations, the loan repayments are generally limited to the sale proceeds of the borrower's residence, and the mortgage balance consists of cash advanced and interest compounded over the life of the loan and premium that represents a portion of the shared appreciation in the home's value. To the extent the reverse mortgages are material, the analyst should evaluate the reserve established by the insurer to offset the value of the asset underlying the mortgage loan. Reverse mortgages are subject to the risks of mortality, collateral, and interest rate and should be recorded net of an appropriate actuarially calculated valuation reserve. The assumptions for calculating the reserve, cash flow projections, and evaluation of risk should be reviewed annually.	CR, MK
D	The analyst should consider the information provided in Section (D) to determine how closely the insurer followed the principles of valuation and prepayment assumptions of loan-backed securities as prescribed by SSAP No. 43R. As described in SSAP No. 43R paragraphs 48f, 48g and 48h, insurers are also required to disclose certain aggregate information about securities with recognized other-than-temporary impairments and	CR, MK

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	impaired securities (fair value is less than cost or amortized cost) for which other-than-temporary impairments have not been recognized in earnings. Prepayments are a significant and variable element in the cash flow of a loan-backed security because they affect the yield and determine the expected maturity against which the yield is calculated. As interest rates fall, the prepayment of the mortgages accelerates and shortens the duration of the underlying security. This causes the insurer to reinvest assets sooner than expected at potentially lower interest rates. This is called prepayment risk. In contrast, rising interest rates slow repayment and can significantly lengthen the duration of the security and create extension risk. The insurer should periodically review sources used to determine prepayment assumptions and cash flows and make changes when necessary. In doing so, the insurer should use relevant valuation sources and rationale to determine prepayment assumptions. Loan-backed securities should be revalued using either the prospective or retrospective adjustment methods. As a rule, prepayment assumptions should be applied consistently across portfolios to all securities backed by similar collateral with respect to coupon, issuer, and age of collateral. To the extent that interest rates have changed materially from the prior year, the analyst should review the Note carefully to better understand the insurer's assumptions and develop more specific questions regarding the impact of the rate changes on the portfolio.	
E, 1–2	The analyst should use the information provided in Section (E) to gain an understanding of the insurer's policy for requiring collateral or other security under repurchase agreements and/or securities lending agreements. Insurance companies invest in repurchase agreements to purchase securities with the intent to resell them at a stated price on a specified date within 12 months of the purchase. Under SSAP No. 103R, repurchase agreements should be accounted for as collateralized loans. It should be noted that the underlying securities should not be accounted for as investments owned by the insurer, but rather as short-term investments. The analyst should review the description of the security underlying the agreement, as well as the book value, fair value, interest rate, and maturity date. To the extent the insurer has significant repurchase agreements, and interest rates have changed significantly, the analyst should determine whether the estimated fair value of the security has fallen below the amount agreed upon in the repurchase agreement and if additional collateral was required.	CR, MK
E, 3	Per SSAP No. 103R, if the insurer or its agent has accepted collateral that is permitted by contract or custom to sell or repledge, the insurer should disclose certain information by type of program (repurchase agreement, securities, lending or dollar repurchase agreement) regarding the collateral including aggregate amount of contractually obligated open positions, (the fair value or cash received for which the borrower may request the return of on demand), positions under 30-day, 60-day, 90-day, or greater than 90-day terms and the fair value as of the date of each statement of financial position presented of that collateral and of the portion of that collateral that it has sold or repledged. This allows the analyst to determine if there is a risk that the value of reinvested collateral may not be sufficient to cover the amount of collateral that could be requested to be returned to the borrower.	CR, MK
E, 4	Under SSAP No. 103R, securities lending transactions administered by an affiliated agent in which "one-line" reporting of the reinvested collateral is optional at the discretion of the reporting entity, the aggregate value of the of the reinvested collateral that is "one-line" reported and the aggregate reinvested collateral that is reported within the investment schedules should be disclosed by the insurer.	CR, MK

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E, 5	The reporting entity should also provide information by type of program (repurchase agreement, securities lending, or dollar repurchase agreement) the amount of the reinvestment of the cash collateral and any securities which the entity or its agent receives as collateral that can be sold or repledged. This should include the aggregate amount of the reinvested cash collateral (amortized cost and fair value). The reinvested cash collateral should be broken down by the maturity date of the invested asset: under 30 days, 60 days, 90 days, 120 days, 180 days, less than 1 year, 1 to 2 years, 2 to 3 years, and more than 3 years. If the maturity dates of the liability (collateral to be returned) does not match the invested assets, the insurer should disclose additional sources of liquidity to manage the mismatches.	CR, MK
E, 6	The analyst should use the information to understand contract terms and the collateral's current fair value on transactions where the collateral is not permitted by contract or custom to be sold or repledged.	CR, MK
E, 7	The analyst should use the information to understand the type of collateral held for securities lending transactions that extend beyond one year from the reporting date.	CR, MK
F – I	The analyst should use the information provided in Sections (F-I) to gain an understanding of the insurer's policy for requiring collateral or other security under repurchase agreements and/or reverse repurchase agreements. Insurance companies invest in repurchase agreements to purchase securities with the intent to resell them at a stated price on a specified date within 12 months of the purchase. Under SSAP No. 103R, repurchase agreements should be accounted for as collateralized loans. It should be noted that the underlying securities should not be accounted for as investments owned by the insurer, but rather as short-term investments. For repurchase agreements, the analyst should determine whether the estimated fair value of the security has fallen below 95% and therefore requires additional collateral. For reverse repurchase agreements, the analyst should determine whether the estimated fair value of the security has fallen below 100% and therefore requires additional collateral.	CR, MK
J	The information provided in Section (J) of this Note can be helpful in quantifying the insurer's investment in real estate determined to be impaired. The analyst should use this information to determine whether the insurer has recorded the investment in real estate recognized as impaired as prescribed by SSAP No. 40R. In addition, if the insurer engages in retail land sales operations, the analyst should use this information to determine whether accounts receivable and expenditures have been accounted for properly as prescribed by SSAP No. 40R. The analyst should consider the information disclosed in this section to evaluate the insurer's investment in impaired real estate. The analyst should note the amount of the impairment and how fair value was determined. Also, the analyst should use information in this section regarding retail land sales operations to assess the maturities and quality of accounts receivable, planned expenditures and recorded obligations for improvements.	CR, MK
K	The analyst should use the information provided in Section (K) of this Note to gain an understanding of an insurer's investment in LIHTC properties. The insurer is required by SSAP No. 93 to provide the number of remaining years of unexpired tax credits and the required holding period for the LIHTC investments, as well as comment on whether any LIHTC properties are currently subject to any regulatory reviews and the status of such review. The insurer is also required to provide details regarding the ownership, accounting policies, and valuation of each partnership or limited liability company investment if the aggregate investment in LIHTC properties exceeds 10% of total admitted assets. In addition, the insurer is required to disclose any recognized impairments and the nature of any write-	CR, MK

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	downs or reclassifications made during the year. The information can be helpful in the rare instances where insurers hold this type of investment to help identify the extent of the insurer's exposure and any issues regarding impairment write-downs or reclassifications.	
L	Section (L) requires the reporting entity to disclose the amount and nature of any assets pledged to others as collateral or otherwise restricted (e.g., not under exclusive control, assets subject to a put option contract, etc.) by the reporting entity. The analyst should review the detail on restricted assets provided in this Note for any restricted assets greater than 10% of total cash and invested assets. Restricted assets impact liquidity as they are not assets available to pay policyholder claims.	CR, MK
M	Section (M) requires the reporting entity to disclose certain working capital finance investments on an aggregate basis regarding the BACV, by NAIC designation as required by SSAP No. 105R. Per SSAP No. 105R, working capital finance investments represent a confirmed short-term obligation to pay a specified amount owned by one party (the obligor) to another (typically a supplier of goods), generated as a part of a working capital finance investment program currently designated by the NAIC Investment Analysis Office. The information provided assists the analyst in the review of this Schedule D category. Like other Schedule D investments, the analyst should consider NAIC designation, other-than-temporary impairments and credit risk associated with the investment.	CR, MK
N	Section (N) for Life/Accident and Health (A&H) insurers, Fraternal Societies and Health entities only requires the reporting entity to disclose certain quantitative information (separately for assets and liabilities) when derivative, repurchase and reverse repurchase, and securities borrowing and securities lending assets and liabilities are offset and reported net in accordance with a valid right to offset per SSAP No. 64. Assets and liabilities that have a valid right to offset but are not netted because they are prohibited under SSAP No. 64 are not required to be captured in these disclosures. The information in this note assists the analyst in gaining a better understanding of the netted assets, if material, by providing the gross and offset amounts.	CR, MK
O	Section (O) requires the reporting entity to disclose the following per the P&P Manual: the Committee on Uniform Security Identification Procedures (CUSIP), actual cost, fair value, and BACV of the structured note. The reporting entity is also required to disclose if the structured note is a Mortgage-Referenced Security.	CR, MK
P	Section (P) requires the reporting entity for each annual reporting period to provide a comparable disclosure to the prior annual reporting period of the number 5* securities, by investment type, and the BACV and fair value for those securities, per the P&P Manual, Special Reporting Instructions.	CR, MK
Q	The analyst should use the information provided in Section (Q) of this Note to gain an understanding of an insurer's utilization of short sales. The insurer is required by SSAP No. 103R, for unsettled short sale transactions, to provide the amount of proceeds received and the fair value of the securities to deliver, with current unrealized gains and/or losses, and the expected settlement timeframe (# of days), including current transactions that were not settled within three days. For settled short sale transactions, the aggregate amount of proceeds received and the fair value of the security as of the settlement date with recognized gains and/or losses, including the aggregated fair value of settled transactions that were not settled within three days and that were settled through a securities borrowing transaction.	CR, MK
R	Section (R) requires the reporting entity to disclose the following: the number of CUSIPs sold, disposed or otherwise redeemed and the aggregate amount of investment income generated as a result of a prepayment penalty and/or acceleration fee.	CR, MK

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Note 6 – Joint Ventures, Partnerships and Limited Liability Companies

This Note focuses on investments in joint ventures, partnerships and limited liability companies that exceed 10% of the admitted assets of the insurer and specific information on impairments.

Section		*Risks*
A, B	The accounting guidance for the above types of investments is addressed in *SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies*. SSAP No. 48 defines a corporate joint venture as a corporation owned and operated by a small group (the joint ventures) as a separate and specific business or project for the mutual benefit of the members of the group. SSAP No. 48 defines a general partnership as an association in which each partner has unlimited liability, and a limited liability company as a hybrid organization that falls between a corporation and a partnership, whereby the owners have limited liability to their percentage ownership or equity interest in the company. These types of investments are potentially problematic because of their illiquid nature and their various valuation methods. Sometimes accounting treatments are not in accordance with statutory guidance, including—but not limited to—goodwill, non-admitted assets and fair value adjustments (e.g., the reporting for limited partnerships in which the entity has a minor ownership interest). The analyst should use the information included in this Note to gain a better understanding of the type and amount (exposure) of these investments, and if any such investments have been impaired. The analyst should use the Note to determine if these investments are valued in accordance with the appropriate accounting method, generally the equity method of accounting according to SSAP No. 48. The analyst should also determine if the company has disclosed a carrying value that is different from the quoted market price and whether the amount of the difference is material. Finally, the analyst should use this Note to evaluate the relationship of the insurer's overall risk in these types of investments compared to its equity position.	CR, MK, LQ

Note 7 – Investment Income

This Note focuses on the insurer's basis for non-admitting due and accrued investment income as required as a result of *SSAP No. 34—Investment Income Due and Accrued*, *SSAP No. 26R—Bonds* and *SSAP No. 32R—Preferred Stock*. The Note also discloses the amount the insurer non-admits upon determining collectability of due and accrued investment income. The information is helpful to the analyst in reviewing the financial statements and related exhibits and schedules for real estate, mortgage loans, and long-term bonds.

Section		*Risks*
A, B	The analyst should use the information provided in Section (A) to understand the insurer's rationale for determining assets as nonadmitted. The analyst should review investment schedules A, B and D to assess the materiality of assets in near default or impairment. In conjunction, the analyst should review the investment income earned exhibit for reported due and accrued investment income. SSAP No. 34 defines investment income due as investment income earned and legally due to be paid to the insurer (i.e., receivable) as of the reporting date. Investment income accrued is investment income earned as of the reporting date but not legally due to be paid to the insurer until subsequent to the reporting date. Investment income should be recorded as an asset on the balance sheet. However, the analyst should review *SSAP No. 4—Assets and Nonadmitted Assets* to obtain an understanding of the distinction between an asset that has a probable future economic benefit versus an asset that is unavailable to	MK, LQ

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	meet policyholder obligations due to encumbrances or third-party interests. The nonadmitted asset should not be included on the balance sheet, nor should the balance for investment income due and accrued. To the extent the nonadmitted investment income is material, the analyst should question the collectability of the remaining investment income due. The analyst should review SSAP No. 26R, SSAP No. 32R and *SSAP No. 5R— Liabilities, Contingencies and Impairments of Assets* to obtain an understanding of the principle of asset impairment and the collection of investment income. The analyst should also review SSAP No. 37 for further understanding of impairments of mortgage loans. If an asset is determined to be in default, it is probable that the investment income due and accrued balance is uncollectable and should be written off and charged against investment income. Interest can be accrued on mortgage loans in default if interest is deemed collectable. But if interest is deemed uncollectable, it cannot be accrued, and any previously accrued amounts should be written off and charged against investment income. If a mortgage loan in default has interest 180 days past due that has been determined to be collectable, all accrued interest should be reported as a nonadmitted asset.	

Note 8 – Derivative Instruments

This Note focuses on:

A. The exposure to market risk, credit risk and the cash requirements of each category of derivative instruments and is required as a result of *SSAP No. 86—Derivatives*.

B. The insurer's investment strategy and objectives for holding or issuing derivative financial instruments as also required under SSAP No. 86.

C. How each category of derivative instrument is reported in the financial statements as required by SSAP No. 86.

D. Identification of whether the reporting entity has derivative contracts with financing premiums.

E. The portion of the unrealized gains or losses on derivatives that represents derivatives excluded from the assessment of hedge effectiveness.

F. The portion of the unrealized gains or losses on derivatives that represents derivatives no longer qualifying for hedge accounting.

G. Details about derivatives accounted for as cash flow hedges of a forecasted transaction.

H. Aggregate, non-discounted total premium cost and the premium due in each of the following four years, and thereafter.

For additional discussion of derivative instruments, see Section IV. – A. Supplemental Analysis Guidance – Financial Analysis and Reporting Considerations.

Section		*Risks*
A	Derivative instruments are often complex and involve substantial risk of loss. The analyst should use the discussion provided in Section (A) of this Note to evaluate the impact of the derivative instruments on the insurer's risk exposure. Derivatives are financial market instruments used by some insurers to minimize the risk of a change in value, yield, price, cash flow, quantity of assets or liabilities, or future cash flows. Transactions entered into for the purpose of reducing market changes related to price or interest rate or currency exchange rate risks are *hedging* transactions. Because the market rates and indices from which derivatives derive their value can be volatile, the value of these instruments may fluctuate significantly, resulting in significant gains and losses.	MK, ST

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B	The analyst should use the information provided in Section (B) to gain an understanding of the insurer's objectives for investing in or issuing derivative instruments, as well as the investment strategy for achieving those objectives. Insurance companies primarily invest in derivative instruments for hedging activities. SSAP No. 86 provides criteria for transactions to qualify as *hedging* vs. *other than hedging*. Most insurance regulators prohibit insurance companies from entering into speculative transactions. An analyst should consider the assets, liabilities, or future cash flows for which the derivative transactions were entered into or issued to hedge against.	MK, ST
C	The analyst should consider the information disclosed in the balance sheet and summary of operations, as well as the supporting information in Schedule DB and the exhibits for investment income and realized and unrealized gains and losses. Accounting procedures for derivatives vary widely depending on the nature of the derivative. SSAP No. 86 provides specific guidance for accounting procedures for the various categories of derivatives. The analyst should give special attention to this Note if derivative investment income accounts for more than 5% of net investment income, 10% of capital and surplus, or if the insurer is experiencing capital losses on derivative instruments of more than 10% of capital and surplus.,	MK, ST
D	The analyst should consider the information disclosed in Section (D) to determine if the insurer has derivative contracts with financing premium. SSAP No. 86 provides guidance regarding scenarios in which the premium cost is paid at the end of or throughout the derivative contract.	MK, ST
E	The analyst should consider the information disclosed in Section (E) in conjunction with information provided in the balance sheet and summary of operations as well as the supporting information in Schedule DB and the Exhibit of Capital Gains (Losses). The gain or loss on a derivative designated as a hedge and assessed to be effective is reported consistently with the hedged item. However, if the company's risk management strategy for a particular hedging relationship excludes a specific component of the gain or loss on the hedging derivative from the assessment of hedge effectiveness, that excluded component of the gain or loss shall be recognized as an unrealized gain or loss. For example, if the effectiveness of a hedge with an option contract were assessed based on changes in the option's intrinsic value, the changes in the option's time value would be recognized in unrealized gains or losses. Time value is equal to the fair value of the option less its intrinsic value.	MK, ST
F	The analyst should consider the information disclosed in Section (F) to help in determining whether the derivative qualifies for hedge accounting. A derivative instrument is either classified as an effective hedge or an ineffective hedge. Derivative instruments used in hedging transactions that meet the criteria of a highly effective hedge shall be considered an effective hedge and valued and reported in a manner that is consistent with the hedged asset or liability which is referred to as hedge accounting. Under hedge accounting, the valuation method used for the derivative shall be consistent with the valuation method used for the hedging item, either amortized cost or fair value. Derivative instruments used in hedging transactions that do not meet the criteria for an effective hedge shall be accounted for at fair value and the changes in the fair value should be recorded as an unrealized gain or loss referred to as fair value accounting.	MK, ST
G	The analyst should consider the information disclosed in Section (G) to help in determining if a forecasted transaction is eligible for designation as a hedged transaction in a cash flow hedge. The forecasted transaction must be verifiable and the probability should be supported by observable facts. The length of time until a forecasted transaction is projected	MK, ST

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	to occur and the quantity of the forecasted transaction should be considered in determining probability. Included in the circumstances that should be considered in assessing the likelihood a transaction will occur is the extent of loss or disruption of operations that could result if the transaction does not occur.	
H	The analyst should use the information provided in Section (H) to gain an understanding of the insurer's aggregate, non-discounted total premium cost for these contracts and the premium cost due in each of the following four years, and thereafter. The aggregate fair value of derivative instruments with financing premiums excluding the impact of the deferred or financing premiums is also provided in this section.	

Note 9 – Income Taxes

Background

When the NAIC codified statutory accounting principles, it developed three fundamental concepts to be used in the development of all accounting principles. One of these principles was recognition. Because the recognition principle requires liabilities to be recognized as they are incurred, and because deferred tax assets (DTAs) and deferred tax liabilities (DTLs) result from transactions or events that have already occurred, they must be recognized in the financial statements. Said differently, the transaction or event has already occurred, and *SSAP No. 101—Income Taxes, A Replacement of SSAP No. 10R and SSAP No. 10* simply requires the recognition of the tax consequences of that transaction or event in the financial statements. Note that SSAP No. 101 became effective Jan. 1, 2012. A detailed primer on types of DTAs and DTLs is provided below. In addition, SSAP No. 101 Exhibt A contains an extensive Implementation Question and Answer section.

Income Tax Assets

Current income tax recoverables include all current income taxes, including interest (net of federal tax), reasonably expected to be recovered in a subsequent accounting period, whether or not a tax return or claim has been filed with the taxing authorities. These amounts are to be recorded and admitted if they are reasonably expected to be recovered. Current income tax recoverables are reasonably expected to be recovered if the refund is attributable to overpayment of estimated tax payments, errors, carry-backs, or items for which the reporting entity has substantial tax authority, as that term is defined in Federal Income Tax Regulations.The determination as to whether "substantial tax authority" exists requires an analysis of the tax law and its application to the relevant facts. Substantial authority is present if the weight of the authorities supporting the tax treatment is substantial relative to the weight of authorities supporting a contrary position.

Deferred Tax Liabilities and Deferred Tax Assets

DTLs represent temporary differences that will result in future taxable amounts. DTAs represent temporary differences that will result in future deductions and operating losses, capital losses, and tax credit carryforwards. However, those unfamiliar with deferred taxes might not understand what is meant by the term "temporary differences." Because an admitted DTA will result in an increase in capital and surplus, the analyst should obtain an understanding of what is included in the insurer's DTA. Because a net DTL will result in a decrease in capital and surplus, the analyst should obtain an understanding of what is included in the insurer's DTL.The easiest way to understand the concept of a temporary difference is to review an example of one.

Temporary Difference Example – Proxy DAC

One of the most common types of temporary differences for life insurers is deferred acquisition expenses. *SSAP No. 71—Policy Acquisition Costs and Commissions* requires that all costs incurred in the acquisition of new and renewal insurance contracts shall be expensed as incurred. However, for tax purposes, insurers are not allowed to deduct (expense) all of these costs up front. Instead, the Internal Revenue Service (IRS) requires that an insurer set up what is known as a Proxy DAC (deferred policy acquisition expense) asset.

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The Proxy DAC asset that is set up by insurers for tax purposes is based on a percentage of net premiums from specified insurance contracts (e.g., life, annuity, and A&H), not to exceed the insurer's actual expenses for the year. The capitalized costs are then amortized on a straight-line basis over a 120-month period (60 months for certain small insurance companies), beginning on the first day of the second half of the taxable year. Proxy DAC reverses ratably over the amortization period. Setting up the Proxy DAC for tax purposes has the effect of spreading out an insurer's deductions. To the extent that an insurer was allowed to receive the deduction for these expenses when they were incurred, it would provide for an ineffective matching of an insurer's revenues (taxable income) with expenses (deductions). Many of the other temporary differences that exist for insurance companies recognize these same differences in revenue and expense streams. The following illustrates the temporary difference that exists for Proxy DAC.

Proxy DAC Example:

Insurer XYZ incurred $10 million of policy acquisition expenses to establish ordinary life policies in the current year, which brought in $100 million of premium income in that same year. For statutory purposes, all of these costs are expensed in the current year since the expenses have been incurred. As a result, the insurer's book income is reduced by the entire amount in the current year. For tax purposes, the insurer establishes a Proxy DAC asset of approximately $7.1 million ($100 million premium income multiplied by 7.07%—IRS percentage). The insurer will amortize this asset (for tax purposes) over the next 10 years, resulting in annual amortization of $710,000. However, in the current year, the insurer will only be allowed to amortize $355,000, because the amortization cannot begin until the first day of the second half of the taxable year. As a result of the above, the insurer sets up the following on its statutory and tax balance sheets:

	Stat	Tax	Diff	DTA
Deferred Acquisition Costs	$0	$6,745,000	$6,745,000	$2,360,750

The $0 recorded for statutory purposes reflects that the insurer has expensed the entire amount of expenses in the current period. It also reflects that the insurer will have no more expenses recorded in the financial statements in the future for these costs. The $6.7 million recorded for tax purposes reflects the maximum allowable Proxy DAC, in accordance with the IRS calculation, less the first year's amortization. It also represents an additional $6.7 million of expense (or deductions) that the insurer will record in the future for these costs. Because the insurer will have the ability to deduct these expenses on its tax return in the future, the temporary difference (difference between book and tax) that has been created with respect to these costs represents an asset to the insurer. It is an asset because it will result in future deductible amounts. The DTA ($2.4 million) is calculated by multiplying the temporary difference by the insurer's corporate tax rate (35%), because this is the amount that taxes will be reduced in the future as a result of the temporary difference. This is just one example of how temporary differences are calculated under SSAP No. 101 and one example of the type of temporary differences that exist on an insurer's balance sheet. Below is a listing of other temporary differences that are common to insurance companies.

Other Common Temporary Tax Differences

Property/Casualty and Health Insurance Companies

Discounting of Unpaid Loss Reserves: This difference is similar to the reserve revaluation for life insurance companies because it results in higher reserves for statutory purposes than for tax purposes. The IRS requires companies to discount all types of reserves (the IRS discount tables vary by products), which results in lower reserves for tax purposes. Because this difference will represent higher future deductions for the insurer, this temporary difference will result in a DTA.

Change in Unearned Premiums: This temporary difference is similar to that which exists for life insurers for Proxy DAC, because it is the IRS's attempt to match a company's expenses with its revenues. For tax purposes, an insurer must include 20% of the annual change in unearned premiums in income. This temporary difference

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will reverse as the unearned premium is earned. Although the calculation varies from the Proxy DAC, it usually results in the same effect, a DTA.

Life, A&H and Fraternal Insurance Companies

Reserve Revaluation – This is perhaps one of the largest differences that exist for a life insurer and results from the difference in how reserves are calculated for statutory purposes compared to tax purposes. Because the statutory reserves are calculated on a conservative basis, and because the IRS would consider overstated reserves to be aggressive, tax reserves are always lower than statutory reserves. Using the same balance sheet approach, as above, this type of difference would result in a DTA because the insurer will take lower deductions (compared to statutory) in the early years (past years) and will take higher deductions in future years.

Reserve Strengthening – Statutory accounting requires that reserve strengthening, as well as reserve reductions, be recorded immediately. Tax requires that companies take these items in over a period of time to match the companies' expenses with its revenues. Because of this, temporary differences can result. If the above results in higher reserves for statutory purposes, a DTA will result. If the above results in lower reserves for statutory purposes, a DTL will result.

All Insurance Companies

Accrued Market Discount: For statutory purposes, SSAP No. 26R requires insurers to accrue any market discount into income over the life of the bond. For example, if a bond is purchased for $900 thousand with a par value of $1 million, the $100 thousand discount is accrued into income (increases investment income) over the life of the bond. This has the effect of adjusting the investment income on a bond to reflect the true yield on the initial investment, $900 thousand in this case. However, for tax purposes, companies generally do not amortize this market discount into income and, instead, are taxed on the gain ($100 thousand ($1 million for consideration received when the bond matures minus $900 thousand cost paid)) when the bond matures. A similar type of effect would result if the insurer sold the bond before it matured. Because the above temporary difference will result in future taxable income when the bond matures or is sold, this type of temporary difference will result in a DTL. The insurer can also have DTAs on its bonds if it has purchased them at a premium. These types of differences are common for all types of insurance companies because they hold large amounts of bonds.

Unrealized Gains/Losses: This temporary difference is similar to that which exists for accrued market discount. It will result in a DTL if an insurer has recorded a significant amount of unrealized gains or, if an insurer has recorded a significant amount of unrealized losses, it will result in a DTA. The difference applies to all types of companies, but basically results from the general cash basis that the IRS uses for calculating tax expense for any given year. The difference results because, for tax purposes, gains and losses are not recognized until they are realized (until the asset is sold). For statutory purposes, stocks are marked to market, and any changes are reflected in an insurer's change in surplus section as unrealized gains/losses. The only thing different about this item is that SSAP No. 101 requires unrealized gains and losses to be shown net of tax. So the change in the DTA or DTL resulting from this temporary difference will run through the change in unrealized gains and losses in the insurer's change in surplus section instead of running through the change in DTA/DTL line that has been set up in the same section of the NAIC Blank.

Balance Sheet Approach

As noted in the above example, SSAP No. 101 uses what is known as a balance sheet approach to measure an insurer's temporary differences. This is consistent with *Statement of Financial Accounting Standards* (FASB) *No. 109*, but differs from the approach used in *FASB No. 96*, which uses an income statement approach. The balance sheet approach is simpler than the income statement approach because it does not require the insurer to schedule out the temporary differences that exist. In other words, the insurer does not need to know what the insurer's book to tax differences will be in future years to perform this calculation. However, SSAP No. 101 does use some conservatism that requires the insurer to determine what will reverse in the next year or subsequent three-year period when applicable.

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Admission of Deferred Tax Assets

The admission of deferred tax assets generally requires the expectation of future taxable income or the ability to recover previous taxes paid under a carryback. The conservative nature of statutory accounting limits the admissability of deferred tax assets as they are not assets that can be utilized immediately for policyholder claims. The admitted portion of adjusted gross DTAs is based upon the three component admission calculations included in paragraph 11 of SSAP No. 101. Prior to the admission calculation, gross DTAs are adjusted by the statutory valuation allowance, which reduces the gross amount of DTAs to the amount that is more-likely-than not to be realized by the entity. All entities may admit adjusted gross DTAs as the sum of:

(1) Federal income taxes paid in prior year that can be recovered through loss carrybacks for existing temporary differences that reverse during a timeframe corresponding with IRS tax loss carryback provisions, not to exceed three years, including any amounts established in accordance with the provision of SSAP No. 5R.

(2) The reporting entity shall admit:

a) The amount of adjusted gross DTAs, after the application of paragraph 11.a, expected to be realized within the applicable period following the balance sheet date limited to the amount determined in paragraph 11.b.ii.

b) An amount that is no greater than the applicable percentage of statutory capital and surplus as required to be shown on the statutory balance sheets of the reporting entity for the current reporting period's statement filed with the domiciliary state commissioner adjusted to exclude any net DTAs, electronic data processing (EDP) equipment, and operating system software and any net postive goodwill.

(3) Amount of gross DTAs (after 1 and 2) that can be offset against existing DTLs. If an entity meets RBC requirements per paragraph 11.b of SSAP No. 101, after admitting DTAs based upon the sum of 1, 2 and 3 above, an entity that is subject to RBC requirements or is required to file an RBC Report with the domiciliary state, shall use the *Realization Threshold Limitation Table – RBC Reporting Entities* in this component of the admission calculation. For mortage guaranty insurers or financial guaranty insurers that are not subject to RBC requirements and not required to file an RBC Report with the domiciliary state, and the reporting entity meets the minimum capital and reserve requirements for the state of domicile, the reporting entity shall use the *Realization Threshold Limitiation Table – Financial Guaranty or Mortgage Guaranty Non-RBC Reporting Entities* in this component of the admission cacluation. If the reporting entity 1) is not subject to RBC requirements, 2) is not required to file an RBC Report with the domiciliary state, 3) is not a mortgage guaranty or financial guaranty insurer, and 4) meets the minimum capital and reserve requirements, then the reporting entity shall use the *Realization Threshold Limitation Table – Other Non-RBC Reporting Entities*.

See SSAP No. 101 for other specifics of the calculation.

Reporting

As mentioned above, a change in the amount of DTAs and DTLs from one period to the next is recorded directly to capital and surplus through a line within the capital and surplus section of the insurer's financial statements. Even though DTAs and DTLs are calculated on a gross basis, they should be reported in the balance sheet on a net basis. That is, if the DTA exceeds the DTL, the net should be reported as a net DTA on the assets page. Or if the DTL exceeds the DTA, the net should be reported as a net DTL on the liabilities page. In addition, the "additional" admitted DTA is to be reported separately in the *aggregate write-ins for gains and losses in surplus* line and in the *aggregate write-in for special surplus funds* line.

Disclosure

The disclosure requirements of SSAP No. 101 are rather extensive and require the insurer to disclose:

A. Financial components (assets, liabilities, and surplus impact) of the deferred taxes.

B. Any DTLs that are not required to be reported as a liability in connection with paragraph 31 of FASB 109.

C. Significant components of its current income taxes incurred.

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D. Types and amount of temporary differences that affect the insurer's effective tax rate.

E. Certain information on operating loss and tax credit carry forwards.

F. Certain information on consolidated tax returns, if applicable.

G. An estimate of the range of the reasonably possible increase in the total liability.

Section	*Financial Components*	*Risks*
A	The analyst should use the information required in Section (A) of this Note to determine the overall impact that SSAP No. 101 has had on the financial position of the insurer. The first section requires the insurer to report its gross, adjusted gross, admitted and non-admitted DTAs by tax character, total DTLs by tax character as well as the net change during the year by component, total non-admitted DTAs and overall surplus impact. SSAP No. 101 also requires the disclosure of certain information resulting from the application of paragraph 11 of SSAP No. 101, including if the insurer elected to admit DTAs; the increased amount and change in admitted adjusted gross DTAs; components of the calculation and RBC level; amounts of admitted DTAs; admitted assets, surplus and TAC in the RBC calculation; and the increased amount of DTAs, admitted assets and surplus and, finally, the impact of tax-planning strategies on the determination of adjusted gross DTAs and the determination of net admitted DTAs, by percentage and tax character. As indicated above, this accounting is consistent with the concept of recognition. However, as also indicated above, there are limitations put on the amount of DTAs that an insurer can admit. Using information from the balance sheet and the Note, the analyst should also determine if the insurer has appropriately netted its DTAs with its DTLs. Because a significant amount of ratios compare various items to net admitted assets, those ratios can be distorted if an insurer has not reported these items on a net basis as required by SSAP No. 101. The analyst should also determine if the insurer has appropriately limited the DTA to 10% of capital and surplus. Under SSAP No. 101, if the insurer is subject to RBC requirements and meets the requirements outlined in SSAP No. 101 paragraph 11, the insurer may elect to admit a higher amount of adjusted gross DTAs up to a limit of 15% of capital and surplus. It should be noted that the 10% limitation requirement within SSAP No. 101 actually includes some additional calculations that make the limitations even more conservative.	OP
Section	*DTLs Not Reported as a Liability*	*Risks*
B	The analyst should use the information required in Section (B) of this Note to better understand the financial position of the insurer. Paragraph 31 of FASB 109 allows a DTL resulting from a temporary difference not to be recorded in certain circumstances. One circumstance listed in paragraph 31 of FASB 109 is a temporary difference resulting from a stock life insurer's policyholders' surplus account. (See the Internal Revenue Code for further discussion.)	OP
Section	*Significant Components of Income Taxes Incurred*	*Risks*
C	The analyst should use the information required in Section (C) of this Note to better understand the components of an insurer's total income taxes incurred. This section provides the analyst with information on investment tax credits and operating loss carry forwards, adjustments for enacted changes in tax laws that are not disclosed elsewhere as well as disclosures of adjustments to gross DTAs due to changes in circumstances that cause a change in judgment about the realizability of related DTAs. The analyst should pay particular attention to the adjustments for enacted tax laws to determine if the insurer has used the correct statutory tax rates in the calculation of its DTAs and DTLs. SSAP No. 101	OP

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	prohibits the use of anticipated tax rates in its application.	
Section	*Types of Temporary Differences*	*Risks*
D	The analyst should use the information required in Section (D) of this Note to understand the significant temporary differences of an insurer. This disclosure could be the most helpful part of this Note. The disclosure requires the insurer to compare the expected tax expense (based on the corporate tax rate) with the actual incurred tax expense. This disclosure also requires the insurer to divulge all of the significant reconciling items between the two amounts. Again, this disclosure can be helpful in analyzing the significant temporary differences that an insurer maintains.	OP
Section	*NOLs and Carry Forwards*	*Risks*
E	The analyst should use the information required in Section (E) of this Note to understand if the insurer's DTA includes a provision for a net operating loss. As noted above, the calculation limits an insurer to those DTAs that can be utilized within one year. However, if a significant portion of the DTA includes an operating loss carry forward, the analyst should consider if the insurer will be able to utilize the amount within one year or three years as applicable.	OP
Section	*Consolidated Financial Statements if Applicable*	*Risks*
F	The analyst should use the information required in Section (F) of this Note to determine if the insurer has appropriately applied the principles of SSAP No. 101 to its financial statements regardless of a consolidated tax return being prepared. SSAP No. 101 allows the allocation of taxes between affiliated entities that file a consolidated tax return, but the basic requirements of SSAP No. 101 still must be met. The analyst should review the disclosure to ascertain that the insurer has not avoided the recording of any DTLs through its income tax allocation agreement.	OP
Section	*Range of Reasonably Possible Increase in Liability*	*Risks*
G	The analyst should use the information required in Section (G) of this Note to understand if the insurer has disclosed an estimate of the range of the reasonably possible increase in total liability within 12 months of the reporting period, or a statement that an estimate of the range cannot be made. Refer to SSAP No. 5R and SSAP No. 101 for accounting guidance.	OP

Potential Reporting Problems

As illustrated above, the reporting requirements of this Note and the complications in calculating an insurer's deferred taxes are quite significant. Most insurers do not have any internal tax department that can perform a deferred tax calculation. Because of this, many insurers will have to rely on a certified public accountant (CPA) firm to perform this calculation. The insurer's reliance on a CPA firm to perform this work on an annual basis might not present a problem, but it is anticipated that some insurers may not update the calculation on a quarterly basis. The analyst should review the change in the DTA and DTL on a periodic basis to determine if the change recorded is reasonable based on changes in the insurer's reserves and invested assets.

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 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	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 transactions with affiliates. 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. 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.	CR, LQ, OP, ST
E	It is important to evaluate the effect of any guarantees or undertakings with affiliates 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.	LQ, OP, ST
F, G	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 transactions with affiliates 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.	CR, LQ, OP, ST
H, I, J, L, M, N, O	The amounts disclosed in the Notes to Financial Statements should be consistent with other schedules and filings. If the company is part of a holding company system, the company's current year Form B registration statement should include the appropriate disclosures agreeing with the Notes to Financial Statements. The Form B registration statement should also include the consolidated financial statements of the group. The analyst should use this information, or other information available on the consolidated group or the holding company alone (e.g., 10-K filing), to understand the amount of debt	CR, LQ, OP, ST

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	or cash flow requirements at the holding company level. Funds from the insurance companies are often needed to service debt at the holding company level, which can be a concern. For any current-year changes from the previous year, Form C should highlight these changes. If there were significant transactions or changes to agreements, a Form D should have been submitted requesting approval by the Department. A Form E (or other required information) would have been submitted if a merger or acquisition transaction involved a competitive impact. The insurer may also disclose the payment of extraordinary dividends. Schedule Y disclosures should be consistent with the Note. Significant changes in corporate structure may materially impact the insurer's future financial condition and generally require prior regulatory approval. The analyst should use the balance sheet value (admitted and non-admitted) disclosed in Section (M) and Section (N) of this Note to evaluate and gain an understanding of the book value and monetary effect of the subsidiary, controlled and affiliated (SCA) investments on assets, net income and surplus. The analyst should refer to SSAP No. 97 in regard to aggregate gross value and for additional guidance. Investments in SCA may affect liquidity as these investments may not be readily marketable and converted to cash to meet claims obligations. The analyst should also assess and understand the business purpose, valuation and the investment return on these types of investments. The analyst should refer to Section (O) of this Note in cases where the insurer's share of losses in an SCA exceed its investment. The insurer is required to disclose its share of losses, regardless of any guarantees or commitments of future financial support. The analyst should refer to SSAP No. 97 and SSAP No. 5R.	

Note 11 – Debt

This note discloses information related to all other debt, including capital notes as provided by *SSAP No. 15—Debt and Holding Company Obligations*. SSAP No. 15 requires a full description of the type of borrowing, (e.g., amounts, interest rates, collateral, interest paid, debt terms, covenants and any violations) and information related to agreements with the Federal Home Loan Bank (FHLB).

Section		*Risks*
A	The analyst should use the information in this Note to review the insurer's total debt. In cases where the insurer's total debt exceeds 10% of capital and surplus, special attention should be given. For all debt, the analyst should verify that the insurer has a sufficient matching of assets to meet the debt repayment schedule given its current cash flow needs and the maturity of investments. If any new debt has been reported, the analyst should evaluate the reasons or need for additional funding. Another important area to review is repayment conditions, restrictions, or covenants. In particular, the analyst needs to be aware of any violations of the covenants or restrictions and possible ramification (e.g., collateral pledged) to the insurer for these violations. The analyst should also determine if there are any provisions in the debt to require early payment. For capital notes, the analyst should evaluate the quality of assets received in exchange for the note and determine if the insurer has properly valued the assets.	ST, LQ
B	The analyst should review any agreements the insurer has entered into with FHLB. The analyst should evaluate the type of funding (advances, lines of credit, borrowed money, etc.) and intended use of the funding. The analyst should also evaluate the amount of collateral pledged to FHLB, the amount of FHLB stock purchased as part of the agreement, and the total borrowing capacity currently available to the insurer. In particular, the analyst needs to be aware how assets and liabilities related to the agreement with FHLB are classified within the general and separate accounts, and the elements that support	ST, LQ

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	these classifications. FHLB agreements that are reported as deposit-type fund contracts are reported in Note 31, while FHLB agreements reported as debt are reported in Note 11.	

Note 12 – Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefits

This Note requires the insurer to disclose:

A. Details of reporting entity-sponsored defined benefit plans as required by *SSAP No. 102—Pensions* and *SSAP No. 92—Postretirement Benefits Other Than Pensions*

B. Investment policies and strategies

C. Classes and fair value of assets

D. Narrative description of the basis used to determine expected long-term rate-of-return-on-assets

E. Details of defined contribution plans and other postretirement benefit plans as required by SSAP No. 102 and SSAP No. 92

F. Multi-employer plans as required by SSAP No. 102 and SSAP No. 92

G. Parent or holding company sponsored plans as required by SSAP No. 102 and SSAP No. 92

H. Postemployment benefits and compensated absences that do not meet the conditions for accrual as a liability as required by *SSAP No. 11— Postemployment Benefits and Compensated Absences*

I. The impact the Medicare Modernization Act has on postretirement benefits as discussed in SSAP No. 92 and INT 04-17

Section		*Risks*
A	As discussed in SSAP No. 102, a defined benefit plan defines the amount of the pension benefit that will be provided to the plan participant at retirement or termination. The analyst should use the information provided in this first section of the Note to gain an understanding of the insurer's defined benefit plan and to determine if the costs and changes in liabilities associated with the plan have a material impact on the insurer.	OP
B	The description on investment policies and strategies and other factors that are pertinent to understanding those policies and strategies—such as investment risk, risk management practices, permitted and prohibited investments and the relationship between plan assets and benefit obligations—should give the analyst an indication of the reporting entities' risk appetite.	OP
C	The fair value of each class of plan assets as of each date for which a statement of financial position is presented enables the analyst to assess the inputs and valuation techniques used to develop fair value measurements of plan assets at the reporting date.	OP
D	The analyst should use the narrative description to understand the basis used to determine the overall expected long-term rate-of-return-on-assets assumptions, such as the general approach used, the extent to which the overall rate-of-return-assets assumption was based on historical returns, and adjustments made to those historical returns in order to reflect expectations on future returns.	OP
E	As defined in SSAP No. 102, a defined contribution plan defines the amount of the reporting entity's contributions to the plan and its allocation to plan participants. Less disclosure is required for this type of pension plan. In Section (E), the reporting entity is required to disclose the cost recognized for the defined contribution plan separately from the amount of cost recognized for defined benefit plans, and a description of significant changes to the	OP

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	plan. The analyst should evaluate the plan disclosures to determine the impact to the financial statements.	
F	Section (F) of this Note provides information on multi-employer plans similar to Section (E). As with defined benefit and defined contribution plans, the analyst should evaluate the impact of costs and changes in liabilities for multi-employer plans on the operations and balance sheet of the insurer.	OP
G	Employees of many reporting entities are members of a plan sponsored by a parent company or holding company, where the entity that participates is not directly liable for the plan obligations. The analyst should use the information to evaluate the net expense for the holding company's qualified pension and other postretirement benefits for which the insurer is allocated and determine the impact of this expense on the entity's operations.	OP
H	As defined in SSAP No. 11, postemployment benefits are all types of benefits provided by an employer to former or inactive employees or agents, their beneficiaries, and covered dependents after employment but before retirement. Compensated absences include benefits such as vacation, sick pay, and holidays. Generally, a liability is accrued for postemployment benefits and compensation for future absences when several conditions are met as discussed in SSAP No. 11, paragraph 3. In a situation where a reporting entity does not accrue a liability for postemployment benefits and compensation of future absences in accordance with SSAP No. 11 because the amount cannot be reasonably estimated, that fact and the reasons shall be disclosed in the Notes to Financial Statements. The analyst should evaluate the type of benefits disclosed and the reasons they could not be estimated to determine if there is concern regarding a potential impact to the financial statements.	OP
I	Section (I) of this Note applies only to the sponsor of a single-employer defined benefit postretirement health care plan where the employer has concluded that prescription drug benefits available under the plan are actuarially equivalent to Medicare Part D, thereby qualifying for the subsidy under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The analyst will want to consider any disclosures the insurer makes per SSAP No. 92, such as a reduction in the net postretirement benefit, amortization, reduction in current period service cost or interest cost, or any other significant changes.	OP

Note 13 – Capital and Surplus, Dividend Restrictions and Quasi-Reorganizations

This Note covers key areas of an insurer's overall capitalization.

Section		*Risks*
1–10	The first portion of the Note (#1–#10) is capital and surplus. The analyst should be familiar with the overall holding company structure of the insurer before reviewing and analyzing the information included in this Note. The analyst should use the information in this area of this Note to obtain a greater understanding of the capital structure of the insurer. The first item of this Note provides the number of shares of capital stock authorized, issued, and outstanding as of the statement date. Items #2–#10 of this Note disclose restrictions on dividends and surplus, along with other information on the company's capital and surplus. These items should be reviewed by the analyst to determine the amount of the insurer's surplus that is available to meet policyholders' liabilities. When considering the overall capital structure of the insurer, the analyst should take into account any recent Form A filings made by the insurer. If there is any change in the capital stock of the insurer, the analyst should consider if a Form A was necessary and, if it was filed, reviewed, and	ST

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	approved by the insurance department.	
11	The analyst should use the information in the second portion of the Note to obtain a greater understanding of the insurer's surplus note obligations. The analyst should be able to determine if the insurer has issued any surplus notes recently. Insurers must have prior insurance department approval for the issuance of surplus notes and each payment. The analyst should review any new surplus notes to verify appropriate approvals were given for the issuance of surplus notes. Additionally, the analyst should verify: 1) the proper accounting for the notes and any associated interest; 2) the payment schedule for repayment and if the insurer will be able to meet this schedule; 3) the type and quality of assets received in the transaction; and 4) if the notes were issued to a parent or affiliate. If the notes were issued to an insurance affiliate, the analyst should consider reviewing the affiliate's financial statements to verify the notes are appropriately reported by the other entity.	OP
12, 13	The third portion of this Note provides information on quasi-reorganization. Insurers must receive prior regulatory approval for quasi-reorganizations. The analyst should verify approval was given. Quasi-reorganizations are generally rare and are usually only allowed if certain conditions are met. If the insurer has received prior approval, the analyst should verify proper disclosures and accounting for this transaction. (See *SSAP No. 72—Surplus and Quasi-Reorganizations* for further discussion.)	ST

Note 14 – Liabilities, Contingencies and Assessments

This Note focuses on: contingent commitments, assessments, gain contingencies, claims related extra contractual obligation and bad faith losses stemming from lawsuits, product warranties (property/casualty (P/C) insurers only), joint and several liabilities, and all other contingencies. The accounting guidance for contingencies is addressed in SSAP No. 5R and for specific items, in *SSAP No. 35R—Guaranty Fund and Other Assessments*; SSAP No. 97, *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses*; and SSAP No. 48.

Section (Statement Type)		*Risks*
A	Contingencies are defined in SSAP No. 5R as an existing condition, situation, or set of circumstances involving uncertainty as to possible loss or gain to an enterprise that will ultimately be resolved when one or more future event(s) occur or fail to occur. It is important for the analyst to ensure the company has reported all contingent commitments to an SCA, joint venture, partnership, or limited liability company (SSAP No. 97 and SSAP No. 48). The Note requires detailed disclosure of guarantees on indebtedness of others, for example a guarantee on the indebtedness of a subsidiary.	LG, OP
B	Assessments, including guaranty fund assessments and other assessments, could also have a material impact on the company's surplus. The analyst should refer to SSAP No. 35R for specific statutory reporting guidance and required disclosure in this Note.	LG, OP
C	Per SSAP No. 5R, a gain contingency is defined as an existing condition, situation or set of circumstances involving uncertainty as to possible gain to an enterprise that will ultimately be resolved when one or more future events occur or fail to occur. A gain is defined as an increase in surplus which results from peripheral or incidental transactions of a reporting entity and from all other transactions and other events and circumstances affecting the reporting entity except those that result from revenues or investments by owners. Gain contingencies are not to be recognized in a reporting	OP

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	entity's financial statement. If a gain contingency is realized subsequent to the reporting date, but prior to the issuance of the financial statement, the gain is disclosed in the Notes to Financial Statements but the unissued financial statement should not be adjusted to include the gain. The gain is generally realized when non-cash resources or rights are readily convertible to known amounts of cash or claims to cash. The analyst should review the Note for any estimate of potential contingent gains.	
D	Situations may arise where an insurer is involved in an extra contractual obligation lawsuit, including bad faith lawsuits. These extra contractual liabilities and expenses may arise out of the handling of an individual claim or a series or group of claims. Any adjustment expenses arising from such lawsuits are reported as adjusting and other per SSAP No. 55. The analyst should review the claims details to determine how much an insurer has in losses stemming from extra contractual obligations or bad faith claims from lawsuits.	LG, OP
E (P)	As discussed in SSAP No. 5R, product warranties are excluded from the initial recognition and initial measurement requirements for guarantees and therefore a guarantor is not required to disclose the maximum potential amount of future payments. The analyst should refer to SSAP No. 5R for disclosure requirements.	LG, OP
E, F (P)	As discussed in SSAP No. 5R, when the insurer has a joint and several liability arrangement, where the total obligation amount is fixed at the reporting dates, it should be reported as the sum of the following: 1) the amount the insurer has agreed to pay among its co-obligors; and 2) any additional amount the insurer expects to pay on behalf of its co-obligors.	LG, OP
F, G (P)	As discussed in SSAP No. 5R, loss contingency estimates are recorded as a charge to operations if it is both probable that a liability has been incurred or an asset has been impaired at the reporting date, and the loss or impairment can be reasonably estimated. If a loss contingency is not recorded because only one of the conditions is met, the loss contingency or impairment of the asset is disclosed in the Notes when there is at least a reasonable possibility that a loss may have been incurred. The analyst should review the Note for any potential loss estimates. The loss contingency estimates should be analyzed to project the impact that future events may have on the balance sheet and whether they have the potential to materially affect the insurer's future operations.	OP

Note 15 – Leases

This Note focuses on the disclosure of items related to lessee arrangements and lessor business activities.

Section, Part		*Risks*
A, 1–2	As defined in *SSAP No. 22R—Leases,* a lease is an agreement conveying the right to use property, plant, or equipment usually for a stated period of time. Under SSAP No. 22R, all leases are considered operating leases. For lessees, rent on an operating lease is charged to expense over the lease term as it becomes payable. The analyst should review part (1) and part (2) of Section (A) to the *Annual Statement Instructions* to determine the impact of current and future rental expense on the insurer's operating expenses and, ultimately, operating income. Any restrictions imposed by the lease agreements (such as dividend restrictions or additional debt) should be noted and examined to ensure that they would not pose a threat to the insurer's operations or conflict with statutory regulations.	OP

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A, 3	Per SSAP No. 22R, a sale-lease back transaction involves the sale of property, plant, or equipment by the owner and a lease of the asset back to the seller. Under a normal leaseback transaction, the seller-lessee records the sale, removes the assets and related liabilities from its balance sheet, and accounts for the lease as described above. If the leaseback transaction includes continuing involvement provisions (such as seller-lessee obligation to repurchase and investment return guarantees), it is accounted for under the deposit method. According to SSAP No. 22R, under the deposit method, the seller recognizes no profit or loss on the sale, does not record notes receivable, and continues to report in its financial statements the property and the related existing debt (even if it has been assumed by the buyer). Lease payments decrease, and collections on the buyer-lessor's note, if any, increases the seller-lessee's deposit account. Leaseback transactions occur for several reasons. Under a normal leaseback transaction, the insurer's appropriate asset and associated debt are removed from the balance sheet, and a gain/loss is recorded. Companies may choose to do this to reduce debt leverage, gain additional funds, or restructure (related to affiliated leasebacks). The analyst should review part (3) of Section (A) to determine which leaseback transaction the insurer has chosen and to gain a better understanding of how the transaction impacts the financial statements.	OP
B, 1	Section (B) relates to the disclosure of the lessor's business activities. Part (1) of Section (B) includes the description, cost/carrying amount by major class of property, related depreciation, future rentals, and contingent rentals. Per SSAP No. 22R, operating leases for lessors shall be included with or near property, plant, and equipment in the balance sheet and depreciated in the lessor's normal policy. Rental income shall be reported as income over the lease term as it becomes receivable according to the provisions of the lease. Initial direct costs shall be deferred and allocated over the lease term in proportion to the recognition of rental income. The analyst should review part (1) of Section (B) to gain an understanding of the terms of the lessor's leases and how they are classified on the balance sheet and income statement. Lessors that complete this section may rely on leasing for revenue, net income, and assets. The analyst should review property-type asset concentrations and examine the lessor's current and future profitability reliance on its rental income.	OP
B, 2	Generally, leveraged leases are those in which the lessor acquires, through the incurrence of debt (such that the lessor is substantially "leveraged" in the transaction), property, plant, or equipment with the intentions to lease the asset(s) to the lessee. The lessor is required to record its investment net of the nonrecourse debt. Thus, investment in leveraged leases includes rental receivables net of that portion of the rental applicable to principal and interest on the nonrecourse debt, investment tax credit receivables, the estimated residual value of the lease asset, and unearned and deferred income. Leveraged leases are unique in that the rental income must be sufficient to cover the debt payments and administrative expenses associated with the lease equipment. The analyst should review part (2) of Section (B) to determine the profitability and reporting treatment of leveraged leases. In addition, the analyst should examine the components of net investment in leveraged assets to judge the accuracy of the amount.	OP

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Note 16 – Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

This Note is required by *SSAP No. 27—Off-Balance-Sheet and Credit Risk Disclosures*.

SSAP No. 27 applies to, but is not limited to, short-term investments, bonds, common stocks, preferred stocks, mortgage loans, derivatives, financial guarantees written, standby letters of credit, notes payable, and deposit-type contracts. Off-balance sheet financial instruments are not recognized on the balance sheet because they fail to meet some of the criterion for recognition as an asset or liability as defined in SSAP No. 4 and SSAP No. 5R. However, due to the nature of the instrument, they pose a financial risk to the insurer. Concentration of credit risk exists where financial instruments share activity, region, or economic characteristics that would impair their ability to meet contractual obligations if affected by changes in economic or other conditions. Concentrations pose a risk to the insurer when significant fluctuations in one area of the financial market result in material adverse financial consequences. Off-balance sheet financial instruments and financial instruments with concentrations of credit risk are therefore required to be disclosed in the Notes.

Section		*Risks*
1	Part (1) of this Note, the insurer has identified the face amounts of financial instruments with off-balance sheet risk, listed by class. The analyst should use the first part of this Note to assess the level of materiality of an insurer's investment in financial instruments with off-balance sheet risk.	CR, MK, LQ
2	Part (2) discusses the credit risk, market risk, cash requirements of the instrument and the accounting policies related to the instrument. The analyst should use Part (2) to gain an understanding of the nature and terms of the financial instruments, including the nature of the risks involved, and to review the related accounting policies disclosed in this part of the Note. An analyst should use the discussion in the second part of the Note to evaluate the impact of the off-balance sheet risk on the insurer's total risk exposure.	CR, MK, LQ
3	The analyst should use Part (3) of this Note to evaluate the risk to the insurer for a default on the terms of the contract or the risk to the insurer should the collateral or other security for the amount due have no value for the insurer. As in the second part, the analyst should use the information disclosed in this part of the Note to evaluate the impact of the risks of default and collateral with no value on the insurer's total risk exposure.	CR, MK, LQ
4	Part (4) focuses on the insurer's policies for requiring collateral or other security to support financial instruments subject to credit risk and requires the insurer to disclose the nature and description of the collateral or other security. Part (4) discloses collateral requirements and provides a description of the collateral or other securities supporting the financial instruments. The analyst should use the information provided in this part of the Note in the evaluation of the risks associated with the insurer's collateral.	CR, MK, LQ

Note 17 – Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

This Note focuses on the transfer of receivables reported as sales as is required by *SSAP No. 42—Sale of Premium Receivables* and the transfer and servicing of other financial assets and wash sales as required by SSAP No. 103.

Section, Part		*Risks*
A	Section (A) requires an insurer to disclose the proceeds received and the amount of gain or loss recorded on the sale of any premium receivables. The analyst should use this	OP,

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	information to determine the overall impact that the sale of the insurer's premium receivables might have on its financial position. The analyst should also consider if the insurer has other premium receivables on its balance sheet and determine what type of impact the sale of its remaining premium receivables would have on its financial position. In assessing the potential impact that the sale of the remaining premium receivables would have on the insurer, the analyst should consider the quality of the receivables sold, if known, and any anticipated changes in the economy that could affect the value of the receivables. The analyst should also consider reviewing information in the insurer's annual audit report on fair value of financial instruments as required by SSAP No. 27.	MK
B, 1	Section (B), Part (1) requires an insurer to disclose certain information on loaned securities, including the amount, as well as the Company's policy for requiring collateral and the type of collateral held. The analyst should use this information to help understand the types of investing and financing contracts the insurer uses to maximize profits and liquidity.	OP, MK
B, 2	Section (B), Part (2) requires an insurer to disclose a description of inherent risk in servicing assets and servicing liabilities, as well as contractually specified fees, and quantitative and qualitative information about the assumptions used to estimate the fair value.	OP, MK
B, 3	Section (B), Part (3) requires an insurer to disclose certain information regarding servicing assets and liabilities that are subsequently measured at fair value. The analyst should use this information to help understand the materiality of the servicing process in relation to the insurance operations.	OP, MK
B, 4	Section (B), Part (4) requires an insurer to disclose certain information regarding securitized financial assets in which the transfer is accounted for as a sale when the transferor has continuing involvement with the transferred financial assets. In addition, the insurer is required to provide a sensitivity analysis or stress test showing the hypothetical effect on the fair value of those interests of two or more unfavorable variations from the expected levels for each key assumption that is reported. The analyst should use this information required to evaluate the possible impact of adverse outcomes highlighted in the sensitivity analysis or stress test.	OP, MK
B, 5	Section (B), Part (5) requires an insurer to disclose requirements for transfers of financial assets accounted for as secured borrowing.	OP, MK
B, 6	Section (B), Part (6) requires an insurer to disclose any transfers of receivables with recourse. The analyst should use this information to gauge the materiality of possible effects of recourses associated with transfers of receivables.	OP, MK
B, 7	Section (B), Part (7) requires an insurer to provide a description of the securities underlying dollar repurchase and dollar reverse repurchase agreements, including book values and fair values. It also requires the insurer to provide the maturities for securities subject to dollar repurchase agreements and securities subject to dollar reverse repurchase agreements.	OP, MK
C	Section (C) requires an insurer to disclose certain information regarding its use of "wash sales" as defined in SSAP No. 103R. The analyst should use this information to help understand the purpose and types of various financial contracts the insurer uses.	OP, MK

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Note 18 – Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

This Note focuses on the profitability of uninsured and partially insured A&H plans under administrative services only (ASO) contracts and Administrative Service Contract (ASC) plans,and Medicare or similarly structured cost-based reimbursement contracts. The accounting guidance is in *SSAP No. 47—Uninsured Plans*. An uninsured A&H plan may be either an ASO plan or an ASC plan. (Title companies do not complete this Note.)

Section		*Risks*
A, B, C	Under an ASO plan, claims are paid from a bank account owned and funded directly by the uninsured plan sponsor; or, claims are paid from a bank account owned by the reporting entity, whereby the funds are provided to the reporting entity prior to claim payment. Under an ASC plan, the reporting entity pays claims from its own bank accounts and only subsequently receives reimbursement from the uninsured plan sponsor. Uninsured A&H plans also include federal, state or other government department funded programs, such as Medicare cost contracts where there is no underwriting risk to the reporting entity. Under uninsured plans, the reporting entity performs administrative services, such as claims processing for a third party that is at risk and does not provide insurance. As such, the plan bears all of the insurance risk, and there is no possibility of underwriting loss or liability to the administrator. However, the administrator may be subject to credit risk. ASC contracts are particularly subject to credit risk due to the fact that the reporting entity pays claims from its own bank account and then relies on reimbursement from the plan sponsor. Uninsured plan administrators face risks associated with these plans in that all costs incurred under the contract might not be reimbursable, and revenues may be adjusted based on subsequent challenges of costs included in filed cost reports, the terms of the contract or other external factors. The analyst should determine the extent that administrators are exposed to these threats. This Note provides detail for the analyst to use in determining if the insurer is profitable in its servicing of uninsured plans. It also provides information necessary to establish the extent to which the insurer depends on uninsured business. If an insurer's profitability is concentrated in the administration of uninsured plans, it faces greater exposure to the threats listed in the paragraph above. The analyst should examine the administrator's claim and fee revenue from uninsured plans to total claim and revenue volume to determine if the administrator faces concentration risk. The analyst should also use this Note to perform a more comparable analysis of general insurance expenses from one year to the next because the reimbursements on these types of plans are netted against an insurer's general expenses.	CR

Note 19 – Direct Premium Written/Produced by Managing General Agents/Third-Party Administrators

This Note requires the insurer to disclose the amount of direct premiums written through each managing general agent (MGA) and third-party administrator (TPA) that exceeds 5% of surplus. (Title companies do not complete this Note.) This Note is required by *SSAP No. 53—Property and Casualty Contracts-Premiums* and *SSAP No. 54R—Individual and Group Accident and Health Contracts*. MGAs and TPAs produce or solicit business for an insurer and also provide one or more of the following services: underwriting, premium collection, claims adjustment, claims payment, and reinsurance negotiation. MGAs and TPAs are used by insurers to increase the

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volume of business written or to facilitate entry into new lines of business or geographical locations. (See Section III, Operational Risk Assessment for procedures on MGAs and TPAs.)

Section		*Risks*
N.A.	The analyst should use the information to calculate the percentage of aggregate business produced by the listed MGAs and TPAs compared to total direct premiums written to determine whether this amount is material. The analyst should compare the current percentage to that of the previous reporting period. It is critical to determine whether there has been an increase in the percentage of aggregate business written by MGAs and TPAs. If the increase is significant, it might indicate that the insurer has contracted new MGAs and TPAs or is increasing overall production to improve cash flow.	OP, RP
N.A.	For each MGA and TPA that meets the disclosure requirement of this Note, the insurer is required to disclose information detailing the name and address of the MGA and TPA, the federal employer identification number, whether the entity holds an exclusive contract, the types of business written, the type of authority granted (e.g., underwriting, claims payment, etc.), and total premium. The analyst should review the lines of business written by each MGA and TPA. The analyst should determine whether the insurer recently began writing a new line of business or has experienced a significant increase in writings for a particular line of business that the MGA and TPA produce. It is important to review the loss experience by line of business and determine whether the MGA and/or TPA produced significant writings for a line that is experiencing an excessive loss.	OP, RP

Note 20 – Fair Value Measurements

Fair value is generally an estimate of the value that a particular asset might bring in the marketplace. There are three levels in which an insurer may use to determine the fair value measurements of certain balance sheet items. The analyst should use this Note as guidance to determine what elements and methods an insurer used to derive fair value for its assets and/or liabilities, And, additionally, to assess that the value obtained is fair between two specific parties in a transaction, taking into account the respective advantages and disadvantages that each would stand to gain from the transaction.

Section		*Risks*
A	During the review process, the analyst should ascertain the level within the fair value hierarchy that the insurer chose to utilize in determining its fair value measurements. These levels or components refer broadly to the assumptions that insurance entities would use in pricing the asset or liability, including assumptions regarding risk. The analyst should review the inputs the insurer utilized in pricing whether it was Level 1 measurements which included live market quotes; Level 2 observable inputs using pricing derived from those assumptions that market participants would use in pricing based on market data obtained from sources independent of the reporting entity; or Level 3 unobservable inputs using the insurer's own assumptions developed based on the best information available under the current circumstances. If the insurer used Level 3 assumptions, the analyst should determine whether a reconciliation of the assets and/or liabilities (including realized and unrealized gains or losses, purchases, sales, and transfers) ties to the estimated value as assigned by the insurer. Investments reported at net asset value (NAV) shall not be captured within the fair value hierarchy but shall be separately identified.	MK
B, C	In reviewing assets and liabilities at fair value on a recurring basis, the analyst should evaluate the sources and valuation techniques used to measure fair value and assess any changes in valuation methods and related components, if any, during the period. The analyst should identify and assess the assumptions utilized in determining fair value in	MK

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	pricing assets or liabilities, including risk assumptions such as investment and market risk and the effect of those measurements on earnings (or changes in net assets) for any given period.	
D	In reviewing assets and liabilities at fair value on a nonrecurring basis, the analyst should assess the inputs used to develop those measurements. The analyst should evaluate the insurer's rationale for utilizing its own valuation techniques and related inputs to develop assumptions in determining fair value versus the observable inputs based on actual market data.	MK
E	Section (E) requires an insurer to disclose information that helps reviewers understand the nature and risks of the investments and whether the investments, if sold, are probable of being sold at amounts different from NAV per share.	MK

Note 21 – Other Items

This Note is required by various SSAPs, INTs and other sources and focuses on:

A. Unusual or infrequent items as required by SSAP No. 24

B. Troubled debt restructuring for debtors as required by SSAP No. 36

C. Other miscellaneous amounts not recorded in the financial statements that represent assets pledged to others as collateral in accordance with SSAP No. 1

D. Business interruption insurance recoveries, including information related to the nature and aggregate amount of losses and recoveries recognized due to business interruption

E. State transferable and non-transferable tax credits

F. Subprime mortgage-related risk exposure and related risk management practices

G. Use of retained asset accounts for beneficiaries (life/A&H insurers, fraternal societies and health entities only)

H. Insurance-linked securities (ILS) contracts

Section		*Risks*
A	Section (A) requires the insurer to disclose the nature and financial effect of any unusual or infrequent items. Under SSAP No. 24, an insurer is required to account for any unusual or infrequent item using the same lines that are used to report continuing operations. Section (A) allows the analyst to understand the impact that the event or transaction considered unusual or infrequent items have had on each of the financial statement line items and in total. This Note should be used to better understand the impact of the item on the insurer's overall financial position and allows the analyst to more easily compare the financials of the current period with prior periods.	CR, LQ
B	Section (B) requires the insurer to disclose specifics regarding any troubled debt restructuring that occurred within the past year, including a description of the terms and the gain or loss recorded on the restructure. The analyst should use this information to obtain a greater understanding of the impact that such a transaction may have had on the insurer's current year financial statements. If the current year gain (or loss) was material, or if the insurer holds significant investments in other loans, the analyst should consider asking the insurer for detailed information on other mortgage loans to determine if similar events are likely to occur on other loans.	CR, LQ
C	Section (C) requires the insurer to disclose various items that do not meet the definition of an asset, a liability, revenue or expense as defined within the AP&P Manual but are relevant	CR, LQ,

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	to the overall financial position of an insurer. Such items include amounts not recorded in the financial statements that represent segregated funds held for others. The analyst should review the information in this section to determine the overall materiality of each of the items and determine the potential impact that the item could have on the financial statements if certain events or transactions occur that require the items to be recorded in the financial statements. To the extent material, the analyst should gain a better understanding of the facts pertaining to each by discussing the item with the insurer.	OP
D	Section (D) requires the insurer to disclose information related to business interruption insurance recoveries received during the period. This information includes the nature of the event that resulted in losses, the aggregate amount of the recoveries and the line items on the statement of operations in which those recoveries are classified, and the amounts defined as extraordinary items. The analyst should review this information to determine if these recoveries have had a material impact of the operations of the insurer.	CR, OP
E	Section (E) requires the insurer to disclose information regarding state transferable tax credits. The total unused transferable state tax credits represent the entire transferable state tax credits available. The information includes the following: 1) the carrying value of transferable and non-transferable state tax credits gross of any related state tax liabilities and total unused transferable and non-transferable state tax credits by state and in total; 2) the method of estimating utilization of remaining transferable and non-transferable state tax credits or other projected recovery of the current carrying value; 3) the impairment amount recognized by the reporting period, if any; and 4) the identity of state tax credits by transferable and non-transferable classifications, and the admitted and nonadmitted portions of each classification. To the degree the amount of the transferable tax credits is material to the insurer, the analyst should perform a more in-depth review.	OP
F	Section (F) requires the insurer to disclose information pertaining to subprime mortgage related risk exposure and related risk-management practices in the statutory financial statements, regardless of materiality. The analyst can find definitions of commonly recognized characteristics of subprime mortgage loans, as well as the sources of exposure, in the NAIC *Annual Statement Instructions*. The insurer should provide a narrative description of the definition of the exposure to subprime mortgage related risk as well as a discussion of the general categories of information considered in determining the exposure, the direct exposure through investments in subprime mortgage loans, the direct exposure through other investments, and the underwriting exposure to subprime mortgage risk through mortgage guaranty or financial guaranty insurance coverage. To the extent exposure is material to the insurer additional analysis should be performed.	LQ, CR, MK
G	Section (G) for *life/A&H insurers, fraternal societies and health entities only* requires the reporting entity to disclose information regarding its use of retained asset accounts for beneficiaries. For purposes of this disclosure, retained asset accounts represent settlement of life insurance proceeds which are retained by the insurance entity within its general account for the benefit of the beneficiaries. Amounts held outside of the insurance entity, (e.g., in a non-insurance subsidiary), affiliated or controlled entity accounted for under SSAP No. 97, such as an interest-bearing account established in the beneficiary's name with a bank or thrift institution (and subject to applicable Federal Deposit Insurance Corporation coverage) are only required to be described in the context of the structure of the reporting entity's financial statements; however, quantitative information regarding retained asset accounts transferred outside of the reporting entity are not required.	LQ
H	Section (H) requires the insurer to disclose information regarding when they receive possible proceeds as the issuer, ceding insurer or counterparty of ILS. ILS can be defined as	CR, MK,

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	securities whose performance is linked to the possible occurrence of pre-specified events that relate to insurance risks. It should be noted that, while catastrophe bonds may be the most well-known type of ILS securities, there are other non-cat bond ILS, including those based on mortality rates, longevity and medical-claim costs. ILS may be used by an insurer, or any other risk-bearing entity in addition to the purchase of insurance or reinsurance. The analyst should use the information disclosed to determine whether the insurer received possible proceeds as the issuer, ceding insurer, or counterparty of ILSs as a way of managing risks related to directly-written insurance risks or assumed insurance risks as an alternative to reinsurance transactions.	ST

Note 22 – Events Subsequent

Subsequent events are required to be disclosed per *SSAP No. 9—Subsequent Events*. Subsequent events are events or transactions that have occurred subsequent to the balance sheet date, but prior to the issuance of the financial statements and auditor's report, which have a material effect on the financial statements and, therefore, require adjustment and/or disclosure in the statements. Subsequent events are considered either Type I Recognized Subsequent Events and Type II Nonrecognized Subsequent Events. Type I focuses on events that provide additional evidence with respect to conditions that existed at the date of the balance sheet and affect the estimates inherent in the process of preparing financial statements. Type I recognized subsequent events or transactions provide relevant information to evaluate the financial condition of an entity. Type I events are recorded in the financial statements and, if material, disclosed in the Notes to Financial Statements. Type II focuses on events that provide evidence with respect to conditions that did not exist at the balance sheet date but arose subsequent to that date. Type II nonrecognized subsequent events provide relevant information needed to evaluate the information in the financial statements. This includes disclosure of the assement payable under Section 9010 of the federal Affordable Care Act. Type II events are only disclosed in the Notes to Financial Statements.

Section		*Risks*
1	The analyst should use the information disclosed in Type I of this Note to determine what impact recognized subsequent events had to the financial statements for the current period. SSAP No. 9 requires that the criteria, conclusion, and circumstances surrounding material Type I financial statement adjustments be disclosed in the Notes to Financial Statements. Not adjusting the financial statements would create a misleading picture of the insurer's financial position because the conditions existed at the date of the balance sheet and affect the reported line item estimates. For these reasons, analysts should review Type I recognized subsequent events disclosed in this Note in conjunction with the financial statements to get a clear picture of the changes in the insurer's financials and the reasons behind them.	OP
2	The analyst should use the information disclosed in Type II of this Note to assess and quantify the impact that nonrecognized subsequent events—having conditions that did not exist at the balance sheet date but arose subsequent to that date—would have on the current and future financials of the insurer. While Type II events do not result in an adjustment to the current financial statements, they do provide additional knowledge and information on pending financial effects. The impact that Type II events have on net income, asset and liability balances, capital and surplus, cash flow, and insurer structure should be carefully examined. Pro forma supplements, if provided, should also be incorporated into the analysis. For the annual reporting period ending Dec. 31, 2013, and thereafter, a reporting entity subject to the assessment of the federal Affordable Care Act (ACA) shall provide a disclosure of the assessment payable in the upcoming year consistent with the guidance provided	OP

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	under SSAP No. 9. The disclosure shall provide information regarding the nature of the assessment and an estimate of its financial impact, including the impact on its RBC position as if it had occurred on the balance sheet date. In accordance with SSAP No. 9, the reporting entity shall also consider whether there is a need to present pro forma financial statements regarding the impact of the assessment, based on its judgment of the materiality of the assessment. In addition, for annual reporting periods ending on or after Dec. 31, 2014, the reporting entity should disclose the amounts reflected in special surplus in the data year. The disclosure should provide information regarding the nature of the assessment, the estimated amount of the assessment payable for the upcoming year (current year and the prior year), amount of assessment paid (current and prior year) and written premium (current and prior year) that is the basis for the determination of the fee assessment to be paid in the subsequent year. The disclosure should also provide the total adjusted capital (TAC) and authorized control level (ACL) before and after adjustment to reflect the fee as of the annual reporting date as if it had been reported on the balance sheet date. The reporting entity should also provide a response and statement as to whether an RBC action level would have been triggered had the fee been reported as of the balance sheet date. The analyst should review the health care procedures in Section III.B. Annual Repository – 9. Strategic Risk Assessment.	

Note 23 – Reinsurance

This Note's sections vary by statement type. The analyst should gain a better understanding of the insurer's reinsurance program and any risk the insurer is exposed to under the program.

Reinsurance is a vital part of an insurer's risk management and financial stability. Certain transactions or conditions of an insurer's reinsurance could have a significant and disparaging impact on its financial health. Dependence on reinsurance or its potential effect on the insurer's surplus is part of the NAIC hazardous financial condition standards as stated in the Model Hazardous Financial Condition Law. These standards include the ability of the assuming reinsurer to perform its obligation to the ceding reinsurer. As stated therein, "There should be sufficient protection for the insurer's remaining surplus after taking into account the insurer's cash flow and classes of business as well as the financial condition of the assuming reinsurer (credit risk to the insurer)." Whether any affiliate, subsidiary, or reinsurer is insolvent, threatened with insolvency, or delinquent in payments of its monetary or other obligations (reinsurance and business risk to the insurer) is another part of the standards. Therefore, an assessment of the financial stability of the reinsurer is an extremely important task of the analyst.

P/C and Title Insurers

Section (Statement Type)		*Risks*
A	The analyst should use the information provided in Section (A) to determine if the insurer has had any individual unsecured reinsurance recoverables in excess of 3% of policyholders' surplus. If so, the analyst should review the unsecured aggregate recoverable pertaining to that reinsurer, or if part of a group, the total unsecured aggregate recoverables for the entire group.	OP, ST, CR
B	The analyst should use the information provided in Section (B) to determine if any disputed recoverables have been noted. If so, the analyst should issue an inquiry to the insurer to determine the steps being taken to recover the amount(s). The analyst might	OP, ST, CR

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	want to question the validity of the credit being taken for disputed items.	
C	The analyst should use the information provided in Section (C) to determine the potential impact of the cancellation of reinsurance agreements.	OP, ST, CR
D	The analyst should use the information provided in Section (D) to determine if any uncollectable reinsurance has been written off. If so, the analyst should determine the financial impact the reinsurance written off will have on the financial statements and on the level of risk of the insurer.	OP, ST, CR
E	The analyst should use the information provided in Section (E) to determine if the insurer has had any commutation of reinsurance. If so, the analyst should determine the financial impact the commutation will have on the ceding company (its domestic) and should request a pro-forma financial statement reflecting the effects of the commuted agreement.	OP, ST, CR
F	The analyst should use the information provided in Section (F) to determine if the insurer has entered into any retroactive reinsurance agreements. If so, the analyst should send a request to the insurer asking for the accounting entries associated with the agreement. Due to the potential for abuse involving the creation of surplus, special accounting treatment has been developed. The analyst should determine whether the insurer has properly accounted for the new retroactive reinsurance (ref. *SSAP No. 62R—Property and Casualty Reinsurance*, Section 28).	OP, ST, CR
G	The analyst should use the information provided in Section (G) to determine if the insurer has entered into any reinsurance agreements that do not transfer both components of insurance risk (underwriting risk and timing risk) and are accounted for as a deposit. SSAP No. 62R, Section 35, provides accounting guidance.	OP, ST, CR
H (P)	The analyst should use the information provided in Section (H) (for P/C insurers only) to determine if the reporting entity has entered into any agreements that qualifies them to receive P/C run-off accounting treatment pursuant to SSAP No. 62R. A property and casualty run-off agreement is not a novation, as the transferring insurer or reinsurer remains primarily liable to the policyholder or ceding entity under the original contracts of insurance or reinsurance.	OP, ST, CR
I, H (T)	The analyst should use the information provided in Section (I) to determine if there has been a ratings downgrade on any of the certified reinsurers and the resulting impact. See SSAP No. 62R for additional guidance.	OP, ST, CR
J (P)	The analyst should use the information provided in Section (J) (for P/C insurers only) to determine if the reporting entity has been approved for the use of reinsurer aggregation contracts covering asbestos and pollution liabilities in accordance with SSAP No. 62R. The analyst should review the terms of the retroactive reinsurance agreement, including the established limits and collateral as security and the amount of unexhausted limit as of the reporting date. The analyst should use this information to determine the impact on the provision for reinsurance the impact including the impact on overdue amounts.	OP, ST, CR

Life/A&H, Fraternal and Health Insurers

Section		*Risks*
A	The analyst should use the information provided in Section (A) to get a better understanding of the reinsurers and to determine the potential impact of the cancellation	OP, ST,

	of reinsurance agreements.	CR
B	The analyst should use the information provided in second Section (B) to determine if any uncollectable reinsurance has been written off. If so, the analyst should determine the financial impact the reinsurance written off will have on the financial statements and on the level of risk of the insurer. Under SSAP No. 61R, "The ceding and assuming companies must determine if reinsurance recoverables are collectable. If it is probable that reinsurance recoverables on paid or unpaid claims or benefit payments will be uncollectable, consistent with SSAP No. 5R, these amounts shall be written off through a charge to the Statement of Income utilizing the same accounts which established the reinsurance recoverables."	OP, ST, CR
C	The analyst should use the information provided in the third Section (C) to determine if the insurer has had any commutation of reinsurance. If so, the analyst should determine the financial impact the commutation will have on the ceding company (its domestic) and should request a pro-forma financial statement reflecting the effects of the commuted agreement.	OP, ST, CR
D	The analyst should use the information provided in Section (D) to determine if there has been a ratings downgrade on any of the insurer's certified reinsurers and the resulting impact. See SSAP No. 61R for additional guidance.	OP, ST, CR
E, F, G (L)	Section (E) and (F) requires the insurer to report specific information on reinsurance of variable annuity contracts with an affiliated captive reinsurer including the type of benefits being reinsured, a description of the purpose of the transaction, terms of the reinsurance agreement, the ultimate risks involved, reserve credit and collateral. Section (G) requires disclosure of RBC shortfall by captive reinsurer for entities utilizing captives to assume reserves subject to XXX/AXXX captive framework. The analyst should use the information provided in Sections (E), (F), and (G) to understand the insurers reinsurance program and the financial impact with respect to its use of captive reinsurers for variable annuity contracts and XXX/AXXX reserves.	OP, ST, CR

Note 24 – Retrospectively Rated Contracts and Contracts Subject to Redetermination

This Note requires the insurer to disclose general information regarding its premium volume under retrospectively written contracts. (This Note is not applicable to title insurers.) The accounting guidance for retrospectively rated contracts is addressed in *SSAP No. 66—Retrospectively Rated Contracts*. SSAP No. 66 defines a retrospectively rated contract as one that determines the final policy premium based on the loss experience of the insured during the term of the policy (including loss development after the term of the policy) and the stipulated formula set forth in the policy. The periodic adjustments might involve either the payment of return premium to the insured or payment of an additional premium by the insured, or both, depending on experience. Policy periods do not always correspond to reporting periods, and because an insured's loss experience may not be known with certainty until sometime after the policy period expires, retrospective premium adjustments are estimated based on the experience to date. Contracts with retrospective rating features are referred to as loss-sensitive contracts.

Section		*Risks*
A, B, C	Although these types of contracts generally subject the insurer to less risk than more traditional contracts, the analyst should use the information in the Note to determine if the amount of retrospective premiums is material in relation to total net premiums written. This Note also requires the insurer to disclose how it determined the estimated premium adjustment. The disclosure should include all business that is subject to the accounting guidance provided in SSAP No. 66, including business that is subject to medical loss ratio rebate requirements pursuant to the Public Health Service Act or	PR/UW, RV

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	otherwise known as the ACA. The analyst should review the Note to determine whether the reported amount is recorded in compliance with statutory guidance.	
D	Section (D) requires reporting on the ACA medical loss ratio rebates. The analyst should use this information to assess if rebates were paid and/or liabilities established, as well as calculate the materiality and impact of rebates on the capital and surplus of the insurer.	PR/UW, ST
E (P)	For P/C companies, the analyst should compare the admitted amount reported in the Note for accrued retrospective premiums to what is recorded on the balance sheet.	PR/UW, RV
E, F (P)	One of the most significant new drivers of uncertainty attributable to the ACA is its premium stabilization programs, which are referred to as the 3Rs—risk adjustment, reinsurance benefits and risk corridors. These programs primarily affect the commercial individual and small-group markets starting in 2014. The impact on a specific health entity will be somewhat dependent on its concentration in those markets. Each of the premium stabilization programs is designed to provide protection to the health insurance entity by mitigating adverse financial outcomes; however, these programs could have a negative impact as well. Moreover, each program includes a retrospective settlement process. The health entity's annual financial statements will include estimates of amounts payable or receivable under these programs. However, these estimates may be uncertain in magnitude and direction, and may be large in relation to the forecasted annual net income for the affected lines of business. The analyst should monitor an insurer's writings and determine whether the insurer wrote any A&H insurance premium which is subject to the ACA risk-sharing provisions. It is also recommended that the analyst identify whether the impact of underestimating the amount of health premium subject to the ACA risk-sharing provision is greater than their level of capital would allow. The analyst should review the health care chapter in Section III. B. Annual Repository– 9. Strategic Risk Assessment. Any reporting entity that reports A&H insurance premium and losses on their statement that is subject to the ACA risk-sharing provisions must complete the tables provided within Note 24 for the purpose of disclosure of the impact of risk-sharing provisions of the ACA on admitted assets, liabilities, and revenue by program for the current year even if all amounts in the table are zero.	PR/UW, ST

Note 25 – Changes in Incurred Losses and Loss Adjustment Expense

(For this Note, Health insurers should replace "Incurred Losses and Loss Adjustment Expense" with "Claims and Claim Adjustment Expense.")

Section		*Risks*
	This Note requires an insurer to report any reasons for changes in the provision for incurred loss and loss adjustment expenses (LAE) attributable to insured events of the prior year. This Note provides for supporting documentation if there is a change in the prior-year provision for incurred losses and LAE, or reserve development in the current year. Reserve development results from the company's initial estimates differing from the actual results, either through changes in the current reserves or differences in actual payments compared to prior reserves. Because reserve development is reflected in income as the changes incur, reserve development effectively transfers income or loss from the prior year to the current year. An increase in the provision for incurred losses and LAE or adverse development is a	RV

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	larger issue because it indicates that the surplus of the prior period was overstated. The provision for incurred losses and LAE is estimated and subject to some volatility. Although the instructions do not establish a specific threshold at which the company must complete the Note, when the development reaches 5% to 10% of surplus or higher, the analyst should reasonably expect some additional information regarding the reason for the change in the provision for incurred losses and LAE. The response to this Note should address the specific lines of business and/or policy types involved and to what extent the development is due to changes in incurred but not reported (IBNR), including bulk reserves, case basis reserve changes, or actual paid claim differences. In addition, the company is required to comment on whether additional premiums or return premiums resulted from the incurred development. The Note does not require the company to report the amount of development. If the development and/or the company's response to the Note cause the analyst some concern, prior reserve analyses might be reviewed, or the analyst might need to question the company's reserves and address supplemental procedures for unpaid losses and LAE.	

Note 26 – Intercompany Pooling Arrangements

This Note requires an insurer to report certain information on reinsurance pooling arrangements with affiliated insurers. (This Note is not applicable to Title insurers).

Section		*Risks*
A–G	The analyst should review the insurer's percentage of direct written business in comparison to the insurer's participation percentage in the pool. If the participation percentage assumed from the pool exceeds the percentage of direct written business, the analyst needs to consider the impact to the insurer and do any necessary follow-up. Reinsurance transactions between affiliated insurance companies do not reduce risk for the group but, instead, shift risk among affiliates. Reinsurance between affiliated companies presents opportunities for manipulation and potential abuse. In a group of affiliated insurers, interinsurer reinsurance may serve to obscure one insurer's financial condition by shifting loss reserves from one affiliate to another. Improper support or subsidy of one affiliate at the expense of another may adversely affect the financial condition of one or more companies within the group. The analyst should determine whether each member of the pool is obtaining reinsurance and ceding to the pool on a net basis, or whether the pool is obtaining reinsurance and each member of the pool is ceding to the pool on a direct basis. In the event that the pool is obtaining reinsurance, the analyst must determine if each pool participant is a party to the reinsurance agreement or if only the lead company is named. If there is a change in the pooling agreement, the analyst should determine if the insurer can support the change in the interinsurer pooling agreement, and determine if it appears that other affiliates are supporting any adverse results of the insurer or if the company is supporting adverse operating results of others.	OP, CR, LQ, ST

Note 27 – Structured Settlements

The purpose of this Note is to provide guidance on disclosing structured settlements and the transactions for reporting them in the financial statements. (This Note is not applicable to Health insurers)**.** The accounting guidance for structured settlements is addressed in *SSAP No. 65—Property and Casualty Contracts*. SSAP No. 65 discusses structured settlements, which are essentially extended periodic payments used by insurance companies in paying claims in order to ensure that the funds are available to meet the long-term needs of the

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claimant. They come through "arm's-length agreements" between the claimant and the other party, generally in settlement of litigation. A structured settlement is a completely voluntary agreement between the injured victim and the defendant. Under a structured settlement, an injured victim doesn't receive compensation for his or her injuries in one lump sum. Rather, the injured victim will receive a stream of tax-free payments tailored to meet future medical expenses and basic living needs.

Section		*Risks*
A–B	Historically, damages paid due to an injury lawsuit came in the form of a single lump sum. This kind of payment, especially in catastrophic injury cases, often placed the injury victim in a precarious position. The injured party would have all the funds in hand, but medical payments might continue for years. The victim would end up focusing on adapting to a new lifestyle that often involved unforeseen financial obligations. Today, structured settlements are flexible and can be designed for nearly any set of needs. They are funded through annuities so as to guarantee that the money promised at the time of the settlement is there when the payments are due. Reporting entities may purchase an annuity in which the entity is the owner and payee, or an annuity in which the claimant is the payee. A relatively simple payment schedule can be set up that provides for equal payments at set intervals—e.g., every month for 20 years—yet payments need not be in equal amounts. Someone who will need a new wheelchair every three years might elect to receive a larger payment every 36 months to help defray the cost. A structured settlement's inherent flexibility means that they are well suited to compensate victims for a wide variety of injuries. The analyst should use the information in this Note to gain a better understanding of the amount of structured settlements the insurer has entered into, as well as any specifics on the arrangements. It is important to determine whether the insurer has adequately disclosed the amount of reserves no longer carried. The extent that the company is contingently liable should be disclosed because there is some exposure under these types of settlements. The name, state of domicile, location of the insurance company and the aggregate statement value of annuities due from life insurers should be disclosed. A quick check on the financial rating of the life insurer might provide the analyst with some assurance that the insurer has the ability to meet its payments.	RV, OP

Note 28 – Health Care Receivables

(For Health insurers only, Note 28 is for supplemental reserve and requires disclosure of discounting, the method, rate and amount of discount.)

This Note requires disclosure on pharmaceutical rebate receivables and information on risk sharing receivables. While this Note contains quarterly information, the disclosure is only required annually unless material changes occur. The Note for health care receivables is required by *SSAP No. 84—Health Care and Government Insured Plan Receivables*. Exhibit C—Implementation Guide of SSAP No. 84 provides additional accounting guidance for the practical application of SSAP No. 84. Note that when reviewing health care receivables, amounts from government insured plans may be admitted if they are in excess of 90 days, provided the receivable originates from the government.

Section, Part	*Pharmaceutical Rebate Receivables*	*Risks*
A	As stated in SSAP No. 84, pharmaceutical rebates are arrangements between pharmaceutical companies and insurers in which the insurer receives rebates based on the drug utilization of its subscribers. These rebates are recorded as receivables by the insurer and include both billed amounts and estimated amounts.	LQ

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A, 1	Estimates are calculated using a variety of methods. Section (A) of the Note addresses the method used by the reporting entity to estimate pharmaceutical rebate receivables. As stated in Exhibit C of SSAP No. 84, the insurer should use the most accurate method possible utilizing historical information and should consider such things as contractual changes in rebate amounts, seasonality differences, changes in membership or premium revenue, changes in utilization for various rebate levels, etc. An analyst should use the information in the Note to gain an understanding of the method used for estimating receivables. If an insurer has not taken into consideration all of the factors that can impact the amount of the receivable, material differences might exist between the estimated receivable and the actual receivable. Section (A) of the Note also contains a table (from Exhibit A of SSAP No. 84), which discloses, for the most recent three years, the estimated balance of pharmacy rebate receivables, pharmacy rebates as billed or otherwise confirmed, and pharmacy rebates received. The simplest way to understand the table is with the example provided at the end of the Note. The disclosure for pharmaceutical rebates was developed to compare an insurer's actual pharmacy rebates to its estimated pharmacy rebates. By comparing the second column, titled Estimated Pharmacy Rebates as Reported on Financial Statements (the estimate), to the third column, titled Pharmacy Rebates as Invoiced/Confirmed (the actual amount), the analyst can gain an understanding of the insurer's ability to reasonably estimate their pharmacy receivables. If an insurer reported significant discrepancies between its estimated and actual receivable balances, the analyst may consider doing further analysis into causes for the discrepancy and the methods used by the insurer to calculate the estimated receivable.	LQ
A, 2	When reviewing this Note in conjunction with the balance sheet and statement of revenue and expenses, the analyst should consider that, while Column A of the Note should only reflect amounts recorded as admitted assets on the balance sheet, rebates on uninsured plans are included in the Note. Uncollected rebates on uninsured plans are only admitted to the extent that they exceed offsetting rebates due to the uninsured plan. Further, pharmacy rebates for uninsured plans (including admitted receivable balances) are reported as reductions in administrative expenses, while rebates on insured plans are reported as a reduction in pharmacy claims expense on the Statement of Revenue and Expenses. The analyst should also be aware that, as stated in SSAP No. 84, adjustments to previously billed amounts (billed or confirmed in writing) would be included in the disclosure. This could result in variances between the estimate and the billed/confirmed amount. Any material variances should be explained in the Note. The analyst should consider additional analysis if any material variances exist that is not explained in the Note.	LQ
A, 3	The Note was also designed to provide information on collectability. If, in accordance with SSAP No. 5R, it is probable the balance of a receivable is uncollectable, any uncollectable receivable shall be written off and charged to income. This also applies to risk-sharing receivables (discussed below). As in the example above, an analyst can use the information in the fourth, fifth, and sixth columns of the table to gain an understanding of the collectability of the receivables. Significant discrepancies between the actual amount of the receivables and the amount collected might indicate to the analyst that the insurer has not appropriately evaluated the collectability of pharmaceutical rebate receivables, and certain receivables should be written off if they are deemed to be uncollectable.	LQ
Section, Part	*Risk Sharing Receivables*	*Risks*

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B, 1	SSAP No. 84 defines risk-sharing agreements as contracts between insurers and providers with a risk-sharing element based on utilization. These agreements can result in receivables due from providers if the actual utilization differs from the estimates. Section (B) of the Note should disclose the method used by the reporting entity to estimate its risk-sharing receivables. Gross receivable and payable balances should be disclosed in the Note if any receivable or payable amounts with the same provider have been netted. As stated in Exhibit C of SSAP No. 84, receivables consist of estimated amounts and billed amounts. The estimated amounts represent the reporting entity's best estimate of the receivable. When determining an estimate, an insurer should use the most accurate methods possible that utilize inception-to-date encounter data relative to outpatient surgery encounters, hospital days, etc. An analyst should use the information in the Note to gain an understanding of the method used for estimating receivables. If an insurer has not taken into consideration all of the factors that can impact the amount of the receivable, material differences might exist between the estimated receivable and the actual receivable. The Note also contains a table that discloses, for the most recent three years, the risk-sharing receivables estimated and reported in the prior year for annual periods ending in the current year; risk-sharing receivables estimated and reported for annual periods ending in the current year or in the following year; risk-sharing receivables invoiced as determined after the annual period; risk-sharing receivables not yet invoiced; and amounts collected from providers as payments. Exhibit B of SSAP No. 84 provides an illustration of the disclosure and an explanation of the amounts in the table. Exhibit C, Question #17 of SSAP No. 84 provides a detailed explanation of what should be reported in the columns for risk-sharing receivables (columns 3–6). In addition to the guidance in the SSAP, it is helpful to note that the sum of the columns titled "Risk-Sharing Receivable Invoiced" and "Risk Sharing Receivable Not Invoiced" should equal the balance in the column entitled "Risk-Sharing Receivable as Estimated and Reported in the Current Year," unless the company has invoiced amounts in a certain year and collected on that invoice in the current year.	LQ
B, 2	The purpose of this disclosure is to show how an insurer's risk-share balances have changed over time (i.e., estimated and billed amounts), to show how much of the receivable is estimated amounts or subsequently billed amounts, and to provide information on collectability. An analyst's review of this section should be similar to the analysis of the pharmaceutical rebate receivable section of the Note. If an insurer reported significant discrepancies between their estimated and actual receivable balances, the analyst might consider doing further analysis to determine the causes for the discrepancy and to evaluate the methods used by the insurer to calculate their estimated receivable. Significant discrepancies between the actual amount of the receivables and the amount collected may indicate to the analyst that the insurer has not appropriately evaluated the collectability of risk-sharing receivables, and certain receivables should be written off if they are deemed to be uncollectable. Risk-sharing receivables from affiliated entities are included in this footnote and are reported as Health Care Receivables.	LQ

Pharmacy Rebates Example:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Invoiced/ Confirmed	Actual Rebates Collected Within 90 Days of Invoicing/ Confirmation	Actual Rebates Collected Within 91 to 180 Days of Invoicing/ Confirmation	Actual Rebates Collected More Than 180 Days After Invoicing/ Confirmation

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12/31/2014	$150 (A)				
9/30/2014	130 (B)	$133 (C)	$62 (D)		
6/30/2014	142	143	138	$5	
3/31/2014	157	152	150	1	$1
12/31/2013	125	132	129	3	0
9/30/2013	123	129	125	1	0
6/30/2013	112	120	110	4	6
3/31/2013	110	118	118	0	0
12/31/2012	68	75	69	5	3
9/30/2012	60	59	58	1	0
6/30/2012	57	60	49	8	1
3/31/2012	45	50	48	1	1

This example assumes a financial statement date of Dec. 31, 2014, and further assumes full implementation of SSAP No. 84 retroactive to Jan. 1, 2012, with no transition. Exhibit C of SSAP No. 84 provides guidance on the implementation and transition periods.

A. The $150 represents the company's best estimate of rebates on drugs filled in the fourth quarter of 2014.

B. The $130 represents the company's best estimate of rebates to be received on drugs filled in the third quarter of 2014.

C. $133 is the actual amount of rebates determined for the third quarter of 2014, (i.e., the amount billed to the pharmaceutical company or confirmed to the pharmacy benefit manager). This amount was billed by Nov. 30, 2014. Therefore, the company estimated rebates of $130, but will actually receive $133 of rebates for the third quarter.

D. Assuming the $133 was billed on Nov. 30, 2014, the $62 represents the actual rebates received by the company during December 2014. In subsequent disclosures, the company would "update" this to include amounts received in January and February of 2015.

The admitted asset balance for pharmacy rebates at Dec. 31, 2014, would equal $150 + 133 – 62 = 221. (A+C–D)

Note: The collection columns do not represent quarterly time periods; e.g., first quarter, second quarter. They represent the three months following the date of billing. For the 3/31/14 (first quarter of 2014) line, actual rebates would have to be billed by May 31, so the column titled "Actual Rebates Collected within 90 Days of Invoicing/Confirmation" would represent collections between June 1 and August 31 (assuming the company billed on May 30).

Note 29 – Participating Policies

This Note requires the insurer to disclose information on participating contracts as required by *SSAP No. 51R—Life Contracts* and SSAP No. 54R. This Note is not applicable to title insurers.

Section		*Risks*
N.A.	Participating policies are policies where the contract holder is entitled to share in the insurer's equity earnings through dividends. The dividend amount reflects the difference between the premium charged and the actual experience. A participating policy dividend may be paid in cash, applied to premiums, left on deposit to accumulate interest, or applied to the purchase of, for example, an increment of paid-up insurance or term life insurance. The purpose of this disclosure is to provide information about the relative percentage of participating insurance, the method of accounting for policyholders' dividends, the amount	OP

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	of dividends, and the amount of any additional income allocated to participating policyholders in the financial statements. Dividends paid on participating insurance could potentially impact the insurer's financial position; therefore, the analyst should review the disclosure to determine the extent of any impact policyholder dividends have on the insurer's financials.	

Note 30 – Premium Deficiency Reserves

This Note requires the insurer to disclose information on premium deficiency reserves as required by SSAP No. 53 and SSAP No. 54R. This Note is not applicable to title insurers.

Section		*Risks*
N.A.	Premium deficiency reserves are established when anticipated losses, LAE, commissions and other acquisition costs, and maintenance costs exceed the recorded unearned premium reserve and any future installment premiums on existing policies. An additional liability for the deficiency and the corresponding charge to operations are recorded. This note requires the insurer to disclose the amount of premium deficiency reserves, the date of evaluation for premium deficiency reserves, and whether the reporting entity utilized anticipated investment income as a factor in the premium deficiency calculation. Premium deficiency reserves could impact the insurer's financial position; therefore, the analyst should review the disclosure to determine the extent of any impact on the insurer's financials.	RV

The remaining Notes are divided into three sections: 1) P/C; 2) Life/A&H and Fraternal; and 3) Health.

P/C Insurers

Note 31 – High Deductible Policies

This Note requires the insurer to disclose some basic information on high deductible policies. The information allows the analyst to gain a better understanding of the total credit risk the insurer is exposed to under these types of policies. The accounting guidance for high deductible policies is addressed in SSAP No. 65. High deductible plans are available from insurers; however, this type of plan is most often used with workers' compensation coverage. Under a high deductible plan, the insurer often settles all claims incurred under the policy (including claims that have yet to meet the deductible amount) and will need to recover the amounts from the insureds that fall within the deductible amount. In many states, the insured party is required to provide collateral for the deductible amount, while the insurer is responsible for periodically reviewing the financial viability of the insureds under the plan.

The liability for loss reserves under high deductible policies is determined in accordance with SSAP No. 55. Under SSAP No. 55, the insurer shall reserve losses from the inception of the policy period, not over the period after the deductible has been reached. Loss reserves established by the insurer should be net of deductible; however, no reserve credit should be permitted for any claim where any amount is due from the insured and determined to be uncollectable.

The insurers are permitted to report as an asset amounts recoverable from insureds for deductible reimbursements that are related to paid losses. The recoverable amounts need to be reported in accordance with policy provisions and be aged in accordance with their contractual due dates. Statutory accounting principles require an insurer to establish and report as non-admitted assets 10% of those deductible recoverable amounts due on paid losses that are in excess of the collateral specifically held and identifiable, on a per policy basis. In addition, any amounts in excess of the 10% that are not anticipated to be collected should also be non-admitted.

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Section		*Risks*
A	The analyst should review the financial statements for reserve credit that has been recorded for high deductibles on unpaid claims. If the amount is material, it is crucial that the analyst request additional information from the insurer to determine that an excessive credit has not been taken against the outstanding reserves. It is also important for the analyst to review the financial statements to determine whether the assets (deductibles recoverable) that have been billed and recoverable on paid claims are not past due and determine whether the proper amount of assets have been reported as non-admitted assets.	CR, OP, RV
B	For unsecured high deductible recoverables, the analyst should review the information provided in the Note to determine whether the individual obligor is a part of a group under the same management or control, such as a professional employer organization (PEO), and evaluate the total unsecured aggregate recoverables on high deductible policies for the entire group and the impact on credit risk.	CR, OP, RV

Note 32 – Discounting of Liabilities for Unpaid Losses or Unpaid Loss Adjustment Expenses

This Note requires the insurer to report certain information on reserves that have been discounted using a tabular basis or a non-tabular basis, and certain information if the insurer has made any changes in the assumptions used to discount its reserves.

Section		*Risks*
A	The analyst should use the information required in this Note to determine if the insurer has discounted its unpaid losses and/or LAE and, if so, whether concerns exist regarding the amount of the discount or the interest rate used. Present value discounting of P/C loss reserves is generally not an accepted statutory accounting practice, except in the instances of fixed and determinable payments, such as those resulting from workers' compensation tabular indemnity reserves and long-term disability claims. However, some state insurance departments may permit insurers to discount certain other long-tail liability lines of business, such as medical professional liability, on a non-tabular basis. All discounting, other than tabular discounting, must be approved by the domiciliary state insurance department and must be disclosed in General Interrogatories Part 2, #4.1 and #4.2 of the Quarterly Financial Statement. This disclosure includes a discussion of the discount rates used and the basis for using those rates.	RV
B	When establishing discounted loss reserve liabilities prescribed or permitted by the state of domicile using a non-tabular method, the liability shall be determined in accordance with *Actuarial Standard of Practice No. 20, Discounting of Property and Casualty Loss and Loss Adjustment Expense*, but according to SSAP No. 65, shall not exceed the lesser of two minimum requirements. The first requirement provides that if the reporting entity's statutory invested assets are at least equal to the total of all policyholders' reserves, the insurer's net rate of return on statutory invested assets, less 1.5%, should be used. Alternatively, if the reporting entity's invested assets do not at least equal the total of all policyholders' reserves, the insurer's average net portfolio yield rate less 1.5%, as indicated by dividing the net investment income earned by the average of the insurer's current and prior year total assets, should be used. The second requirement provides that the current yield to maturity on a United States Treasury debt instrument with maturities consistent with the expected payout of the liabilities should be used.	RV

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C	In addition to the above, if the rates used to discount prior accident years' reserves have changed from the previous Annual Financial Statement, the insurer is required to disclose the amount of discounted current reserves (excluding the current accident year) at current interest rate assumptions, the amount of discounted current reserves (excluding the current accident year) at previous interest rate assumptions, and the change in discounted reserves due to the change in interest rate assumptions.	RV

Note 33 – Asbestos/Environmental Reserves

This Note provides specific information on the insurer's asbestos and/or environmental (A&E) business as addressed in SSAP No. 65. This Note assists the analyst in determining whether unpaid losses and/or LAE include A&E reserves and, if so, whether concerns exist regarding the amount of A&E reserves. These types of claims are not as predictable as other types of risks and can be long-tail in nature; therefore, it is more difficult to establish an accurate reserve.

Section		*Risks*
A–F	It is key to determine if an insurer has recorded the A&E reserves in accordance with SSAP No. 55. The analyst should review the Note to ensure that an insurer's case or IBNR reserving methodologies are consistent with those required in SSAP No. 55. It is also necessary to make certain that the entity is fully disclosing all amounts paid and reserved for losses and LAE for A&E claims on a direct, assumed, and net of ceded reinsurance basis. Special attention may be raised as net A&E unpaid loss and LAE reserves surpass 15% of policyholders' surplus or there are significant shifts in A&E reserving. It is critical to review the Actuarial Opinion and verify that the figures in the Opinion are consistent with those reported in the Note. The Opinion might also provide additional disclosures that could be valuable to an analysis, such as information on the specific lines of A&E business.	RV

Note 34 – Subscriber Savings Accounts

Subscriber savings accounts (SSA) are defined in SSAP No. 72 as a portion of a reciprocal insurance company's surplus that has been identified as subscribers (policyholders) accounts. SSA is unique to reciprocals, as the policyholders are also the owners of the company.

Section		*Risks*
N.A.	The analyst should use the information in this Note to gain a better understanding of the amount and specifics of the insurer's SSA, including the conditions for repayment. There are two sources for deposits to SSAs. In the first, the individual subscriber may be the source of certain deposits to subscriber accounts, as some reciprocals may require subscriber contributions to join the reciprocal. In the second, the reciprocal is the source. By identifying as an SSA, a portion of its unassigned surplus is generated from its operations. The source of SSA deposits has a bearing on the proper financial statement presentation. The analyst might want to determine that the source of the funds from the individual subscriber is recorded as Other than Special Surplus. Likewise, the source of amounts from the reciprocals operations is reported as Unassigned Surplus. In this case, the individual subscriber accounts are merely an internal recordkeeping device and not an indicator of restrictions on the funds or an obligation to pay these amounts to the subscribers. The amount of surplus from operations that is identified as SSA is generally at the	OP

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	determination of the management of the company and its board of directors. SSA balances may be paid to subscribers, depending on domiciliary state law, upon termination of their association with the company, regardless of the source of the SSA. In this instance, any unpaid amounts owed to terminated subscribers must be reported as a liability. If the company has declared that it will distribute a certain amount of its Unassigned Surplus identified as SSA but has not actually distributed the amounts by the next reporting date, the company should decrease Unassigned Surplus by the amount approved and report the unpaid amount as a liability.	

Note 35 – Multiple Peril Crop Insurance

This Note requires the insurer to disclose information regarding the unearned premium reserve and administrative expense payments associated with multiple peril crop insurance and its subsidized relationship with the Federal Crop Insurance Corporation (FCIC). The Note for multiple peril crop insurance is required by *SSAP No. 78—Multiple Peril Crop Insurance*.

Section		*Risks*
N.A.	A liability for unearned premium reserve is established to reflect the amount of premium for the portion of the insurance coverage that has not yet expired. The Note requires the insurer to disclose the method used to compute the unearned premium reserve. FCIC subsidizes a percentage of premiums for administrative expenses associated with selling and servicing crop insurance policies, including the expense associated with adjusting claims. Catastrophic insurance is designed to provide farmers with coverage against extreme loss, whereas buy-up insurance covers more typical and smaller crop losses. The expense payment associated with the catastrophic coverage is recorded as a reduction of loss expenses, whereas the expense payment for the buy-up coverage is recorded as a reduction of other underwriting expenses. The insurer is required to disclose the total amounts received for each type of coverage. The analyst should review the disclosure to determine the extent of any impact these payments have on loss and underwriting expenses and net income.	RV, OP

Note 36 – Financial Guaranty Insurance

The underlying principles for financial guaranty insurance and accounting details are discussed in *SSAP No. 60—Financial Guaranty Insurance*. SSAP No. 60 defines financial guaranty insurance as protection against financial loss as a result of default, changes in interest rate levels, differentials in interest rate levels between markets or products, fluctuations in exchange between currencies, inconvertibility of one currency into another, inability to withdraw funds held in foreign countries as a result of government imposed restrictions, changes in value of specific assets or commodities, financial or commodity indices, or price levels in general. Financial guaranty insurance does not provide loss protection for events that occur due to fortuitous physical events, equipment operation failure or deficiency, or the inability to extract natural resources. Financial guaranty does not provide protection for losses related to various types of bonds (individual or schedule public official bonds, contract bonds, court bonds), credit insurance, guaranteed investment contracts, and residual value insurance.

Section		*Risks*
A, B	This Note requires the insurer to disclose information that enables the analyst to better understand the factors affecting the present and future recognition and measurement of financial guaranty insurance contracts. The analyst should review SSAP No. 60 to gain an overall understanding of financial guaranty insurance and the various risk/reserve requirements of each type of risk included in the Note. This will assist the analyst in	RV

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	understanding the overall risks in which the insurer is most exposed. This will also assist the analyst in determining any error by the insurer in reporting contracts that are (or are not) financial guaranty insurance that should (or should not) be reported under this Note.	

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LIFE, A&H AND FRATERNAL INSURERS

Note 31 – Reserves for Life Contracts and Annuity Contracts

The disclosures included in this Note will assist the analyst in evaluating the adequacy of reserves reported in Exhibits 5 and 7 of the Annual Financial Statement. The insurer's Statement of Actuarial Opinion is an additional source of information that may be helpful in evaluating the disclosure reported in this Note. See section III.B.8.b.i Statement of Actuarial Opinion Worksheet for specific guidance on evaluating an insurer's Statement of Actuarial Opinion. Due to the scope and complexity of the issues related to the establishment of life and deposit-type contract reserves, the analyst may wish to consider referring unusual disclosures to a qualified actuary for further review.

Life insurance reserves represent the liability for future policy benefits. Life reserves represent in theoretical terms the present value of future benefits to be paid less the present value of future net premiums receivable under the contract. The future benefits include but are not exclusive to such benefits as death benefits, endowment benefits or cash surrender values. The primary purpose of establishing life reserves is to ensure that future commitments to policyholders and their beneficiaries are met. See Section III. B. Annual Repository and Annual Reference Guide for Actuarial Opinion Assessment and Reserving Risk Assessment for specific guidance on evaluating an insurer's life reserves.

The principal guidance on establishment of life and deposit-type contract reserves is contained in SSAP 51 and *SSAP No. 52—Deposit-Type Contracts*. Detailed requirements regarding reserves are provided in Appendix A and C of the AP&P Manual. The Note requires specific disclosure relating to: 1) general reserving practices; 2) reserve methods for substandard policies; 3) deficiency reserves; 4) tabular interest and costs on life contracts; 5) tabular interest and costs on deposit-type contracts; and 6) other reserve changes. The following specific Appendices may provide further guidance to the analyst in evaluating the disclosures in this Note:

- Appendix A-585 establishes minimum reserving methods for universal life-type contracts
- Appendix A-620 discusses reserve requirements for accelerated benefits
- Appendix A-820 discusses provisions for reserving methodologies and assumptions used in computing policy reserves
- Appendix A-822 provides guidance on asset adequacy analysis
- Appendix C contains actuarial guidelines

Section		*Risks*
1	Disclosure of reserve practices required by SSAP No. 51 and SSAP No. 52 are illustrated in the NAIC *Annual Statement Instructions*. Actual disclosures included in the Note should be reviewed in relation to these typical illustrations. Unusual deviations or additional disclosures that appear material in relation to aggregate reserves reported by the insurer may be cause for further review. Specific attention should be given to material reserves disclosed in Exhibit 5, Section G, Miscellaneous Reserves, and in the footnotes to Exhibit 5.	RV
2	Substandard policies, or rated contracts, are those policies that were issued on lives that involved extra hazards due to physical condition, occupation, habits or family history and are therefore charged an extra premium. Reserving methods often differ for substandard policies. The analyst should use the information provided in the second part of this Note to evaluate these methods.	RV
3	A minimum reserve requirement is established in Appendix A-820 in situations where the gross premium charged is less than the valuation net premium (deficiency reserve). The analyst should use the third part of the Note to evaluate the amount of insurance in force	RV

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	that exists for which the gross premiums are less than the valuation net premiums. These deficiency reserves are typically reported as a separate item in Exhibit 5, Section G or may be reported with other life reserves in Section A.	
4, 5	Any disclosure that life contract or deposit-type contract tabular interest and/or costs were computed by a method other than that required by the NAIC *Annual Statement Instructions*, may be cause for further review. The analyst may refer to the NAIC *Annual Statement Instructions* for page 7, Analysis of Increase in Reserves During the Year, of the Annual Financial Statement, which describes a formula for calculating tabular interest, tabular less actual reserves released and tabular cost.	RV
6	Part six of this Note discusses other reserve changes that have occurred during the period. Significant changes in the valuation basis of reserves are reported in Exhibit 5A, and will be direct adjustments to the capital and surplus account on page 4 of the Annual Financial Statement. Disclosures may also relate to items reported on line 7 of page 7, Analysis of Increase in Reserves During the Year. Material amounts reported in the Annual Financial Statement or disclosed in the Note may be cause for concern and the analyst should consider whether further review by a qualified actuary is required.	RV

Note 32 – Analysis of Annuity Actuarial Reserves and Deposit Type Contract Liabilities by Withdrawal Characteristics

This Note provides information on the withdrawal characteristics of a reporting entity's annuities, deposit-type funds and other liabilities without life or disability contingencies and a reconciliation of total annuity actuarial reserves and deposit fund liabilities. The total of Part 1 should equal the total of Part 2, and the components of Part 2 should agree with the respective sections of Exhibits 5 and 7 of the general account Annual Financial Statement and Exhibit 3 and Page 3, Line 3 of the Separate Accounts Annual Financial Statement.

Section, (Part)		*Risks*
1 (A, B)	**Interest Rate Risk** The interest rate risk is the risk of losses due to changes in interest rates. The impact of interest rate changes will be greatest on those products where the guarantees are most in favor of the policyholder and where the policyholder is most likely to be responsive to interest rate changes. A mismatch of long-term or illiquid assets backing short-term liabilities could occur (the opposite could also occur). The Life RBC formula uses essentially the same categories as this Note to determine interest rate risk on annuity and deposit-type (ADF) reserves. For RBC purposes, ADF liabilities that are not withdrawable or withdrawable with market value adjustment are generally considered low risk and are captured in Sections B and A (1), respectively, of this Note. ADF liabilities withdrawable at book value less a current surrender charge of 5% or more are generally considered medium risk and are captured in Section A (2) of this Note. ADF liabilities withdrawable at market value are not assigned interest rate risk under RBC and are captured in Section A (3) of this Note. However, ADF liabilities that are withdrawable at book value without adjustment are generally considered high-risk and are captured in Section A (5) of this Note.	MK, LQ, RV
1 (E)	The analyst should review this Note and the information above to consider the overall interest rate risk that an insurer is exposed to. (The RBC formula also nets reinsurance ceded and policy loans, and adds modified coinsurance assumed, for the respective risk	MK, LQ, RV

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	categories.)	
1 (A–E)	**Liquidity Risk** In addition to interest rate risk, an insurer having ADF liabilities is subject to liquidity risk. Because this Note includes information on the charges that policyholders are subject to, the Note can also be useful in determining the amount of policyholder liabilities that could potentially be withdrawn in a stress scenario or otherwise (for instance, rollovers). However, this Note does not disclose the additional liquidity risk that might exist in guaranteed interest contracts (GICs) due to features imbedded in the contracts and the sophistication of GIC contract holders. GICs and other types of funding agreements are generally sold to sophisticated buyers, and high ratings are demanded by the marketplace (such as minimum ratings of AA- from Standard & Poor's and Aa3 from Moody's Investors Services). However, a highly rated insurer might enter into a fronting arrangement with a weaker reinsurance partner. In the event either or both the fronting insurer or the reinsurance partner do not manage their risks appropriately, they could both be destabilized by a "run on the bank." For insurers having significant direct and assumed exposure to GICs, it may be appropriate for the analyst to obtain additional information regarding the characteristics of the products being written by the insurer, with particular emphasis on features that may subject the insurer to significant liquidity risk. Such features may include contracts that allow for the surrender at book value in the event of a drop in credit ratings or seven-day to one-month put options. The institutional investors that invest in GICs and Funding Agreements seek safety. An external event such as a rating agency downgrade, general economic conditions resulting in a mismatch of an insurer's asset/liability yield curve or maturity distribution, or adverse publicity regarding the insurer, a reinsurer, a competitor, or the Company's peer group, could cause a stress scenario. It is imperative that a GIC issuer understands the risks imbedded in its contracts and has sound asset/liability management and liquidity risk management programs, and a specific contingency plan in place to deal with a stress scenario.	MK, LQ, RV
2 (F)	The insurer should reconcile total annuity reserves and deposit fund liabilities amount disclosed to the appropriate sections of the Aggregate Reserves for Life Policies and Contracts Exhibit and the Deposit Funds and Other Liabilities without Life or Disability Contingencies Exhibit, of the Life, A&H Annual Statement and the corresponding lines in the Separate Accounts Statement.	MK, LQ, RV

Note 33 – Analysis of Life Actuarial Reserves by Withdrawal Characteristics

This Note provides information on the amount of account value, cash value and reserve for the breakouts of life insurance by withdrawal characteristics, separately from General Account products, Separate Account with Gurantees products and Separate Account Nonguaranteed products.

Section		*Risks*
A - E	The analyst should review this Note and consider the overall risk that an insurer is exposed to. Please refer to the Interest Rate Risk and Liquidity Risk noted in Note 32 for additional guidance.	LQ, RV
F	The insurer should reconcile total life insurance reserves amount disclosed to the appropriate sections of the Aggregate Reserves for Life Policies and Contracts Exhibit (Exhibit 5) of the Life, Accident and Health Annual Statement and the corresponding lines in	LQ, RV

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	the Separate Accounts Statement. The reconciliation is a single presentation including all amounts from the sections on Individual Life insurance and Group Life Insurance.	

Note 34 – Premium and Annuity Considerations Deferred and Uncollected

This Note illustrates the premium and annuity considerations deferred and uncollected for each of the following business lines: industrial business, ordinary new and renewal business, credit life, and group life and annuity. The section includes uncollected and deferred premiums and annuity considerations, for each line of business listed above, on a gross basis and net of loading.

Section		*Risks*
N.A.	The reporting of deferred and uncollected premium and annuity considerations are addressed in SSAP No. 51. Per SSAP No. 51, uncollected premiums are gross premiums that are due and unpaid as of the reporting date, net of loading. Per SSAP No. 51, deferred premiums are modal (monthly, quarterly, semiannual) premium payments due after the valuation date, but before the next contract anniversary date. Reserves are calculated assuming payment of the current policy year's entire net annual premium, but the actual premiums are often paid in installments throughout the year. As such, reserves are overstated by the amount of modal premiums (net of loading) due between the valuation date and the next contract anniversary date. As a result, this asset is reported to offset the overstatement of the policy reserve. Deferred premium assets represent a liability offset and cannot be liquidated for solvency needs. The analyst should examine deferred premium assets in relation to total assets to help identify a liquidity problem. Additionally, high concentrations of uncollected premiums could point to collection problems and persistency problems.	CR, LQ
N.A.	Loading is the difference between net and gross premium. It represents the portion of a product's price designed to reimburse the insurer for its operating expenses, specifically commissions, premium taxes, and general operating expenses (excluding benefit and investment costs). Both uncollected and deferred assets are reported net of loading. This difference of recording the premium revenue and the corresponding asset requires that the change in the loading amount thereon for the period be recorded as an expense. When the load is negative (i.e., net premium is greater than the gross premium), it represents a deficiency reserve. Companies use deficiency reserves to lower the cost of a policy either to gain market share or because their own mortality experience is significantly better than the assumptions used in statutory accounting. Deficiency reserves, as captured in Exhibit 5, should be examined to determine if the insurer is relying too heavily on its experience to cover loading related expenses.	CR, LQ

Note 35 – Separate Accounts

This Note discloses detailed information on the reporting entity's separate account activity, a description of the general nature and characteristics of separate accounts business conducted by the insurer included in the company's Separate Accounts Statement as prescribed by *SSAP No. 56—Separate Accounts*, and a reconciliation of the amounts reported as transfers between the general and separate accounts in their respective summary of operations.

Separate accounts are authorized by state statutes to allow insurance companies to accumulate assets without investment restrictions for specific purposes pursuant to product agreements. SSAP No. 56 defines separate accounts as segregated pools of assets owned by a Life/Health insurer in which the investment experience is credited directly to the participating policies. Generally, performance is not guaranteed. Separate accounts were

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first used primarily to fund pension accounts. Now they are used for investment type products with unique life options and/or guaranteed returns. The investment income and any realized and unrealized capital gains or losses emanating from the separate account assets are credited or charged against the separate account policyholders. Separate accounts fund the liabilities for variable life insurance and annuities, modified guaranteed life insurance and annuities, or various group contracts under pension or other employee benefit plans.

SSAP No. 56 states that the separate account statement reports the assets, liabilities and operations of the separate account. Moreover, the Separate Accounts Annual Statement is concerned primarily with the recording of the cash flow of funds related to investment activities and obligations of the separate accounts and to document the transfer of funds between the separate account and the general account. Certain products found in the separate accounts contain risks that are the responsibility of the general account. Some of these are: Modified Guaranteed Annuities, Modified Guaranteed Life, and separate accounts established and filed with the regulator that provide guaranteed benefits – such as interest rate guarantees built into the product.

Section		*Risks*
A	Section (A) provides a detailed summary of the general nature of the reporting entity's separate account activity on the general account. In reviewing this note, the analyst should be able to identify those assets on the separate account that are legally isolated from claims on the general account. This note should also provide a total for those products on the separate account that have guarantees that are backed by the general account. This should include providing the total maximum guarantees, the amount of risk charges paid to the general account over the prior five-year period as compensation for the risk transferred to the general account and the total amount of guarantees paid by the general account to the separate account over the past five years. The analyst should gain an understanding of general account guarantees on separate account products. If the General Interrogatories indicate that the insurer provides guarantees on separate account assets, then there should be some risk charges paid to general accounts. Otherwise the insurer is not charging any risk fees for providing guarantees that could result in contingent liabilities to the general account. Note that while group products require risk charges, there may be no requirements for risk charges on individual products. The analyst should determine whether there were any securities lending transactions within the separate account and conduct a separate review of the amount of loaned securities within the separate account. The analyst should determine whether the investment policies and procedures for the separate account differ from those for the general account.	OP, RV
B	Section (B) focuses primarily on the impact that separate accounts activities may have on the general account. It should help to answer the question, to what extent is the general account at risk due to the separate account products. Most of the exposure to the general account is caused by the nature and structure of the products held in the separate account. The general account may have inherent financial risk due to the potential deficiency in the assets of separate accounts backing minimum payment or guarantee products. An example is a variable annuity contract containing a guarantee for the return of consideration paid on the death of the contract holder occurring within a certain time period. Any excess of the benefit paid over the separate account asset value is charged against the general account. The analyst should determine whether and to what extent the general account is at risk. Part A is the most critical for making that determination. With many of the separate account products, the policyholder absorbs the entire investment risk. However, other types of separate accounts products include guarantees in the form of minimum death benefits, minimum interest rates and waiver of surrender charge under certain conditions.	OP, RV

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	Any minimum guaranteed obligation must be recorded on the general account of the insurer since, by definition, the entire asset transferred to the separate account is at risk. More specifically the analyst should review the information provided in this section of the Note to determine if the company (general account) has any liability to its separate account caused by imbedded obligations or guarantees granted to products recorded in the separate account. They should evaluate the quantitative breakdown for each of the risk categories – indexed, non-indexed, with guaranteed rates no greater than 4%, with rates greater than 4%, etc. – as reported to determine whether the amounts are large enough to cause significant risk to the general account. In the case of investments involving equity indexed separate accounts, the risk to the general account is normally minimal. The risk on these products is normally minimal because investments are usually hedged. Non-indexed separate accounts with interest guarantees in excess of a year that do not exceed 4% are moderately risky. The risk on these products is moderate because in a market downturn, the insurer could have difficulty providing this return, but in most cases, the guarantee should be easily obtained. However, this risk would generally have to be picked up by the general account. Non-indexed separate accounts with an interest guarantee in excess of a year that exceeds 4% are at the highest risk. The risk on these products can be high because in a market downturn, the insurer may not be able to meet the guarantee with the assets supporting the risk. Non-guaranteed separate accounts consist of variable separate accounts where the benefit is determined by the performance and/or market value of the investments held in the separate account. The accounts are low risk, nominal expense and minimum death benefit guarantees. The analyst should note whether the reserves were established with withdrawal characteristics such as subject to discretionary withdrawal, have a market value adjustment or withdrawal at book value without a market value adjustment and with or without surrender charge. The analyst should refer to Note 12 for further discussion of various types of liquidity risk for the various products. However, in most cases, liquidity risk for the insurance company for most separate account products is limited.	
C	In Section C, the analyst should verify whether the reconciliation provided by the insurer disclosing the amount reported as transfers to and from separate accounts in the Summary of Operations of the separate account statement agrees to the amount reported as net transfers to or from separate accounts in the Summary of Operations of the general account statement.	OP, RV

Note 36 – Loss/Claim Adjustment Expenses

This Note discloses the balance of liabilities for unpaid loss/claim adjustment expenses, incurred loss/claim adjustment expenses, the payment of loss/claim adjustment expenses and estimates of the average salvage and subrogation. Life and annuity contracts are not subject to this disclosure requirement.

Section		*Risks*
1–3	The reporting of claim liabilities and claims adjustment expenses are addressed in SSAP No. 55. SSAP No. 55 addresses claim adjustment expenses on A&H contracts and managed care contracts. Claims adjustment expenses are those costs that are expected to be incurred in connection with the adjustment and recording of A&H claims. Certain claim adjustment expenses reduce the number or cost of health services thereby resulting in lower premiums or lower premium increases. Claims adjustment expenses can be divided into cost containment expenses and other claim adjustment expenses and are further defined in SSAP No. 55.	RV

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	An analyst should review the Note and the liability for unpaid claims, unpaid losses and loss/claim adjustment expenses to determine if they appear reasonable. Further analysis may be necessary to determine if the method used to calculate the liability is consistent with SSAP No. 55. If the reserve development and/or the company's response to the Note cause the analyst some concern, prior reserve analyses may be reviewed or the analyst may need to question the company's reserves and loss/claim adjustment expenses and address supplemental procedures for reserves.	
4	Salvage refers to the amount received by an insurer for property on which the insurer has paid a claim. Subrogation refers to the right of an insurer to pursue any course of action against a third party for a loss to an insured for which the insurer has paid a claim and to receive reimbursement from the third party. SSAP No. 55 states that the estimated amounts of salvage and subrogation recoverables shall be determined in a manner consistent with the accounting guidance for estimating the liability for claim reserves, claim liabilities, unpaid losses and loss/claim adjustment expenses. Salvage and subrogation are deducted from the liabilities for unpaid claims or losses.	RV

HEALTH INSURERS

Note 31 – Anticipated Salvage and Subrogation

This Note requires a health entity to disclose salvage and subrogation recoverables. The accounting guidance for salvage and subrogation is included in SSAP No. 55. Salvage refers to the amount received by a health entity for property on which the health entity has paid a claim. Subrogation refers to the right of a health entity to pursue any course of action against a third party for a loss to an insured for which the health entity has paid a claim and to receive reimbursement from the third party. SSAP No. 55 states that the estimated amounts of salvage and subrogation recoverables shall be determined in a manner consistent with the accounting guidance within the SSAP for estimating the liability for claim reserves, claim liabilities, unpaid losses and loss/claim adjustment expenses. Salvage and subrogation are deducted from the liabilities for unpaid claims or losses.

Section		*Risks*
N.A.	SSAP No. 55 requires a health entity to disclose estimates of anticipated salvage and subrogation including amounts recoverable from second injury funds, other governmental agencies, or quasi-governmental agencies, where applicable. An analyst should review the Note and the liability for unpaid claims and losses to determine if the estimated recoverable appears reasonable. Further analysis may be necessary to determine if the method used to calculate the recoverable are consistent with SSAP No. 55 and to determine the impact on the balance sheet of any large recoverable amounts.	RV

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Medical Insurance Markets

There are a number of different entities that are licensed or authorized to do business in Health insurance. These entities may be licensed differently and subject to entity specific accounting rules and regulations. They may also report their annual and quarterly financial data on differing NAIC statement blanks and calculate risk-based capital (RBC) requirements on entity specific RBC blanks. Although some differences in treatment remain, codification and changes in reporting blank requirements and RBC rules recognize the similarities between these types of entities. In addition, the various types of entities may focus on differing methods of providing health coverage. Health insurance is a very encompassing line of business. It includes the primary lines, comprehensive major medical, dental and vision, plus similar products, but it also includes disability, long-term care (LTC) and other non-traditional health coverage that entities covered by this Handbook may underwrite.

The primary risk for Health entities in the medical insurance market is that the premiums charged may not cover the cost of the services provided or benefits paid. This can happen when health care cost increases are more than those estimated when premiums are calculated. Health care insurance premiums are driven primarily by the claims costs that they pay for. Rising health care costs and the related increase in the numbers of uninsureds are topics of national concern, but few understand all of the forces behind these issues and how they affect health entities. Health care claims costs are driven by the overall cost of health care and the increase in the number and types of services covered.

1. Different Types of Health Carriers

Many Blue Cross Blue Shield Plans and Delta Dental plans are licensed as Hospital, Medical and Dental Service or Indemnity Corporations (HMDIs). Health Maintenance Organizations (HMOs) generally provide prepaid health service and may be licensed by State Insurance Departments and/or issued Certificates of Authority by other state regulatory bodies (e.g., the State Department of Health). Health entities licensed as Limited Health Service Organizations (LHSOs) are organized to provide a single specific type of coverage such as dental or vision.

The HMDIs, HMOs and LHSOs were consolidated into one statutory financial reporting blank and one RBC formula in 2001. Although the accounting has been standardized, each are subject to state laws and regulations based upon their state license. These entities generally issue managed care contracts that pay participating providers of medical care directly with limited expense to the policyholder. HMDIs tend to provide service benefits via Preferred Provider Organizations (PPO) and HMO lines of business, and some offer indemnity policies similar to those offered by Life and Accident and Health (Life/A&H) insurers and Property/Casualty (P/C) insurers.

Companies licensed as Life or A&H file the Life/A&H blank and use the Life RBC formula. Some Blue Cross Blue Shield Plans are licensed as Life/A&H carriers, possibly with a separate income statement and supporting exhibits for the HMO line. Companies filing the Life/A&H blank are subject to some accounting rules that differ from the rules followed by Health blank or P/C blank companies (e.g., mostly involving the Asset Valuation Reserve (AVR) and Interest Maintenance Reserve (IMR) requirements). The Life RBC formula often results in higher RBC requirements due to its treatment of individual health insurance and other factors. After the Health Statement Test is implemented, a company that writes more than 95% health[1] will use the Health RBC formula and file the Health blank and hence will be considered a health entity for purposes of this handbook, but the company will still be subject to some laws and regulations specific to Life/A&H insurers such as the Standard Valuation Law. Life insurers will be required to perform asset adequacy analysis pursuant to the requirements of the state's valuation manual. In contrast to most asset adequacy analysis, for most health entities, it will generally be sufficient to consider the adequacy of the future premiums (assuming that short-term assets exceed short-term liabilities).

[1] For the purposes of the Health Statement Test, "health" is defined to include comprehensive major medical, dental and vision, plus similar products. Premiums for health coverage like disability income (DI) and long-term care insurance (LTCI) do not count toward the 95% requirement. The 95% rule must be passed based on both earned premiums and reserves.

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State law may also permit insurance companies to be licensed to write only A&H business. Such insurance companies generally will not be subject to the Standard Valuation Law and will file a Health blank.

P/C companies also have certain accounting standards that are not applicable to health entities**,** a different statutory blank, and a different RBC formula. There are a small number of Blue Cross Blue Shield Plans that are licensed as P/C carriers. After the Health Statement Test is implemented, a P/C company that meets the Health Statement Test will use the health RBC formula and file the Health blank.

Life/A&H insurers and P/C insurers generally issue indemnity policies, which reimburse policyholders a set dollar amount for claims they pay or make direct payments to providers who have been assigned payments (under the policy), by the policyholder.

Many health entities develop their own PPOs that sometimes resemble HMOs. There are several large national provider groups—Independent Provider Associations (IPAs)—that have created PPOs, contracting with providers for discounts and entering into contracts with insurers to supplement insurers' networks locally or nationally to render health services to policyholders of the health entity. PPOs can also perform medical management such as utilization review and inpatient pre-authorization. IPAs are normally not allowed to assume insurance risk for the services provided by its contracted providers and often contract directly with self-funded employers. In some states, IPAs are required to be licensed by the Insurance Department.

A term that is sometimes used is "risk bearing entity" (RBE). While in the past RBE has often been used as a generic term for any type of entity that is taking on insurance type risk, the *Health Maintenance Organization Model Act* (#430), NAIC uses the term RBE to refer specifically to provider groups and similar unlicensed entities that take insurance type risks from health entities. In some states, RBEs are required to do special reporting to insurance regulators, and some states require special licenses for RBEs to monitor for solvency. This occurred in the early years when IPAs were paid a capitation for services and then paid the contracted providers on a reduced fee-for-service basis as they are assuming insurance risk. If the IPA became insolvent because the costs of health care being provided were more than the capitation payments, the health entity was responsible for finding other providers for its members. Over the past 10 years, such network arrangements have become more commonplace, and more attention has been paid to ensure financial solvency. New payment arrangements, with more sophisticated technology to enable them, are now seen. Federal programs to encourage value-based payment and the development of Accountable Care Organizations (ACOs) have stimulated providers and insurers to work together as well.

More detail on types of coverage and underlying arrangements is presented in the Health Lines of Business section.

2. Health Care Cost Increases – General

Pressures come from many directions - from new technologies, new specialty drugs, new medical devices, new treatments, new ways to provide health care, an increased number of preventive care mandates that help in identifying underlying conditions, and mandated requirements to cover additional services. Health entities in the voluntary market face the financial pressures to keep premiums down while still covering all the services they insure. Overall, the cost of health care is increasing much more than general inflation.

Despite the common belief that the aging of America and the high cost of medical malpractice are driving these costs, those factors are not the main drivers of the increase in health care premiums. The key drivers of health care premium increases are advances in medical technology and subsequent increases in utilization, excess price inflation for medical services, drugs and the new biologics, cost-shifting, the high cost of regulatory compliance, and patient lifestyle choices (e.g., physical inactivity and increases in obesity). The overall cost of health care also increases as the services are used more. The average number of services used by Americans is also increasing. As with any industry, use of services increases with advertisement. Aggressive prescription drug advertising stimulates increased use of many prescription drugs. And lower co-payments for prescriptions have masked the true cost to the consumer and contributed to higher demand.

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We see more cures for certain conditions and more treatments for cancer. Yet new treatments, technology and drugs add cost to the health care market in two ways. First, they provide new and often expensive services to the range of treatments available. Second, those procedures, along with the use of long-term treatments or drugs—sometimes for the rest of the patient's life—potentially add many years of higher health care consumption to a person's life.

3. Health Care Cost Increases – Insurance Issues

The cost of health insurance is affected by the factors that contribute to overall health care costs, and by economic pressures. First, when services are covered by insurance there is a tendency by individuals to use more services. An individual that has to pay for services directly may decide that they are not worth the cost, but if the services are virtually free to the consumer or are available at a significantly reduced cost, then the individual will have more of a tendency to utilize them.

Individuals with high health care costs are more likely to purchase more comprehensive insurance and are less likely to drop their coverage. In a totally voluntary health insurance market, segments of the market would become too expensive as self-selection (also known as adverse-selection or anti-selection) crowds out the price-sensitive healthy individuals, leaving the frequent users of health care. The health insurance market in the United States is primarily paid for by employers, with employees paying only a small part of their insurance premiums. This eliminates many of the problems of self-selection, but its effects on premiums can be seen in the individual and small group markets where there is more self-selection. The changes made in the individual and small group markets since the federal Affordable Care Act (ACA) went into effect beginning in 2010—and with revised market rules, essential health benefits (EHB) mandate, and health insurance exchanges and the Small Business Health Options Program (SHOP) that went into effect January 1, 2014—saw the challenges of adverse selection. Health entities have to be careful that their benefit designs are not appreciably richer than the competition or include benefits not found elsewhere in the market, as they run the risk that self-selection will drive up their health care claims cost.

Legislators have often urged coverage for health care services that might otherwise not be covered by insurers in their states. Sometimes providers whose services are not covered under health policies lobby state officials to mandate their services be covered. At other times, individuals with special needs, or their public advocates, lobby to have benefits, such as treatments for infertility, covered by all health plans. As these benefits are mandated, they lead to more utilization in the insured population than prior to the mandate, thereby increasing the health care costs of insured individuals.

Another reason that the cost of health insurance may increase faster than overall health care costs is "deductible leveraging." This phenomenon occurs when the insured person must pay some "corridor" amount that is not covered by the insurance policy (first-dollar deductible, copayment, etc.), and the corridor is not proportionate to the full claim amount. Deductible leveraging reflects the fact that, if the insured person's responsibility for payment is limited to a fixed dollar amount, then the health entity must pay the entirety of any remaining medical cost increase and not just a proportionate share. This perhaps can be seen most clearly from an example. Insurance coverage provides for payment of medical expenses in excess of a $1,000 deductible. If a person's medical expenses are $1,500, the health entity will pay $500. If the expenses increase by 10% in the next year, to $1,650, and the deductible has not been changed, then the health entity will pay $650, an increase of 30% over the health entity's prior-year payment of $500. Since the health entity's expense has increased 30%, that increase, and not merely the underlying 10% increase, will have to be reflected in premium rates. The impact of deductible leveraging can be mitigated only by shifting additional costs directly to the insured. It is noted that many plans adjust their copayments and deductibles for inflation on an annual basis.

The combination of the general and insurance cost increases described above have resulted in two phenomena. First is an increase in Employment Retirement Income Security Act (ERISA) uninsured plans. These plans are often administered by health entities and are referred to as Administrative Service Only (ASO) or Administrative Service Contract (ASC) plans. The plan designs and coverages are more flexible and

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are not regulated by State Insurance Departments. Second is an increase in the number of employers discontinuing sponsored coverage, leading to increases in the number of uninsured and in the size of the voluntary individual market.

The issue of increased cost and its impact on availability can be addressed through various risk sharing methods including the following:

- Premium risk sharing – the most obvious is experience rating of large employers.
- Claim risk sharing – the use of deductibles and coinsurance or co-pays shares the risk with the claimant and is designed to encourage the use of only necessary services.
- Health Savings Accounts (HSAs) – the use of a federally qualified high-deductible health plan (HDHP) linked to a health savings account is increasingly used by employers that contribute to the dedicated health savings account[2] (that is portable, belonging to the employee/accountholder) that employees can use in covering the deductible and other federal tax-eligible health expenses.
- Provider risk sharing – the use of capitation, withholds, provider discounts, bundled payments, value-based payments and plans to encourage quality care through bonuses, shared savings and shared risks programs that share the risks and rewards of effective health coverage with the providers.
- Stop-loss risk – this risk relates to infrequent but very high cost claims. Health entities may transfer this risk through excess-of-loss reinsurance. For individual stop-loss coverage, the reinsurer provides payments to the health entity when a single claim exceeds a specified loss figure, generally called retention. Stop-loss may have a high individual limit (above the limit applied to an individual, where the health entity is assuming risk, the health entity would be at risk) and/or an aggregate limit (e.g., when the total claims for the group exceeds some factor times the expected claims).

  Integrated health plans, which are health care providers and health systems that offer integrated health insurance, also use stop-loss coverage. And health entities also assume individual or aggregate stop-loss risk from other health entities. Health entities also assume the risk of infrequent but very high-cost claims from self-insured employers having ASO/ASC contracts or from capitated providers. To attract ASO business or encourage provider risk-sharing, the health entity may need to offer insurance (assume the risk) against the most costly claims.

  A health entity's past experience when using any of these risk-sharing approaches should be part of the analyst's assessment. Note that the manner in which they can be used will differ from market to market.

4. Regulatory Landscape

The health insurance industry is highly regulated. Besides the mandated benefits and review of payment methodologies mentioned above, there are state and federal regulations in financial and non-financial operations of all health entities. Historically, insurance has been regulated at the state level, unless preempted by ERISA. In recent history, there are more and more federal laws and regulation of health entities. Typically the federal regulation will prevail unless the state regulation is more restrictive.

Analysts should be familiar with federal regulations on a high level and have a detailed understanding of state regulations that affect financial issues. On a federal level, ERISA preempts self-insured employer groups from state laws. The self-funded uninsured plans are exempt from premium tax and state mandated benefits. The Health Insurance Portability and Availability Act (HIPAA) is a federal law that, among other things, specifies requirements for guarantee issue and renewability for individual and small group health insurance. HIPAA also has rules for claims data coding and privacy of health information. HIPAA was also

[2] A health savings account (HAS) is a tax-exempt trust or custodial account the employee sets up with a qualified HSA trustee to pay or reimburse certain medical expenses they incur. To be eligible for an HSA, the individual must be enrolled in a high-deductible health plan (HDHP).

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amended by the ACA, and subsequent rulemaking regarding individual and small group product renewals, modifications and terminations has gone into effect after Jan. 1, 2014.

One of the risks that health entities face is state or federal requirements that they did not anticipate when pricing their products, or the risk that the cost of complying is higher than they estimated when calculating premiums. A health entity can be placed at a competitive disadvantage if it is subject to a state law that does not affect its competitors. This happens when a law applies to one segment of the market and not to another. For example, certain health entities may be subject to certain state rating restrictions that do not apply to other types of health entities.

The ACA included new rate review requirements for state insurance regulators that went into effect in 2012 and rate filing requirements for health entities that went in to effect Jan. 1, 2014. The ACA medical loss ratio (MLR) provision went into effect in 2011. This ACA provision requires health insurance companies to spend no less than 80% in the individual and small group market and 85% of premium dollars in the large group market on health and medical care quality improvement, or else be required to provide a rebate to their policyholders. The NAIC Annual Statement Supplemental Healthcare Exhibit assists state insurance states regulators in identifying the unadjusted components that comprise the MLR calculation (not the final federal MLR). The exhibit is also intended to provide a means to compare individual financial results of healthcare business and its impact upon insurance companies.

State health insurance regulation covers both financial and market conduct. Financial regulations include deposit requirements, RBC requirements, and mandated benefits. Market conduct requirements can affect financial strength if they become expensive to administer, such as adding to costs by reducing the ability to control waste and fraud or through defensive medical insurance administration. Certain entities such as HMOs have some or all aspects of their business regulated by state agencies other than the state insurance department.

Guaranty Associations – In the event that a health entity becomes insolvent, a state guaranty association may make payment of claims for which the insolvent entity does not have sufficient funds, within prescribed limits. (Note that HMOs are not members of guaranty associations in all states, and in states where HMOs are not members, the claims of insolvent HMOs will not be paid by the associations.) The cost of funding these benefits is assessed against the association members, who may in turn receive the right to offset their assessments against future premium tax payments or to recover the assessments by some other means such as premium surcharges.

For HMOs, most states have adopted some version of Model #430, which protects policyholders in several ways. If an HMO becomes insolvent, the other HMOs in the state are obligated to issue policies to the "orphaned" policyholders of the insolvent entity. Also, all HMO contracts with network providers must include clauses that the providers will "hold harmless" or not bill policyholders for services if the HMO is unable to pay. These protections do not protect policyholders from non-network provider claims and do not guarantee the policyholders can purchase coverage at their current premium rates or have access to their current providers.

State law may also require HMOs to establish a plan to address the risk of insolvency in order to ensure at least temporary continuation of coverage to policyholders. Some of the methods used may include insolvency reinsurance, special deposits and third-party financial guarantees.

5. Public Insurance Products

Public health care programs, including Medicare and Medicaid, cover a large portion of the population. Medicare and Medicaid mitigate their costs by paying enabled reduced amounts to providers that are set by law. Every year, the cost trends for Medicare and Medicaid must be within governmental budgets. Since these cost trends are, as a result, frequently lower than the increase in medical inflation, the result is "cost shifting" to hospitals and physicians, who then may charge more to non-Medicare and non-Medicaid patients in order to make up the difference. This cost shifting exacerbates the tendency for private (non-

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public) health insurance costs to increase at a rate exceeding the overall rate of medical inflation. States have increasingly used Medicaid funded programs to insure children and the working poor to counteract the increase in the uninsured population. Most public health products are fully supported by federal or state programs (Medicare and Medicaid) although some health entities may also be involved on a risk-taking basis. In most of these cases, the health entity must provide all the care/benefits that the program requires but is paid a fixed fee by the program (e.g., Medicaid HMOs, Medicaid Managed Care Organizations (MCOs), and Medicare Advantage and Medicare Part D for prescription drugs). These sub-markets involving health entities have different risks than the primary markets (non-government) since the primary markets do not have fiscal constraints. The Health Lines of Business section below will describe these risks.

Public Employee Plans – Many states provide health coverage for their employees through contracts with a health entity. Regardless of whether the health entity retains the risk, or whether the state retains the risk, and the health entity serves as administrator, these are really no different than private insured plans or uninsured ASO/ASC plans of large employers, with one exception. Frequently because of budget problems, the state may have temporary difficulty keeping the funding of its health coverage current. While statutory accounting does not require receivables from state groups and other large public programs to be non-admitted after 90 days. Analysts should make sure that the amount held is truly payable within a reasonable time.

Assessment Plans – Some health coverage may be provided through programs where the premium is not intended to cover the health care costs and administration (e.g., high risk pools or small employer reinsurance pools) and health entities are subject to assessments for the pool's deficiency. Assessments may be required to cover the costs of the insolvency of another health carrier or health entity through a state's guaranty fund assessments. Assessments may be prescribed by legislatures to address unpaid amounts demanded by providers. In most situations these assessments are reasonably small but cannot be forecasted with any accuracy. Analysts should review the history of assessments paid by the entity and any requests that are outstanding to determine that appropriate liabilities have been established and premium adequacy tests reflect anticipated costs. Note that most of these assessment programs have escape clauses so that health entities in financial trouble do not have to pay their assessments. Unfortunately, few health entities are willing to request this public declaration of financial trouble because of the impact on their business.

Assigned Risk Plans – Some health coverage may be "forced issue" of standard rate coverage to a proportional share of a high-risk market (uninsurable or group-to-individual HIPAA eligibles). The inadequate revenue from these few individuals is expected to be subsidized within the standard rate for all lives. Proper recognition of the additional risk in premium assumptions is necessary, so that there is an adequate margin to cover potential additional costs of "after-the-fact" adjustments.

6. Private Insurance Products

These products make up the voluntary market as the insured (employer, employee, and individual) may decide to start or continue coverage by paying the required premium. As these premiums increase, the insured may opt to revise benefits or even drop the coverage. Health entities must, generally, renew any policy already issued unless they can offer similar policies to replace a terminated product (a HIPAA product withdrawal, which requires 90-day notices by federal law and in most states). If they have no other products to offer in that market (individual market or small group market) it would be considered a market exit, which would prohibit the health insurer from reentering that market for five years (a HIPAA market exit requires 180 days' notice by federal law). As noted elsewhere, some of the markets have specific additional requirements for guaranteed issues or mandated benefits and premium subsidization. These are described in the Health Lines of Business section.

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Health Lines of Business

This section describes the variations in lines of health insurance that can be written by a health entity. The Product Types section will describe in more detail the additional distinctions within the primary line of health coverage – comprehensive major medical.

These variations arise from the nature of the relationship between the health entity and the insured population and the type or types of coverage provided by contract, including variations in provider networks and in processing.

Nature of the Relationship

The relationship may be direct (Individual), through employment (Employer Group), by affiliation (Association) or under a government-sponsored/subsidized arrangement. Distinctive risks for each of these relationships will differ by the type of coverage and will be discussed within the next subsection below.

- Individual coverage represents a small portion of the primary health coverage but is a larger share of certain other lines (disability income, LTC, specified disease and Medicare supplement). The contract may cover the insured as well as family members. The renewal provisions of individual contracts are important. Prior to the ACA, medical underwriting in the individual comprehensive insurance meant that if the insurance was cancelled, many of the insureds were not able to replace it because of their poor health. The ACA required the elimination of non-coverage of pre-existing conditions in the individual and small group markets beginning Jan. 1, 2014.[3] (Recent federal legislation is considering repeal of some portions of the ACA, but this is an area unlikely to change.)

- Employer Group coverage represents the largest portion of the primary health coverage lines and a growing portion for most other lines. The market needs to be sub-categorized into components because the regulations (and risks) of each sub-category are very different.

    - Small Group Market – Group size depends on state laws but is generally from 2-50 employees and applies only to primary health coverage. States (with limits defined by HIPAA) have adopted specific laws for guaranteed issue to these groups. Employers pay the premium with employees sharing the cost on a non-discriminatory basis (i.e., rates can vary depending on the age of the employee, the number of family members covered and location, but not based upon the employee's health). Some states mandate full community rating in this market. The ACA market rules mandate a version of adjusted community rating that allows age, number of family members covered, geography and smoking/non-smoking to be considered. ERISA rules allow for regulation of the insurance contract and most contracts are for participants all living in a single state, but some may include variations in benefits by state of residence of the insured employee to meet state mandates.

    - Large Group Market – Groups that are larger than the state definition of small group and again apply to primary health coverage. There generally are no guaranteed issue policies in this market, but there is also little problem for these groups to obtain coverage given their size and internal ability to spread risk. Employers pay the premiums with employees sharing the cost (generally only varies by employee-only versus family coverage) although many of these employers offer more than one plan to employees. This aspect creates potential risk for the health entity offering the richest benefit package unless the employee share is substantially higher than for other packages. Rates for this market are generally set based upon the experience of the group. In addition, the largest of these groups have considerable options for risk sharing, from fully insured, to complete retention of risk through ASO/ASC, to high deductible minimum premium policies or retrospective experience rating.

    - Association Health Plans – Primary health coverage may be available for many employers (some are structured for individual professionals) through a common association. These arrangements will provide

[3] *https://www.gpo.gov/fdsys/pkg/CFR-2010-title45-vol1/pdf/CFR-2010-title45-vol1-sec147-108.pdf*.

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similar coverage and pooling to the employers (or individuals) who participate. Currently, these arrangements use a health entity to provide the insurance and the contract is subject to varying state regulation depending on the status of the contract and the manner in which states deal with certificates for out-of-state groups. The ACA affected individual professionals in Association Health Plans as owner-operators with no employees were not able to obtain group coverage through Association Health Plans but were rated as individuals.

- Other Types of Coverage – Most other types of employer-based coverage will be described below as a part of Affiliation coverage. Three areas of broad employer coverage are disability income (DI) coverage (which may be employer-pay or employee-pay but the benefits are defined in terms of salary and long-term disability versus short-term disability), Accidental Death & Dismemberment (which is provided or offered as multiples of annual salary) and cafeteria plans (where the employer contribution and additional pre-tax employee salary reductions can be used to select from a list of health and non-health benefits – this approach again creates risk to health entities with rich benefit packages).

- Affiliation coverage includes both primary health coverage (Association Health Plans above) as well as most other types of coverage. The affiliation may be the employer (but without any contribution), an association (e.g., American Association of Retired Persons (AARP)), a labor union or an interest group (Sierra Club). Besides primary health coverage, this can include the sale of limited pay/supplemental coverage ("workplace" sales of accident, specified disease, hospital indemnity, etc.), Medicare supplement, disability income, and LTC using a group contract where the certificate comes close to an individual policy contract. Premiums may be based on the entire group, the group within a state or the actual individual (with underwriting based premium variations - substandard, non-tobacco use discounts, etc.).

- Government Sponsored/Subsidized Arrangements include primary health care (Federal Employees Health Benefit Plan (FEHBP), Children's Health Insurance Plans (CHIP), Medicaid, Medicare Advantage), as well as the federal Long-Term Care Insurance (LTCI) offering to government employees, retirees, and military. When government units act as the employer, the coverage would be included in the above sections since these arrangements do not have unique risks. The ones mentioned in this paragraph have the 'normal' insurance risk plus added risks that deal with the federal regulations involved as well as the frequent exemption from state regulations.

Types of Coverage

The characteristics of each type of coverage that define the risks derive from the manner in which benefits are provided (breadth of coverage), the effect of changes in medicine and delivery of medical care (morbidity and claim costs) and specific regulations that apply (e.g., individual health insurance exchange Qualified Health Plans (QHPs), SHOP, Small Employer regulations, Medicare supplement standardized plans, LTC level premium and inflationary protection).

- Individual – Prior to the ACA, comprehensive coverage was frequently underwritten and, therefore, subject to rate variations based on the applicant's health to offset self-selection. States varied allowable underwriting practices and addressed the availability of individual coverage for people who met HIPAA eligibility for Group-to-Individual conversion. The unique risks for this market are the heightened impact of self-selection (both at issue and through the effects of healthier individuals lapsing coverage). However, the ACA's permanent risk adjustment program is intended to mitigate that risk by reallocating premium among issuers based primarily on the health status of individuals. There are high administrative costs relative to other relationship arrangements, both annually and for acquisition of new business. The increased access under the ACA for the uninsured through state or federally facilitated health exchanges added additional administrative costs for QHP insurers, and represented increased risk volatility and higher claims costs in the individual market. Each year since 2010, there were mandated changes in coverage or market rules, creating more regulatory challenges in the individual insurance market. From a regulatory point-of-view, this market will typically be a smaller portion of the health entity's total business.

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One aspect of risk is to review the health entity's participation in a state's health benefit exchange, or the state's other provision for offering coverage to the uninsured and HIPAA eligible. States may use various approaches—such as high-risk pools, reinsurance pools or group conversion policies—other than through an assessment or may require all or some to offer specific coverage even if the individual would not pass normal underwriting rules. These are issues that may be reconsidered by Congress, and if given the option to do so, in the states.

- Small Employer – Variations by state are key in determining the unique risks for this market. Prior to the ACA, state insurance regulators would need to consider the benefit packages that were required to be offered and pricing allowances for demographic differences (e.g., age, sex, location) or health (claims experience and morbidity). Post ACA, each state selected the EHB package that would be required beginning in Jan. 1, 2014 (except for pre-2010 grandfathered plans or pre-2014 grand mothered plans). The ACA adjusted community rating also eliminated rating by gender, industry or health status. The degree of limitations and the share of the market together create different levels of risk to health entities. Some allowances for demographics and/or health allow companies with a small share of the market to participate while the lack of any pricing allowance (i.e., community rating) presents a much higher risk for a company with a 1% share than a company with a 25% or greater share, since it is unlikely that all companies will end up with exactly their share of the small employers with the highest actual costs. As in the case of individual coverage, the ACA's permanent risk adjustment program is intended to mitigate the associated risk. In addition, administrative costs are higher for small employers than for large employers where much of the administrative work is done by the employer's own staff or through consultants and TPAs. Most small employers rely on the health entity and its local agent or broker to provide these services.

  Small employers appear to be more willing to change carriers (price sensitive), as they are less involved in the administrative details and fewer people are affected than when a large employer changes carriers. This creates greater potential for self-selection by small employers, particularly for the very small employers with two to five employees where the "boss" may be aware of the need for medical care by key employees and revise/obtain coverage to meet those needs.

  Some small employers seeking lower costs are using self-insurance with stop-loss coverage to avoid state mandates and allow greater flexibility in rating – they can avoid subsidizing other small groups when their own employees and families are healthy. Others may seek to avoid paying for the high-cost individuals by looking for ways to have these individuals find non-group coverage. Some states enacted purchasing groups or alliances for small groups. By early 2009, at least 28 states had created or authorized such cooperatives by state law or regulation. However, many of those programs are no longer operational, utilizing the standards of the ACA small group markets instead.

- Large Employer – This market is less affected by self-selection at the employer level (contracts can offer experience rating or the use of ASO/ASC). There is little subsidy of less healthy groups as the rates are designed to cover the actual costs for each employer and the implications of changing plans is dealt with annually prior to offering choices to employees. This market will frequently use and directly pay benefit consultants and TPAs to meet specific needs (e.g., Request for Proposals for specified benefit packages, enrollment and claims management), so the premiums have less expenses included.

  A health entity's risk in this market relates to the impact of losses from experience rated contracts (since an employer's health plan gains on an experience rated contract cannot be used to offset losses, the ability of the health entity to "carry-forward" and recover some portion of the gains in later years is dependent upon the employer remaining with the health entity until the recovery or forgiveness of the employer's experience rated gain) and the potential impact of employee choice among health plans with different "price/benefit" options. Cafeteria plans are the most frequent basis for presenting these offerings on an annual basis to employees. Current health status will affect the employee's own choice – to pay more for richer benefits that will meet the medical need versus paying much less for a high deductible option when no use of the coverage is anticipated.

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- Association Health Plan – This market has unique risks in the manner in which the actual members obtain coverage and in the retention of members. In addition, increased state and federal regulatory oversight may add to administrative costs or limit the areas where the plan can be marketed or the market to which it can be marketed.

- FEHBP – This market is subject to very different federal regulation and is exempt from most state regulation. This results in separate reporting of premiums and claims on the Health blank and distinct RBC treatment. Benefit packages and rates must be determined well in advance of the contract period and for some health entities (BC/BS plans) the package may be developed and rated by a national organization, but the results affect the entity. Rate stabilization reserves are established to reduce the potential that a loss from a single year's results will affect the health entity's results.

- Medicaid – Some health entities' primary focus is this government market. For others, it may be minor or one of several major markets. The key risk is assessing the income received from the state against the package of benefits and the cost of administration. In most cases the health entity has little negotiating ability for either benefits or rates and must decide on a take-it or leave-it basis. The more important the line is to covering costs and maintaining a network, the harder it is to leave. There is increased use of managed care arrangements in this market, where now more than 70% percent of the Medicaid market is now managed care[4].

- Medicare Advantage and/or Medicare Prescription Drug Plans (Part D) – This market is primarily for individuals over age 65 but includes the disabled. It allows the entity to define benefit packages, subject to meeting required benefits provided by Medicare. Medicare Advantage programs (Part C) almost all include managed care arrangements. The different types of Medicare Advantage plans include HMOs, PPOs, Private Fee for Service (PFFS), Special Needs Plans (SNPs) and Medical Savings Account (MSA) plans (structured like HSA plans). Carrier income comes from the federal Centers for Medicare & Medicaid Services (CMS) for the federal share and the normal beneficiary monthly payment for Medicare Part B. Health entities may charge additional premiums for added benefits or use savings from the cost of Medicare benefits to finance them. A key risk is the variation in actual income from CMS resulting from risk adjustment and the effects of annual open enrollment involving a population focused on their health care needs. Additionally, the majority of Medicare Advantage plans incorporate the Medicare Part D program (referred to as MA-PDs), which can have additional risks and costs. And some carriers offer stand-alone Medicare Prescription Drug Plans, especially those that also offer supplemental coverage.

- Supplemental Coverage – This coverage is generally sold by another company than the carrier for primary health coverage. It may coordinate with (e.g., Medicare supplement), be in addition to (e.g., hospital indemnity) or may be unrelated to the primary health coverage (e.g., accidental death and dismemberment (AD&D)). In certain cases the coverage may be an addition by the primary carrier (e.g., dental or vision supplements). Except for these last examples, the coverage is almost always paid fully by the insured, even if sold using a group policy or offered through the employer/workplace—often called voluntary options. As such, these products are generally guaranteed renewable so only the premium may be changed and termination by the carrier is not an option. The risks relate to the amount of underwriting or waiver of normal rules (for sufficient applicants from an employee group or when required by law—e.g., Medicare supplement open enrollment requirements) and the actuarial pricing adjustments, if any, needed to maintain a reasonable relationship between premiums and claims over the life of the policy form. This involves monitoring experience, filing for rate increases when necessary and obtaining timely approval when required as well as meeting statutory loss ratio standards.

- Level Premium Coverage – These types include products which anticipate the accrual of significant contract reserves (e.g., individual DI and LTC—both group and individual) as well as a number of products where the claim costs are generally level and small contract reserves are expected (e.g., specified disease and hospital

[4] *www.pwc.com/us/en/healthcare/publications/assets/pwc-the-still-expanding-state-of-medicaid-in-the-united-states.pdf - page 5*.

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indemnity). The products are either guaranteed renewable or in the case of many of the DI products, even non-cancelable. The risks are the same as those above for supplemental coverage as well as the potential risk that persistency experience may be better than assumed and the "lapse-supported" expectations of contract reserves being released will not occur or that investment income assumed in the contract reserves is not realized. Certain long duration products may have additional risks from longer life spans, less lapse (more persistency), changes in the standards for benefit eligibility (e.g., Activity of Daily Living assessment for LTC and disability for DI) and the terms for continuing benefits that result in higher claim costs (greater frequency of claims or more benefits paid for continuation than assumed in premiums or claim liabilities and reserves). Recent changes to the LTC Guidance Manual seek to address this to provide guidance to state insurance regulators regarding what constitutes a reasonable range of assumptions across the industry.

Product Types

Different products have different risk characteristics. Also, products called by the same name in different companies may have different risk characteristics based upon the contracts with the providers.

Medical products in general have different variations on a number of characteristics including:

- Covered benefits
- Deductibles
- Coinsurance
- Co-payments
- Maximum out-of-pocket expenditures
- Provider networks
- Pharmacy networks

Covered benefits define the types of services that will be covered by the medical policy. These are general inclusions of medically necessary services and general exclusions for experimental or cosmetic treatments. Experimental treatments are excluded because their efficacy has not yet been conclusively established, so they cannot be demonstrated to be medically necessary. Such treatments usually are paid for outside of the insurance marketplace through public and private financing of medical research. Beginning Sept. 23, 2010, the ACA requires insurers to cover participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition and not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial—even if the treatment's efficacy is not yet certain. Cosmetic treatments are excluded because they are not medically necessary. There is much debate concerning specific services and whether they are medically necessary or cosmetic procedures. Is a cosmetic treatment that reduces stress from having an abnormality medically necessary or cosmetic? When does a treatment cease to be experimental and become generally accepted? Proponents for a service often bring their case to the legislature and laws are passed mandating benefits that would otherwise not be included.

The other benefit characteristics determine how much of a medical expense is reimbursed by a health entity. Co-payments (co-pays) are payments made by the insured person at the time of service, for physician visits and prescription drugs. Co-pays are generally applicable when the services are rendered by the providers. Coinsurance is the cost sharing amount the insured person pays of the allowed amount (payment) to providers. In the individual and small group markets, co-pays, coinsurance and deductibles contribute to the annual maximum out-of-pocket amounts. Co-pays and coinsurance are not credited to deductibles. Prescription drug co-payments or coinsurance vary depending upon whether or not the drug is generic and may vary by drug classification or drug tiers. (Common tiers, for example, are generic, preferred branded, non-preferred branded and specialty). Emergency room co-payments are often higher to discourage inappropriate emergency room use and may be waived if the individual is admitted to the hospital.

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Deductibles are fixed amounts applied annually and represent the portion of the medical expense that is shared by the insured individual and must be met before the health entity reimburses the insured health claims. Deductibles apply to most services, although the ACA enacted the requirement in 2010 for all comprehensive health insurance (individual, small and large group, and self-funded plans) to cover preventive services prior to deductible and with no cost-sharing. Deductibles and co-payments may vary by in-network services and out-of-network services, but are more common for out-of-network services. An operational risk for insurers is that individuals may choose not to submit claims to a health entity for reimbursement until meeting their deductible amount, resulting in manual claims processing and sometimes incomplete data. This is less true with PPO arrangements, where the individual gets the advantage of lower contracted rates if they seek the services of a contracting provider but must submit a claim in order for the health entity to determine the contracted fee for the service.

Once the deductible amount is met, an individual pays a percentage of the allowed amounts for the claims until the maximum out-of-pocket expense is met. This is often referred to as coinsurance. Normally, the health entity will not make payments based upon the full charge of the claim, but determines the allowed amount for the service, and then determines if the insured is responsible for any deductible and coinsurance payments based on that amount. A maximum deductible usually applies for family coverage that is a multiple of the individual maximum. Some policies have an annual in-network maximum out-of-pocket and an out-of-network maximum out-of-pocket. After an individual meets his/her maximum out-of-pocket(s), the health entity pays 100% of the allowed amounts for covered services.

Medical products sold by health entities can incorporate varying degrees of managed-care elements. On the side of the least managed are the indemnity plans (no longer seen in comprehensive medical plans) and at the other extreme are the closed panel HMOs. Indemnity plans had become almost extinct until the backlash against managed care and patient protection initiatives resulted in many health entities moving to more indemnity type products.

Health insurers have also begun to focus on provider networks and creating tiered networks as a means of providing more affordable coverage while focusing on quality care. Other elements being incorporated to try to control benefit costs is value-based design utilizing ACOs, rewarding providers for quality of care with share savings or shared risk arrangements.

In the comprehensive medical plans, as employers attempt to protect themselves from rising health care costs and litigation, new types of plans are emerging. Some companies hope to solve the problem of rising health care cost by offering PPO products with high deductibles, federally qualified HDHP HSAs (previously mentioned). Not only do these plans pass on more of the health care cost to the individual, it is hoped that patients will become more conscientious consumers as they share more of their health care costs. High deductible plans must offer preventive care and may include several outpatient visits without being subject to deductibles. The result is that some physician and prescription drug services may be available with low or no co-pays while policies after deductibles generally pay for costly diagnostic procedures, treatments, surgeries and other expensive services such as hospital stays and rehabilitation. In addition to self-funded uninsured ASO/ASC plans, other alternatives to insured products have gained popularity as employers try to control benefit costs.

Employers look to financial tools for employees, such as high-deductible plans offered in conjunction with MSAs or other defined contribution arrangements. Funds contributed to the defined contribution accounts can be used to pay for services until the deductible or maximum out-of-pocket levels are met. Typically, there is a "corridor" between the fully-funded account balance and the plan deductible, for which the insured will be entirely responsible. The expectation is that the insured will become a more efficient user of medical services, in order to minimize the risk of exhausting the account and having to pay out-of-pocket for costs that fall in the corridor. At the same time, the high-deductible insurance coverage will significantly protect the insured against the costs of catastrophic illness or injury. All of the products combining high-deductible insurance coverage with some form of spending account share those same basic principles, but there are many important differences in the details, such as: whether the accounts are funded by the employer or the employee, the tax treatment of

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contributions to the accounts, the types of medical expenses that can be paid for with funds from the accounts, the ability to carry over unused funds from one plan year to the next, portability from one place of employment to another, accrual of interest on account funds, whether the plans can be network-based, and, of course, details such as the level to which the account is funded and all of the usual variables (plan deductible, etc.) for the high-deductible insurance coverage.

Managed care techniques include the use of a primary care physician as a "gatekeeper" and other care management and cost control techniques such as:

- Requiring preauthorization for some services such as inpatient hospital admissions
- Requiring second surgical opinions for some surgeries
- Reviewing ongoing hospital stays to ensure that additional days were medically necessary
- Providing incentives to patients to use outpatient rather than inpatient facilities
- Moving patients to less intensive settings or into home health care
- Providing care managers or case managers to assist patients in their course of treatment and in navigating a complex medical system

As PPO plans added more managed care mechanisms and HMOs started to use contracted providers rather than their own panel providers, the two became more similar. This similarity increased as providers wanted to move away from capitated payments and HMOs offered benefits for out-of-network services.

HMO contracts with providers cover a spectrum of risk transfer to providers, which is designed to limit insurance risk. On the one end, HMOs can pay providers on a reduced fee-for-service basis or capitations with or without bonuses and withholds can be used to transfer risk to the providers. Global capitations transfer the most risk to the providers. Under global capitations, the provider group is responsible for all services under the global capitation agreement, which may include hospital, physician, lab, and prescription drug. Often the providers were protected from catastrophic losses by provider stop-loss coverage that limited claims to a specific dollar amount. More carriers are limiting the services under the capitation, leaving the health entity with the risk for non-capitated services. Capitation agreements have moved to only capitating primary care physician services. They can provide incentives to providers by using bonuses or withholds that are payable if certain claims cost criteria are met. Payment arrangements sometimes pay bonuses if claims per member per month (PMPM) are below a floor, return withholds if claims PMPM are between the floor and ceiling, and retain withholds if claims PMPM are above the ceiling. Usually, the bonuses and withholds are graded between the levels. In this way, risk is shared with providers up to the ceiling. Above the ceiling, the health entity is at risk.

Even if providers are paid a reduced fee, risk can be reduced by having contracted primary care physicians perform a gatekeeper function that gives the responsibility for what services are provided to the contracted primary care physician (PCP). In a tightly managed HMO, the PCP must authorize all or most specialty care and hospitalizations. However, most HMOs have moved to an "open HMO" structure, allowing insured persons to receive care within the HMO without a required authorization from the PCP.

In point-of-service plans, members of HMOs may go out of the network and continue to have services covered. The circumstances, benefits, and amount of coverage are defined in the contract. Financial incentives such as deductibles and coinsurance attempt to encourage members to use the services of contracted physicians. Typically, the health entity is responsible for out-of-network claims, but some aggressive providers have wanted to take on all risk including the out-of-network services.

PPOs are used by HMDIs and insurers to bring elements of managed care to their products by contracting for discounted fees from participating providers, and incorporating some of the new payment methodologies that focus on quality-based services and value-based benefit designs. They may also perform other managed care functions such as pre-authorization and utilization review, and include case management for complex cases.

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Company Financial Structure

Health entities may be organized as either for-profit, mutual, or not-for-profit companies. Each of these types of companies can have a different focus concerning premium structures and profit margins, but the financial structure alone does not dictate how management will run the company or interact with the public. For example, there are not-for-profit companies whose management conduct themselves just like their for-profit counter parts. In addition, the financial structure of the ultimate parent, if the health entity is a member of a holding company, will strongly influence behavior.

As a generalization, management in a for-profit health entity is responsible to their owners, usually stockholders, often of an unregulated parent holding company. Management in a mutual company is responsible to their policyholders and management in a not-for-profit entity has a greater mission to serve the public interest, which is exercised via its board of directors, which typically contains representatives from various sectors of the public. Mutual companies in principle can share profits with their policyholders by paying participating policyholder dividends, but in practice it is rare for health entities organized as mutuals to pay dividends. Instead, mutual companies, like their not-for-profit counterparts, often benefit policyholders by using excess profits from one year to keep premiums lower in subsequent years. Enabling legislation defining the ways that not-for-profit health entities can be established, varies by state. Some not-for-profit health entities can be chartered as charitable organizations responsible to the citizens of the state in which they are chartered. Historically, certain of these entities cover insured individuals that cannot get insurance elsewhere. Some, but not all, not-for-profit health entities are exempt from federal income tax due to their form of organization. Similarly, some, but not all, not-for-profit health entities have been given advantages, such as exemption from premium tax, by their domiciliary state. State law may dictate specific health entity responsibilities due to the tax waiver or the law may only include a vague indication of what the health entity's responsibility is due to the waiver.

Access to capital varies between these types of health entities. Not-for-profit and mutual health entities typically do not have parent entities as a potential source of capital, nor do they have access to the equity markets. As a result, their primary source of capital is retained earnings, with surplus note issuance the principal means of obtaining external capital. For-profit health entities are more likely to be able to rely on parent entities as a source of capital, and in addition may be able to issue stock to raise needed funds.

Management is responsible for fulfilling the goals of the health entity including maintaining adequate capital and profitability. Profits from for-profit health entities are first used to maintain capital levels[5], then to meet obligations on debt issued, and then are available as dividends to owners or stockholders. Because owning stock is considered riskier than making loans, the profit rate of return needed on stock investments will be more than loan interest rates. This requirement for higher return is why for-profit health entities are seen as more focused on profits than not-for-profits. However, mutual, and not-for-profit health entities also need to generate operating gains in order to maintain capital levels and fund needed technology enhancements. Higher profits can come from charging higher premiums, keeping claims cost down, increasing investment earnings, or providing more efficient administration. In most markets, premiums are already very competitive leaving little room to charge excess premiums. Reducing claims costs through risk selection or managed care techniques has recently received significant backlash and are not as effective as they once were, in particular given the ACA's restrictions on underwriting. Generating increased investment earnings can be counterproductive due to high RBC charges assessed to those asset classes having higher expected returns. Therefore, many health entities focus on efficiency and innovation to allow them to generate the profits required. Innovation may focus on health education, providing quality of care information on the Internet, or other techniques that attempt to educate the health care consumer. Efficiency may be aimed at technological advances, such as electronic claim filing or other techniques that reduce administrative costs.

[5] Risk-based capital (RBC) requirements will generally increase for the same number of covered lives because of medical trend increases.

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Health entities that increase their level of debt or leverage have to generate sufficient profits to meet scheduled principal and interest payments. If a health entity does not have the liquid financial resources to pay scheduled interest and principal payments, the lender can demand payment and the health entity could be forced into bankruptcy. Stockholders do not have a right to their invested funds and cannot force the health entity into bankruptcy.

When not-for-profit or mutual companies convert to for-profit status, the interests of the prior stakeholders need to be recognized. In the case of mutual companies, funds are set aside to provide dividend protection for participating policyholders, but as noted above it is rare for a mutual health entity to issue dividends. More generally, policyholders are given stock according to an actuarially determined allocation formula, one component of which is typically in proportion to the profit that they have contributed to the company. In the case of not-for-profit companies, a charitable foundation may be created with the surplus of the company and/or with stock of the converted company or parent company, regardless of whether or not the not-for-profit company had previously been chartered as a charitable organization. Also, the converted company will probably be subject to income and premium tax, if it was previously exempt.

Types of Ownership Structure

Closely related to a health entity's financial structure is their ownership structure. Many health entities are owned by parent organizations. A mutual company may not be owned by a for-profit organization, but a mutual company may own a for-profit company. Some mutual and not-for-profit companies have attempted to operate like a for-profit by creating a for-profit subsidiary and then moving assets and membership to their for-profit subsidiary. They can then sell stock in the subsidiary to raise capital. When this happens management may have the same pressures as they would in a full for-profit company.

Health entities can be related in holding company structures that in effect merge the management and interests of the individual subsidiaries. For example, a number of Blue Cross Blue Shield plans have been joined in holding company structures. This is particularly true for HMOs, which often must operate on a state-by-state basis via mono-state affiliates. When health entities are organized into a holding company structure, capital, assets, and profits can be moved between the entities. Ownership of one health entity by another can result in a "stacking" of capital, with the capital of the parent health entity dependent on the capital of the subsidiary health entity. Analysts should be aware of any regulatory restrictions on these transactions, which may limit movement of capital between entities.

One common method of moving capital to a weak health entity is through the use of a surplus note. The cash received by the entity is accounted for as paid-in-capital and not as a liability. Usually, the domiciliary state insurance regulator must approve repayment of the surplus note and may also be required to approve any payment of interest, or capitalization of interest, to the holder of the surplus note.

Operations can be centralized in one entity and the other affiliates pay a fee for the services provided through management and service agreements. Commonly centralized services include data processing, actuarial, investment management, accounting, and payroll. The service agreements may be merely a vehicle to move funds from one affiliate to another if the services are not supported by a cost/benefit analysis and/or service charges are not based upon a reasonable cost allocation methodology.

Profitability can also be moved from one affiliate to another by moving policyholders from one entity to another. Profitable products and their policyholders can be moved to the controlling entity leaving the subsidiary in a weaker financial position. However, this type of transaction, such as movement of policyholders, may be subject to regulatory approval.

Reinsurance by one affiliate of the others can be used to manage capital and change RBC requirements. This can result in more centralized RBC than would exist without the reinsurance. Also, captive reinsurers can be used to move profits and capital requirements to another entity in another state.

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Health entities that are owned by provider organizations such as hospitals have unique relationships in the community. A hospital may consider it advantageous to own a health entity so that patients can be directed to their facility. Losses in the health entity may be made up by profits from the increase in patient care. If the health entity's losses become too much, the hospital may decide to close the health entity rather than continue to support it.

Non-health insurance companies may own health entities or have significant health lines of business. A non-health insurer may see an advantage of offering multiple products to its policyholders. Having a health entity subsidiary allows it to offer health coverage as part of a package. This is becoming less common since the health market is changing so fast and profits are falling. It may not be enough of an advantage to offer "one stop shopping".

Solvency and Liquidity

There are two primary considerations in financial analysis of health entities - financial solvency and liquidity. The first looks at the assets compared to the obligations including a margin for adverse experience (i.e., reserves plus minimum capital). The second looks at the potential timing when cash is needed and the available sources of the cash requirements. Financial solvency focuses on the adequacy of reserves (for expected levels of the obligations, including expenses, not yet paid - conservatively estimated) and capital (for the unexpected) while liquidity focuses on the potential need for cash in unusual situations.

The adequacy of reserves and capital is determined by an analysis of the following:

1. The claim liability and claim reserve – determine if claim liabilities and reserves cover actual payments for existing obligations.
2. The assumptions underlying contract reserves – determine that an adequate portion of current premiums is being retained for future obligations.
3. The adequacy of current premiums (including unearned premium reserves and contract reserve changes) to cover all same period obligations – when inadequate, premium deficiency reserves are required so current premiums plus current reserves cover current and future obligations (claims and expenses).
4. The adequacy of existing capital – the RBC formula compares actual capital (in the form of Total Adjusted Capital (TAC)) to a minimum level for the risk of the health entity assuming adequate valuation of assets and reserves (in accordance with statutory accounting standards).

Note that when reserves are inadequate, the most likely source of funds to address this inadequacy is the capital of the health entity. Thus, determining that capital is adequate must start with a determination that reserves are adequate.

The liquidity of the health entity's assets should be determined by an analysis of the value of the assets under "forced sale" circumstances. Most health entities invest their funds in assets where immediate sale will produce a value consistent with the reported value (these values are prescribed by Statutory and GAAP accounting systems). An immediate need for cash that requires the liquidation of invested assets is, therefore, not a critical issue for most health entities. It is possible that some health entities have assets that are not easily liquidated. In those situations, specified stress tests may be useful in determining potential financial risk caused by a lack of liquidity. There are numerous types of financial risks for a health entity. The NAIC *Troubled Insurance Company Handbook* Chapter 3 – Causes of Trouble, discusses causes of insolvency that are related to all types of insurers. The following discusses the most common causes of trouble that have most frequently been the source of problems for health entities in the past.

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Causes of Solvency Risks

1. Premiums may be inadequate - premiums are to cover all current obligations of the health entity for the contracts to provide health insurance or services. They may prove to be inadequate if:

   a. Actual claims exceed expected levels (examples include but are not limited to):

      i. This may be due to more claims (frequency), higher value claims (severity), unexpected claims (new technology, alternative services, use of out-of-network facilities) or an underestimation of the combined effect of these factors when adjusting prices from recent periods to current or future periods (trend).

      ii. The demographics of the insured population are inconsistent with the expected values - where premiums cannot differentiate for demographic values (e.g., age, sex, marital status), the health entity must make assumptions as to the likely demographic composition of the actual insured population. When the actual is materially different from what was expected (e.g., more older insured, fewer males), the premiums may be inadequate.

      iii. Assumptions with regards to the effects of provider networks are not realized - savings may not be achieved if insureds do not utilize network providers to the level anticipated, if provider networks do not control costs to the level anticipated or if the failure of prepaid providers requires the health entity to incur additional costs.

      iv. The health status of the insured population is inconsistent with expected values - many health coverages do not allow the health entity to adequately reflect the actual potential for losses (e.g., a requirement to guarantee issue of health coverage may allow a level of self-selection by new insureds that was not anticipated and cannot be reflected in premiums).

   b. Actual expenses exceed expected levels - this may occur because less business is serviced than anticipated, additional services are required or the cost to provide the services exceeds expected costs, assumptions with regards to geographic diversity cannot be achieved, for example, through the potential for catastrophic natural disasters or geographic events.

   c. Assumptions with regards to persistency are not realized - when level premiums (generally issue age rating) are charged, the amount of contract reserves developed depends upon the lapse assumption to reflect release of reserves when lapse or death occurs. Lapse-supported products may not collect sufficient premiums if low lapse rates occur.

   d. Rate increases are not implemented on a timely basis due to delays in applying for or receiving rate increases for regulated products.

   When premiums are not sufficient to cover all current “costs”, the health entity will likely report a loss. This loss may be substantial if premiums cannot be adjusted immediately, and premium deficiency reserves need to be established or increased.

   Premiums are more likely to be inadequate in situations where claims costs are difficult to predict. Health entities monitor claim data closely to protect against undetected shifts in cost or utilization; the two components that determine health care claim costs. Claim reporting lags along with data process lags means that premiums must be set based on data that is several months old and shifts may be missed.

   Benefit designs are changing to shift more of the cost of health care back to the individual. Economists believe that this will reduce inappropriate utilization that resulted from individuals being unaware of the actual cost of services. Having the individual pay more of the cost of each service may reduce large jumps in costs when new services are introduced by lowering the demand, but there is little risk reduction.

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Managed care techniques often make claims costs less variable and therefore easier to predict. The more services being provided that come from contracted providers, the more predictable claims costs are and the lower the risk of underestimating premiums.

- Capitations control for both cost and utilization variation and are the most effective way of reducing risk for the covered services.
- Fee-based contracts allow better prediction of the cost of services but do little to control utilization which may be increased by providers to make up for lower fees.
- The use of primary care physicians as gatekeepers as well as bonus and withhold incentives can be used to better influence utilization and make it more predictable. The effectiveness of these arrangements has been reduced recently with the influence of and the push back from providers and patients.

2. Reserves and liabilities may be inadequate – Assumptions used in the development of premiums often contribute to the determination of reserve levels. Thus, underestimation of claim costs often leads to under-reserving as well as underpricing. Reserves can be inadequate for other reasons as well. Changes in the processing of claims may not be appropriately recognized when using claim paid-to-incurred tables. New risks may not be reported and paid under the same time sequence as historical completion tables. New technology may create higher claim payments for the same medical need. New claims processing systems or higher than average turnover in claims processing personnel may increase claim backlogs. If increases in claim backlogs are not adequately taken into consideration, claim reserves will be underestimated. To reduce the risk of underestimates, health entities may increase monitoring of claims backlogs or attempt to pay claims more promptly in order to better predict reserves.

   Contract or policy reserves may become inadequate over time as actual experience deviates from what was assumed, (e.g., persistency of lapse-supported products). The actual cost of processing claims may require more expenses.

   Note that underestimated claim reserves will overstate income as well as capital.

   Converse to the above, there are cases where reserves may be considered too conservative and surplus too high. While this does not represent a risk to solvency, it may be indicative of other issues. Reserve margins that are significantly above the industry norm, or that are growing excessively may indicate that rate increases cannot be supported based on incurred claims experience. Unfortunately, there are no definitions of excess margins, appropriate increases in reserves or reserve margins, or appropriate levels of surplus. Regulators must use their judgment when financial statements show trends that are too dissimilar from those of similar health entities in the industry.

Other Solvency Risk Considerations

1. Transfer of Risk – The following are methods frequently used by health entities to reduce overall risk unique to the health industry:

   a. Risk sharing with insurers – Reinsurance is the most direct form of risk transfer. Reinsurance can be used to transfer specific risks such as transplant reinsurance. Reinsurance can also be used to keep risk below a certain level either per individual or on a block of business. For coverage of individuals, reinsurance pays over a specified amount (stop-loss) or it can pay a specified percentage of claims (quota share). On a block of insurance, reinsurance can also be written on a stop-loss or quota share basis. There are endless variations of agreements that combine these elements. For example, the reinsurance could cover a percentage of claims in a corridor and then cover all claims above the corridor. In this case the health entity is responsible for all claims until the corridor is reached and for a percentage on claims until the upper end of the corridor is reached, at which time the health entity is not responsible for additional claims.

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Reinsurance availability changes as the market changes. A health entity cannot depend on being able to purchase reinsurance in the future and, even if reinsurance is available, the cost increases may make it prohibitive in the future.

b. Risk sharing with employer/policyholders – Some large employer groups want to take on more of the insurance risk and thus reduce the risk premium that they are paying to the health entity. If the policyholder assumes all of the risk, the agreement is called either ASO or ASC. In both cases the employer is responsible for all claims payment and the health entity is responsible for the administration of the coverage. The employer also benefits from these arrangements in that they pay for health services using the contracted rates that the health entity has with providers. If an employer does not want all of the financial risk they can purchase stop-loss reinsurance, which is generally available from health entities in the ASO market.

   Health entities also share risk with employers through experience rating contracts. Experience rated contracts contain settlement formulas that allow the health entity to collect more premium if health care costs are above the formula amount or require a refund if claims experience is lower than expected. These are effective risk transfer techniques but may not be totally effective if employers cancel contracts before claims can be recaptured or employers become insolvent and unable to pay.

c. Risk sharing with providers – Health entities have many risk sharing agreements with providers. Staff Model HMOs reduce their risk by hiring providers as employees. In this case, payroll costs make up a large share of the claims cost and are more predictable. More typical risk sharing with providers consists of paying for services on a PMPM or capitated basis. The more services that are covered by the capitated payment, the more risk is transferred. Physician groups are more willing to be responsible for outside services such as prescription drugs than individual physicians.

   Withholds and bonuses can be used to share risk with providers, as well as to provide incentives to keep utilization down. Withholds are amounts retained from fees or capitations that are paid if specific financial metrics are met. The amount of risk transferred to the providers equates to the amount of withhold retained by the health entity. Bonuses are additional payments that are made if specific financial metrics are met. Bonuses that are paid based on quality measures are becoming more common and are not considered risk transfer. (Withholds and bonus arrangements may also be based on non-financial metrics. In those cases, the influence on risk is much less direct—for example, arising from improvements in health care quality.)

   Risk is transferred to hospitals by the use of Diagnosis-Related Group (DRG) payments[6]. DRG payments are scheduled amounts to be paid for any admission in specific DRGs. If more care is needed than the scheduled amount, the hospital is still only paid the DRG payment. There is usually allowance for individuals that have complicated circumstances or extreme cases as “outliers”. Additional payments will then be approved for outlier cases. Risk may also be transferred to hospitals by the use of per diem payments, which pay a fixed amount per inpatient day.

d. Risk-sharing for specialties – Health entities may contract for the provision of care for certain portions of the coverage under broad medical insurance contracts on an exclusive basis with another entity – mental health or substance abuse care and drug benefits through a pharmacy benefits manager are frequently seen examples. In some cases, this risk-transfer may be to another health entity, but it may be to an organization that is not regulated for insurance purposes. The contract may provide for full transfer of risk or a sharing of favorable and unfavorable results.

2. Capital (as measured by minimum capital or RBC calculations) may be inadequate to cover variations from expected values – assumptions about the value of assets may not be realized when the asset is sold,

[6] Diagnosis-Related Groups (DRGs) are categories of diagnosis use to determine the amount per admission paid to a hospital based on the anticipated severity of the typical patient having the assigned DRG.

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earnings may not increase at a rate higher than the increase in risk as determined by RBC, unusual or very infrequent levels of risk may occur, which are outside normal bounds (e.g., legal settlements, claim continuation patterns during slow economic times).

Business plans that necessitate rapid growth or getting into new lines of business creates potential risks to capital from:

- The "normal" level of statutory surplus strain from above average levels of new business;
- The greater potential that aggressive assumptions used to produce very competitive premiums (including writing business at a small loss to grow rapidly) will not be achieved; and
- The high probability that assumptions and practices in new lines can only be realized following seasoning of the line.

Non-financial risks can impact financial results. Few can be restated into a financial value, but all are likely to have a financial impact:

- The health entities rating by public rating agencies, if downgraded, may create difficulties for the company in meeting its business plan;
- Relations with networks may deteriorate producing fewer benefit savings than assumed. If the problems become public, the ability to renew existing business at adequate premium levels, to maintain a sufficiently broad network and to satisfy contractual obligations with different network providers can all reduce earnings, make reserve estimation more tenuous, and/or require the focus of management on certain issues so others do not receive the normal, necessary review.
- Legislation (both federal and state) and resulting regulation create changes that need to be reflected in contracts with policyholders, providers and other vendors.

RBC Formula Risk Assessment – The NAIC models using the RBC approach seek to establish a level of capital related to the existing risks of an insurer or health entity such that the regulator will, when capital values fall into "RBC action levels," have sufficient time to rectify the causes of capital inadequacy and allow the insurer or health entity to remain in business meeting all of its obligations. In general, the NAIC has tried to establish this timeframe as three to five years. States generally also have minimum absolute dollar levels of capital required to maintain a license to write various types of insurance.

For health entities, the underwriting risk or risk for underpricing health insurance contracts generally overwhelms all of the other risks. The RBC formula applies factors to premiums (adjusted by the loss ratio to translate premiums into incurred claims for most medical coverage), and allows for reductions for risks transferred to providers (e.g., the amount of RBC risk is reduced for the value of withholds, reduced more for capitation payments and reduced the most when salaried providers are used). Some ancillary coverages (e.g., stop loss) have factors applied to premiums without further adjustment. The RBC factors are developed using consistent risk-assessment models and historical information. The RBC formula recognizes that the health entity's risk is less than the sum of all independent risks (because these are not likely to occur simultaneously) through a "covariance" calculation.

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V. Domestic and Non-Lead State Analysis

A. Holding Company Analysis Procedures (Non-Lead State)

B. Form A Procedures

C. Form D Procedures

D. Form E (or Other Required Information) Procedures

E. Extraordinary Dividend/Distribution Procedures

F. Analyst Reference Guide

Legend of Abbreviations

Branded Risk Classifications		
Symbol	**Risk**	**Description**
CR	Credit	Amounts actually collected or collectible are less than those contractually due or payments are not remitted on a timely basis.
LG	Legal	Non-conformance with laws, rules and regulations, prescribed practices or ethical standards (in any jurisdiction in which the entity operates) will result in a disruption in business and financial loss.
LQ	Liquidity	Inability to meet contractual obligations as they become due because of an inability to liquidate assets and/or obtain adequate funding without incurring unacceptable losses.
MK	Market	Movement in market rates or prices (such as interest rates, foreign exchange rates or equity prices) adversely affect the reported and/or market value of the investments.
OP	Operational	The risk of financial loss resulting from inadequate or failed internal processes, personnel and systems, as well as unforeseen external events.
PR/UW	Pricing/ Underwriting	Pricing and underwriting practices are inadequate to provide for risks assumed.
RP	Reputation	Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.
RV	Reserving	Actual losses and/or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.
ST	Strategic	Inability to implement appropriate business plan, to make decisions, to allocate resources or to adapt to changes in the business environment will adversely affect competitive position and financial condition.

Special Notes: The following procedures are intended to be performed by non-lead domestic states to develop and document an analysis of the impact of the holding company system on the domestic insurer.

Form procedures do not supersede state regulation but are merely additional guidance an analyst may consider useful.

Name of Holding Company System _____

Name of Lead State _____

Compliance Assessment – Form B (and C)

1. Review the registration statement to determine if it was filed in accordance with the state's Insurance Holding Company System Regulatory Act[1] (#440) and if it included the required current information. The information provided should include a description of the transaction or agreement, including, at least, the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to the transaction, and the relationship of the affiliated parties to the registrant. (LG)

2. Did the domiciled registered insurers properly report dividends and other distributions to shareholders in accordance with the following Model #440 requirements? (LG)

3. If dividends and other distributions to shareholders were considered extraordinary, did the transaction receive proper regulatory approval? (LG)

4. Did the insurer receive proper prior regulatory approval for any transaction that occurred during the last calendar year involving the insurer and others in its holding company system that required such prior regulatory approval? (LG)

Assess the Impact of the Holding Company Group on the Domestic Insurer

Assessment of Group Profile Summary from the Lead State

5. Obtain a copy of the lead state's Group Profile Summary (GPS).

6. Consider the GPS's branded risk assessment in determining the impact of the holding company on the domestic insurer.

7. Review the conclusion and supervisory plan of the GPS. Did the lead state identify any holding company risks impacting the domestic insurers in the group and/or supervisory plans that impact your state's domestic insurer?

8. Consider the nature of the domestic insurer(s)' interdependence on the holding company group or affiliated entities for business operations or financial stability (e.g., employees, services provided, reinsurance and/or capital support in the near term). (OP, CR, ST)

9. Consider the level of reputational risk that the holding company (as a group) poses to the domestic insurer(s). (RP)

[1] The list provided is based on the NAIC *Insurance Holding Company System Regulatory Act* (#440). However, analysts should review the Form B compliance in relation to their own state's requirements.

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10. Determine if income of the domestic insurer(s) is being used to service holding company debt or other corporate initiatives (e.g., acquisitions). (OP, ST)

11. Review the information provided in the GPS regarding the Corporate Governance Annual Disclosure (CGAD) and other related corporate governance information provided by the lead state. Does it identify any risk or concerns that require questions or follow-up to the lead state? Does it highlight any issues that are only relevant to your state's domestic insurance entity? Do any material concerns exist regarding corporate governance that could impact the domestic insurer's financial condition (e.g., operations, policyholder surplus or capital position)?

12. Review the information provided in the GPS regarding risks or concerns noted in the Enterprise Risk Report (Form F) or any other related information provided by the lead state. Does it identify any risk or concerns that require questions or follow-up to the lead state? Do any material concerns regarding enterprise risk have the potential to impact the financial condition of the domestic insurer risks or pose an immediate material risk to the domestic insurer's policyholder surplus or risk- based capital position, insurance operations (e.g., changes in writings, licensure, and organizational structure), balance sheet, leverage, or liquidity?

Assessment of Form B (and C)

13. Based upon a review of the registration statement, were any significant and/or unusual items noted, such as, but not limited to, the following?
    a. Person(s) holding 10% or more of any class of voting security who also have a history of transacting business of any kind directly or indirectly with the insurer. (OP, ST)
    b. Biographical information about directors or officers, which may elevate concerns such as convictions of crimes. (OP, ST)
    c. Any litigation or administrative proceeding involving the ultimate controlling entity or any of its directors and officers, such as criminal prosecutions or proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company, such as bankruptcy, receivership, or other corporate reorganization. (LG)
    d. The absence of an affirmative statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions to avoid statutory threshold amounts. (OP, ST)

Assessment of Affiliated Risks on the Domestic Insurer

14. Were any material deficiencies or risks noted during the annual review of the domestic insurer's Notes to Financial Statements, Interrogatories, Schedule Y – Part 2, Holding Company Forms B & C, or recent examination reports with respect to affiliated transactions? (CR, LQ, OP, ST)
    a. Management agreements
    b. Third-party administrative agreements
    c. Managing general agent agreements
    d. Investment management pools
    e. Reinsurance agreements and pools
    f. Consolidated tax sharing agreements
    g. Other

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15. If any of the following forms have been filed with the domestic regulator since the last review, indicate if risks or concerns were noted in any of the reviews of these forms.
    a. Form A (Acquisition of Control or Merger)
    b. Form D (Prior Notice of a Transaction)
    c. Form E (Pre-Acquisition Notification) or Other Required Information
    d. Extraordinary Dividend/Distribution

Assessment of Own Risk and Solvency Assessment (ORSA), if applicable

16. Obtain the lead state's analysis of the ORSA Summary Report (See section VI.F-Own Risk and Solvency Assessment Procedures.)

17. Did the lead state document in its analysis any risks or concerns that in its opinion have an impact on the overall financial condition of the insurance holding company system? If so, do any of the risks or concerns identified pose a material risk to the domestic insurer?

Communication & Follow-Up with the Lead State

- ❑ Notify the lead state of any additional material events or concerns applicable to the domestic insurer, or the group as a whole, that the lead state may not otherwise be aware of, and that should be considered in the evaluation of the overall financial condition of the holding company system.
- ❑ If any material risks or events were identified during your holding company analysis that were not discussed in the lead state's holding company analysis, communicate those findings to the lead state.

Update the Insurer Profile Summary

Update the Insurer Profile Summary of the domestic insurer with the summary and conclusion of the impact of the holding company system on the domestic insurer based on the above analysis performed.

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

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

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

Model Act and Database Procedures

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

Initial Review

1. Determine if the filing is complete, note the missing items and promptly send a deficiency letter to the Applicant. A filing may not be considered complete and active until all relevant information has been received. Enter any changes to the status of the filing or other data elements into the NAIC Form A database within 10 days of receipt of Form A. Data and information should be entered by the state's designated person.
    a. Identify attorneys, party contacts (all stakeholders), and other insurance regulators reviewing the Form A, including the lead regulator.
    b. Assign appropriate analyst, legal, and other professional staff to conduct regulatory review.
    c. Carefully consider whether regulatory review can be completed by Applicant's target close date, including any interim deadlines and obtain deemer extension or waiver if appropriate.
    d. Schedule and notice hearing/consolidated hearing, if applicable, within statutory timeframes.
    e. Review the NAIC Form A database to determine whether the current Form A is pending or has been approved, denied, or withdrawn in another state. Assess any reasons noted for denial and document any risks or concerns.
2. Establish contacts with other states and regulators to discuss the status and/or disposition of the current and prior filings made with those states. Where multiple jurisdictions are involved, coordination of information between the states and functional regulators should be initiated by the lead states(s). Perform the following steps:
    a. The domestic state should notify the lead state regulator of the holding company group of any merger or acquisition of a domestic insurer in the group.
    b. The lead regulator should obtain key contact information from each state reviewing the Form A and consider organizing a regulator to regulator call to discuss concerns with the filing.
    c. Create a contact list of relevant persons and representatives.
    d. Separate confidential and public documents, information, and communications and maintain as appropriate.
    e. Contact and collaborate with other reviewing regulators involved in the review process, as appropriate, including the lead state regulator regarding ORSA and ERM reviews.
    f. As applicable, contact other regulators of noninsurance entities of the acquiring party or target.
    g. Based on the nature and materiality of the transaction, the lead state and domestic state(s) should regularly communicate with all states and other functional regulators, as necessary throughout the filing

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review process, to provide updates on the transaction, states' reviews, and to share feedback between regulators.

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

Compliance Assessment and Review

Transaction Details

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

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

   b. Contains the following information:

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

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

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

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

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

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

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

4. Perform analysis review considerations, in addition to the compliance review in #3 as necessary, to analyze the details of the transaction, which may include, but is not limited to the following:

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a. Document any risks or concerns by carefully reviewing transactional documents (e.g., merger, stock purchase, stock exchange).

   i. Consider disposition of all classes of target shares, including addressment of any beneficial owners.

   ii. Ascertain propriety of disposition of minority interests and concerns, if applicable.

b. Consider any affiliate or employee benefit as appropriate.

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

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

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

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

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

h. Determine if after the change of control:

   i. The insurer will be able to satisfy the requirements for the issuance of a license to write the classes of insurance for which it is presently licensed.

   ii. The insurer's surplus will be reasonable in relation to its outstanding liabilities and adequate for its financial needs.

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

   i. Determine the target's estimated post-acquisition financial condition and stability.

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

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

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

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

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

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

p. Consider with disfavor any plans to liquidate the target or sell its assets, consolidate or merge, that may be unfair, unreasonable, or hazardous to policyholders.

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q. Review required statutory deposits and authorized lines of business.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   e. Does the Form A provide adequate background information (e.g., biographical affidavits including third-party background checks) on the applicant (if an individual) or all persons who are directors, executive

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officers, or owners of 10% or more of the voting securities of the applicant (if the applicant is not an individual)?

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

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

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

Purchase Consideration

7. Analyze the source, nature, and amount of consideration used (or to be used) in effecting the merger or acquisition of control and assess the ability of the entity to fund the insurance company.

   a. Determine fairness (equivalency) of total amount to be paid to total value to be received, including derivation of price and value of target under standard valuation methodologies or to book value.

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

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

   d. Consider source, type and valuation basis of funds to be used for consideration.

      i. If funds are from a regulated entity, confirm the existence and valuation of such assets with that entity's regulator.

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

   f. Will dividends from the insurer be required to support debt payments of the applicant or the applicant's subsidiaries?

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

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

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

   c. Does the Form A:

      i. Describe any purchases of any voting securities of the insurer by the applicant, its affiliates, or any person during the 12 calendar months preceding the filing of the Form A.

      ii. Describe any recommendations to purchase any voting securities of the insurer made by the applicant, its affiliates, or any person—or by anyone, based on interviews or the suggestion of the applicant, its affiliates or any person—during the 12 calendar months preceding the filing of the Form A.

      iii. Describe the terms of any agreement, contract, or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions, or other compensation to be paid to broker-dealers.

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d. Perform additional review considerations as necessary to analyze the purchase conditions and implications of any debt financing, which may include, but is not limited to the following:

i. The mechanics of any debt financing to be used to fund the transaction, whether funds are being borrowed in the ordinary course of business or on terms that are less favorable than generally commercial loans.

ii. The percentage of debt versus non-debt funds to be used.

iii. The source of funds or stream of income to be used by the parent for repayment and the ability of the acquiring party to repay the debt from sources other than the target.

iv. Identity of the creditor(s) and creditors' financial condition.

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

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

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

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

Market Impact

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

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

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

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

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

Record Maintenance and Conclusion

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

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

- File and maintain documents under state procedures

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

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14. Perform any additional procedures, as deemed relevant, to evaluate the Form A application in accordance with the specific circumstances identified, which may include, but is not limited to, the following:
    - Contact the insurer seeking explanations or additional information
    - Obtain the insurer's business plan
    - Meet with the insurer's management
15. Develop and document an overall summary and conclusion regarding the holding company Form A application.
    - If application approval is deemed appropriate, consider whether any conditions precedent, specific ongoing stipulations or conditions subsequent should be included with the approval.
16. Add any material items from the Form A review to the Insurer Profile Summary.

Post-Approval

Post-Approval Considerations (if applicable)

17. Receive notification of changes to effective closing date.
18. Confirm compliance with conditions precedent.
19. Receive waivers for market conduct or financial examination.
20. Receive notification if transaction does not close and consider withdrawal of approval.

Post-Acquisition Considerations

21. Receive confirmation of the transaction following the closing, per your state's statutory requirement timeframe.
22. Request written details of the final purchase price after all adjustments are complete on the transaction.
23. Request confirmation of any capital contribution contemplated in the transaction. Request the names and titles of those individuals who will be responsible for the filing of the amended Insurance Holding Company System Annual Registration Statement.
24. Request an amended Insurance Holding Company System Registration statement per your state's statutory timeframe within each applicable state's statutory required timeframe after the close of the proposed transaction.
25. Consider requesting for a period of two years, commencing six months from closing, a semiannual report under oath of its business operations in your state, including but not limited to, integration process; any changes to the business of the Domestic Insurers; changes to employment levels; changes in offices of the Domestic Insurers; any changes in location of its operations in your state; and notice of any statutory compliance or regulatory actions taken by other state regulatory authorities against the acquiring parties or the Domestic Insurers.
26. Consider prior approval of all dividends for a two-year period from the close date.
27. If concerns are identified during the post-acquisition review, consider the following actions:
    - Conduct a target financial and/or market conduct examination

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- Hold a meeting, conference call or requesting additional information from the insurer or applicant
- Require additional interim reporting from the insurer
- Obtain a corrective plan from the insurer

28. Confirm compliance or satisfaction with any other conditions subsequent or undertakings.

29. Monitor target's market performance to projections two years after transaction close date.

Summary and Conclusion

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

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

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

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

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Special Notes:

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

Form D – Prior Notice of a Transaction

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

Compliance Assessment

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

2. Did Form D include the following information for each party to the transaction (Form D of *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions*, (#450):
   - Name
   - Home office address
   - Principal executive office address
   - The organizational structure
   - A description of the nature of the parties' business operations.
   - The relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.
   - The name(s) of the affiliate(s) that will receive, in whole or in substantial part, the proceeds of the transaction, when the transaction is with a non-affiliate.

3. Does Form D include the following information for each transaction for which notice is being given:
   - A statement as to the section of the holding company regulation Form D filing is being made.
   - A statement as to the nature of the transaction.
   - A statement of how the transaction meets the 'fair and reasonable' standard of the state's insurance holding company law or regulation; and
   - The proposed effective date of the transaction.

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

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5. If the transaction involves consideration other than cash, does Form D provide a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation?

6. If the transaction involves a loan, extension of credit or a guarantee, does the Form D provide a description of the maximum amount that the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest?

7. If the transaction involves an investment, guarantee or other arrangement, has the time period been stated during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements? Does Form D provide a brief statement as to the effect of the transaction upon the insurer's surplus?

8. If the transaction involves a loan or extension of credit to any person who is not an affiliate, does the Form D include the following:
   - A description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extension of credit.
   - A specification regarding what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate.
   - A description of the amount and source of funds, securities, property or other consideration for the loan or extension of credit.
   - For transactions involving consideration other than cash, a description of its cost and its fair value and basis for evaluation.
   - A brief statement as to the effect of the transaction upon the insurer's surplus.

9. If the transaction is a reinsurance agreement or modification thereto or a reinsurance pooling agreement or modification, does Form D include the following:
   - A description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year.
   - The period of time during which the agreement will be in effect.
   - A statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more affiliates.
   - A brief description of the consideration involved in the transaction.
   - A brief statement as to the effect of the transaction upon the insurer's surplus.

10. Determine if the reinsurance agreement complies with the requirements for credit for reinsurance.

11. Determine whether the reinsurance agreement's right of offset limits the offset specifically to the reinsurance agreement(s) and not other balances that may accrue as a result of other transactions.

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).

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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 other than cost.' If other than cost, include the rationale for not using 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, does the agreement[1]:
    - Identify the person providing services and the nature of such services.
    - Set forth the methods to allocate costs.
    - Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the AP&P Manual.
    - Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement.
    - State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance.
    - Define records and data of the insurer to include all 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 records and data of the insurer are and remain the property of the insurer, and:
        - Are subject to the control of the insurer.
        - Are identifiable.
        - Are segregated from all other persons' records and data or are readily capable of segregation at no additional cost to the insurer[2]
    - State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer.

[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.

[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.

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- 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]:
    - 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 records and data will immediately be made available to the receiver or the insurance commissioner, shall be made available in a usable format, and shall be turned over to the receiver or insurance commissioner immediately upon the receiver or the commissioner's request and the cost to transfer data to the receiver or the commissioner shall be fair and reasonable[3].
    - The affiliated person(s) will make available all employees essential to the operations of the insurer and the services associated therewith for the immediate continued performance of the essential services ordered or directed by the receiver or commissioner.
- Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to the [supervision and receivership acts].
- 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] 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.

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

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Assessment of Form D – Prior Notice of a Transaction

16. Review Form D for any significant and/or unusual items or inconsistencies. Determine if the transaction is fair and reasonable as required under Section 5A(1)(a) of Model #440 by considering the following:
    a. For reinsurance agreements, are the general terms, settlement provision, and pricing consistent with those of 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?
    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?
    g. Does the transaction comply with the state's requirements regarding the insurer's ownership of data and records that are held by an affiliate, and control of premium or other funds belonging to the insurer that are collected or held by an affiliate?[4]
    h. Do unusual circumstances, risks or concerns exist?
    i. Any other state-specific requirements for determining and reviewing fair and reasonableness.
17. Determine whether the transaction was accounted for properly, based on statutory accounting principles, with the NAIC AP&P Manual.

Assessment of Form D – Captive Reinsurance Transactions

Transactions Subject to AG48:

18. For all transactions proposed to be entered into on or after Jan. 1, 2015, perform the following (either directly or by reviewing the work of the captive state) initially upon being presented the transaction for approval:
    a. Require the insurer to submit a statement as to whether some or all of the risks ceded under the transaction qualify for an exemption from Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued Under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG48). If so, require the insurer to identify with specificity the basis for claiming the exemption.
    b. Require the insurer to submit five years of pro forma financial statements of the affiliated captive reinsurance entity (assets, liabilities, equity and income) including specifically projected statutorily required reserves.
    c. Require the insurer to list and value (in accordance with the valuations used in AG 48) all funds to be held by or on behalf of the insurer as security under the reinsurance contract. The insurer should identify any

[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.

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funds so listed that are: (1) Primary Security (as that term is defined in AG 48); and/or (2) held by or on behalf of the insurer on a funds withheld, trust, or modified coinsurance basis.

d. If no exemption under AG 48 applies, require the insurer to submit current and five-year projected calculations, and support therefor, of: (1) the statutory reserves with respect to the XXX/AXXX business being ceded; and (2) the Required Level of Primary Security, as defined in AG 48.

e. If no exemption under AG 48 applies, require the insurer to state whether, both at the inception of the transaction and thereafter: (1) funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, will be held by or on behalf of the insurer, as security under the reinsurance contract, on a funds withheld, trust, or modified coinsurance basis; and (2) funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to subsection (1) above, will be held by or on behalf of the insurer as security under the reinsurance contract.

f. Consider the following in determining if the transaction should be approved:

   i. If no exemption under AG 48 applies, consider: (1) whether funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, will be held by or on behalf of the ceding insurer, as security under the reinsurance contract, on a funds withheld, trust or modified coinsurance basis; and (2) whether funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to subsection (1) above, will be held by or on behalf of the ceding insurer as security under the reinsurance contract.

   ii. The extent of refinancing risk present within the transaction given they may involve financing of long duration reserve liabilities with short or medium duration assets. If the financing transaction is scheduled to mature when the best estimate amount that would need to be refinanced is a substantial percentage of statutory reserves, consider whether: (1) the terms of the transaction provide the insurer with flexibility to either refinance (with the same finance provider or a replacement finance provider) or to recapture without incurring a material reduction to the insurer's Total Adjusted Capital; or (2) the insurer otherwise has a contingency plan to manage its capital at transaction maturity.

   iii. Conditions imposed by the financing provider that require the assets available to satisfy policyholder claims be used before payment is made by the financing provider. Request information from the insurer as to whether assets supporting reserves contain conditions or "priority of payment" provisions that could make the asset unavailable to satisfy general account liabilities. If so, consider if such provisions are consistent with existing law.

   iv. Contact the lead state to determine the financial position of the group as a whole and the group's ability to absorb material unexpected losses from the transaction given the specific terms of the financing transaction given the specific terms of the financing transaction. In determining the ability to absorb material unexpected losses, consider either reviewing the group's Own Risk and Solvency Assessment (ORSA) Summary Report or obtaining similar information that may demonstrate available capital above existing group capital.

   v. Consider if there are high-quality assets supporting the surplus of the captive that provide additional cushion to absorb material unexpected losses.

   vi. Determine if other provisions are in place within the captive transaction that may help to limit exposure to the group. This may include specific capital requirements on the captive, limitations on the ability of the captive to pay dividends to the parent, additional reinsurance to a third-party reinsurer or other risk-reduction strategies.

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vii. Contact the lead state and every domiciliary state insurance regulator within the group to determine if they have any input in approving the transaction, although ultimately the decision must be made by the state of domicile.

viii. Consider if the captive will be retroceding business to other affiliates or non-affiliates.

Captive Reinsurance Transactions on Other Lines of Business Not Subject to AG 48:

i. Utilize the information in the Form D for affiliated captive transactions and other annual reporting (annual statement, actuarial reporting), and if necessary, ask the company, to gain an understanding of the purpose of the use of captive (non-traditional) reinsurance to better assess the insurer's overall reinsurance strategy.

ii. Consider Handbook procedures similar to the procedures above for AG 48 captive reinsurance if any procedures are applicable to assessing transactions on other business types.

iii. Within the Form D affiliated reinsurance transaction filing, require the insurer provide RBC projections of the impact of the ceding insurers longevity risk charge based on a gross reserve basis for approved affiliated reinsurance transactions.

iv. Within the department's Form D analysis, document the assessment of how the affiliated reinsurance transaction affects the level playing field and competition in the marketplace, consideration of the impact to RBC for the affiliated reinsurance transaction and reserving, specifically, asset adequacy.

v. As part of the Form D review and approval process, if concerns are noted, consider including conditions on the approval of the Form D reinsurance transaction, such as:

1. All new affiliated business assumed under the agreement must be submitted to the Department for an assessment of fair and reasonableness and arms-length terms. Only business evaluated by the Department's actuary through the Form D review are permitted to be ceded.

2. On an annual basis, the ceding insurer will provide the following of the captive reinsurer:
    a. The audited GAAP financial statements and audited [international jurisdiction] statutory financial statements.
    b. Current business plan and any subsequent changes to this plan.
    c. Actuarial report.

3. On an annual basis, the ceding insurer will prepare a separate asset adequacy analysis on business assumed by the captive reinsurer for the Department's evaluation, including cash flow testing and sensitivity tests. The sensitivity tests, at a minimum, must include: lapse test (stress the lapse rates); utilization test (stress the utilization rate); combined surrender/utilization test; and credit defaults tests. The results of this analysis will be referenced in the reinsurance section of the Actuarial Opinion and Memorandum. This asset adequacy analysis must be used to true-up the statutory sufficiency of the reserve credit taken on the related gross reserves. This true-up is regardless of any offsets from redundancies found within the gross reserves of other business.

4. Prepare and submit financial projections to the Department to demonstrate the impact on RBC as if the affiliated transaction with the captive reinsurer was not in place.

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Summary and Conclusion

Following the review of previous procedures develop 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.
- 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.
- Consider the need to engage external resources to assist in the review of complex agreements with affiliates (i.e., 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:	

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Special Notes:

The following procedures do not supersede state regulation but are merely additional guidance analysts may consider useful. The following procedures are intended only for the review of compliance with filing requirements and are not specific to the decision process for approval of a transaction.

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

Form E or other required information 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 from Form E.

1. Does Form E or other required information state the names and addresses of the individuals who are providing notice of their involvement in a pending acquisition or change in corporate control?

2. Does Form E or other required information contain the following information:
   - State the names and addresses of the individuals affiliated with the individuals listed in question 1
   - Describe their affiliations

3. Does Form E or other required information state the nature and purpose of the proposed merger or acquisition?

4. Does Form E or other required information state the nature of the business performed by each of the individuals listed in questions 1 and 2?

5. Does Form E or other required information provide the following information:
   - State the market and market share in each relevant insurance market the individuals identified in questions 1 and 2 currently benefit from in this state
   - Historical market and market share data for each individual identified in questions 1 and 2 for the past five years
   - Provide a determination as to whether the proposed acquisition or merger, if consummated, would violate the competitive standards of the state. If the proposed merger or acquisition would violate competitive standards, provide justification of why the acquisition or merger would not substantially lessen competition or create a monopoly in the state.
   - The sources of the above information

Assessment of Form E or Other Required Information

6. If the Form E or other required information identifies certain thresholds that are exceeded, indicating evidence of the transaction's violation of the competitive standards within the state, has the applicant provided appropriate information or arguments that support the transaction does not violate the competitive standard? If "no," explain.

7. In the department's review of the Form E or other required information, did the Department note any concerns or risks regarding the impact of the proposed merger or acquisition on the market share or competition within the state? Explain.

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Summary and Conclusion

Develop and document an overall summary and conclusion regarding the review of the holding company Form E or other required information.

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

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

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

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Special Note: The following procedures do not supersede state regulation but are merely additional guidance analysts may consider useful. The following procedures are intended only for the review of compliance with filing requirements and are not specific to the decision process for approval of a transaction.

Extraordinary Dividend/Distribution

Extraordinary Dividend/Distributions are transaction-specific and are not part of the regular annual/quarterly analysis process. The review of these transactions may vary as some states may have regulations that differ.

1. Does the request for approval of the extraordinary dividend or distribution include the following?
    - The amount of the proposed dividend
    - The date established for the payment of the dividend
    - A statement as to whether the dividend is to be in cash or other form and, if in other form, a description, its cost, and its fair value together with an explanation of the basis for the valuation
    - A copy of the calculations determining that the proposed dividend is extraordinary
    - A balance sheet and statement of income for the period between the last annual statement filed and the end of the month prior to the month in which the request for dividend approval is submitted
    - A brief statement as to the effect of the proposed dividend on the insurer's surplus, the reasonableness of surplus in relation to the insurer's outstanding liabilities, and the adequacy of surplus relative to the insurer's financial needs
2. Does the notice include adequate information regarding the purpose of the dividend?
3. Does the purpose of the dividend/distribution appear reasonable?
4. Based on the information above, is the dividend or other distribution, in fact, extraordinary in nature?
5. Does the transaction comply with statutory accounting rules?
6. Will the insurer have adequate surplus?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company.

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

- Contact the insurer seeking explanations or additional information
- Obtain the insurer's business plan
- Meet with the insurer's management
- Other (explain)

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

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Non-Lead State Holding Company System Analysis Procedures

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

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

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

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

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

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

Form B – Insurance Holding Company System Annual Registration Statement

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

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

Form D – Prior Notice of a Transaction

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

Holding company regulations require that affiliated transactions be fair and reasonable to the interests of the insurer. Generally, affiliated management or service agreements should be based on actual cost in order to meet the fair and reasonable standard.

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The appropriate Statement of Statutory Accounting Principle should be reviewed within the NAIC *Accounting Practices and Procedures Manual* to ensure proper accounting.

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

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

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

Extraordinary Dividend/Distribution

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

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

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

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

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

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

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PROCEDURES #5-6 assist analysts in reviewing the background and financial information provided on the ultimate controlling person (UCP) to ensure that the Form A filing is in compliance with application requirements. Additionally, the procedures provide for review considerations of the UCP, Officers and Directors.

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

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

PROCEDURES #11-16 provides steps for completion of the approval or denial of the Form A application and developing an overall conclusion regarding the Form A.

POST-APPROVAL PROCEDURES #17-29 provide administrative steps for the conclusion of the Form A approval process as well as analytical steps for post-acquisition financial solvency analysis and compliance review. It is important for the department to conduct follow-up analysis and/or examination to ensure that stipulations or conditions of the acquisition approval have been met, that actual results are in line with the financial projections, business operations and strategy of the insurer that were provided with the Form A, and if not, to understand the reasons for variances.

When performing the procedures listed above, it is appropriate to first consider the general statutory standards that regulators must apply in consideration of a Form A, namely that:

- The financial stability of the insurer would not be jeopardized
- Policyholders will not be prejudiced
- The acquiring party's future plans are not unfair and unreasonable to policyholders
- The transaction is not likely to be hazardous or prejudicial to the insurance-buying public

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

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

In considering exposure to branded risk classifications, the issues of legal risk and reputational risk are generally well incorporated into the Form A application and its review. Many of the other risks (pricing and underwriting and reserving) tend to be most concentrated in the area of the insurers and therefore in these cases, it is reasonable that analysts initiate conversations with regulators of existing insurers in the applicant's group (domestic states or foreign jurisdictions) to determine if there are any concerns in these areas. However, the proposed transaction may put additional pressure on the insurer and the group from the standpoint that it may increase the leverage (operating or financial) which has the potential to increase the risks in each of these areas. The Form A application already contemplates obtaining proforma results for the insurer and the group. As analysts review proposed transaction, they may want to consider requesting additional information related to

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such proformas, such as how such results, and perhaps key ratios (e.g., operating or leverage) may look under certain feasible stress scenarios, particularly those that can be the most problematic for the group given its existing products or those included in its proposed business plan. However, stress scenarios should be evaluated in the context of how the company, as currently configured, would perform under the same stress scenarios. This may also be helpful in further assessing credit, market or liquidity risk. The results of such stresses should not be overemphasized but should be considered when evaluating whether the proposed transaction meets the previously mentioned criteria. Such an analysis may also be helpful in evaluating the strategic risk of the company and the group. However, strategic risk may be difficult to evaluate without additional information beyond the proforma financial statements. This is because the proforma financial statements may not reveal enough information to permit analysts to evaluate the ability of the group to execute its business plan.

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

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

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

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

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Further analysis of these presumably unrelated party transactions may be necessary to determine if the risks of the non-insurance affiliates may pose enterprise risks that may affect the insurer.

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

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

Stipulations for limited period of time:

- Requiring RBC to be maintained at a specified amount above company action level/trend test level. Because capital serves as a buffer that insurers use to absorb unexpected losses and financial shocks, this would better protect policyholders.
- Requiring quarterly RBC reports rather than annual reports as otherwise required by state law.
- Prohibiting the insurer from paying any ordinary or extraordinary dividends or other distributions to shareholders unless approved by the Commissioner.
- Requiring a capital maintenance agreement from or establishment of a prefunded trust account by the acquiring entity or appropriate holding company within the group.
- Enhancing the scrutiny of operations, dividends, investments, and reinsurance by requiring material changes in plans of operation to be filed with the commissioner (including revised projections), which, at a minimum, would include affiliated/related party investments, dividends, or reinsurance transactions to be approved prior to such change.
- Requiring a plan to be submitted by the group that allows all affiliated agreements and affiliated investments to be reviewed, despite being below any materiality thresholds otherwise required by state law. A review of agreements between the insurer and affiliated entities may be particularly helpful to verify there are no cost-sharing agreements that are abusive to policyholder funds.

Continuing stipulations:

- Requiring prior Commissioner approval of material arms-length, non-affiliated reinsurance treaties or risk-sharing agreements.
- Requiring notification within 30 days of any change in directors, executive officers or managers, or individuals in similar capacities of controlling entities, and biographical affidavits and such other information as shall reasonably be required by the commissioner.
- Requiring the filing of additional information regarding the corporate structure, controlling individuals, and other operations of the company.
- Requiring the filing of any offering memoranda, private placement memoranda, any investor disclosure statements or any other investor solicitation materials that were used related to the acquisition of control or the funding of such acquisition.
- Requiring disclosure of equity holders (both economic and voting) in all intermediate holding companies from the insurance company up to the ultimate controlling person or individual, but considering the burden on the acquiring party against the benefit to be received by the disclosure.

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- Requiring the filing of audit reports/financial statements of each equity holder of all intermediate holding companies but considering the burden on the acquiring party against the benefit to be received by the disclosure.
- Requiring the filing of personal financial statements for each controlling person or entity of the insurance company and the intermediate holding companies up to the ultimate controlling person or company. Controlling person could include for example, a person who has a management agreement with an intermediate holding company.

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

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

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

- Examining the insurer and its affiliates to ensure that the investment strategy provides a prudent approach for investing policyholder funds or does not create excessive contagion risk.
- Requiring ongoing annual stress testing of the insurer and the group in accordance with existing laws and regulations. This includes stress testing not only the investments but also the policyholder liabilities to ensure that the assets and liabilities continue to be properly matched.
- Conducting periodic and possible ongoing review of the investment management and other affiliated agreements, including a review of the equity firm fees and fee structure charged or to be charged to the insurer, if any, as well as arrangements with intercompany broker to ensure that they continue to be fair and reasonable. Also examine the flow of funds related to such agreements.
- Coordinating a meeting with multiple regulators and even all states to the extent there is a need for all regulators to better understand the business plan and operations of the group.
- Coordinating an examination with another regulator of a non-affiliated insurer where the direct writer has ceded a material portion of its risk to a separately controlled insurer.

Lead State Role in Form A Reviews

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

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

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

The lead state(s) or designee should coordinate a consolidated public hearing, if deemed necessary by the lead state as set forth in the *Insurance Holding Company Model Act* (#440) §3(D)(3). Refer to the state's laws regarding public hearing requirements.

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

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

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

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

Acquisitions of Control Exemption

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

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

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

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

- Nature of the acquisition
- Consideration of the acquisition
- Organizational chart – pre and post acquisition

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

Standards of Management of an Insurer Within a Holding Company System

Form A Exemptions

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

Reputational Risk – Market Disruption Regarding 10% Investor Limitation

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

Best Practices

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

Operational Risk – Ability to Influence Management and Policy Decisions

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

Best Practices

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

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

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

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Best Practice

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

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 guidance on the Lead State's holding company analysis procedures.

PROCEDURE #1 assists analysts in reviewing Form B for completeness. It guides analysts through each of the major items of information required by Form B.

While analysts should base this review on the domestic state's holding company law, according to Model #440, the following should be included in Form B.

- The capital structure, general financial condition, including the most recent Annual Financial Statement, ownership, and management of the insurer, and any person controlling the insurer.
- The identity and relationship of every member of the insurance holding company system.
- The following agreements in force and transactions currently outstanding or which have occurred during the last calendar year between the insurer and its affiliates:
    - Loans, other investments, purchases, sales, or exchanges of securities of the affiliates by the insurer or vice versa, involving 0.5% or more of the registrant's admitted assets as of Dec. 31 of the most recent prior year ended.
    - Purchases, sales, or exchange of assets involving 0.5% or more of registrant's admitted assets as of Dec. 31, of the most recent prior year ended.
    - Transactions not in the ordinary course of business.
    - Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, involving 0.5% or more of registrant's admitted assets as of Dec. 31 of the most recent prior year ended, other than insurance contracts entered into in the ordinary course of the insurer's business.
    - All reinsurance or management agreements, service contracts, consolidated tax allocation agreements, and cost-sharing arrangements.
    - Dividends and other distributions to shareholders.
- Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.
- Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the Commissioner.
- A summary outlining all items in the current registration statement representing changes from the prior registration statement (Form C).

PROCEDURES #2-3 assists analysts in determining whether dividends to shareholders were proper and in accordance with regulatory guidelines. Analysts should be particularly alert to extraordinary dividends, which require prior regulatory notification.

PROCEDURE #4 assists analysts in reviewing other types of transactions involving the insurer and other entities in its holding company system. It guides analysts through each type of transaction that requires prior regulatory notification/approval. Analysts should identify disclosures about the holding company that may potentially affect the insurer. Analysts should focus specifically on shareholders that may also have a relationship with the

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insurer, and on litigation or administrative proceedings involving the holding company that may affect the insurer, such as bankruptcy, receivership, or other corporate reorganizations. Analysts should also closely review the holding company financial statements for unusual items, such as heavy reliance on dividends from the insurer to fund debt service requirements. Analysts should also determine whether there are inconsistencies between evidence of affiliated transactions or agreements as indicated in the insurer's annual or quarterly statement, and the information presented by the insurer in its Form B filing that may merit further investigation.

While analysts should base this review on the domestic state's holding company law, according to Model#440, the following are types of transactions discussed in Form B.

- Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments where the transactions equal or exceed:
    - With respect to non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as of Dec. 31 of the most recent prior year ended.
    - With respect to life insurers, 3% of the insurer's admitted assets as of Dec. 31 of the most recent prior year ended.
- Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transactions are equal to or exceed:
    - With respect to non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as of Dec. 31 of the most recent prior year ended.
    - With respect to life insurers, 3% of the insurer's admitted assets as of Dec. 31 of the most recent prior year ended.
- Reinsurance agreements or modifications thereto, in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds 5% of the insurer's surplus as of Dec. 31 of the most recent prior year ended, including those agreements which may require, as consideration, the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer and non-affiliate that any portion of such assets will be transferred to one or more affiliates of the insurer.
- All management agreements, service contracts, and cost-sharing arrangements.
- Any material transactions specified by regulation, which the Commissioner determines may adversely affect the interest of the insurer's policyholders.

PROCEDURES #5-17 assist analysts in assessing the impact of the holding company system on the domestic insurer. This includes five primary segments of the analysis as follows.

- ***#5-12*** **ASSESSMENT OF THE GROUP PROFILE SUMMARY (GPS) FROM THE LEAD STATE**: If the Lead State is not your state, the Lead State should provide a GPS to the non-lead states in the group by Oct. 31. Using the GPS consider the risks identified and assessed by the Lead State to determine any material impacts on the branded risks of the domestic insurer, the interdependence of the holding company and its affiliated entities, including the domestic insurer, dividend obligations of the domestic insurer to service holding company debt or fund other holding company initiatives, the holding company's reputation, enterprise risk management and corporate governance.
- ***#13*** **ASSESSMENT OF FORM B (AND C):** Model #440 defines insurance holding companies and the related registration, disclosure, and approval requirements. Form B is the insurance holding company system annual registration statement. Model #440 requires every insurer, which is a member of an insurance holding company system, to register by filing a Form B within 15 days after it becomes subject to registration, and annually thereafter. Any non-domiciliary state may require any insurer that is authorized to do business in

the state, which is a member of a holding company system, and which is not subject to registration in its state of domicile, to furnish a copy of the registration statement.

An insurance holding company system consists of two or more affiliated individuals, one or more of which is an insurer. An affiliate is an entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, another entity. Control is presumed to exist when an entity or person, directly or indirectly, owns, controls, holds the power to vote, or holds proxies, representing 10 percent or more of the voting securities.

- ***#14-15*** **ASSESSMENT OF AFFILIATED RISKS ON THE DOMESTIC INSURER**: Affiliated risks may exist due to interdependence of the holding company and its affiliated entities through affiliated transactions. Consider also the guidance included in section III.B.5.d Operational Risk Repository – Analyst Reference Guide as well as guidance in this section regarding supplemental form filings for review of affiliated agreements.
- ***#16-17*** **ASSESSMENT OF OWN RISK AND SOLVENCY ASSESSMENT (ORSA):** If the Holding Company files an ORSA Summary Report, it is the responsibility of the Lead State to review and perform analysis of the report. At the completion of this review, the lead state should prepare a thorough summary of its review, which would include an initial assessment of each of the three sections. The lead state should also consider and include key information to share with other domestic states that are expected to place significant reliance on the lead state's review. Non-lead states are not expected to perform an in-depth review of the ORSA, but instead rely on the review completed by the lead state. The non-lead state's review of the lead state's ORSA review should be performed only for the purpose of having a general understanding of the work performed by the lead state, and to understand the risks identified and monitored at the group-level so the non-lead state may better monitor and communicate to the lead state when its legal entity could affect the group. Any concerns or questions related to information in the ORSA or group risks should be directed to the lead state.

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.

PROCEDURES #17ix – 17xiii assist analyst in reviewing captive reinsurance transactions other than those subject to Actuarial Guideline 48. Refer to the guidance in chapter III.B.9.b. Strategic Risk Repository – Analyst Reference Guide, procedure 9cc for an explanation of potential risks. Where risks are noted at the time of the Form D review or if follow-up is recommended, consider requesting any follow-up be conducted as part of the next financial condition examination to review against expected results.

Best Practices for 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 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.

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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.

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. 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

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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 may not be acceptable in all jurisdictions. As such, the review of a Form D using this method should confirm that cost-plus is required (i.e., by another regulator or jurisdiction) and/or that there is no acceptable alternative approach. The regulator should determine if the Company has provided documentation sufficient to support the cost-plus methodology or if another methodology should be suggested.

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

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

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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.

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.
  - Allocation method (cost or 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 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.

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- 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

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., 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?

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- 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 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.

Form D – Captive Reinsurance Transactions

PROCEDURE #17 assists analysts in identifying and analyzing specific types of captive reinsurance agreements specifically, those agreements where the underlying business ceded is term life and universal life with secondary guarantees (ULSG). For these specific products (commonly referred to as XXX/AXXX), there is a perception that the full amount of the required statutory reserves may not be needed to pay policyholder claims. As a result of this perception, many domestic regulators have allowed XXX/AXXX business to be reinsured through captives or special purpose vehicles in a manner that attempts to reduce the need for high-quality assets to support the portion of the statutory reserve that has a lower chance of being needed. The regulatory community has concluded that such XXX/AXXX transactions raise risks that should be reviewed by regulators pursuant to a regulatory framework using consistent review procedures. The procedures in this section are intended to serve this purpose. The primary goal of the procedures is to ensure that the reserves backing the XXX/AXXX business of the ceding insurer are backed by high-quality and accessible assets in amounts sufficient to pay policyholder claims as they come due.

The procedures refer to, and incorporate certain definitions used in, Actuarial Guideline *XLVIII – Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Section 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation* (AG 48). Analysts are encouraged to become familiar with the terms of AG 48 before conducting the procedures.

The procedures distinguish between reinsurance transactions that qualify for an exemption from AG 48 and reinsurance transactions that are subject to AG 48, although there is substantial overlap between the procedures used in, and the regulatory goals of, both cases. For transactions qualifying for an exemption under AG 48, the procedures call for a review based primarily on the procedures historically used by the NAIC Financial Analysis Working Group (FAWG) to review XXX/AXXX reinsurance transactions.

Analysts should review security standards for reinsurance of "grandfathered policies" to ensure that any credit for alternative reinsurance arrangements must be dependent on security that meets reserve valuation and asset quality requirements, as initially approved by the domiciliary regulator, that are at least as protective as those in place at the time the arrangement received its grandfathered status (12/31/14). The risk associated with grandfathered policies is that these policies are not subject to the primary security requirements established in AG 48 because the grandfathering provisions of the Framework reflect an agreement to honor the terms under which various regulators had approved existing captive reinsurance arrangements before the effective date of the Framework's uniform requirements. A potential risk could occur if ceding insurers replaced existing "hard asset" collateral with Other Security of lesser quality, and thus met the primary security requirements without providing any new collateral by draining the existing security from grandfathered business and reallocating it to new Covered Policy business.

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For transactions that do not qualify for an exemption under AG 48, the procedures call for a review based primarily on the regulatory framework for XXX/AXXX reinsurance transactions adopted in concept by the NAIC in 2014 (the "Framework"). In general terms, the Framework requires (among other things) that:

- The ceding insurer establishes gross reserves, in full, using applicable reserving guidance (currently, the "formulaic" approach).
- The ceding insurer holds "Primary Security" (certain high-quality assets) in at least an amount equal to the "Required Level of Primary Security", and that such security be held on a funds-withheld, trust, or modified coinsurance basis.
- Portions of the statutory reserve exceeding the Primary Security Requirement are supported by security acceptable to the commissioner ("Other Security").

The procedures relating to transactions not qualifying for an exemption under AG 48 are designed to help analysts identify whether the terms of the Framework have been satisfied.

For all transactions (whether qualifying for an exemption under AG 48 or not), the procedures include (i) obtaining five years of pro forma financial statements relating to the ceded business; (ii) obtaining information regarding the nature and amount of all funds held by or on behalf of the ceding insurer as security for the reinsurance contract; and (iii) obtaining information necessary to assess the overall financial stability of the ceding insurer and the group as a whole. Because XXX/AXXX reinsurance transactions may be structured in a way that could have an impact on the holding company group as a whole, the state of domicile should contact the lead state and other domestic state regulators of the group to determine if they have any input in approving the transaction, although ultimately the decision must be made by the state of domicile.

Form E (or Other Required Information) – Pre-Acquisition Notification Form

PROCEDURES #1-2 provide analysts with names and addresses of all the parties involved with the proposed merger or acquisition.

PROCEDURES #3-7 assist analysts in gaining a clear understanding of the rationale and goals of the proposed merger or acquisition.

Extraordinary Dividend/Distribution

PROCEDURES #1-6 assist analysts in ensuring that any extraordinary dividend or distribution was approved by all the appropriate channels, was fair and reasonable, and did not result in inadequate surplus for the insurer.

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VI. Group-wide Supervision Procedures and Analyst Reference Guide

A. Framework

B. Roles and Responsibilities of Group-wide Supervisor/Lead State

C. Insurance Holding Company System Analysis Guidance (Lead State)

1. Group Profile Summary Example

2. Non-Insurance Company Grid

D. Corporate Governance Disclosure Procedures

E. Enterprise Risk Management Process Risks Guidance

F. Own Risk and Solvency Assessment (ORSA) Review Template

G. Form F – Enterprise Risk Report Procedures

H. Group Capital Calculation (Lead State) Procedures

I. Group Capital Calculation (Lead State) Analyst Reference Guide

J. Periodic Meeting with the Company Procedures

K. Targeted Examination Procedures

L. Supervisory Colleges

M. Group Code Assignment

Introduction

The framework for group-wide supervision within the state-based system of regulation is set forth in the *Insurance Holding Company System Regulatory Act* (#440), the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450), the *Model Law on Examinations* (#390) and other NAIC tools. These NAIC models and tools, along with individual state laws and regulations establish the guidance for the analysis of insurance holding company systems. This includes a risk-focused approach to group supervision, where specific risks that are germane to most insurance holding company structures are addressed directly through regulation, while other more broad-based risks are addressed in the supervision review process.

Throughout this document, the term "regulation" is used to describe statutory provisions required under state laws, state regulations, or similar requirements. Also, throughout this document, the term "supervision" and "supervisory process" is used to describe the process(es) of monitoring the financial condition of the insurance group, or what is commonly referred to as the analysis process/function or examination process/function. This terminology is used to help clarify those risks addressed through statute or regulation versus those risks addressed through supervision.

State insurance regulators believe that group-wide supervision is key to helping fulfill the regulatory mission cited in the *United States Insurance Solvency Framework* (U.S. Solvency Framework), which states: "To protect the interests of the policyholder and those who rely on the insurance coverage provided to the policyholder first and foremost, while also facilitating an effective and efficient market-place for insurance products." The state-based system uses both regulation and supervision to fulfill this regulatory mission but is focused more on the supervision process for group-wide supervision as that lends itself to a more balanced approach between free markets and solvency protection. The supervision review process is flexible as to the nature, scale and complexity of the risks presented to the group. Plus, the supervision review process is flexible in dealing with risk exposure, risk concentration and the interrelationships of risks among entities within the group. However, there are situations where specific statutory authority and regulations are deemed more appropriate.

Internationally Active Insurance Group: For internationally active insurance groups (IAIGs) where a state insurance regulator is acting as the group-wide supervisor (see VI.B for criteria and definitions), it may be necessary to address additional areas regarding group-wide activities and risks. Such areas are largely consistent with the International Association of Insurance Supervisors' (IAIS's) Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) and have been incorporated throughout this chapter, as deemed appropriate by state insurance regulators. While such considerations and procedures are applicable to insurance groups identified as IAIGs (see state adoption of Model #440 Section 7.1), similar procedures applicable under the state's adoption of Model #440 Section 6 may also be appropriate for use in the supervision of other large insurance groups that do not meet the IAIG criteria. In assessing any such application, analysts must not exceed their legal authority, and any supervisory measures should be risk-based and proportionate to the size and nature of the group.

Likewise, because the ComFrame is to be applied flexibly and proportionately, not every additional area of IAIG supervision will apply to each IAIG, in the same way, or to the same extent. Group-wide supervisors have the flexibility to tailor the implementation of supervisory requirements and the application of insurance supervision. The ComFrame is not a one-size-fits-all approach to IAIG supervision, as the goal is to achieve the intended outcomes set forth in the ComFrame. IAIGs have different models of governance (e.g., more centralized or more decentralized). The ComFrame does not favor any particular governance model, and it is intended to apply to all models. The organization of an IAIG can be structured in various ways as long as the intended outcomes are achieved. Proportionate application, which is called for in IAIS guidance, involves using a variety of supervisory techniques and practices tailored to the insurer. The techniques and practices applied should not go beyond what is necessary in order to achieve the intended outcomes of the IAIS's Insurance Core Principles (ICPs) and the ComFrame.

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The following are excerpts from the NAIC models that help set forth the authority for the group-wide supervision framework.

Authority Related to the Supervision Review Process

Supervision review Model #440: (bolding and underlining used for emphasis).

Section 6. Examination

A. Power of Commissioner…the commissioner shall have the **power to examine any insurer registered under Section 4 and its affiliates to ascertain the financial condition of the insurer,** including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

Section 1. Definitions

F. "Enterprise Risk." "Enterprise risk" shall mean any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, **is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole,** including, but not limited to, anything that would cause the insurer's Risk-Based Capital to fall into company action level as set forth in [insert cross reference to appropriate section of Risk-Based Capital (RBC) Model Act] or would cause the insurer to be in hazardous financial condition [insert cross reference to appropriate section of Model Regulation to define standards and commissioner's authority over companies deemed to be in hazardous financial condition].

Section 7.1. Group-Wide Supervision of Internationally Active Insurance Groups

A. If the commissioner is the group-wide supervisor for an IAIG, **the commissioner is authorized to engage in any of the following group-wide supervision activities**:

(1) Assess the enterprise risks within the IAIG to ensure that:

(a) The material financial condition and liquidity risks to the members of the IAIG that are engaged in the business of insurance are identified by management.

(b) Reasonable and effective mitigation measures are in place.

(2) **Request, from any member of an IAIG subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk**, including, but not limited to, information about the members of the IAIG regarding:

(a) Governance, risk assessment, and management.

(b) Capital adequacy.

(c) Material intercompany transactions.

(3) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the IAIG are domiciled, **compel the development and implementation of reasonable measures designed to ensure that the IAIG is able to timely recognize and mitigate enterprise risks** to members of such IAIG that are engaged in the business of insurance.

(4) Communicate with other state, federal, and international regulatory agencies for members within the IAIG and share relevant information subject to the confidentiality provisions of Section 8 through supervisory colleges as set forth in Section 7 or otherwise.

(5) Enter into agreements with or obtain documentation from any insurer registered under Section 4; any member of the IAIG; and any other state, federal, and international regulatory agencies for members of the IAIG, providing the basis for or otherwise clarifying the commissioner's role as group-wide supervisor,

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including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state.

(6) Other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the commissioner.

Model #390:

Section 1. Purpose

The purpose of this Act is to provide an effective and efficient system for examining the activities, operations, financial condition and affairs of all persons transacting the business of insurance in this state and all persons otherwise subject to the jurisdiction of the commissioner. **The provisions of the Act are intended to enable the commissioner to adopt a flexible system of examinations** that directs resources as may be deemed appropriate and necessary for the administration of the insurance and insurance related laws of this state.

Section 3. Authority, Scope and Scheduling of Examinations

A. The commissioner or any of the commissioner's examiners **may conduct an examination under this Act of any company as often as the commissioner in his or her sole discretion deems appropriate…**

Scope of Group Regulation

The Model #440 defines the scope of group-wide regulation through various means including defining specific important terms such as the insurance holding company system, an affiliate, and control. These are important terms as they are used to define the scope of the group being the ultimate controlling person or entity, and all of its direct and indirectly controlled subsidiaries, and therefore subject to the requirements of the Model #440. It is important to note that these definitions also consider the extent to which there is either direct or indirect participation in the group, influence and contractual obligations that suggest there is control or influence over the group. Consequently, group-wide regulation and supervision includes all insurers, all operating and non-operating holding companies, non-regulated entities and special-purpose entities. It also includes other regulated entities such as banks, utilities or securities companies. In all cases, the lead state would need to understand all such entities and the risks that such entities pose to the insurer or group as a whole. However, with respect to the other regulated entities, Section VI.C. – Insurance Holding Company System Analysis Guidance (Lead State) of this Handbook discusses that the lead state's role is to establish a plan for communicating and coordinating with the other regulators, as well as other supervisors (e.g., international insurance regulators), if significant events, material concerns, adverse financial condition or prospective risks are identified.

Multi-Jurisdictional/Functional Cooperation

The scope of group-wide regulation under Model #440 is clearly meant to apply to all entities within the controlled group; it also makes an equally important distinction regarding authority. Under the U.S. group supervision approach, the lead state is responsible for understanding all the risks posed by the regulated and non-regulated entities within the group, but it does not have authority over the other regulated entities within the group. For many years, state insurance regulators have developed different methods of cooperating with each other in an effort to maximize the effectiveness of regulation while respecting the authority that each state has to protect the policyholders in their state. The states have worked together in a multitude of ways to provide these benefits. One of the best examples of cooperation is state participation in the NAIC's Financial Analysis (E) Working Group (commonly referred to as "FAWG"). The Working Group's primary role is to identify insurance companies and groups of national significance that are, or may be, financially troubled, and determine whether appropriate regulatory action is being taken, and if not, what action should be taken. This group of state regulators meets and holds conference calls throughout the year. This peer review process is an essential part of the state-based system

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of insurance regulation in that it reinforces the communication and cooperation that is necessary to regulate insurers and insurance groups.

Internationally Active Insurance Group: In addition, Model #440 provides definitions for IAIG and group-wide supervisor, which allow state insurance regulators to fulfill roles consistent with the ComFrame for cooperation across international jurisdictions in supervising IAIGs. See additional information in VI.B.

Supervision Review Process (Risk-focused Financial Surveillance Process)

States use specific procedures in carrying out the risk-focused financial surveillance process. Many of these procedures are focused on monitoring of the insurance legal entity and group. The legal entity regulation is performed in order to have a bottom-up view of the group, whereas the holding company analysis uses the top-down approach.

Communication: All domestic states are encouraged to communicate any significant findings or concerns they have up to the lead state for consideration in the comprehensive holding company analysis. In addition, lead states of IAIGs are expected to communicate any significant findings or concerns to the group-wide supervisor, if different than the lead state, through the use of supervisory colleges, crisis management groups, or other means necessary to address any enterprise-wide concerns that arise. Domestic and lead states should not take regulatory action or place sanctions on an insurance legal entity or key individual within a broader holding company system without first communicating with the lead state and/or group-wide supervisor.

Financial Analysis Handbook and Role of the Analyst

As part of the risk-focused surveillance approach, the financial analyst role is to provide continuous off-site monitoring of a group's financial condition, monitor internal/external changes relating to all aspects of the insurer and work with examination staff to review specific risks through an on-site examination. The holding company analysis procedures are designed to determine what risks exist at the holding company. Every holding company system is reviewed in order to derive an overall assessment that highlights areas where a more detailed analysis may be necessary. The procedures are intended to be used at the discretion of analysts depending upon the sophistication, complexity and overall financial position of the holding company system, as well as the degree of interdependence and interconnectivity within the holding company system. Also, consistent with the risk-focused surveillance approach, analysts should have a firm understanding of the following branded risk categories for each group:

- **Credit (CR)—**Amounts actually collected or collectible are less than those contractually due or payments are not remitted on a timely basis.
- **Legal (LG)—**Non-conformance with laws, rules, regulations, prescribed practices or ethical standards in any jurisdiction in which the entity operates will result in a disruption in business and financial loss.
- **Liquidity (LQ)—**Inability to meet contractual obligations as they become due because of an inability to liquidate assets or obtain adequate funding without incurring unacceptable losses.
- **Market (MK)—**Movement in market rates or prices, such as interest rates, foreign exchange rates or equity prices adversely affects the reported and/or market value of investments.
- **Operational (OP)—**The risk of financial loss resulting from inadequate or failed internal processes, personnel and systems, as well as unforeseen external events.
- **Pricing/Underwriting (PR/UW)—**Pricing and underwriting practices are inadequate to provide for risks assumed.

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- **Reputational (RP)—**Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.
- **Reserving (RV)—**Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.
- **Strategic (ST)—**Inability to implement appropriate business plans, to make decisions, to allocate resources or to adapt to changes in the business environment will adversely affect competitive position and financial condition.

Analysts should also consider any prospective risk to the group. A prospective risk is a residual risk that affects future operations or conditions for the group. These prospective risks can be identified through assessments of company management and/or operations or risks associated with future business plans. Common types of such risks for insurers may include underwriting strategy, investment strategy, and reinsurance strategy and diversification/concentration. However, other risks from non-insurers can also include off-balance sheet exposures and other risks driven by the business model of that non-insurer. The analyst's understanding of the above nine risk classifications includes an assessment of the level of that risk and the ability of the entity to appropriately manage the risk during the current period and prospectively. The assessment of these nine risk classifications both currently and prospectively should be part of the quantitative and qualitative analysis completed within the holding company analysis.

The overall risk-focused surveillance process requires a significant amount of communication and coordination between the analysis and examination function to be effective. Analysts should identify and document all material current and prospective solvency risks and communicate those risks to the respective examiners for periodic on-site inspection.

Communication across functions is also discussed in more detail below (see Coordination in Risk-Focused Surveillance), as well as in Section I.A Department Organization and Communication of this Handbook.

At the conclusion of the basic holding company analysis performed on all groups, the lead state is required to document an overall summary and conclusion regarding the financial condition of the group, including its strengths and weaknesses and any risks identified. This summary and conclusion should be provided in the Group Profile Summary (GPS) that is maintained and updated on a regular basis. See the VI.B. for discussion of the GPS.

Financial Examination Assessment

Communication and/or coordination with other regulators are crucial when considering the financial condition of a group. There are various risks that the lead state may want to examine more closely through an on-site examination. The most common of such risks, or potential risk mitigators, is that which is derived from the group's governance and risk management practices. Both of these are reviewed during a full-scope examination. This information is then communicated and shared with analysts, the lead state and other regulators as necessary. The lead state should also consider whether these areas, or components of each, should be examined more periodically. There may be several other areas where the lead state may want to consider a targeted exam with respect to the group. In considering such a targeted review, it is important to consider both the flexibility envisioned within Model #390 for such reviews, as well as the work conducted during a full-scope examination.

The fundamental purposes of a full-scope financial condition examination report are: 1) to assess the financial condition of the company; and 2) to set forth findings of fact (together with citations of pertinent laws, regulations and rules) with regard to any material adverse findings disclosed by the examination. The report on examination is structured and written to communicate to regulatory officials' examination findings of regulatory importance. Management letter comments are considered to be examination work papers and can be used to present results and observations noted during the examination. As it relates to groups, most of the examination work completed on a group basis is not expected to result in a report of examination, but rather is intended to communicate any concerns noted internally. In most cases, the work completed will merely inform analysts and other state

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regulators as it pertains to a particular area. However, to the extent the examiner witnesses practices that are noteworthy, and for which there is a need to pursue a change in such practices, a management letter may be produced. Such a management letter provides an opportunity to alert management that, if left uncorrected, could ultimately lead to financial concerns.

Management letter comments generally contain the following information:

- A concise statement of the problem found
- The factors that caused or created the problem
- The materiality of the problem and its effect or potential effect on the financial statements
- The financial condition of the group
- The examiner's recommendation to the group regarding what should be done to correct the problem.

The effectiveness of the financial examination process is enhanced if effective follow-up procedures have been established by the lead state. Periodically, after a financial examination report or management letter comment has been issued, inquiries should be made to the group to determine the extent to which corrective actions have been taken on report recommendations and findings. Because the examiners have usually moved on to another examination, many states use the financial analysts to perform this function. A lack of satisfactory corrective action by the group may be cause for further action.

The concept of risk in the risk-focused examination encompasses not only risk as of the examination date, but risks that extend or commence during the time in which the examination was conducted, and risks that are anticipated to arise or extend past the point of completion of the examination.

The risk-focused examination anticipates that risk assessment may extend through all seven phases of the examination.

- **Phase 1** – Understand the Company and Identify Key Functional Activities to be reviewed—This involves researching key business processes and business units.
- **Phase 2** – Identify and Assess Inherent Risk in Activities—These risks include credit, market, pricing/underwriting, reserving, liquidity, operational, legal, strategic, and reputational.
- **Phase 3** – Identify and Evaluate Risk Mitigation Strategies/Controls—These strategies/controls include management oversight, policies and procedures, risk measurement, control monitoring, and compliance with laws.
- **Phase 4** – Determine Residual Risk—Once this risk is determined, the examiner can determine where to focus resources most effectively.
- **Phase 5** – Establish/Conduct Detail Examination Procedures—Upon completion of risk assessment, determine nature and extent of detail examination procedures to be performed.
- **Phase 6** – Update Prioritization and Supervisory Plan—Incorporate the material findings of the risk assessment and examination in the determination of the prioritization and supervisory plan.
- **Phase 7** – Draft Examination Report and Management Letter—Incorporate into the examination report and management letter the results and observations noted during the examination.

The goals of the risk-focused examinations can also apply to group-wide supervision and are as follows:

- Assessing the quality and reliability of corporate governance to identify, assess and manage the risk environment facing the insurer in order to identify current or prospective solvency risk areas. By understanding the corporate governance structure and assessing the "tone at the top," the examiner will

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obtain information on the quality of guidance and oversight provided by the board of directors and the effectiveness of management, including the code of conduct established in cooperation with the board.

- Assessing the risks that a company's surplus is materially misstated.

The procedures above are performed for the purpose of completing a full-scope examination on an insurance legal entity. However, procedures related to governance and risk management can be performed at the group level when appropriate (See Section VI.B. for further discussion). In addition, for all other procedures, the states coordinate the examination of multiple insurance legal entities wherever possible. This typically involves identifying the systems that are common among members of the insurance group and only subjecting those common systems to one examination. This requires coordination among all domestic states and then further coordination in actually testing the particular system so that all domestic states can rely upon such work for their legal entity examinations.

Communication between analysts and examiners in preparation of an examination should include a thorough discussion of key risks, current and prospective. This communication and coordination may be best accomplished not only through written documentation but through face-to-face interaction. For example, the examiners and analysts should meet for pre-examination planning, conduct follow-up meetings/calls to discuss analysis of subsequent filings and finally meet at the end of the examination whereby examiners can communicate examination findings to analysts that in turn may help analysts focus on their next review.

Internationally Active Insurance Group: In addition to the general governance and risk management considerations and the targeted procedures related to specific concerns incorporated into financial examinations, there are additional considerations highlighted in the ComFrame that may be appropriate for incorporation into ongoing IAIG financial exams led by the group-wide supervisor. These considerations generally relate to ComFrame elements that are more effectively evaluated through on-site examination activities, such as the effectiveness of corporate governance, risk management, and internal control frameworks in place at the head of the IAIG. For more information on IAIG examination considerations, please see Section 1.I.F of the NAIC's *Financial Condition Examiners Handbook*.

Coordination in Risk-Focused Surveillance

Most, but not all state insurance departments follow a staffing model whereby separate units are responsible for off-site financial analysis and on-site financial examination activities. Such a staffing model can lead to challenges in supervising insurance groups if state departments do not emphasize the importance of communication and coordination across units. In some cases, financial examination activities are outsourced to third parties, which can lead to additional complications. To encourage effective coordination and communication across units, state insurance departments use the common language of branded risk classifications (see discussion above) to identify and assess insurance company risk exposures and incorporate this language into meetings and reports shared across units, i.e., GPS, Own Risk and Solvency Assessment (ORSA) Lead State Summary, Exam Summary Review Memorandum. In addition, formal meetings and ongoing communication between the two units, if separate, are required during the planning, fieldwork, and wrap-up stages of each financial examination to ensure effective coordination. Similar requirements are also in place to promote communication and coordination between analysis/examination staff and any subject matter experts (SMEs)—i.e., actuaries, investment specialists, information technology (IT) specialists, reinsurance specialists—that are supporting financial surveillance efforts.

Internationally Active Insurance Group: Given the level of complexity of many IAIGs and the critical need to ensure effective coordination in supervision, state insurance departments are encouraged to consider the benefits of customized approaches to financial surveillance staffing for IAIGs. For example, in some jurisdictions, both domestically and internationally, group-wide supervisors utilize a team-based approach to IAIG supervision whereby financial analysts; financial examiners; department supervisors; and specialists, both internal or external,

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are integrated into a single unit for the purposes of group supervision. Such an approach can promote the use of a more well-rounded and integrated team of supervisors with different backgrounds and skillsets in reviewing group regulatory reporting, holding periodic meetings with the group, conducting group risk assessments, performing on-site inspections of group functions, and leading ongoing supervisory college sessions. However, there may be other approaches to financial surveillance staffing that can be applied to address the nature and complexity of IAIGs. As such, state insurance departments acting as group-wide supervisors for IAIGs are encouraged to consider the benefits of more customized approaches to staffing in this area.

Other Holding Company Specific Risks Addressed Directly in Regulation

State insurance regulators have consistently reviewed and monitored groups through the Form B, Form D required filings, required dividend distributions and Form A acquisition. Insurers are required to submit Form D filings for management agreements, service contracts, tax allocation agreements, guarantees, loans and all cost-sharing arrangements. All such contracts must be submitted for regulatory approval to avoid the possibility of management moving cash out of the regulated entity, which is a risk that the business model for the insurance industry is susceptible to. It also includes reinsurance agreements, where there are similar opportunities and where there must be a regulatory review of such agreements to ascertain that risk transfer has occurred within the contract. The fact is that intragroup transactions and exposures are subject to potential abuse and state insurance regulators have addressed these risks directly in this way. Also, subject to review under Model #440 are "extraordinary dividends" and change in control, since again these transactions have the potential to pose risk to the insurance group and the insurer and its policyholders.

Lead State Summary

The Lead State Summary Report is located in iSite+, within Summary Reports, and provides a listing of all insurance groups and the companies within each group. The purpose of the report is to improve communication between regulators regarding group examinations. It can be sorted on a particular group code or group name to determine the lead state for that group or by state to view all of the insurance groups for which that state is the lead. The report also contains contact information for the department's analyst and chief analyst for a particular insurance group and other information such as premiums, assets and latest exam information. States should actively update its contact information throughout the year as changes occur.

Within the Lead State Summary Report the user can view the Domestic Report, which displays each group that includes an insurer domiciled in the state selected by the user. The Consolidated Domicile Data report displays consolidated data (direct and gross premiums written and percentage distribution and net admitted assets) by state within each group. For more information on the lead state refer to VI.B.

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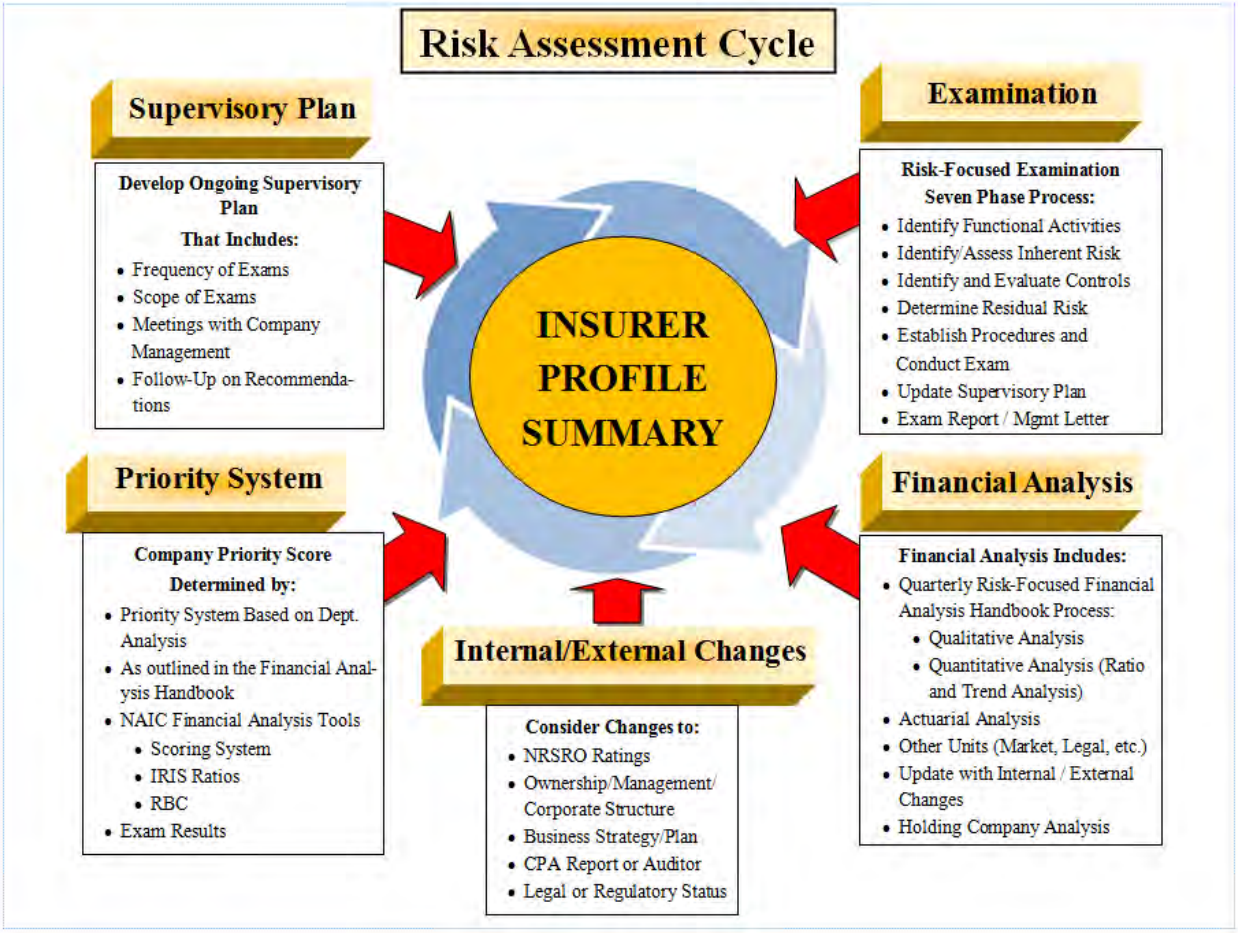
The following diagram illustrates the risk assessment cycle:



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Introduction and Overview

The previous section introduced the U.S. group supervision framework. This included references to the NAIC model laws, including respective state laws and regulations that help set forth the framework, followed by a discussion of the supervision review process. As previously discussed, in the U.S., the supervisory review process consists primarily of off-site and on-site monitoring activities. This section will discuss the roles and responsibilities of the group-wide supervisor/lead state.

For purpose of this Handbook, the terms "group-wide supervisor" and "lead state" are used somewhat interchangeable, but with greater use of the term lead state. This is due to the fact that the states have used the term lead state for years, however there are some instances where both would exist, and therefore it is important to understand that distinction. The lead state is generally considered to be the one state that "takes the lead" with respect to conducting group-wide supervision within the U.S. solvency system. The concept of the lead state and determining the lead state is discussed more in the following section. A U.S.-based company that only conducts business in the U.S., unless the group also has banking or similar functions, would result in the lead state being the group-wide supervisor. In the case of an international-based company, the group-wide supervisor would typically be a foreign-based regulator. (See Section VI.J. Supervisory Colleges Guidance, regarding international supervisory colleges). Ideally, when a foreign-based group-wide supervisor is involved, the U.S. lead state regulator should be able to defer some of his or her responsibilities to the foreign-based group-wide supervisor. However, it is possible that the U.S. lead state may not be able to obtain group-wide information from the foreign-based group-wide supervisor, and, therefore, the U.S. lead state regulator may need to complete a portion of the group-wide analysis.

Before discussing the roles and responsibilities of the lead state/group-wide supervisor further, the following is defined:

> **Group-wide supervision** – The process of promoting effective and coordinated supervision of an insurance group on a group-wide basis, including coordinating the input of insurance legal entity supervisors, as a supplement to insurance legal entity supervision.

The process for monitoring the financial condition of a group is similar to monitoring a specific insurer in that it requires the use of basic financial information, coupled with the ability to gather additional information produced by management. The information produced by the group's management that is generally considered to be the most helpful is that which is associated with managing the group's risks, or more specifically those risks that may ultimately have financial implications on the financial condition of the group, including prospective risks. During this supervision review process, the regulators role is to understand the various risks faced by the group and how the group is managing such risks.

One of the primary reasons for determining a lead state/group-wide supervisor is to increase the efficiencies and effectiveness of group supervision. The state-based system framework for group supervision is centered on the *Insurance Holding Company System Regulatory Act* (#440), which provides, among other things, that every domestic state within the insurance group should have the ability to evaluate the group and its potential impact on the domestic insurer. The use of a lead state or group-wide supervisor has the benefit of retaining this authority but sets up a system in which states regularly defer this authority to a key regulator. However, even if domestic regulators are not technically required to defer this authority, this deferral is considered a best practice that should be used in virtually all cases, with few exceptions. This has the effect of increasing efficiency and effectiveness of group regulation.

Lead State/Group-Wide Supervision Concept

The operations of an insurance company often are not limited to one state. When multiple states are involved in monitoring the activities or approving the transactions of a company or insurance holding company system, it is prudent to coordinate regulatory efforts.

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These coordinated activities should include:

- The establishment of procedures to communicate information regarding troubled insurers with other state insurance departments.
- The participation on joint examinations of insurers, when appropriate.
- The assignment of specific regulatory tasks to respective state insurance departments and/or other jurisdictions in order to achieve efficiency and effectiveness in regulatory efforts and to share personnel resources and expertise.
- In the case of troubled or potentially troubled insurance groups, the establishment of a task force or crisis management group consisting of personnel from various state insurance departments and/or international jurisdictions to carry out coordinated activities.
- Coordination and communication of insurance holding company system analysis.

If significant concerns are identified related to the internationally active insurance group's (IAIG's) current or prospective solvency, whether due to legal entity or group-wide risks, the group-wide supervisor should determine whether additional supervisory measures, as outlined in Model #440, should be implemented. Model #440 provides the group-wide supervisor the authority to obtain the information necessary and appropriate to assess enterprise risk. In addition, Model #440 provides for coordination, through the authority of the regulatory officials of the jurisdictions where members of the IAIG are domiciled, to compel the development and implementation of reasonable measures designed to ensure that the IAIG is able to timely recognize and mitigate enterprise risks to members of the IAIG that are engaged in the business of insurance.

The concept of lead state/group-wide supervision is not intended to relinquish the authority of any state or jurisdiction, nor is it intended to increase any state or jurisdiction's statutory authority or to put any state or jurisdiction at a disadvantage. It is intended to facilitate efficiencies when one state coordinates the regulatory processes of all states and/or jurisdictions involved. Nevertheless, the lead state/group-wide supervisor should coordinate with non-lead states and/or other jurisdictions on all regulatory items that affect the group, or multiple legal entities contained in the group, to make it clear which state is responsible for activities and reduce regulatory duplication.

Procedures for Determining the Lead State

Insurance holding company systems with more than one U.S. insurance legal entity are deemed U.S. insurance groups and assigned NAIC group codes (see Section VI.K for more information on group code assignment). For U.S. insurance groups with insurance entities domiciled in more than one U.S. state/jurisdiction, a lead state is selected to oversee the group. The ultimate decision of who should function as the lead state is up to the domestic state insurance regulators of the group where a majority of such domestic states must agree to the decision. However, in practice, it has generally occurred through a consensus decision. The determination of a lead state is affected by the following factors:

- The state with the insurer/affiliate with largest direct written premiums
- Domiciliary state/country of top-tiered insurance company in an insurance holding company system
- Physical location of the main corporate offices or largest operational offices of the group
- Knowledge in distinct areas of various business attributes and structures
- Affiliated arrangements or reinsurance agreements
- Lead state must be accredited by the NAIC

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The Lead State Report is located in iSite+, within Summary Reports, and provides an up-to-date listing of all insurance groups and the companies within each group. The purpose of the report is to improve coordination and communication between regulators. The report also contains current contact information for the state's assigned insurance company analyst and the state's chief analyst which is maintained by state department staff. Within the Lead State Report the user can view the Domestic Report which displays each group that includes an insurer domiciled in the state selected by the user. The Consolidated Domicile Data Report displays consolidated data (direct and gross premiums written and percentage distribution and net admitted assets) by state within each group.

Procedures for Identifying an Internationally Active Insurance Group

U.S.-based insurance holding company systems that operate internationally are designated IAIGs if they meet the following criteria included in Model #440:

1. Premiums written in at least three countries.
2. The percentage of gross premiums written outside the U.S. is at least 10% of the insurance holding company system's total gross written premiums.
3. Based on a three-year rolling average, the total assets of the insurance holding company system are at least $50 billion or the total gross written premiums of the insurance holding company system are at least $10 billion.

Any involved supervisor of an insurance group operating internationally may prompt the process of identifying an IAIG. If no group-wide supervisor has been determined (see discussion on determination below), the supervisor most demonstrating the characteristics of a group-wide supervisor should lead the identification process and invite other involved supervisors to participate. The scope of an insurance group should be determined before considering whether the criteria for determining whether the group is an IAIG are met. If there is already a supervisory college for a group, it should be used to facilitate the determination as to whether the group is an IAIG.

In addition to the primary criteria for use in identifying an IAIG, although not explicitly addressed in Model #440, in limited circumstances, it may be appropriate for the group-wide supervisor to utilize discretion to determine that a group is not an IAIG even if it meets the criteria or that a group is an IAIG even if it does not meet the criteria, if permitted under state law. If discretion is used, then the reasons for exercising such discretion should be based on verifiable and documented quantitative and qualitative information. Examples of situations where it may be appropriate to determine that a group is an IAIG, even if it does not currently meet the criteria, include, but are not limited to:

- Growth/expansion or acquisition plans of the group.
- Significant off-balance sheet assets.
- Situations where a temporary event or fluctuation causes the group to fall below thresholds.

Examples of situations where it may be appropriate to determine that a group is not an IAIG, even though it currently meets the criteria, include, but are not limited to:

- Planned contraction or disposal of business.
- Situations where an unusual event or fluctuation causes the group to temporarily exceed thresholds.
- Situations where the group's business outside the U.S. exceeds 10% in aggregate, but its business in any one foreign jurisdiction is negligible.

The group-wide supervisor should regularly review its decision to determine whether the group continues to meet the criteria and invite other involved supervisors to participate in that process. At a minimum, the group-wide supervisor should review its decision once every three years and whenever a significant change or event occurs that affects the group.

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Model #440 states that prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision, the commissioner shall notify the insurer and the ultimate controlling person within the IAIG providing reasons for that decision. The IAIG shall have not less than thirty (30) days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish on the state's website the identity of IAIGs that the commissioner has determined are subject to group-wide supervision.

Procedures for Determining the Group-Wide Supervisor

Model #440 defines group-wide supervisor as the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities, who is determined or acknowledged by the commissioner to have sufficient significant contacts with the IAIG. Model #440 requires a single group-wide supervisor to be identified for any IAIGs operating in the U.S., which could either be a state insurance regulator—i.e., most likely the lead state in the case of a U.S.-based insurance group—or a regulatory official from another jurisdiction, based on individual facts and circumstances. The following factors are considered when making the group-wide supervisor determination:

1. The jurisdiction of domicile of the insurers within the IAIG that hold the largest share of the group's written premiums, assets, or liabilities.
2. The jurisdiction of domicile of the top-tiered insurer(s) in the insurance holding company system of the IAIG.
3. The location of the executive offices or largest operational offices of the IAIG.
4. Whether another regulatory official is acting or seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:
    a. Substantially similar to the system of regulation provided under the laws of this state.
    b. Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials.
5. Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

Procedures for Identifying the Scope and Head of the Internationally Active Insurance Group

In conducting group-wide supervision of an IAIG, it is important for the group-wide supervisor to work with other involved supervisors to identify all the legal entities that are part of the insurance group.

The determination of both the scope and head of the IAIG is significant to group supervision, as review procedures and risk assessments are conducted at this level. Therefore, the group-wide supervisor should carefully consider this guidance, as well as additional best practice considerations outlined in Insurance Core Principle (ICP) 23 – Group-Wide Supervision, in making determinations regarding the scope and the head of the IAIG. However, International Association of Insurance Supervisors (IAIS) materials are not deemed authoritative and should not be viewed as official NAIC guidance if they are not directly incorporated into this chapter. The group-wide supervisor should provide the supervisory college with the main reasons and judgments it made when identifying the head of the IAIG and obtain concurrence from other college members, when possible.

To determine the scope and head of an insurance group, supervisors should:

- First, identify all insurance legal entities within the corporate structure. Model #440 provides the authority to collect all information necessary to determine the scope and head of the IAIG.

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- Second, identify all entities that have control over those insurance legal entities, as defined in Model #440. As noted in Model #440, control is generally presumed to exist based on 10% or more ownership, direct or indirect, of voting securities, but it can also take operational control factors into consideration.
    - If this results in only one entity being identified with control over all the insurance legal entities, this entity is the head of the insurance group.
    - However, if there is more than one entity with control over all the insurance legal entities, supervisors should identify the head of the insurance group, such as the entity that has the greatest level of control over the insurance business, by considering the following factors:
        - The proportion of the insurance business relative to other businesses it controls.
        - The degree of operational control.
        - The degree of shareholder control.

Head of the Internationally Active Insurance Group versus Ultimate Controlling Person: The head of the IAIG is not necessarily synonymous with the Ultimate Controlling Person (UCP) of the holding company system, which is the top-tier company or individual with control over and responsibility for all entities within the holding company system that is not controlled by any other person. As holding company systems may include various business segments and intermediate holding companies, it is the responsibility of the group-wide supervisor, in consultation with other involved supervisors, to identify the entity most responsible for the direct management/control of the insurance operations of the group.

Non-insurance Legal Entities: In determining the scope and head of the IAIG, the group-wide supervisor should consider whether noninsurance legal entities within the group pose risk to the insurance operations. In making this determination, the group-wide supervisor should evaluate whether there is a linkage between the insurance operations and the noninsurance legal entity, other than an investment in or from the noninsurance legal entities, that could adversely affect the insurance operations; and a lack of adequate safeguards, including additional capital, to mitigate risks arising from any such linkages. If so, such noninsurance entities should be included within the scope of the IAIG, and the group-wide supervisor should take this into consideration in identifying the head of the IAIG.

Subsidiary as Head of the Internationally Active Insurance Group: Where a legal entity controls all insurance legal entities within the group and noninsurance legal entities, which pose risks to the insurance operations, the group-wide supervisor has the discretion to identify a subsidiary of that entity as the head of the IAIG if: 1) prudential supervision is exercised by another financial sector supervisor over that entity; and 2) the group-wide supervisor can rely on the other financial sector supervisor to provide sufficient information concerning the risks that this entity and the legal entities it controls pose to the insurance operations.

Lead State or Group-Wide Supervisor Roles and Responsibilities

The following identifies the roles and responsibilities, or procedures that should be performed by the lead state or group-wide supervisor as it relates to supervision of insurance groups. It also includes a short summary of the purpose of each of these duties. Most of these are further detailed in the remaining parts of this section of this Handbook.

Communication and Coordination

Two of the main responsibilities of the lead state are: 1) to establish communication with other identified states, federal regulators and international regulators, including establishing points of contact and 2) to determine the amount of interest in participating in the multi-jurisdictional coordination. It also includes establishing lines of communication and serving as the regulatory contact with top management of the group.

The most important role of the lead state is to act as a communicator of group risk assessment information to other domestic states and then acts as a coordinator with the other states in determining what, if any, further action is appropriate regarding the domestic insurers in the group or the group as a whole. By serving in this

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role, the lead state can coordinate and add efficiency to the states' requests for group-level information. This approach helps to prevent regulatory gaps and, more importantly, efficiently detect problems earlier. In addition, this approach also helps to reduce duplication of regulatory requests with non-lead states only making additional regulatory requests of an insurer's domestic entity(ies) located in that non-lead state. Inquiries seeking group-level information or information concerning entities domiciled in another state or jurisdiction should be coordinated by, and made by, the lead state. Non-lead states should generally not pursue such inquiries directly with the group parent or indirectly through queries channeled via a domestic. To increase the effectiveness of this concept, it may be helpful for the lead state to find a means to make sure that each group for which it is the lead is aware that it is, in fact, the lead state for that group. This may include directing it to certain information or through some other communication.

Confidentiality of Information: Maintaining confidentiality of all information is of utmost importance and as such implementing confidentiality agreements with all regulators is imperative. The lead state is responsible for communicating and coordinating the procedures as to how information will be shared among each other. Verbal or written briefings that are arranged by the lead state, in conjunction with company management, have been the most effective.

Other Responsibilities: The lead state will have many procedures assigned to it, which include determining and documenting: 1) the depth of and approach to the insurance holding company analysis; 2) the assessment of the group's governance and enterprise risk; 3) questions addressed in a periodic meeting with the group; 4) targeted examination procedures; and 5) the extent to which there are any market conduct risks.

Participating States: In addition to the importance of lead state or group-wide supervisor communication and coordination, it is also important for domestic, or non-lead, states to communicate and coordinate effectively regarding the group. Of particular importance is that a domestic state notifies the lead state and/or group-wide supervisor prior to taking any regulatory action or placing sanctions on an insurance legal entity or key individual within a broader holding company system. This type of proactive communication can ensure that state insurance regulators are effectively coordinating and not undermining each other's efforts in conducting group/legal entity supervision.

Holding Company Analysis and the Group Profile Summary

NAIC Model #440, which has been adopted by all the states, establishes the platform for holding company analysis. One of the most important aspects of the holding company analysis is the requirement for the lead state to understand the entire insurance holding company system. As previously noted, the holding company system includes the ultimate controlling person or entity, as well as all of its direct and indirectly controlled subsidiaries. There are various things that must be considered in gaining this understanding, including documenting the nature and function of all non-insurance legal entities within the holding company system. The primary purpose of gaining such an understanding is determining the risks and risk concentrations that each entity may pose to the insurer and the group as a whole.

Another important aspect of the holding company analysis is the analysis of the financial condition of the insurance holding company system. This specifically includes evaluating and assessing how four different areas i.e., profitability, leverage, liquidity, and overall financial condition - impact its exposure to the nine branded risk classifications. Although much of this analysis can be driven by aggregating risks identified in the legal entity analysis (including a review of the Insurer Profile Summary (IPS)) and by reviewing the group's financial statements submitted as part of the registration statement or filed with the U.S. Securities and Exchange Commission (SEC), the analysis may also require further discussion with management of the group. See Section VI.H. – Periodic Meeting with the Group Procedures for further guidance.

Completing the holding company analysis as detailed in Section VI.C. Insurance Holding Company System Analysis Guidance (Lead State) is one of the roles of the lead state. This analysis is intended to be completed by the lead state only. However, as discussed elsewhere in this Handbook, all domestic states are responsible for

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documenting the impact that the holding company group could have on the domestic insurer, which requires a basic level of understanding of the group's risks.

Group Profile Summary: All results of holding company analysis are to be documented in the GPS for purposes of presenting a comprehensive view of the current and prospective risks facing the holding company group as well as the ongoing regulatory plan (or supervisory plan) to ensure effective supervision. A separate supervisory plan document may also be utilized to outline more detailed steps to ensure effective supervision for high-priority or potentially troubled insurers within the group, as necessary. The purpose of the GPS also is to serve as the primary communication tool between the lead state and other regulators that provides consistency between the states. The GPS is intended to serve as a "living document" to "house" summaries of information from legal entity IPSs that are material to the group, such as coordinated risk-focused examinations, financial analysis, internal and external changes, supervisory plans, and other group information. Completing and distributing the GPS to other regulators on a timely basis is the sole responsibility of the lead state.

Analysts are involved in all phases of the risk-focused surveillance approach. There should be a continuous exchange of information between examiners and analysts to ensure that all members of the department are properly informed of solvency issues related to the group. Analysts should work with the examination staff to update the GPS.

Internationally Active Insurance Group: In performing holding company analysis and maintaining a GPS for IAIGs, the group-wide supervisor should ensure that both the scope and head of the IAIG are clearly defined and described within the analysis documentation. In addition, key considerations relevant to IAIGs are highlighted throughout to ensure that they are adequately addressed and incorporated, as appropriate, into holding company analysis processes and the GPS to meet the expectations of other involved international supervisors.

Corporate Governance Risks

The *Model Regulation to Define Standards and Commissioners Authority for Companies Deemed to be in Hazardous Financial Condition* (#385) specifically indicates that if an officer, director, or any other person who directly or indirectly controls the operation of the insurer, fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position, the insurer can be deemed to be a company that is in a hazardous financial condition. Clearly, this inclusion recognizes that such a situation is a risk to a policyholder. For this reason, Model #385 specifically provides the supervisor with the authority to issue and order that insurer to correct corporate governance practice deficiencies, and adopt and use governance practices acceptable to the commissioner.

The NAIC has incorporated into its *Annual Financial Reporting Model Regulation* (#205) specific governance requirements as it pertains to insurers audit committees. Most notably, the regulation requires an increasing amount of independent audit committee members as the premium increases. The calculation of this independence requirement may be provided to the audit committee on an aggregate basis for insurers in the insurance holding company system. However, specific reporting is limited and instead governance is assessed with information gathered during the examination and analysis process.

The *Corporate Governance Annual Disclosure Model Act* (#305) and the *Corporate Governance Annual Disclosure Model Regulation* (#306) provide the analyst with annual reporting from insurers on their corporate governance practices. While there is flexibility in determining the level at which governance information is reported in the annual filing, the insurer or insurance group is encouraged to make the Corporate Governance Annual Disclosure (CGAD) disclosures at the level at which the risk appetite is determined; the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively; the supervision of those factors are coordinated and exercised; or the legal liability for failure of general corporate governance duties would be placed.

Assessing the corporate governance of the group is one of the roles of the lead state and group-wide supervisor, and conclusions regarding this assessment should be incorporated in holding company analysis documentation

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and the GPS. Certain elements of governance that should be reviewed and assessed at the head of the IAIG level are discussed in more detail in Section VI.D.

Enterprise Risk Management (ERM) Risks

As part of the risk-focused surveillance system, analysts and examiners identify and assess the inherent risk in the branded risk categories using their authority under the *Model Law on Examinations* (#390) and specific state laws and regulations. Analysts, although more commonly the examiner, also identifies and evaluates risk mitigation strategies/controls to assess the risk management environment of the group and will consider that in determining the overall supervisory plan. Larger scale insurers and insurance groups are subject to all of the requirements of the *Risk Management and Own Risk and Solvency Assessment Model Act* (#505). This model requires among other things, the maintenance of a risk management framework to assist with identifying, assessing, monitoring, managing, and reporting on its material and relevant risks. It also requires the completion of an Own Risk and Solvency Assessment (ORSA) no less than annually, but also at any time when there are significant changes to the risk profile of the insurer or the insurance group. The ORSA is the insurer/group's internal assessment appropriate to its nature, scale and complexity addressing the material and relevant risks associated with an insurer's current business plan and the sufficiency of capital resources to support those risks. Any follow-up associated with this risk assessment should be coordinated through the lead state to improve regulatory effectiveness and reduce the level of regulatory duplication.

The ORSA has two primary goals:

1. To foster an effective level of ERM, through which each insurer or insurance group identifies, assesses, monitors and reports on its material and relevant risks, using techniques that are appropriate to the nature, scale, and complexity of the insurer's risks, in a manner that is adequate to support risk and capital decisions.
2. To provide a group-level perspective on risk and capital, as a supplement to the existing legal entity view.

If a U.S. state insurance commissioner is the global group-wide supervisor of an IAIG, the U.S. state insurance commissioner should receive the ORSA Summary Report covering all material group-wide insurance operations. In addition, the insurer should work with the U.S. global group-wide supervisor to identify the head of the IAIG and determine which noninsurance operations, if any, within the group should be included within the scope of the ORSA Summary Report. However, for all ORSA filers, the noninsurance operations that present material and relevant risks to the insurer should be included in the scope of the ORSA Summary Report.

Otherwise, the insurer may file ORSA Summary Reports encompassing, at a minimum, the U.S. insurance operations, as long as the lead state receives ORSA Summary Reports encompassing the non-U.S. insurance operations. The lead state commissioner should discuss with the global group-wide supervisor from the relevant foreign jurisdiction(s) the report received to inquire about any concerns and either confirm that the report was compliant with the foreign jurisdictions' requirements or consistent with the applicable principles outlined in the IAIS ICP 16: Enterprise Risk Management (ERM), as well as the *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* (ORSA Guidance Manual), to determine if additional information is needed. The commissioner will, where possible, avoid creating duplicative regulatory requirements for internationally active insurers.

Any follow-up associated with this risk assessment should be coordinated through the lead state to improve regulatory effectiveness and reduce the level of regulatory duplication. Assessing the ERM process risks of the group as detailed in Section VI.E. Enterprise Risk Management Process Risks Guidance is one of the roles of the lead state.

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Market Conduct Risks

This Handbook discusses within Section I.A. Department Organization and Communication the need for communication with other divisions of the insurance department. This Handbook also discusses within Section I.B. Interstate Communication and Cooperation, and specifically discusses regulatory actions taken relative to market conduct issues. The Risk Assessment worksheet within this Handbook also list market conduct actions/findings and documenting in the IPS. The IPS is a tool used for sharing information between states that also encompasses group information. Refer to the *Market Regulation Handbook* for further discussion of these types of risks.

Periodic Meeting with Group

As previously discussed, Model #440 and respective state laws and regulations give state regulators the authority to obtain and examine any information related to the group in order to determine the financial condition impact on the insurer. In addition, there is generally a need to meet periodically with group management in order to ascertain that the regulator has all relevant information he or she needs to have a current understanding of the financial condition of the group and insurer.

How often such a meeting takes place, or the depth of discussion, will vary considerably from group to group. However, an in-person meeting is recommended in the year of an examination. For example, if an examination is as of December 31, 2014, then meet early in 2014. The lead state regulator will use its judgment in making decisions on whether to meet or not, based on what it already knows about the group and insurer. Every holding company situation is different, and for that reason, the lead state should use its judgment in determining how best to gather additional information that can come from this type of process.

With the general objective of better understanding the financial condition of the group, the lead state should tailor any questions or discussion points to most accurately fit what the regulator knows about the group and its financial position and what could be projected into the future without the benefit of understanding what the group is doing to address such items. Therefore, considering what type of questions should be developed, or the focus of such a discussion, either through an in person meeting or a conference call, is one of the roles of the lead state. See Section VI.H. Periodic Meeting with the Group procedures for possible questions to consider for such a meeting.

Targeted Examination Procedures

The need for target examinations should be driven by the results of the risk-focused surveillance process. Therefore, because the general purpose of a targeted on-site examination is to focus resources on a particular risk, such procedures would generally be driven by any change in risks or any weaknesses or concerns given that on-site inspection can provide assurances that cannot be provided through off-site monitoring.

Targeted examinations on groups would generally not need to focus on risks that are already addressed within individual company examinations, unless there appears to have been a change in that risk since the last examination and that particular risk is one that is shared among several insurance legal entities within the group. It may be appropriate for the lead state to involve other domestic states in order to determine if resources for addressing such potential issue can be shared, thus preventing the extraordinary strain on the lead state resources. The targeted group examinations are generally expected to occur on those risks that are either outside the insurance legal entity or risks that are common to all entities within the group. Targeted examinations on changes in governance, risk management and internal controls are the more common areas where such procedures may be expected. Also expected, although not expected to be commonly performed, is targeted examination on particular non-insurance entities within the group. Considering if any targeted examination procedures should be completed is one of the roles of the lead state, and it should consider the guidance in Section V.I. Targeted Examination Procedures and Guidance in making such a determination. Non-lead states should defer to the lead state with regard to whether a targeted group examination is necessary.

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Internationally Active Insurance Groups: For IAIGs, in certain circumstances, targeted exam procedures may include the group-wide supervisor joining on-site inspections of an insurance legal entity in another jurisdiction to address specific issues of concern coordinated by the relevant involved supervisor, with prior consent from that supervisor. In addition, it may be appropriate for the group-wide supervisor or other involved supervisors to conduct targeted exam procedures in response to concerns and risks identified during supervisory college discussions and report the results back to the supervisory college. Finally, in addition to targeted exam procedures to address concerns identified through holding company analysis and supervisory colleges, the *Financial Condition Examiners Handbook* outlines additional examination considerations relevant to IAIGs that are more effectively conducted during an on-site examination.

Supervisory Colleges

The NAIC through the state regulators has defined a supervisory college as a regulatory tool that is incorporated into the existing risk-focused surveillance approach when a holding company system contains internationally active legal entities with material levels of activity and is designed to work in conjunction with a regulatory agency's analytical, examination and legal efforts. The supervisory college creates a more unified approach to addressing global financial supervision issues. Effective and efficient regulatory scrutiny of group-wide issues should occur in the context of an organized global approach and involve all significant regulatory parties, including regulatory agencies from countries outside of the U.S., and other state and federal agencies within the states. In rare cases (e.g., certain large health insurance groups), the use of a supervisory college for U.S.-only insurance groups (no insurance business outside the U.S.) may be beneficial to increasing the efficiency and effectiveness of group regulation. This type of supervisory college is referred to as a regional supervisory college.

A supervisory college establishes a routine communication channel with appropriate company personnel and all regulators, which can be beneficial in identifying the appropriate contacts quickly in the event of a crisis.

The above description of supervisory college is largely consistent with the lead state concept that has been used for years by state insurance regulators. In such situations, one jurisdiction takes the lead in terms of being primarily responsible for the coordination and communication between the insurance group and the other states, as well as other potential responsibilities. But ultimately each jurisdiction may have to do what it believes is necessary, and that is in the best interests of the policyholders in its jurisdiction. In addition, the supervisory college acts as a peer review process similar to how the NAICs Financial Analysis € Working Group acts as a peer review process of troubled or potentially troubled insurers or insurance groups. This peer review process has the effect of allowing other jurisdictions to defer some of their authority. To the extent issues arise, the collective group makes them known to all jurisdictions so that the group-wide supervisor and the other jurisdictions can discuss how best to deal with the issues. Alternatively, the collective group can make the jurisdiction aware that more may need to be done. State insurance regulators have been dealing with these types of multi-jurisdictional issues for years. Both state insurance regulators and the IAIS are aware that these situations demand mutual cooperation in order to build the relationship and trust needed.

Internationally Active Insurance Group: For IAIGs, the group-wide supervisor establishes a supervisory college, which is expected to meet at least annually. In addition, the members of the IAIG's supervisory college are expected to communicate and exchange relevant information on an ongoing basis, including information on group capital prepared by the group-wide supervisor, as well as a summary of any additional reporting related to group capital that has been reported at the option of the group-wide supervisor. Furthermore, through the supervisory college process, the group-wide supervisor should establish a crisis management group (CMG) for the IAIG, with the objective of enhancing preparedness for, and facilitating the recovery and resolution of, the IAIG. To facilitate this, the group-wide supervisor should put in place a written coordination agreement between the members of the IAIG CMG. The structure, participation in, and role of an IAIG supervisory college or CMG is ultimately the responsibility of the group-wide supervisor.

Guidance for use in conducting supervisory colleges and related activities is included in Section VI.J. Supervisory Colleges are one of the roles of the lead state.

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The following information is intended to provide a narrative description of the issues/considerations for analysts when performing insurance holding company analysis as well as procedures and processes for developing a Group Profile Summary (GPS). As discussed in Section VI.B Roles and Responsibilities of the Lead State/Group-wide Supervisor, the Group-wide Supervisor/Lead State is not intended to eliminate any authority that any jurisdiction has over a legal entity insurer. Rather, group-wide supervision is intended to increase the efficiencies and effectiveness for each insurance group by emphasizing that one state is responsible for completing certain duties that allow all other domestic states to focus their efforts in other areas.

States' Roles in Performing Insurance Holding Company Analysis

It is important for analysts to understand the concept that the lead state has certain responsibilities pertaining to insurance holding company analysis and understanding that many of these responsibilities focus on increasing communication and coordination. There are several other coordination activities involved with group-wide supervision, particularly if the result of the group analysis identifies areas that targeted examination procedures are warranted within the insurance operations and as a result involve other states. The following table lists the possible scenarios and actions for lead and domestic states completing an insurance holding company system analysis:

When your state is the lead state and another state has a domestic in the group:	**When your state is sharing duties with a lead state:**	**When your state is the lead state and all insurers within the group are domestics of your state:**	**When there is no group code, but your state's domestic is a multi-state writer and part of a holding company system (i.e., you receive a Form B):**	***When your state domestic has a group code, but your state is NOT the lead state:**
• Complete an insurance holding company analysis that considers procedures similar to those contained within the *Financial Analysis* Handbook Insurance Holding Company Analysis guidance and document results in the GPS. • The insurance holding company analysis chapter represents guidance that the accreditation team will use to evaluate the sufficiency of depth and documentation considerations. • Complete before October 31st.	• Coordinate the completion of holding company analysis and preparing a GPS. • The *Financial Analysis Handbook* Insurance Holding Company analysis chapter represents guidance that the accreditation team will use to evaluate the sufficiency of depth and documentation considerations. • Complete before October 31st.	• Complete an insurance holding company analysis that considers procedures similar to those contained within the *Financial Analysis* Handbook Insurance Holding Company Analysis guidance and document the analysis results in the GPS. • Complete before December 31st.	• Complete an insurance holding company analysis that considers procedures similar to those contained within the *Financial Analysis Handbook* Insurance Holding Company Analysis guidance and document the analysis results in GPS. • Complete before December 31st.	• Offer a copy of the "legal entity IPS" or other applicable information to the lead state to assist in the completion of the insurance holding company analysis. • Obtain and review the GPS from the lead state and update the impact of the holding company on the insurer section of the domestic Insurer Profile Summary (IPS). • If a copy of the analysis has not been received from the lead state by November, contact the lead state and consider completing your evaluation of the impact of the insurance holding company system on the domestic insurer without the benefit of a detailed insurance holding company analysis.

*Each state should still review Form B for its domestic companies (See also chapter V.A. Holding Company Procedures (Non-Lead State) and V.F. Holding Company Procedures (Non-Lead State) Analyst Reference Guide for possible Form B and C compliance and assessment procedures and guidance).

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Responsibilities of the Lead State

Insurance Holding Company System Analysis

The lead state or an agreed upon other designated state(s) is responsible for completing the insurance holding company analysis. The domestic state is responsible for completing and documenting an evaluation/analysis of the impact of the insurance holding company system on the domestic insurer. The distinction of these responsibilities is set forth in the following.

The depth and frequency of the insurance holding company analysis will depend on the characteristics (i.e., sophistication, complexity, financial strength) of the insurance holding company system (or parts thereof), availability of information (e.g., SEC Form 10K or Form 10Q) and the existing or potential issues and problems found during review of the insurance holding company filings. Analysts are required to document the results of the insurance holding company system analysis once annually but will update it periodically as needed. The Form B, Form C and any other holding company filings should be analyzed by October 31st for analysis conducted by the lead state. (See also chapter V.A. and V.F. for possible Form B and C compliance and assessment procedures and guidance.)

Documentation and Communication of Insurance Holding Company System Analysis

Documentation in the GPS of the analysis work performed by the lead state (or the domestic state for those groups with only one multi-state insurer or with multi-state insurers domiciled in only one state) should include sufficient evidence of a review of the insurance holding company system. The GPS should be updated and shared with other domestic states within the group prior to October 31 each year. If the GPS includes information from the analyst's summary of the Own Risk and Solvency Assessment (ORSA) analysis, analysts are reminded of the sensitivity of the information in the ORSA Summary Report and that it includes proprietary and trade secret information. Before sharing the GPS with another domestic state or other impacted regulator, the lead state should verify the ability of each regulator to keep the shared information confidential, consistent with state law. Analysts may consider consulting with the state's legal counsel before sharing with another regulator.

The lead state may choose to rely on the analysis work performed by an international insurance supervisor (e.g., work products from a supervisory college) or another functional regulator. If such reliance takes place, the lead state is still responsible for documenting and distributing to other domestic states an analysis of the overall financial condition of the group, significant events, and any material strengths and weaknesses of the holding company group. Additionally, if the lead state has material concerns with respect to the overall financial condition of the holding company group, it is responsible for notifying all other domestic states.

Responsibilities of Each Domestic State

Evaluation of the Impact of Holding Company System

The domestic state is responsible for completing an evaluation of the impact of the insurance holding company system on the domestic insurer. In doing so, the domestic state is responsible for identifying and understanding the affiliated risks within the insurance holding company system. This information and understanding can be obtained from several sources, including the supplemental filings (i.e., Form A, Form B, Form D, and Form E). The Form B, Form C and any other holding company filings should be analyzed, to at least some extent, by December 31st for analysis conducted by the domestic state (See also chapter V.A. and V.F. for possible Form B and C compliance and assessment procedures and guidance.) Additionally, the domestic state should obtain a GPS from the lead state containing the risk assessment of the group that is necessary to evaluate the impact that the insurance holding company system could have on the domestic insurer. The domestic state is responsible for summarizing a conclusion regarding this evaluation. This should be included in either the annual or quarterly financial analysis work papers and summarized in the Insurer Profile Summary (IPS) of the respective domestic insurer on a yearly basis.

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Communication of Holding Company System Analysis

The communication with the lead state should be documented in order to substantiate the domestic department's understanding of the insurance holding company analysis that was performed and included in the financial analysis work papers of the respective domestic insurer on a yearly basis. Such documentation should include the bulleted items in the section above included in the GPS. If a state relies on the insurance holding company analysis of another regulator, communication of such by the lead state should be completed by October 31.

Holding Company System Analysis Consideration and Guidance

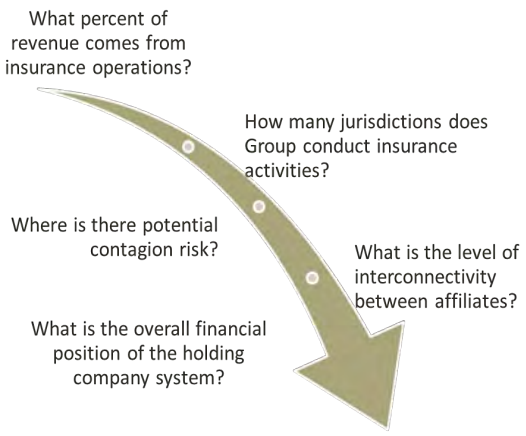
Overview of Insurance Holding Company System Structures

It is important for analysts to gain a thorough understanding of the organizational structure in order to properly analyze how each subsidiary/affiliate in the holding company operates. Organizational structures can vary significantly between insurance holding company systems. Larger holding company systems will often include lower-tier holding companies that manage both non-insurance and insurance subsidiaries independently of the ultimate holding company. Others may be partially held by different individuals and companies or have indirect ownership relationships.

An insurance holding company system may consist of one company that directly or indirectly controls one or more other companies. Control may exist through ownership of the voting shares of a company's common stock or, particularly in the case of a mutual insurer where ownership lies with the policyholders, control may exist or be strengthened through contractual relationships and/or common management. The controlling entity often delegates operational functions to subsidiaries so that it can focus on the management of the overall insurance holding company system. Some insurance holding company structures are established to hold only insurance operations, while others may be more complex and engage in multiple types of businesses. Understanding the insurance holding company system structure and the various types of operations and obligations that the entities within the structure create is critical in performing insurance holding company analysis.

A sophisticated/complex insurance holding company system may include, but not be limited to, the following:

- Insurance and non-insurance operations
- International operations
- Multiple or diverse lines of business
- Numerous entities or segments



This first step in understanding the insurance holding company structure is obtaining an organizational chart. Organizational charts are included in: 1) initial applications for licensure; 2) holding company registration statements (Form B); and 3) the Annual Financial Statement Schedule Y, which is also required to be updated and reported to regulators quarterly if there any changes from the prior year-end. The first step in understanding the organizational chart is identifying all the insurance subsidiaries and non-insurance affiliates in addition to identifying all the states and other jurisdictions responsible for regulating those subsidiaries.

There can be variations as to how an insurance holding company is classified. The most common types of

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insurance holding company structures are described below, each of which has different implications for understanding the impact that the structure may have on the financial condition of the group.

Public Holding Company

A public holding company is an entity that controls various other affiliates, including financial intermediaries, such as insurance companies, banking institutions, security firms, etc. The shares in a public holding company are open to investors (thus making them shareholders), which can be purchased via a public securities exchange market, giving such entities greater abilities to access additional capital. Transactions that result from the public holding company are approved by the board of directors. A public holding company may be obligated to pay dividends in order to maintain expectations of their shareholders. No two groups are the same and, only through conversations with management and/or reviewing external historical actions can these things be properly evaluated.

Private Holding Company

A private holding company is a separate legal entity designed to hold either investments or operating assets. The shares in a private holding company are held by or on behalf of the beneficial owners. All transactions regarding the holding company must be approved by or on behalf of the beneficial owners. A private company has some of the same characteristics as a public company in terms of expectations, but usually such expectations differ from a public company. A private company may have some access to capital that mutual insurers do not have, but it also may be just as limited.

Mutual Insurance Company

A mutual insurance company is formed and bound by its policyholders. A mutual insurer does not issue stock and, therefore, does not have stockholders. The initial net worth of a mutual insurer is limited to surplus paid-in by the original policyholders or by a third-party contributor. A mutual insurer can create or acquire subsidiaries, thus becoming the controlling affiliate of an insurance holding company system. It may also create a subsidiary to act as a holding company for downstream affiliates. Although a mutual insurer may be subject to some pressure from its policyholders, such pressure is usually much different from what is experienced by a public company. However, a mutual insurer is limited in terms of its access to capital because it cannot issue new stock. Again, no two groups are alike and understanding these issues usually can only be obtained through conversations with management and/or reviewing historical actions.

Mutual Holding Company

In most states, a mutual insurer may be permitted to restructure by converting from a mutual to a stock insurer, with a new upstream mutual holding company owning a majority of the voting stock. The mutual policyholders' ownership rights are transferred to the mutual holding company. This structure gives the insurer more options to raise funds, through the issuance of stock. Such a conversion is subject to the approval of the policyholders and the domiciliary state's commissioner. Because mutual holding companies have characteristics of both public companies and mutual companies, there are implications of how such a structure affects its operations.

Non-profit Health Company

The term non-profit organization is generally most associated with the treatment of organizations under the Internal Revenue Code. The Internal Revenue Service (IRS) generally associates not for profits with charitable organizations, churches and religious organizations, political organizations and private foundations. Insurers that are non-profits are generally charitable organizations and it is not uncommon that some types of insurers, particularly those that provide health insurance, to have some history as a non-profit. It may be helpful to understand these types of dynamics when considering a particular insurance holding company structure.

Fraternal Associations

State insurance departments have authority over fraternal benefit society insurers, and although each state may define them slightly differently, such definitions usually provide that they are a corporation, society, order,

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supreme lodge or voluntary association, without capital stock, conducted solely for the benefit of its members and their beneficiaries. Because of this structure, regulators often find similarities between a fraternal benefit society and a mutual insurer because both can be limited in terms of their ability to raise additional funds. Although this is a general consideration for the regulator when evaluating the insurance holding company system, there is generally much more that must be understood before coming to this conclusion because in some cases, the fraternal may be able to assess its members or take other actions that can serve a similar purpose as raising capital.

Reciprocal Exchanges

State insurance departments have authority over reciprocal insurance exchanges and although each state may define them slightly differently, such definitions are generally centered on the notion of a group of persons who agree to share each other's insurance losses. The IRS provides that a reciprocal is an organization or group of subscribers, including individuals, partnerships and corporations, who may insure each other by "exchanging" insurance contracts through their commonly appointed attorney-in-fact. All such insurance contracts are executed on behalf of all the subscribers by their designated attorney-in-fact. Because of this structure, regulators often find similarities between reciprocal exchanges and fraternal benefit societies and mutual insurers because they can be limited in terms of their ability to raise additional funds. Although this is a general consideration for the regulator when evaluating the insurance holding company system, there is generally much more that must be understood before coming to this conclusion because in some cases, the reciprocal may be able to assess policies that can serve a similar purpose as raising capital.

Sources of Insurance Holding Company Information

Statutorily Required Filings: The most readily available source for gaining an understanding of an insurance holding company structure is through the statutory filings submitted by insurers. Analysts may use the statutory filings to gain an understanding of: 1) the entities included in the insurance holding company system; 2) where revenue comes from; 3) how many jurisdictions the insurance holding company system writes in along with the percentage of U.S. versus foreign revenues; and 4) contagion risks. Insurers are required to submit an organizational chart and details of affiliated transactions in Schedule Y—Part 1, Part 1A, and Part 2. Part 1A includes the relationships within the insurance holding company system to the ultimate controlling person(s) or entity. This schedule provides valuable insight into the ownership structure, insurance holdings, locale and affiliated relationships within the insurance holding company system. To understand the different levels of interconnectivity and impact within the insurance holding company system, analysts should review Form D which includes the management service agreements, tax sharing agreements and affiliated reinsurance. Analysts should also review Form B to assess the overall financial condition of the insurance holding company system as Form B includes the holding company's profitability, debt, equity and assets. Review and consider the impact any holding company debt reported by the holding company and whether the insurers fund this debt through upstream dividend payments (See also chapter V.A. and V.F. for possible Form B and C compliance and assessment procedures and guidance).

Form B - Insurance Holding Company System Annual Registration Statement: Form B is filed annually on June 1 and contains information on identity and control of the registrant, organizational structure, ultimate controlling person(s), biographical information on directors and officers, transactions, relationships and agreements, litigation, statement regarding plans or service transactions, and financial statements and exhibits.

Note #10: Under guidance from *Statement of Statutory Accounting Principles (SSAP) No. 25 - Affiliates and Other Related Parties*, insurers are also required to provide detailed information on related party transactions and relationships in Note #10. Refer to Section IV.B. Analysis of Notes to Financials for more information.

MD&A and Audited Financial Statement: These filings also contain information on the insurance holding company structure. These reports are filed with the NAIC by April 1 and June 1, respectively, of the year following the annual reporting period. Specifically, the MD&A provides background information on organizational structure, product lines, marketing systems, and actions such as corporate restructuring,

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acquisitions, and dispositions. It is a narrative that provides information to regulators that enhances understanding of the insurer's financial position, results of operations, changes in capital and surplus, and cash flows. The report often explains transactions or events that have occurred during the year that affect the financial condition of the insurer. It may also contain information about affiliated relationships or changes in those relationships.

Audited Financial Statement: This statement provides an overview of the background, operations, affiliated transactions, mergers and subsidiary holdings regarding a holding company. Several of the footnotes (Related Party Information, Reinsurance and Other Insurance Transactions, Reorganization, Acquisitions and Dispositions, and Summary of Ownership Relationships of Significant Affiliated Companies) also provide valuable insight into organizational structure and affiliated transactions. These footnotes provide disclosures on such issues as affiliated transactions, agreements, guarantees, reinsurance transactions, capital contributions, and organizational structure, which allow analysts to gain an understanding of how the different entities within the holding company operate together.

SEC Filings: Disclosures on non-insurance entities found within the holding company may be limited. For publicly traded companies, analysts can reference reports filed with the U.S. Securities and Exchange Commission (SEC) to gain insight on the insurance holding company structure. The SEC filings provide significant background information about the holding company and its subsidiaries. Form 10-K is used to report the entities' annual financial data. An example of sections within the Form 10-K that may provide valuable background information includes:

- Business**:** This section includes a general discussion of the entity's business, financial information, and industry segments. The industry segment section allows analysts to assess the organization by its major operating business segments.
- Directors and Executive Officers: This section helps analysts identify key officers, owners, and family relationships.
- Security Ownership of Certain Beneficial Owners and Management: This section identifies certain beneficial owners of the filer's securities and possible subsequent changes in control.
- Certain Relationships and Related Transactions: This section discusses affiliated transactions and business relationships.

Form 10-Q is used to report quarterly financial data and is much more limited in scope than Form 10-K, but it does require condensed financials as well as some background information. Form 8-K is required after certain significant changes in business occur, including change in control, bankruptcy or receivership, and resignation of directors.

Combined Statutory Financial Statements: These statements are required for property/casualty insurers only. These statements have been adjusted for intercompany transactions and affiliated investments.

Shareholders' Reports: These are generally available on a holding company's website. The scope of the shareholder's report may vary between companies but is generally reported on a consolidated generally accepted accounting principles (GAAP) basis and may contain segment information. An insurance holding company system's Web page may contain additional information such as current stock price information, company history, descriptions of products or business segments, and recent press releases. The insurer's website can be obtained from the Jurat page of the insurer's annual and quarterly statutory financial statements. Links to company websites can also be obtained from the rating agency websites, as well as other financial websites or through tools such as Bloomberg Financial.

Rating Agency Reports: Credit rating providers, each with their own unique methodology for assigning ratings, often provide financial data and/or analysis of an insurer or insurance group. This information is available through purchase or subscription. Some of the organizations include: A.M. Best; Fitch Ratings; Moody's

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Investor's Service; Standard and Poor's (S&P); Dominion Bond Rating Service; RealPoint, LLC (for CMBS only); Kroll Bond Rating Agency (KBRA); and TheStreet.com Ratings.

NAIC database and iSite+ Reports: These iSite+ applications provide information primarily on the insurance companies, rather than the insurance holding company system, with the exception of the property and casualty combined annual financial statement. However, other information or resources on iSite+ may be helpful when reviewing collectively the insurance companies within an insurance holding company system. In addition to the financial statement and financial analysis solvency tools, other reports exist such as summary reports, the Lead State Summary Report and market analysis information. Line reports may be useful in collecting selected lines of data from the financial statements for all insurers within an insurance holding company system.

Internet/Websites: The Internet offers a variety of websites that contain information on the financial background of publicly traded companies. Some financial websites provide a comparison of the company's own financial results to that of their closest competitors and to industry averages. Some of these sites may provide information such as the buying and selling activities of company stock by senior level employees of the company. Additionally, links to news articles concerning the company and the industry are available.

Other Information Sources: These may include prior analysis performed on the insurance holding company system, financial and market examination reports, target examinations or special studies, discussions and other communications with other lead states or foreign regulators, and discussions with company management. The last point to make is that discussions with company management should not be minimized. This may be necessary particularly in those insurance holding company systems where the structure is more complicated, and more difficult to understand. The group should be willing to explain its structure and the purpose of such a structure to its regulators, including more in-depth discussions with the lead state or group wide supervisor. If the lead state or other regulators believe the structure is opaque, or difficult to understand, it should raise the issue with management. In rare cases, the lead state and/or other regulators may want to suggest that management consider some changes to either eliminate such confusion or determine if some additional disclosure could be made to in the public financial statements to reduce such confusion. The domestic regulator may initiate discussions to suggest dissolving, merging, de-stacking or other such transactions with legal entities within the insurance holding company system to facilitate corporate efficiencies and minimize complicated structuring.

International Data Sources: When an insurance holding company system is domiciled in a foreign country, it is necessary to determine the supervisory authority in that country and the filing requirements. Some countries have an agency that functions similar to the SEC, and financial statements may be available through that agency. For example, The System for Electronic Document Analysis and Retrieval is the official site for the filing of documents by public companies as required by securities laws in Canada. This website can provide the annual report for publicly traded insurance companies domiciled in Canada. When information is not readily available through a government source, the company's shareholder's report or other information may be available on the company's website or through regulator request.

For foreign holding companies, certain sources of information may require conversion of financial data to U.S. currency. Conversion rates can be found on a variety of different Internet websites.

Recent News and Rating Information

Analysts should research recent news relevant to the insurance holding company system. Press releases and publications may provide valuable insight about important events and management decisions. These items may include significant transaction activity, changes in the company's stock price, legal or regulatory issues, employee layoffs, losses of key personnel, and issues with customers or providers.

Review current financial strength and debt ratings of the group. Rating agencies often issue separate ratings and analyses on the credit and claims-paying ability of insurers or the holding company. Reports of rating agencies provide a quick overview of a company. Such reports should be scanned for background information

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about the company's operations, management, and significant changes. If a report of the entire insurance group is available, it may be useful as an early step in understanding the relationships of each entity within the insurance group.

Rating agencies focus on liquidity available at the holding company, so much of a subsidiary's cash may be pushed up to the holding company through dividends, management fees, or other intercompany arrangements to gain a better rating. A rating downgrade may have a material effect on the ability of the company to sell its products (particularly in the commercial property/casualty and annuity lines of business), to obtain reinsurance, or to compete in the marketplace in general. Events such as these may place a greater strain on the insurance companies, which may already be coping with various financial issues such as high debt servicing requirements.

Stock Price Evaluation/Debt Prices/Credit Default Swaps

If the stock of the intermediate or ultimate holding company is publicly traded, monitor the stock price and volume. Compare the trends of price and volume of the holding company with peer organizations. Analysts should strive to determine the factors affecting stock prices, which extend well beyond the financial status of the insurer. The use of professional securities analyst reports may provide additional insight regarding the fluctuation of stock prices. In some cases, the intermediate or ultimate holding company debt may also be publicly traded, in which case similar to stocks; analysts should monitor the price and volume. Analysts should strive to determine the factors impacting the change in bond prices. Finally, some intermediate or ultimate holding companies may have credit default swaps issued on them. These should also be monitored where they exist. The NAIC Capital Markets Bureau monitors such information and summarizes the changes in the weekly reports available to state insurance regulators.

International Holding Company Considerations

Many insurance companies domiciled in the U.S. are owned by holding companies that are located in foreign countries. Depending on the country of domicile, for some, financial information is not readily available through a government-sponsored source similar to the SEC. Analysts may find that the investor's page of publicly held international holding companies' websites will provide the best source of financial information.

The regulation of international holding companies varies according to the laws of its country of origin. For most European Union organizations, accounting treatment and reporting is somewhat consistent and is improving due to the efforts of many groups working with the standards developed by the International Accounting Standards Board (IASB). However, for many organizations domiciled in offshore countries, such as Ireland, those located in the Caribbean, and others, the regulation around public financial reporting may be less robust.

Analysts should understand the contact structure of the organization. For example, a German-based holding company may have advisory boards established to communicate with U.S. regulators. Analysts should direct any regulatory concerns to the proper organization contact to ensure a prompt reply or resolution.

Many transactions between a foreign holding company and U.S. companies, including the holding company's U.S. subsidiaries, are governed by special requirements. Transactions such as reinsurance, servicing, investment, the handling of pooling taxes, etc., are controlled by requirements that are in many cases quite different from similar transactions between two domestic entities.

Foreign holding companies invest in their U.S. subsidiaries to nurture profitable operations, to complement existing operations or to add to existing capacity. Some foreign holding companies may consider their U.S. enterprises non-core and consequently show weaker commitment to their ongoing business operations or financial support. In recent years, after sustaining continued losses from U.S. subsidiaries, several prominent foreign holding companies decided to cease their U.S. operations and liquidate their assets.

Analysts should be aware of a holding company's stated commitment to ensure the continued stability of U.S. operations. This commitment may include a written or verbal parental guarantee.

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Some points to consider when assessing a holding company's commitment regarding continued U.S. operations include:

- The importance of the U.S. operations in the insurance holding company structure
- The holding company's historical involvement in supporting its subsidiaries
- Parental guarantees or commitments of financial support, or failures to act on these commitments

Forms A, B, D, E, and Extraordinary Dividend/Distribution

Forms A, D, E and Extraordinary Dividend/Distribution are transaction-specific and are not part of the regular annual/quarterly analysis process. The review of these transactions may vary as some states may have regulations that differ from the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). See section V. procedures for holding company considerations for domestic and non-lead states.

Liquidity Stress Test

In 2021 the NAIC Executive (EX) Committee and Plenary adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) that introduced a new filing requirement for a Liquidity Stress Test (LST). While insurer and insurer groups within the scope of the LST will submit required filings in 2021 under states' examination authority, states are beginning the process of adopting Model #440 amendments into state laws. Additional lead state and non-lead state guidance will be developed in future years as regulators gain experience reviewing the LST filing.

Scope Criteria and LST Framework

- The Scope Criteria for insurers or insurance groups required to perform and file the LST and the instructions for the filings are outlined in the *NAIC 2020 Liquidity Stress Test Framework* which is located on the Financial Stability (E) Task Force web page of the NAIC's at: https://content.naic.org/cmte_e_financial_stability_tf.htm. Once an insurance group with two or more life insurers triggers the Scope Criteria for a specific year, then the LST is performed at the legal entity insurer level within the group. Results are aggregated at the group level.
- Property/Casualty (P/C) and Health: Although the P/C and health insurers are not subject to the Scope Criteria in 2021, if a P/C or health legal entity insurer is deemed, by the insurer group, to pose material liquidity risk to a U.S. group that triggered the Scope Criteria in a future year, then the P/C and health legal entity insurer within the group will perform the LST.

Regulatory Goals of the LST per the *NAIC 2020 Liquidity Stress Test Framework*

The primary goal of the LST, and the specific stress scenarios utilized, are:

- First, for macroprudential uses, the goal is – to allow the Financial Stability (E) Task Force to identify amounts of asset sales by insurers that could impact the markets under stressed environments. Thus, the selected stress scenarios are consciously focused on industry-wide stresses – those that can impact many insurers within a similar timeframe.
- Second, the LST is also meant to assist regulators in their micro prudential supervision, in the context of being helpful for domiciliary and lead state regulators to better understand LST programs at those legal entities' insurers and insurance groups. The LST requires filing of reporting templates and other narrative disclosures referenced in the LST Framework to be submitted to the lead state by Sept. 30.

Non-Lead State Reliance on the Lead State Analysis of LST

- The LST must be reviewed by the lead state and significant findings should be incorporated into the GPS branded risk assessments.
- To reduce duplication, non-lead domestic states may rely on the analysis work performed by the lead state.

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- Because the LST is performed at a legal entity insurer level and aggregated on an insurance group level, if material risks and concerns are identified for a legal entity insurer, the lead state should communicate those concerns to the non-lead domestic state.
- While the LST filing may provide good insights into a legal entity insurer's assumptions, processes and worst-case stress scenario results; a domestic state's assessment of liquidity risk for the legal entity insurer should not rely solely on the LST. It is acceptable that a legal entity insurer may have its own LST scenarios and manage liquidity differently from what is reported for the LST.

Lead State Holding Company Analysis – Process and Procedures

In completing the process of holding company analysis and developing a GPS, analysts are encouraged to customize the work performed and documented at a level commensurate with the nature and complexity of the group. Analysts may elect to limit the amount of analysis and supporting documentation performed outside of the GPS and/or eliminate certain sections of the GPS to promote efficiencies in conducting analysis work. Conversely, analysts working on very complex groups may elect to perform additional analysis (including those listed in the Additional Procedures on Key Risk Areas – Insurance Holding Company System) as well as provide additional documentation within the GPS and/or in supporting analysis workpapers. Keep in mind, the GPS should provide sufficient information about the group and its risks to enable other state, federal and international regulators to understand the group risks that may be relevant to their regulated legal entities.

If the domestic insurers in a holding company system consist of only run-off companies, the domestic regulator, at its discretion, should determine the value, if any of performing a holding company system analysis. If it is determined that a holding company system analysis would be of no added value, this determination should be documented.

As the lead state, the department should coordinate the ongoing surveillance of companies within the group with input from other affected states (with the understanding that the domestic state has the ultimate authority over the regulation of the domestic insurer under its jurisdiction). The documentation contained in the GPS is considered to be part of the workpapers, and represents proprietary, confidential information that is not intended to be distributed to individuals other than state regulators.

Confidentiality of Information: Financial analysts are reminded that information collected from the group, generally under the authority of their holding company statutes or their more specific statutes dealing with the ORSA Summary Report may be confidential by law. Accordingly, before sharing statutorily confidential information with other jurisdictions, regulators will need to review their own statutory authority to do so, which generally requires that the receiving jurisdiction is able to maintain also the confidentiality of such information.

UCP is an Insurer: If the ultimate controlling person (UCP) of the holding company is a U.S. domiciled insurance company with a cocode, analysts may consider preparing one document that includes all the elements of the IPS and the GPS, in order to promote efficiency in the overall analysis. For example, in addition to the standard elements of the IPS, the document may also include sections such as corporate governance, ERM/ORSA, non-insurance affiliates/subsidiaries, etc. In addition, depending on the nature and extent of risks, analysts should consider whether it is more appropriate to assess and document certain risk exposures from a group or legal entity perspective (or both) in the IPS/GPS. In all cases, analysts are expected to document and complete both the legal entity and holding company analysis work in accordance with timeliness expectations. Therefore, the analyst and supervisor should demonstrate that the combined IPS/GPS is updated for both the results of legal entity analysis and holding company analysis through separate signoffs at different dates, as necessary.

Specific Procedures for Completing the Insurance Holding Company Analysis

The following procedures are intended to assist analysts completing a holding company analysis documented in the GPS. The following procedures do not represent additional documentation requirements.

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Understand the Insurance Holding Company System

1. Evaluate and document an understanding of the insurance holding company system. Consider using the following if available and/or applicable: statutory Schedule Y, Form B Registration Statement, Enterprise Risk Report (Form F), Corporate Governance Annual Disclosure (CGAD), ORSA Summary Report, and financial filings of the insurance holding company system and/or person. Summarize the understanding of the holding company in the GPS. If necessary, analysts may also document further details below.
    a. Ultimate controlling entity(ies) or person(s).
    b. Nature and level of complexity of structure (e.g., public, non-public, mutual, complex, simple, etc.) including the level of interdependence within the group structure (e.g., pooling, guarantees, risk structure, etc.).
    c. Business segments and percent of overall revenue per segment (use segments as defined in the most current 10-K or financial statement, if available), including how the group sells and distributes its primary products and whether they expose the group to risk concentrations (geographic or product related).
    d. Number of insurers and respective jurisdictions, including the level of international insurance activities (including branches) within the group. Where are the largest concentrations of international business and which regulatory authorities are charged with oversight?
    e. The existence of captive insurance vehicles within the insurance holding company system as well as their specific purpose and domicile. What type of financial reporting is available/provided to the state of domicile for the entities? What risks do these captives pose to the insurance holding company system?
    f. Nature and function of material non-insurance legal entities that pose a material risk to the insurance holding company system. Are there material risks presented by these non-insurance entities? (Note: It is recommended that the insurer supply information via the non-insurance company grid provided [Excel] to assist with this determination. See also procedure 2 to be completed in conjunction with Procedure 1, to determine how to tailor this grid to the risks of the group and therefore the focus of the remaining analysis)
    g. Recent news, press releases or other information received from the group that identify changes in the holding company system or financial results.
    h. Obtain and review information to consider whether high-level management of the insurance holding company system is suitable for the respective positions held (e.g., does the individual have the appropriate background and experience to perform the duties expected of him/her?). Any suitability and other governance-related concerns identified should be communicated in writing to other relevant regulators both domestically and internationally. Follow-up on any previously-identified corporate governance issues of the insurance holding company system.

PROCEDURES #1 - 2 are intended to be completed simultaneously, as each is anticipated to be informative to the other. In many cases, information obtained from prior years may not have changed**.** That prior information can also be helpful in determining the extent of information regarding individual companies (non-insurance and insurance) that needs to be collected from the group in accordance with Procedure #1f and Procedure #2. Analysts should use such prior analysis and prior knowledge, as well as updated financial and nonfinancial information on the group, or members of the group, to help determine what information update is requested from the group and its affiliates. The information requested is intended to be focused on the primary risks of the group, and changes in the group or economic environment which require additional information to evaluate. For example, a lead state that has previously identified possible concerns with the overall profitability of the group will commonly track measures of profits against some measure, and individual company by company information would be used by the lead state to monitor and better understand and continue to evaluate that

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risk. Another example may be a group for which the lead state has seen a substantial increase in business written without a corresponding increase in group capital. The lead state should use information from other filings (e.g., ORSA Summary Report and/or Form F) in understanding the business change, but may require further detail on the specific products and legal entities for which the business is written to fully understand and evaluate the change in risk. The exclusion or inclusion of entities from the focus of the group-supervision should be re-assessed annually.

PROCEDURE #1 assists analysts in documenting his or her understanding of the insurance holding company system. Various documents are available as a resource in helping to understand the insurance holding company system and its business purpose, but it is also anticipated that much of this information will be accumulated and updated by analysts through inquiries to the group.

As part of this review, analysts should also consider on a regular basis whether high-level management of the insurance holding company system is suitable for the respective positions held. Suitability includes considering whether the individual has the appropriate background and experience to perform the duties expected of his/her position. Any suitability and other governance-related concerns identified should be communicated to other relevant state insurance departments (and also possibly with international regulators). Analysts should also follow-up on any previously identified corporate governance issues of the insurance holding company system.

Complete Lead State Analysis Considerations

After gaining an understanding of the holding company system, complete the following considerations to assist in determining the detailed analysis procedures to be performed.

2. Based upon the information obtained in Procedure 1, and in combination of prior year analysis or prior knowledge of the group, determine the focus of this year's annual holding company analysis. Specifically consider the information obtained regarding both insurance and non-insurance entities and their impact on the entire group. Additionally, include a summary within this analysis that discusses the focus areas and why.

3. Using the Lead State Report on iSite+, identify the primary contact of other involved domestic states. Based on the analysis of the overall holding company structure and the state's preference, analysts may consider whether there is a need to request the confidential IPS report(s) from the applicable U.S. domestic states for insurers within the holding company system, pursuant to the NAIC's Insurer Profile Summary Sharing Best Practices. (E.g., A state may consider using the NAIC Prioritization Summary Report to assess the need to request such reports.) If the IPSs are requested, identify and document any material concerns or risks that were not covered elsewhere in this analysis.

4. Identify and document any other regulated entities within the holding company system and the respective involved supervisor. (Note: Consider using Annual Financial Statement, General Interrogatories – Part 1, #8.1 through #8.4). Consider the following:

    a. Does the size, complexity and/or interconnectivity of the entity with the holding company system warrant communication with the respective regulator/supervisor? If "yes," describe any communication between state, federal and international regulators that has been planned or initiated.

    b. If there is international insurance activity, document which jurisdiction(s) is considered the group-wide supervisor(s) of the insurance holding company system.

    c. Does the size, complexity and/or interconnectivity of the entity with the holding company system warrant a potential supervisory college? If "yes," describe any communication between state, federal and international regulators that has been planned or initiated.

    d. Does the department and/or other domestic state(s) within the group have a MoU to share confidential information with the involved supervisor(s)?

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e. Have any state, federal and/or international regulatory action(s) been taken? If "yes," describe.

f. Determine and document whether it is necessary to develop an overall understanding of the relevant regulatory and supervisory requirements of the authority and document accordingly.

5. If applicable, identify and document contact information for federal or international involved supervisor(s).

6. Establish a plan for communicating and coordinating with the domestic state(s) and other involved supervisors if significant events, material concerns, adverse financial condition or prospective risks are identified.

7. If your state is leading or participating in a supervisory college of the holding company system, review the most recent information obtained as part of the supervisory college to determine if there are any areas of risk that require follow-up or additional analysis.

PROCEDURE #2 assists analysts in determining the focus of this year's annual holding company analysis. A practical method of determining the entities to focus on may begin with some type of internal unaudited consolidating financial statements prepared by the group, if applicable although other more simple methods could be used once the lead state had a better recognition of the size and risks of the individual legal entities. Alternatively, if internal unaudited consolidating financial statements are not prepared by the group, analysts may be able to obtain some information from the ORSA Summary Report. However, in many cases, that report will not contain legal entity information, therefore analysts may instead choose to request the insurer supply information via the non-insurance company grid provided. Analysts should also consider if there are other entities that pose a risk to the group, and for which the lead state analyst can only obtain qualitative information from the group in better evaluating such risks (such entities and these situations are presumed to be rare but can occur under some unique situations). The purpose of this step is to consider if there are any individual legal entities that can be excluded from the scope of group-wide supervision, because individual legal entities that are negligible to the group should be excluded. This procedure also assists analysts in putting together the Holding Company System Summary section of the GPS to indicate which entities have been subject to review and to be used as a starting point in ensuring there are no gaps or duplication in regulatory oversight between all of the states. Such process would conclude when the GPS is distributed and reviewed by the other domestic states and the lead state receives no feedback which would suggest otherwise. Although duplication is expected to be rare, obtaining input from other domestic states regarding the focus of the analysis is considered appropriate because the group can have an impact on each of the domestic insurance entities.

PROCEDURES #3 - 7 assist analysts with regulator/supervisor communication and coordination and supervisory college considerations. See Section VI.J. Supervisory Colleges Guidance for a more detailed discussion of supervisory colleges utilized for internationally active insurance groups.

Conduct Detailed Analysis of the Insurance Holding Company System

Conduct detailed analysis by evaluating the overall financial condition of the holding company system through an assessment of the group's exposure to each of the nine branded risk classifications. Consider both the financial review of insurance and non-insurance entities within the insurance holding company system. In certain cases, the review of non-insurance entities may be mitigated by the lack of interdependence of the entities. Conduct the assessment by using quantitative and qualitative information. Consider utilizing the following, if available and/or applicable: legal entity IPSs; Form B and Form F; ORSA; shareholders' report; combined financial statements; quarterly and annual SEC filings; International Financial Reporting Standards (IFRS) filings; personal net worth statements; audited financial statements; management's assessment of internal controls; auditor's assessment of management's assessment of internal controls; press releases; confidential information from other regulatory/supervisory bodies; and any other available sources.

The following are key areas of review of financial solvency. Below each are examples of the branded risks that may be identified through the analyst's review. The examples of related risks shown below do not represent a complete list; therefore, analysts should use professional judgment in categorizing issues identified during

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analysis into the risk categories. Summarize the overall analysis of the holding company in the branded risk assessment section of the GPS. If necessary, analysts may also document further details below.

8. Profitability: Evaluate the insurance holding company system's operating and net income over the past three years, as well as return on equity (ROE) and document any trends as well as the primary drivers of those trends.

    - Pricing and Underwriting Risk—e.g., volume/growth; new product lines; geographic concentrations; pricing policies; price adequacy as identified through quantitative metrics; segment information identifying profitable vs. non-profitable product lines; impact of insurance vs. non-insurance operations on the profitability of the insurer: etc.
    - Reserving Risk—e.g., reserve development & trends; reserve adjustments; crediting rates; shifts in exposures to product lines: etc.
    - Market Risk—e.g., impact of market changes on investment income/yields; impact of/exposure to interest rate changes; impact of/exposure to changes in foreign exchange rates: etc.
    - Strategic Risk—e.g., planned growth/decline in writings; management expertise; variance to business plans and ability for group to adequately project future profitability; investment strategy and the adherence to it: etc.
    - Operational Risk—e.g., risk of events impacting the overall financial results, such as catastrophe events impacting P/C lines of business, issues with IT systems, cyber-security risks; degree of variability in profitability; high expense structures; TPA/MGA relationships; risks associated with distribution/sales channels; risks associated with unprofitable segments or lines of business: etc.

9. Financial Position**:** Evaluate the insurance holding company system's shareholder's equity (or equivalent), and document any negative deterioration.

    a. If publicly traded, review the holding company's stock price history. Has the value of common stock declined significantly over the past year? If "yes," explain the reasons for the negative trend.

    b. Assess the holding company's sources of capital.

        - Reputational Risk—e.g., sharp fluctuations and/or drops in stock prices or changes in financial strength and credit ratings that may impact market perceptions, sales growth and access to capital markets, etc.
        - Credit Risk—e.g., concentrations in investments; materiality of high risk or low quality investments; credit risks concentrated within certain segments of the group that impact the overall group financial position, etc.
        - Market Risk—e.g., stress test results, concentrations in certain investment market segments, changes in asset valuation due to market shifts, etc.
        - Operational Risk—e.g., impact of overall financial results; have sufficient profits been generated to meet business model needs and to generate capital, etc.
        - Strategic Risk—e.g., capital position; capital plans as may be outlined in ORSA or ERM planning; impact of changes in corporate structure, etc.
        - Legal Risk - e.g., litigation resulting in material contingent liabilities, etc.

10. Leverage: Review the insurance holding company system's leverage positions and document any negative trends and/or deteriorating ranges. In addition to traditional measures of financing leverage (debt to equity, interest coverage, etc.) and operating leverage (e.g., writings to surplus, surplus aid from reinsurance, etc.), evaluate the group's use of derivatives and their purpose including collateral held/required, trends, etc.

    - Market Risk – e.g., use of derivatives to mitigate economic conditions, generate profit, etc.

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- Credit Risk—e.g., asset leverage risk in the insurance vs. non-insurance investment portfolios, extensive use of reinsurance, etc.
- Reserving Risk—e.g., level of operating leverage created by premium growth, etc.
- Strategic Risk—e.g., effectiveness of risk mitigation strategies as may be outlined in ORSA, ERM filings or business plans; risks posed by the use of captive insurance vehicles, etc.
- Operational Risk—e.g., financing leverage as indicated through measurements such as interest coverage ratio and debt-to-equity ratio; amount/type/trend in debt issuance and ability to meet payment schedules, etc.
- Reputational Risk—e.g., impact of reputational risk changes, such as ratings, on debt covenants, sales, etc.

11. Liquidity: Evaluate the insurance holding company's liquidity and document any negative trends and overall strength.

    Liquidity risk—e.g., assessment of cash flow trends; cash and short-term investments held; indications of liquidity shortfalls reflected in quantitative ratios (i.e. liquidity ratio); liquidity needs for high surrender activity impacted by economic changes; liquidity needs created by catastrophic events; liquidity requirements for future debt payments; available lines of credit; and stress testing.

12. Liquidity Stress Test (LST):
    a. If the insurance group is subject to the requirements to perform and file an LST, review and determine if any concerns or material risks exist regarding the liquidity of the insurance group or any of its insurance legal entities performing the LST.
    b. If concerns or material risks are identified, consider requesting further explanation from the insurance group about its liquidity risk management framework and internal LST.

13. If applicable, review the insurance holding company system's independent public audit report. Comment on the following:
    - Auditor's Opinion
    - Notes to Financial Statements
    - Management's Assessment of Internal Controls
    - Auditor's Assessment of Management's Assessment of Internal Controls

14. Document in this analysis any concerns that arose during the lead state's evaluation of its domestic insurer(s) that in the opinion of the lead state have an impact on the evaluation of the overall financial condition of the insurance holding company system.

15. During the holding company analysis process, identify and document any material concerns or conditions within the group that may have a material impact on the lead state's domestic companies. Update the IPS of the state's domestic insurer(s) in the group for the impact of the Holding Company on that insurer(s).

PROCEDURES #8 - 14 assists analysts in determining and understanding the overall financial condition of the insurance holding company system which includes understanding profitability, financial position, leverage, liquidity and the organization's use of derivatives (if applicable). These procedures, and any additional/supplemental procedures that are chosen from the list below, are generally the most critical aspect of the insurance holding company analysis and contribute significantly to the identification and assessment of branded risk exposures as presented in the GPS. The following summarizes some approaches/issues for analysts to consider when completing these procedures. In most cases, analysts will require further information from the group in order to complete his or her evaluation of these key areas. Such information is necessary in part

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because no two groups are the same, and no two groups manage themselves in the same way. For example, in the area of profitability, it may be necessary to request more detail information at a particular legal entity or even product level to determine the cause of the changing trend and its impact on branded risk assessments. Another example is that the group may appear to have a greater than average amount of operating leverage and it may be necessary to gather more legal entity information to understand the source of this leverage. Although this may be discussed in the ORSA Summary Report, in many cases it may not. This approach of requesting further information to further isolate the causes of the profitability, leverage and liquidity trends is consistent with general techniques used in financial analysis. This use of general financial analysis techniques is the primary reason the states approach to group reporting requires only limited information. Consequently, much of the information that should be requested is centered more on the way the group manages itself and its risks.

PROCEDURE #8 assists analysts in evaluating the profitability of the group and the impact of profitability issues on the group's exposure to branded risks. The first step in making such an evaluation would typically begin with analyzing the group's experience over a sufficient period of time so as to draw some conclusions. Although no two groups are the same, a good starting point for evaluating profitability would be looking at the group's operating and net income, as well as return on equity (ROE) (i.e., net income/stockholders equity) over a five-year period. The use of ROE is a common measure because it considers the perspective that the most common stakeholder, a shareholder, may use. Shareholders, or at least potential investors, commonly use ROE since it provides a measurement of the benefit that the company is generating for the potential use of shareholders. The measurement, although simple, can be effective because investors may make a decision to invest, or continue to invest, based on the value that the group can bring to the investors. Although return on equity does not indicate specifically how much value a group has generated for an investor, it provides a good starting point. It is suggested that it be measured over a five-year period, because such a time period is usually likely to show the results of the group under different economic conditions and therefore stresses, and can help to establish a normal expectation along with an expectation as to variables in the group's business plan.

As discussed in other areas, public company investors have different expectations than private investors, and stakeholders of mutual companies and mutual holding companies have even different expectations. Consequently, analysts should use caution in assuming certain things about the group only because its ROE is higher or lower than some of its peers. It is suggested that the information be used instead as a starting point to better understand the specific group. Analysts should use the information in connection with the latest business plan to better understand how the profits compare to what the group expected, and what its investors expect, on a short-term and long-term basis. The group may use other measures to track their experience (e.g., return on assets, return on revenue) but what is important is to understand how well the group is performing compared to its business plan, and how well that business plan allows them to continue to meet all of the demands of being part of a regulated insurance group. The measurement of profitability should not be minimized because, in virtually every single business sector, it is a major driver of strategic actions. The inability to generate sufficient profits can prevent the ability to generate additional capital. Consequently, although the regulator is primarily concerned about the ability of the insurance company, and therefore the group, to have sufficient capital/equity to absorb certain events or situations, a group that is unable to generate sufficient profits may have no ability to generate any new capital. As history has shown, in most cases, groups with insurance operations do not simply raise additional capital in time of stress, but rather find ways to reduce risk. This must be well understood in evaluating the financial condition of a group, and generally speaking, the starting point is the inability to generate the appropriate amount of profits to meet the business model needs. However, because this is a starting point for analyzing the group, and although most group analysis would be done using consolidated GAAP, that is currently not a requirement and therefore insurers may use different accounting basis that can skew such results. In such situations, analysts should consider asking for input from the group itself on the effect that such an issue has on the analysis and again, consistent with previous comments, ask the group to discuss the measures its stakeholders use to measure profitability.

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In addition to measuring, tracking and monitoring profitability, analysts will need to obtain an understanding of what activities drive the profitability (or lack thereof) of the holding company system. As the group may be involved in various business activities across a number of segments, profitability may need to be reviewed and considered at the business segment level. Profitability challenges experienced by the group may indicate, or result from, any one of a number of branded risk exposures (e.g., pricing and underwriting risk, reserving risk, market risk, strategic risk and/or operational risk). Therefore, analysts will need to investigate the cause of profitability challenges to determine the extent of the group's exposure to branded risks in these areas.

PROCEDURE #9 assists analysts in evaluating the overall financial condition of the group and its impact on the group's exposure to branded risks. When performing this procedure, it is necessary for analysts to consider the requirement to obtain and understand the nature and function of all non-insurance entities within the group. This is needed in order to evaluate the potential risk associated with each entity. In connection with obtaining five years of historical profitability figures and obtaining an understanding of the risks of the non-regulated entity, analysts may want to consider requesting consolidating information from those groups that either have a higher degree of variability in their profitability over a five-year period or those groups that have non-insurance entities that have higher potential risk. These are factors that can drive the capital that a group may need to operate its business plan in addition to the capital that is needed for the insurance operations itself, which can be determined at a more granular level at an insurance legal entity and then accumulated up to the group level. Alternatively, or in addition, for those entities that prepare an ORSA, the latter can be easily determined through such a report and can be used as a better starting point for discussing the same issues because they are from the perspective of how the group is managing such risk. (See section VI.E. Enterprise Risk Management Process Risks Guidance for discussion of procedures related to ORSA reports). For those entities that do not, the regulator should use the information from Form F, as well as all of the regulated entities required capital levels, in connection with any additional consolidating information to determine if existing equity levels within non-insurance entities are sufficient to address the needs of the group. However, bear in mind that the ORSA is a report of internal management processes and company business plans and strategies involve management judgment and flexible elements. A deeper discussion with management can provide input to understand management's view of the adequacy of the capital for its business and help analysts better make an appropriate assessment in this area.

In addition to evaluating the group's and individual entity's equity/surplus position, analysts may choose to evaluate the group's stock price and recent trading activity (if publicly traded) and access to additional sources of capital. If the group has been exposed to significant shifts in its stock price, this may be indicative of market concerns regarding the group's financial position. In addition, the sources of capital for the group may provide insight to sources of strength that can be accessed in a troubled company situation and provide greater stability for the group. However, if the sources of additional capital are questionable, this may indicate broader concerns regarding the group's strategy and prospective solvency.

Concerns regarding the group's financial position may indicate, or result from, any one of a number of branded risk exposures including, for example, reputational risk, credit risk, market risk, operational risk, strategic risk and/or legal risk. Therefore, analysts will need to investigate the cause of financial condition concerns to determine the extent of the group's exposure to branded risks in these areas.

PROCEDURE #10 assists analysts in evaluating the leverage of the group. There are generally two kinds of leverage: 1) operating leverage; and 2) financing leverage. Procedures related to operating leverage are generally very closely related to those regarding overall capital/equity adequacy/evaluation. This is because by definition, leverage is generally intended to be a relative measure of risk, and for insurers, operating leverage is created every time they generate an insurance policy. As alluded to within Procedure #4, insurance legal entity capital requirements already address such facts. Additionally, insurance legal entity capital requirements already address the other major causes of leverage created from operations, including asset leverage. Asset leverage is created when insurers generate risk within their invested asset portfolios. However, when considering the group's financial condition and leverage, analysts must consider the extent to which these same types of operating leverage are created by non-insurance affiliates within the group. Consistent with Procedure #8,

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leverage can be measured by reviewing the ORSA Summary Report. For those entities that do not prepare an ORSA, the regulator should use the information from the Form F, in connection with any additional consolidating information to determine if there is other operating leverage within the group. Financing leverage is more easily analyzed when its source is debt, which is generally very transparent and easily analyzed in terms of its impact or potential impact on a group's operations. Most public groups that own insurance operations have some level of debt, although most insurance groups do not carry the same level of debt as other financial institutions. This is important because debt by its very nature can generate a significant amount of strain on any entity. This strain can be captured with another simple ratio that should be considered for analysis on any group with debt, the interest coverage ratio (income/interest expense). Similar to the debt/equity ratio, this ratio should be looked at over a period of time (e.g., five years). The following presents different gauges for evaluating this ratio.

Interest Coverage	Benchmarks
Extremely strong	10 to 1 and higher
Strong	5 to 1
Adequate	4 to 1
Marginal	3 to 1
Weak	2 to 1
Extremely weak	1 to 1

The interest coverage ratio can either be expressed as a percentage or as a factor over 1. The interest coverage ratio is a major driver of any corporate entity's credit rating, and in many cases, it can be as high as 10 to 1 or 1000%. A ratio this high demonstrates that the interest expense is only a small portion of the group's operations, or a very small strain on the operations. As this number decreases, it suggests that such debt is a strain. It also demonstrates the amount of funds that are not available for stockholder dividends. Therefore, it can also indicate a potential concern for investors, and as a result, the ability to raise additional capital, or at a minimum be subject to more pressure from shareholders. More pressure to generate higher profits often times forces a group to take higher risks, and thus creates more leverage.

Another measure of debt is the debt-to-equity ratio (debt/equity). There are different ways to measure this ratio, and usually short-term operating debt is excluded because the intent of the ratio is to demonstrate the overall capital position of the group. As the ratio increases, it creates a greater possibility that shareholders would be left with less value in a bankruptcy because stockholders' claims are subordinate to bondholders. Therefore, similar to other ratios, it is an indicator that it may be difficult for the group to obtain more capital because investors may not be attracted to such groups.

Asset leverage may be demonstrated through the group's use of derivatives or other complex invested assets. Analysts should work with the group to gain a full understanding of the group's purpose for using these instruments, as they may be subject to significant shifts that can impact the profitability, financial position and/or liquidity of the group. Derivatives may be held by the company to hedge against existing business risks or to generate income for the group. The purpose of the group's use of derivatives as well as their effectiveness over an extended period of time should be evaluated and considered. In addition, analysts should consider the impact that any collateral requirements associated with these instruments may have on the group's financial position and liquidity.

Concerns regarding the group's leverage position may indicate, or result from, any one of a number of branded risk exposures including, for example, market risk, credit risk, reserving risk, strategic risk, operational risk and reputational risk. Therefore, analysts will need to investigate the cause of leverage concerns to determine the extent of the group's exposure to branded risks in these areas.

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PROCEDURE #11 assists analysts in evaluating the liquidity of the group. Liquidity is important for any type of organization, but can be more important for others, including certain insurers or types of insurers who may have products or other aspects of their business plan that make them susceptible to immediate withdrawals. Having said that, most insurers' cash flows are predictable, and it is an area that insurance regulation or business practices already address, including asset/liability matching required for life/annuity writers and the maintenance of very liquid assets. But this procedure requires an analysis that can generally only be conducted through understanding information developed by the group, which may be available through the risk-focused examination or otherwise requested by analysts. Updated information may be best obtained in the periodic meeting with the group as discussed within Section VI.F. Own Risk and Solvency Assessment (ORSA) Procedures, unless the group is more susceptible to immediate withdrawals, in which case analysts may want to obtain/discuss the issue with the group sooner. Generally, issues impacting liquidity that are identified through holding company analysis should be presented within the liquidity lisk classification of branded risk assessments.

PROCEDURE #12: The procedure instructs the analyst to review the results of the stress test scenarios included in the LST filing to supplement the assessment of the insurance group's overall liquidity. Because the LST is performed at a legal entity level and risks are aggregated for the group, assess if the results of the LST identifies material risks at the insurance legal entity that should be included in the analysis and/or communicated to the non-lead state domestic state insurance regulator.

The instructions for the LST filings are outlined in the *NAIC 2020 Liquidity Stress Test Framework* which is located on the Financial Stability (E) Task Force webpage of the NAIC's website at: *https://content.naic.org/cmte_e_financial_stability_tf.htm*.

PROCEDURE #13 assists analysts with identifying if there are any concerns regarding the insurance holding company system's independent public audit report and other related reports.

PROCEDURE #14 assists analysts in identifying any significant risks identified through a review of the IPS obtained for its domestic insurer(s) in the group. As the IPS presents the exposure of individual legal entities to the branded risk classifications, the lead state analyst may be able to identify exposures in the legal entity IPS to assist in conducting holding company analysis and preparing a GPS.

PROCEDURE #15 is intended for analysts to identify, evaluate and document during the holding company analysis any material concerns or issues that may have a material impact on the lead state's domestic insurer(s). This may include, but not limited to: affiliated risks, interdependence within the holding company entities and the insurer, reputational risk, and holding company debt service and other corporate initiatives that impact the lead state's domestic insurer(s). A summary of the evaluation of the impact of the holding company on the insurer(s) should be included in the appropriate section of the IPS of the insurer(s).

Additional Procedures on Key Risk Areas – Insurance Holding Company System

The following are available procedures that the lead state may consider performing in analyzing the financial condition of the holding company in part or in total to address current or prospective risks at the discretion of analysts, depending on the level of concern, the area in which the risk was identified, and the degree of interdependence within the holding company entities.

Analysts should use his or her judgment in determining if any of the following procedures should be applied to the group analysis, where the primary input for determining what is appropriate would depend on sophistication, complexity and overall financial position of the insurance holding company system. Documentation of the results of holding company analysis is in the GPS. After each additional procedure, examples of the branded risk classification(s) that may be associated with the procedure have been referenced in parentheses for use in mapping the procedures to branded risk classifications in the GPS.

1. Review the distribution of the insurance holding company's invested assets in order to assess the overall asset quality and note any shift in the mix. (CR, MK, LQ, ST)

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2. Is the insurer(s) the only member(s) or the primary member(s) of the insurance holding company system that holds cash and invested assets? (CR, MK, LQ, ST)
3. If there are significant investments in non-investment grade bonds, unlisted stocks, mortgages, real estate or other invested assets, review the supporting schedules in greater detail to determine exposure to default, credit, and liquidity risk. (CR, MK, LQ, ST)
4. Review the distribution of the non-invested assets, and assess the overall collectability risk. (CR, LQ)
5. Review the level of goodwill and intangible assets. Determine the level of goodwill and intangible assets relative to the value of equity. (LQ, OP) If significant, summarize the following:
    a. Nature of intangible assets
    b. Change or trend in goodwill
    c. Source of goodwill
    d. Impairment of goodwill
6. Assess whether the insurance holding company system is reliant on the insurance operations for any of the following (LQ, ST):
    a. Service debt
    b. Provide financing
    c. Provide revenue streams
    d. Provide services and/or facilities/equipment
    e. Provide guarantees for the benefits of its affiliates
    f. Pledge assets for the benefit of its affiliates
    g. Contingently liable on behalf of its affiliates
7. Has debt shown an increasing pattern? If “yes,” explain any unusual changes. (ST)
8. Determine the level of insurance holding company debt and its relative value-to-equity. (ST, LQ) If significant, summarize the following:
    a. Type of debt
    b. Terms of the debt covenants
    c. Maturity schedules
    d. Interest payment schedules
    e. Ability to meet payments (e.g., principal and interest)
    f. Business purpose
9. Review the insurance holding company system’s commitments and contingent liabilities.
    a. Has the insurance holding company been subject to substantial complaints, class action lawsuits or other litigation or investigations? If "yes”, document the nature and outcome of those matters. (RP, LG)
    b. Are any contingencies expected to have a material impact on the financial condition of the insurance holding company? If so, document whether the holding company estimated the potential costs and established a reserve liability. (RV, LG)

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10. Gain an understanding of and document the use of collateral across the holding company system. (ST, LQ).

Financial Position

11. Review the insurance holding company's statement of shareholders' equity. (ST, OP)
    a. Has equity decreased from the prior year or deteriorated over the past three years? If "yes," describe the reason(s) for the decline.
    b. Does the net worth of the insurer(s) represent the total net worth or the majority of the net worth of the insurance holding company system?
    c. Is the net worth of the insurance holding company system less than the net worth of the insurer(s)?
12. If publicly traded, review the changes in the insurance holding company's outstanding common stock. Document and understand the nature and business purpose of the following: new stock issuance; stock repurchase, stock split, short sales, or change in major exchange listings. (ST)
13. Have any insurer(s) of the insurance holding company paid extraordinary dividends upstream? If "yes":
    a. Assess the nature of the dividends and the amount of dividends paid in relation to prior year surplus to determine the materiality of the insurance company dividends. (OP, ST)
    b. Compare current year extraordinary dividends to prior year dividends to identify any excessive trends in payments. (ST)
14. Review the revenue of the group.
    a. Identify each business segment as identified on the 10K, and review the net income from each. Discuss any notable changes in performance. Are there any business segments that are troubled or pose unusual risks to the insurance holding company system? (PR/UW, ST)
        i. Is the insurer(s) the only or primary revenue producer within the insurance holding company system?
        ii. If affiliates produce net income independently of the insurer(s), what percentage of total net income is produced independently of the insurer(s)?
    b. Has the insurance holding company entered into any new lines of business or types of non-insurance business or discontinued any business? (ST, OP)
    c. Has the volume of business increased or decreased significantly over the prior year? If "yes," explain the reason for the change. (ST, OP)
15. If the insurance holding company group places a significant amount of gross business with reinsurers, assess the following regarding reinsurance agreements:
    a. Risk transfer (CR)
    b. Collateralization to unauthorized reinsurance (CR)
    c. Recent reinsurance transactions (CR, ST)
    d. Credit quality of the reinsurer (CR)
    e. Collectability of recoverables (CR)
    f. Level of surplus aid (ST)
16. The annual group capital calculation (GCC) is a new analytical tool. To gain an understanding of the framework and results provided in the filing:
        a. Follow the five procedure steps as outlined in VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures to review and document the results of the GCC.

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b. Review the background information and context concerning the issues/considerations an analyst should consider when using the GCC for an insurance holding company group that completed the GCC where required as provided in VI.I. Group-Wide Supervision – Group Capital Calculation (Lead State) Analyst Reference Guide.

Profitability

17. Review investment income and realized capital gains and losses.
    a. Has net investment income increased or decreased significantly over the prior year? If "yes," explain the reason for the change. (ST, MK)
    b. Document the amount of investment income by sector that is attributed to dividends received from insurance subsidiaries. (ST)
    c. Document the annual investment yield. Has the yield decreased materially over the prior year? If "yes," explain the reason(s) for the change. (ST, CR, MK)
    d. Review the components of investment income. Has investment income from any asset category changed significantly over the prior year? If "yes," explain the reason for the change. (ST, CR, MK)
    e. Did the insurance holding company report material realized capital gains/losses? If "yes," identify the cause of the loss. (ST, CR, MK)
18. Review all other sources of revenue, and note any material changes or weaknesses. (PR/UW, ST)
19. Review expenses.
    a. Have losses increased or decreased substantially over the prior year? If "yes," explain the reason for the change. (RV)
    b. Have administrative and other expenses increased significantly over the prior year? If "yes," explain the reason for the change. (OP)
    c. Summarize the loss and expense ratios by line of business for material insurance lines and review the trend. (OP, RV, PR/UW)
20. Has the insurance holding company reported any non-recurring revenues or expenses that materially inflate or reduce earnings? If "yes," describe the reason for the revenue or expense. (ST, OP)
21. Did the insurance holding company report income or losses from discontinued operations? If "yes," summarize the nature of those operations and evaluate the earnings from those operations. (ST, OP)
22. Examine cash flow and document if there has been a negative trend in operating, investing, or financing activities over the past year or the past three years. (LQ)
23. Evaluate any downstream payments and explain the reason(s) for the downstream contributions. (LQ)

PROCEDURES #1 - 3 assist analysts in reviewing the invested assets of the group, noting any significant increases or decreases from the prior reporting period. Identify the most significant concentration of assets, and review the quality distribution of the asset portfolio. Assess the group's asset risk including credit, default, sector, and/or concentration risk. Include a review of affiliated ownership and any upstream holdings.

PROCEDURES #4 - 5 assist analysts in reviewing the non-invested assets of the group, noting any significant increases or decreases from the prior reporting period. Assess the group's exposure to risk related to high recoverable and receivables and miscellaneous balances. Also, assess the risk related to any miscellaneous assets such as goodwill or other intangible assets.

PROCEDURES #6 - 10 assists analysts in reviewing the liabilities of the group, noting any significant increases or decreases from the prior reporting period. Determine if debt exists at the holding company level that may be

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material and could affect the insurance companies. Debt includes not only long-term debt financed through the issuance of bonds, but also includes other long-term debt granted by a financial institution, as well as short-term vehicles such as commercial paper, repurchase agreements or bank credit facilities. Consider all types of debt arrangements when determining the amount and timing of cash flow payments.

PROCEDURES #11 - 13 assist analysts in reviewing the holding company's overall financial position. Holding company equity is usually reported on a GAAP consolidated basis and represents the retained earnings of the holding company and its ownership share of the equity of its subsidiaries.

The initial focus of insurance holding company analysis centers on the current level of equity. The amount of equity is primary in evaluating the organization's capacity to write business and its ability to cover unanticipated loss payments and expenses, uncollectible premiums and receivables, and capital losses to invested assets. Analysts should take note of the trend over past reporting periods and the factors that have significantly influenced an increase or decline.

PROCEDURES #14 - 15 assist analysts in reviewing the operations of the group. A required component of certain holding company filings, including SEC filings, is the reporting of premium or other non-insurance business segments. The segment disclosure is fairly broad, including information for each segment on net income, total revenue, and total assets. This information is helpful because it provides analysts with information that management considers in evaluating the results of the entire organization. Reporting segments may include:

- **Operational**—This segment reports the holding company results by categories such as property/casualty, life, bank, non-insurance, or financing and may describe the major operational divisions.
- **Special Sectors**—This segment may identify writing categories or specific lines of business in which an organization specializes. Examples include program business such as artisan contractors.
- **Geographic Concentrations**—Some organizations report their results according to the geographic areas in which the insurance coverage is written or the location of the controlling branch office. This is a fairly common type of reporting for international organizations.
- **Managing General Agents (MGA) and Third-Party Administrators (TPA)**—This segment identifies business produced by MGAs or TPAs. For additional information regarding MGAs and TPAs, refer to Part III. Analyst Reference Guide—Operational Risk.

Analysts should focus on the overall profitability of the segments as well as the stability of earnings over a period of time. To the extent that the segment has reported inconsistent earnings or has reported any losses, analysts may wish to obtain a greater understanding of the causes.

Review the insurer's overall plan of operations, including mission statement, business plan, financial projections, marketing strategies, investment policy and management's philosophy.

- **Mission Statement**—Overall focus and philosophy is clearly stated.
- **Business Plan/Financial Projections**—Determine whether the group has a current business plan that includes details on its primary lines of business and growth strategies, geographic focus, and a plan of operation that contains the group's annual financial and marketing goals. Determine that the group has projected future financial results that appear reasonable based on the variances between plan versus actual results.
- **Marketing Strategies**—Determine whether the group has in place a viable marketing plan that outlines the methods of marketing its products and services, (e.g., direct marketing, agent force, managing general agents, projected sales growth, geographic strategies, and the development and sales of new products).
- **Investment Policy**—Determine the methodology of investment practice, (e.g., investment pool, investment manager, and investment consultants). Ensure that the domestic insurer is in compliance with state investment laws. Evaluate management's philosophy on high-risk securities, affiliated investments (both insurance and non-insurance), and asset and liability matching.

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- **Management's Philosophy**—Gain an understanding of the group's culture, management's expertise, and management's future vision of the group.

Determine whether the reinsurance programs in place support the overall risk profile of the group. Determine whether significant errors exist relating to the accounting for reinsurance. Review reinsurance recoverables for materiality and collectability. Identify whether reinsurance between affiliates within the group involve any unusual shifting of risk from one affiliate to another. Determine whether any of the companies within the group are using reinsurance for fronting purposes, and if so, whether any potential problems exist.

PROCEDURE #16 assist analysts in gaining insight into the background, context, and framework of the GCC analytical tool. The procedure primarily instructs the analyst to refer to the specific procedures provided in VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures in reviewing and documenting the results of the GCC. However, before proceeding with these steps, it is recommended the analyst follow the background information outlined in VI.I. Group-Wide Supervision – Group Capital Calculation (Lead State) Analyst Reference Guide.

PROCEDURES #17 - 21 assist analysts in evaluating the profitability of a holding company, which is measured by its ability to generate earnings and reported on a consolidated basis as net earnings (loss). The earnings statement includes revenues and expenses and the contributing factors to net income. Attention should be focused on special reporting items such as earnings or expenses from discontinued operations. Losses from discontinued operations may represent a significant source of drain on the holding company's earnings. These operations should be investigated thoroughly to identify the types of operations involved, expected durations, and their impact on holding company earnings.

PROCEDURES #22 - 23 assist analysts in reviewing a group's cash flow. The three primary sections within a holding company cash flow statement include cash from operating, investing, and financing. These categories detail the cash inflows and the expenses associated with the activities of the holding company.

A positive cash flow from operations is essential to the continued financial stability of a holding company. A negative cash flow from operations or a negative cash flow trend could present a drain on assets.

Analysts should assess the level of liquid assets to current liabilities to determine the proper matching of assets to claims obligations. Analysts should also assess the material risk associated with low-quality assets and understated reserves.

Additional Procedures for U.S. Based Internationally Active Insurance Groups (IAIGs)

The following general procedures are outlined for the group-wide supervisor of U.S.-based IAIGs to use in analyzing the financial condition of the IAIG. Analysts should use their judgment in determining how to apply the procedures to group analysis and document the results, but they should not duplicate efforts if these considerations are already addressed in other holding company analysis, corporate governance, or ORSA review procedures. However, as other jurisdictions expect the U.S. group-wide supervisor to address these elements on a regular basis, the analyst should consider the level of documentation to produce in this area. In addition, findings and relevant information from the completion of these procedures should be incorporated into the GPS and shared with other affected state insurance regulators, including supervisory college members, as deemed appropriate.

1. Consider and evaluate the complexity of the IAIG's group structure and the resulting risks to effective group-wide supervision.
    a. See also Procedure #1 of Appendix C in Section VI.F Group-Wide Supervision – Own Risk and Solvency Assessment (ORSA) Review Template.
2. Consider and evaluate the impact of the complexity of the IAIG's group structure on the effectiveness of its corporate governance framework.

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a. See also Procedures #6–8 in Section VI.D Group-Wide Supervision – Corporate Governance Disclosure Procedures.

3. Review the IAIG's capital adequacy and the availability of capital to meet group-wide capital expectations, considering the regulatory capital requirements for each insurance legal entity within the IAIG. Consider the information provided in the GCC in conducting this review, as well as information provided in Section 3 of the group's ORSA Summary Report (see related procedures in Section VI.F). When applicable and available, review group capital reporting, such as the Aggregation Method (AM) or the Reference Insurance Capital Standard (ICS) as reported to the International Association of Insurance Supervisors (IAIS), to prepare for discussions with international supervisors participating in a supervisory college. See also Section VI.J for guidance regarding discussions of group capital during IAIG supervisory college sessions.

   a. Recognize and assess the effect of potential legal, regulatory, and operational impediments to the IAIG's ability to transfer capital and assets within the group, including on a cross-border basis.

4. If significant concerns are identified related to the IAIG's current or prospective solvency, whether due to legal entity or group-wide risks, determine whether additional supervisory measures, as outlined in Model #440, should be implemented to obtain the information necessary and appropriate to assess enterprise risk and compel the development and implementation of reasonable measures designed to ensure that the IAIG is able to timely recognize and mitigate enterprise risks to members of the IAIG that are engaged in the business of insurance.

   a. Coordinate with other involved supervisors, including the Crisis Management Group (CMG), if appropriate, before requiring a specific preventive or corrective measure if that measure will have a material effect on the supervision of the IAIG or an insurance legal entity within the IAIG, unless exceptional circumstances preclude such coordination.

   b. Coordinate with other involved supervisors, including the CMG, if appropriate, if the head of the IAIG or an insurance legal entity within the IAIG fails to take action to address the group-wide supervisor's or other involved supervisors' identified concerns.

      i. If an insurance legal entity within the IAIG fails to take preventive or corrective measures, as required by the involved supervisor, inform the head of the IAIG and coordinate with other involved supervisors and the head of the IAIG to address this.

The following procedures—#5 through #11—are outlined for the group-wide supervisor to utilize in assessing various elements of an IAIG's internal control framework, including specific functions, strategies, and policies. As many of these assessments and considerations are detailed in nature and may be more effectively assessed during group examination efforts at the IAIG, the analyst is generally encouraged to collaborate with and place reliance on the examination function in this area, where appropriate. In addition, the analyst should not duplicate efforts if these considerations are already addressed in other holding company analysis, corporate governance, or ORSA review procedures.

5. Review the results of the most recent group examination efforts at the IAIG to understand the internal control assessment performed and determine if any follow-up is necessary to address concerns or recommendations.

   a. Consider the extent to which the examination addressed controls and processes related to the outsourcing of critical functions, including:

      i. Policies and contractual requirements, due diligence prior to entering new outsourcing agreements, ongoing risk assessment and oversight of outsourced functions, and contingency plans for emergencies and service disruptions.

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b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam has the potential to affect the group's ability to address:

i. Diversity and the geographical reach of activities, intra-group transactions, the interconnectedness of entities, and applicable laws and regulations of the jurisdictions in which the IAIG operates.

6. Review the results of the most recent group examination efforts at the IAIG to understand the compliance function assessment performed and determine if any follow-up is necessary to address concerns or recommendations.

a. Consider the extent to which the examination addressed the compliance function's ability to ensure compliance with relevant legislation and supervisory requirements applicable at both the group and material legal entity levels.

b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam have the potential impact on the group's ability to maintain an effective compliance function.

7. Review the results of the most recent group examination efforts at the IAIG to understand the actuarial function assessment performed and determine if any follow-up is necessary to address concerns or recommendations.

a. Consider the extent to which the examination addressed the actuarial function's ability to provide oversight of the group's actuarial activities, functions, and risks emanating from insurance legal entities within the IAIG, including:

i. Policies and controls, actuarial concerns at the group or legal entity level, current and prospective solvency position, adequacy of reinsurance arrangements, actuarial-related risk modelling in ORSA and the use of internal models, coordination with legal entity actuarial functions, and providing independent advice and regular reporting to the IAIG Board or one of its committees.

b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam have the potential impact on the group's ability to maintain an effective actuarial function.

8. Review the results of the most recent group examination efforts at the IAIG to understand the internal audit function assessment performed and determine if any follow-up is necessary to address concerns or recommendations.

a. Consider the extent to which the examination addressed the internal audit function's ability to provide independent assessment and assurance regarding:

i. Policies, processes, and controls; the preservation and protection of assets and the prevention of fraud; the reliability, integrity, and completeness of accounting, financial, management, information technology (IT), and risk reporting information; the capacity and adaptability of IT systems to provide accurate and timely information to the Board and senior management; and the design and operational effectiveness of risk management and internal controls systems.

b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam has the potential to affect the group's ability to maintain an effective internal audit function.

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9. Review the results of the most recent group examination efforts at the IAIG to understand the review performed of the investment policy, or similar policies and practices, and determine if any follow-up is necessary to address concerns or recommendations.

    a. Consider the extent to which the examination addressed whether the investment policies and practices incorporate the following criteria:

        i. Guidelines/limits for investment quality, guidelines/limits to ensure proper diversification and mitigation of asset concentration risk, a counterparty risk appetite statement to limit credit risk from a single counterparty, guidelines/limits for intra-group investments, tracking and monitoring of investments to ensure compliance with policies, and guidelines to avoid placing undue reliance on assessments by credit rating agencies for investment selection and risk management process.

    b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam has the potential to affect the group's ability to maintain effective investment policies and practices.

10. Review the results of the most recent group examination efforts at the IAIG to understand the review performed of the claims management policy, or similar policies and practices, and determine if any follow-up is necessary to address concerns or recommendations.

    a. Consider the extent to which the examination addressed whether the claims management policies and practices incorporate the following criteria:

        i. Guidelines for claims estimation and settlement, feedback into the group's underwriting policy and reinsurance strategy, and claims data reporting for group analysis.

    b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam has the potential to affect the group's ability to maintain effective claims management policies and practices.

11. Review the results of the most recent group examination efforts at the IAIG to understand the review performed on the strategy for reinsurance and other forms of risk transfer and determine if any follow-up is necessary to address concerns or recommendations.

    a. Consider the extent to which the examination addressed whether the following issues are appropriately addressed:

        i. Interaction with the group's risk and capital management strategies; achievement of underwriting risk appetite, both gross and net; appetite for and practices in place to address reinsurer credit risk; policies and practices around legal entity reinsurance arrangements and group aggregation; procedures for managing reinsurance recoverables; intra-group reinsurance strategy and practices; use of alternative risk transfer; and effectiveness of risk transfer in adverse circumstances.

    b. Consider whether any information received through annual filings, meetings with the group, or changes noted in group operations since the last exam has the potential to affect the group's ability to maintain effective strategies for reinsurance and other forms of risk transfer.

IAIG Procedures #1 and 2 assist the analyst in evaluating the impact of the group's complexity on the effectiveness of group supervision and the IAIG's governance processes. As many IAIGs have multiple levels of holding companies, various legal entities incorporated in various jurisdictions, and a significant number of shared services and interconnectedness, it is important for the analyst to consider the impact of this complexity on the group's risks and corporate governance activities.

***IAIG Procedure* #3** assists the analyst in assessing the group-wide capital position of the IAIG, as well as any potential issues related to capital fungibility. The focus of this review should be utilizing information provided in

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the GCC and ORSA Summary Report to assess the IAIG's capital position. For additional guidance on utilizing information provided in the ORSA Summary Report and GCC to assess group capital, see supporting guidance and review procedures at Sections VI.E, VI.F, and VI.H. Also, when applicable, this procedure assists the analyst in understanding the ICS if calculated and provided by the IAIG or other reporting, such as the AM, during the ICS Monitoring Period. Understanding the group capital information reported to the IAIS can assist the analyst in communicating with international supervisors and participating in discussions on the ICS at supervisory college sessions (see additional guidance in Section VI.J). The IAIS's ICS Monitoring Period runs from 2020 through the end of 2024, and it is intended to assess the effectiveness of the newly developed standard. The main objective of the Monitoring Period is to receive feedback from state insurance regulators on the Reference ICS and, if applicable, feedback on additional reporting. During the Monitoring Period, the ICS is not designed for the purpose of supervisory intervention based on capital adequacy. During the Monitoring Period, U.S. IAIGs may report an alternative GCC to the IAIS known as the AM, which is expected to be similar to the GCC. The AM will be subject to a Comparability Assessment, and by the end of 2024, it will be deemed to produce, or not produce, comparable outcomes to the ICS. The NAIC supports the development of the AM as an outcome-equivalent approach for the implementation of the ICS.

IAIG Procedure #4 assists the analyst in determining whether additional supervisory measures should be taken in response to risks or concerns identified during the holding company analysis for the IAIG. As the group-wide supervisor assumes responsibility for overseeing the overall solvency monitoring for the group, it is important that risks or issues requiring supervisory intervention are identified and addressed in a timely manner through coordination with other involved supervisors.

IAIG Procedure #5 assists the analyst in coordinating with the examination function to evaluate control processes and functions. As discussed in Procedures #1 and #2, the structure and complexity of an IAIG can lead to various challenges, including challenges in effectively organizing and coordinating control functions across holding companies, legal entities, and jurisdictions. However, as the evaluation of control processes is generally performed during on-site examination efforts, the analyst should review and follow up on relevant results of the most recent examination and consider whether any recent changes in group structure or strategy have affected control functions.

IAIG Procedure #6 assists the analyst in coordinating with the examination function to evaluate the compliance function and how it ensures compliance with regulatory requirements at both the group and legal entity levels.

IAIG Procedure #7 assists the analyst in coordinating with the examination function to evaluate the actuarial function and its role in providing oversight of the group-wide actuarial activities, functions, and risks emanating from insurance legal entities within the IAIG.

IAIG Procedure #8 assists the analyst in coordinating with the examination function to evaluate the internal audit function and its role in providing independent assessment and assurance regarding internal controls, systems, and risk management practices.

IAIG Procedure #9 assists the analyst in coordinating with the examination function to evaluate investment policies and practices, including whether they set criteria for investment quality and address the selection of, and exposure to, low-quality investments or investments whose security is difficult to assess.

IAIG Procedure #10 assists the analyst in coordinating with the examination function to evaluate claims management policies and practices, including whether they include procedures for claims estimation and settlement, feedback into the group's underwriting policy and reinsurance strategy, and claims data reporting for group analysis.

IAIG Procedure #11 assists the analyst in coordinating with the examination function to evaluate the strategy for reinsurance and other forms of risk transfer, including whether the strategy is consistent with risk and capital management strategies, in line with underwriting risk appetites and addresses credit risk with reinsurance counterparties.

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Contents of the Group Profile Summary (GPS)

The following analysis work should be documented in the GPS:

- **Holding Company System Summary** – Include an understanding the holding company system by discussing the structure and business operations, including any significant recent events, changes in structure, key business segments, international activity, rating organization changes/actions and key entities/persons within the insurance holding company system. Include discussion of new and material affiliated transactions/relationships, management and third-party agreements and non-insurance agreements as well as the impact of these agreements to the group/insurers.
- **Corporate Governance Summary** – Present a summary of the group's overall corporate governance structure, including a review of the Corporate Governance Annual Disclosure – CGAD (if filed on a group basis) and an overall assessment for the holding company system.
- **Enterprise Risk Management Summary** – Present a summary and assessment of the enterprise risk management function in place at the holding company system, as well as a discussion of ORSA Summary Report filing/review status (if applicable).
- **Branded Risk Assessments** – Include a summary assessment of the group's exposure to branded risk classifications, including prospective risks, the financial strength of the insurance holding company system, including finanical position, liquidity, leverage, and profitability. Such documentation should include summarizing key risks noted within the IPSs from respective domestic regulators within the group.
- **Overall Conclusion** – Present an overall conclusion as to the group's financial condition, including key strengths and weaknesses or material concerns that regulators may have with the group's operations going forward.
- **Supervisory Plan** – Present any specifically identified items that require further action and/or monitoring by analysts or specific testing by the examiner.
- **Other Functional Financial Regulators/Supervisors** – Where appropriate, it may be necessary to document an understanding of other functional financial regulators/supervisors involved with legal entities within the insurance holding company system, including international regulators/supervisors and U.S. federal banking regulators.

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XX DEPARTMENT OF INSURANCE

GROUP PROFILE SUMMARY

GROUP NAME

As of 12/31/20XX

Updated as of XX/XX/20XX

Group Number
List here

Lead State
List here

Group-wide Supervisor
List here

Group Credit Rating
List here

Publicly Traded
List ticker and exchange

Contact at Group
List name, phone and email

CPA Firm
List here

Analyst
List here

Last Coordinated Exam
List here

Next Coordinated Exam
List here

Holding Company System Summary

Provide a summary of the structure and business operations of the holding company system, including any significant recent events or changes in structure.

EXAMPLE:

Ultimate Controlling Person*: COMPANY 1 is a mutual holding company that acts as the ultimate controlling person for the group.*

Organizational Structure*: The group is structured as a mutual holding company. The majority of the entities within the group are 100% owned by COMPANY 1. The group provides a wide range of financial products to its customers, but operates under a fairly direct and simple organizational structure.*

Business Segments*: The GROUP is divided into three business segments: insurance, banking and financial services/planning. All of the business segments are designed for and marketed to TARGET MARKET. The insurance segment makes up approximately 70% of the group's total revenue, which includes both personal property & casualty (55% of total revenue) and life insurance (15% of total revenue). Banking services make up approximately 15% of total revenue, with the remaining 15% attributed to financial services/planning and other minor segments.*

Insurance policies are sold through internet, mail and telephone on a direct basis, primarily from its LOCATION office. There are 13 financial centers in cities with TARGET MARKET LOCATION to assist members with insurance, banking and investments. The company is exposed to some level of risk concentration due to its concentration in the TARGET MARKET, which exposes it to certain geographic concentrations.

Insurance Entities and Jurisdictions: *The group has seven different insurance legal entities domiciled across three different states in the U.S. In addition, COMPANY 9 is an alien insurer domiciled in FOREIGN LOCATION. The Company is authorized to provide insurance in the other countries in that region and is subject to insurance supervision by the FOREIGN SUPERVISOR. COMPANY 9 reported $547 million in retained profit in 2011, so its operations are not overly significant to the Group.*

Captives: *The group has established COMPANY 14 as a captive life insurer, to assume XXX and AXXX reserve liabilities from COMPANY 6. COMPANY 14 is domiciled in CAPTIVE STATE X and is subject to coordinated supervision. The initial transaction to transfer reserve liabilities was subject to review and approval by the*

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CEDING STATE and the CAPTIVE DOMICILE and is subject to ongoing review and oversight. During a Dec. 31, 20XX, coordinated examination, it was determined that the group continues to operate in accordance with the approved transaction restrictions and maintains sufficient reserves, collateral and surplus to support the captive reinsurance structure.

Non-Insurance Entities: *The group offers many banking and financial products including credits cards, consumer loans, home equity loans, mortgages, auto loans, checking and savings accounts through COMPANY10 and COMPANY 11. The Office of the Comptroller of the Currency (OCC) and the Federal Deposit Insurance Corporation (FDIC) regulate the banks and the LEAD STATE communicates with those supervisors on a regular basis regarding group issues.*

In 20XX, the Group was examined by the Federal Reserve Bank (FRB). No significant findings were noted during the exam. In 20XX, the Group issued $800 million in additional bank debt through Company 1. However, this additional debt does not appear to significantly increase the group's current leverage position, which is conservative in comparison to most competitors and does not represent a significant concern at this time.

Other Information: *A recent press release announced the group's intentions to partner with UNAFFILIATED COMPANY A to offer additional financial services products to its existing customers. The partnership is not expected to have a significant financial impact in the near term.*

Financial Snapshot (Selected Summary Data)

Provide financial data to outline the group's financial position, which may be more detailed than the insurer profile summary as the availability of group data differs significantly from one group to the next and fewer tools are available at the group level. However, the information presented may vary depending upon the availability of consolidated financial data from one group to the next.

EXAMPLE:

Consolidated Balance Sheet (U.S. GAAP)

Years Ended December 31 (Dollars in millions)	*20XX*	*20XX*
Cash and cash equivalents	*13,447*	*8,786*
Investments	*38,944*	*35,033*
Real estate investments, net	*2,370*	*1,956*
Loans receivable	*38,103*	*37,548*
Premiums due from policyholders	*2,309*	*2,124*
Property and equipment, net	*1,309*	*1,343*
Other Assets	*7,870*	*7,472*
TOTAL ASSETS	*$104,352*	*$94,262*
Insurance reserves	*15,588*	*14,062*
Life insurance-funds on deposit	*15,368*	*13,626*
Bank deposits	*46,432*	*39,775*
Borrowings	*1,974*	*3,441*
Other liabilities	*5,050*	*4,647*
TOTAL LIABILITIES	*$84,312*	*$75,551*
Equity	*$20,040*	*$18,711*

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TOTAL LIABILITIES AND EQUITY	*$104,352*	*$94,262*
Consolidated Income Statement	*20XX*	*20XX*
Insurance premiums	*11,960*	*11,205*
Total investment return	*2,940*	*2,723*
Fees, sales and loan income, net	*3,489*	*3,422*
Real estate investment income	*253*	*190*
Other income	*424*	*406*
Total revenues	*$19,036*	*$17,946*
LOSSES, BENEFITS AND EXPENSES		
Policyholder Benefits	*177*	*157*
Net losses, benefits and settlement expenses	*10,998*	*9,160*
Deferred policy acquisition costs	*574*	*556*
Real estate investment expenses	*189*	*153*
Interest expense	*475*	*604*
Dividends to policyholders	*112*	*223*
Other operating expenses	*3,899*	*3,669*
Total losses, benefits and expenses	*$16,247*	*$14,365*
Pre-tax income	*2,789*	*3,581*
Income tax expense	*661*	*944*
NET INCOME	*$2,148*	*$2,637*
CASH FLOW From Operations	*$4,737*	*$2,828*

EXAMPLE:

Significant Financial Performance Notes:

- *The group continues to experience positive financial results including steady revenue growth, increasing capital/surplus levels, positive net income and positive cash flow from operations.*

Corporate Governance Summary

Provide a summary of the corporate governance structure and an overall assessment for the holding company.

EXAMPLE:

The Group is governed by a board of directors at the mutual holding company level and separate boards are in place for each insurance and banking entity, but they are led by company employees and have limited responsibilities. Strategic direction is set by the COMPANY 1 board and the audit committee for COMPANY 1 has assumed responsibility for the financial reporting and internal controls of all insurance entities. The board is made up of 10 members, 8 of which are independent from management. The Board and its committees are governed by formal written charters and the board meets a minimum of 4 times a year to fulfill its responsibilities. Based on the results of the most recent financial exam, board members of Company 1 were deemed suitable for their positions with a wide-range of experience and expertise demonstrated including financial and actuarial knowledge. A review of insurance board meeting materials and minutes indicated that the

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board is actively engaged in reviewing reported financial results of the organization and taking action to address strategy when necessary.

Senior management is led by a CEO that has been in place since 20XX and has a background in insurance company leadership going back more than 25 years. Based on the most recent discussions with management at the department and through discussions at the last supervisory college, the CEO appears to be well informed in regards to all significant operations of the group. All of the other members of senior management appear to have appropriate knowledge, background and experience to fulfill their responsibilities and appear to be actively engaged in the group's strategic initiatives. The assignment of authority and responsibility across the group appears to be clear and effective and the management team has demonstrated its competence through numerous interviews and meetings with the department. Overall, the Group's corporate governance is assessed as strong.

Enterprise Risk Management Summary

Provide a summary of the enterprise risk management function and an overall assessment for the holding company, as well as a discussion of the ORSA Summary Report filing status.

EXAMPLE:

The Enterprise Risk Management function is organized at the COMPANY 1 level, although an ERM function is also organized for the banking subsidiaries. Both are overseen by a Risk Management Committee of the board. The Risk Management Committee is governed by a charter that makes it responsible for developing, communicating and implementing a risk appetite statement and supporting risk limits/tolerances across the organization. The Chief Risk Officer reports to the Risk Management Committee at least quarterly, providing updates on the organization's compliance with risk limits/tolerances, describing new and emerging risks the organization is facing, and seeking input on changes to risk limits/tolerances and remediation efforts to address breaches. Individual risks are assigned to risk owners for development of mitigation strategies, monitoring and day-to-day management. The results of the organization's ERM efforts are documented in an ORSA Summary Report and similar information is reviewed and approved by the Risk Management Committee and the Board of Directors on an annual basis. The results of the most recent regulatory assessment of the organization's ORSA Summary Report (filed 10/25/XX) indicate that the ERM function is generally performing at "Level 4", which is at or above the majority of its peers in this area. Similar conclusions were reached during the last supervisory college conducted for the Group.

Group Capital Calculation Summary

Provide a summary of an assessment of the GCC both quantitatively and qualitatively, including any such items as may not be applicable to a branded risk category. The GCC summary is intended to be high-level. Therefore, other more detailed observations from reviewing the GCC should generally not be documented into the GPS unless they are specifically insightful, add to a high-level understanding of the group's financial condition, or are specific to a branded risk category as stated.

EXAMPLE:

It may be appropriate to indicate whether the review of the group's GCC indicated the scope of the application is consistent with the lead state's determination and summarize the general scope of the GCC. For example, "*the GCC includes all U.S. and Bermuda operations, but excludes ABC non-insurance operations in South American countries*".

It may also be appropriate to identify key drivers of risks for the group within the GCC as those risks supplement existing risk assessments derived from holding company analysis or are new risks that warrant further review. "*The group's GCC of 201% in the current year was impacted by a decline in total available capital of $X which is related to the group's non-insurance operations in Bermuda and as well as the negative impact of market risks in*

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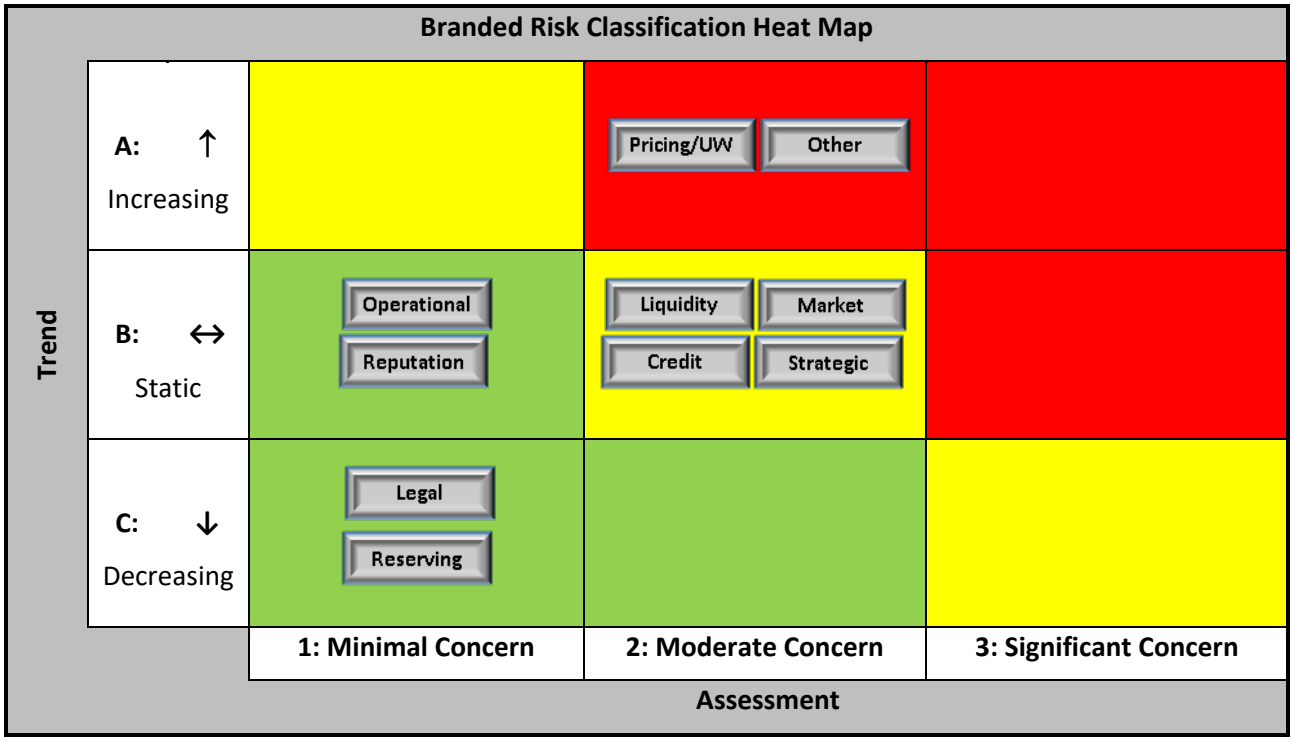
the U.S. insurance legal entity ratio components, which based on further analysis has resulted from the recent financial market volatility".

Branded Risk Assessments

Summarize your assessment of the branded risk classifications for the group based upon both quantitative (e.g., 5-year trending of key ratios) and qualitative information. An assessment of each significant individual risk component (including prospective risks) relevant to the classification should be provided by indicating either "minimal concern," "moderate concern" or "significant concern" as well as the direction in which the risk is trending. If no significant individual risk components are identified for a branded risk classification, documentation should be provided to support this conclusion. Consider the materiality and/or significance of each individual risk component in aggregating the overall assessment and overall trend for each branded risk classification. Update the Branded Risk Classification Heat Map to illustrate your conclusions.

EXAMPLE:



Credit: *Based upon a review of consolidating financial statements, the primary credit risk for the group appears to be in the banking segment. The banks have a significant amount invested in mortgages and automobile loans. Through discussions with the group wide supervisor, the Federal Reserve Bank, and a review of documentation they provided, it appears that the loans carry a moderate risk of default. However, current loans past due are less than 1% of loans receivable, indicating that the Group appears to manage its loan portfolio well. Other investments are heavily concentrated in investment grade bonds associated with the insurance operations, which represent a minimal concern. We requested the group provide us with summary investment information for the group, which indicated that there were no material concentrations in non-investment grade bonds, equities, private securities or other types of invested assets. In addition, the group's ORSA Summary Report does not list credit as an area of material risk. Because most of these assets are within the individual insurers, we also reviewed the legal entity insurer profile summaries and noted no significant concerns with either investments or reinsurance.*

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Minimal Concern	Moderate Concern	Significant Concern	Trend
	Loan Portfolio		↔
Reinsurance/Insurer investments			↔
Overall Credit Assessment: Moderate Concern		**Overall Trend: ↔**	

Legal: *No specific concerns identified through either review of the legal entity insurer profile summaries, results of recent coordinated exam, the ORSA Summary Report, discussions with the Federal Reserve, or any other sources. The group is periodically involved in individual claim lawsuits, but frequency has trended downward and results are not historically significant.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
Claim lawsuits			↓
Overall Legal Assessment: No/Minimal Concern		**Overall Trend: ↓**	

Liquidity: *As previously discussed, although the insurance assets are fairly conservative, and despite finding no Insurer Profile Summaries of legal entities that identified liquidity as an issue, this may be an area requiring greater focus at the group level moving forward. The Federal Reserve indicated that the banking operations were subject to liquidity strain under certain conditions, but did not provide specifics regarding those conditions or the results. In addition, although the ORSA Summary Report provides some information on the insurance operations liquidity management program, a greater understanding is needed given in part the group's exposure to certain types of catastrophic risks as well as certain risks with its banking operations. We suggest this as an area of focus during the next coordinated on-site examination to better understand the entire group's liquidity management.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
	Banking operations		↔
	Liquidity in a cat scenario		↔
Liquidity under normal conditions			↔
Overall Liquidity Assessment: Moderate Concern		**Overall Trend: ↔**	

Market: *Similar to credit risk, through discussions with the Federal Reserve, market risks related to the loan portfolio were identified, as these loans can be subject to market swings during certain economic conditions. Although general concerns were communicated in this area, specific concerns related to the company's stress test results for various scenarios were not communicated. Despite the relatively conservative investment portfolio, the Company identified in its ORSA that market risk was an area where a moderate risk, or at least a moderate amount of capital, may be needed to absorb certain specific economic conditions. However, based on discussions with management, despite the use of various types of derivatives to reduce such risks, the company indicates that its cost-benefit analysis suggests that further hedging is not used to manage this extreme tail risk that has a somewhat low probability. Further review of such need not be performed until the next five-year examination.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
	Loan Portfolio		↔
	Insurance Portfolio		↔

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Overall Market Assessment: Moderate Concern	Overall Trend: ↔

Operational: *Consolidated GROUP reported net income of $2,128 million in the current year compared to $2,637 million in the prior year. In the current year, GROUP P/C companies experienced significant catastrophe events, which included tornadoes, floods, hail, wildfires, earthquakes and hurricanes. However, even with the heightened number of catastrophes faced by the group, the overall financial results were favorable and group capital per the ORSA Summary Report appears to be well above target even under adverse conditions. The group is not structured like most companies and its overall approach is geared towards its policyholders. The group's interest coverage ratio (provided below) shows that the group is not overly reliant on cash flow from the insurance entities to cover holding company debt. However, although the last examination revealed that governance risk was low, certain internal control processes were not clearly documented. The group indicated that it was in the process of working with its internal audit department to enhance its documentation. Through discussions with the Federal Reserve, it appears that the group has recently developed additional documentation around internal controls. These activities will be verified during the next onsite examination.*

	CY	***PY***	***PY1***	***PY2***	***PY3***
Interest Coverage	*4.5X*	*4.4X*	*4.4X*	*2.2X*	*5.2X*

Minimal Concern	Moderate Concern	Significant Concern	Trend
Earnings & Group Capital			↔
Holding Company Debt			↔
	Internal control documentation		↓
Overall Operational Assessment: No/Minimal Concern		**Overall Trend: ↔**	

Pricing/Underwriting: *Our review of pricing/underwriting risk focused on the insurers within the organization, as similar risks in the banking segment were evaluated as an element of credit risk. Per review of the legal entity Insurer Profile Summaries, Company 6 was identified as having a concentration of catastrophe risk in one state, which was identified as a significant concern by State Y. However, after review of the ORSA Summary Report, and after significant discussions with management, we determined that CAT risk for the entire group as a whole was moderate. Additionally, the Company has taken steps in the current year to minimize this risk further by creating a separate legal structure to reduce this risk through the issuance of insurance linked securities, as discussed in the Group's Form F filing. We suggest that although this is a risk mitigator, the details of the structure should be examined more closely during a targeted exam as soon as possible and that regulators monitor this activity closely as it could represent a significant concern if not structured effectively. Also, the group's workers' compensation line of business appears to contain some risk for the group, where despite relatively strong historical performance, we're noticing an industry trend of decreasing prices. As this line of business represents more than 25% of the group's total gross written premiums, we believe a detailed review of national underwriting procedures and current pricing on workers' compensation may be appropriate during the next onsite exam (scheduled for two years from now).*

Minimal Concern	Moderate Concern	Significant Concern	Trend
Auto/home underwriting & pricing			↔
	CAT risk		↔
	WC underwriting and pricing		↑

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		Insurance linked securities	↑
Overall Pricing/Underwriting Assessment: Moderate Concern		**Overall Trend: ↑**	

Reputation: *No significant issues were identified. The Group appears to monitor its reputation on a regular basis as described in its ORSA Summary Report.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
Overall reputation			↔
Overall Reputation Assessment: No/Minimal Concern		**Overall Trend: ↔**	

Reserving: *The group continues to maintain a relatively conservative ratio of reserves to equity of 78% although it has been trending slightly negative. This is offset by a slight shift in the insurer's exposure from less casualty business to more property business and is the primary driver for the change. However, as shown in the insurer's ORSA Summary Report, the insurance group sets aside economic capital to cover a one-in-500-year event in addition to other amounts set aside for other risks.*

	CY	PY	PY1	PY2	PY3
Two Year Develop	*8.0%*	*-10.0%*	*-10.4%*	*-5.6%*	*1.1%*
Loss & LAE/C&S	*77.8%*	*76.2%*	*76.8%*	*73.7%*	*71.9%*

Minimal Concern	Moderate Concern	Significant Concern	Trend
Leverage			↔
Loss development			↔
Overall Reserving Assessment: No/Minimal Concern		**Overall Trend: ↑**	

Strategic: *The primary risks for the Group are divided into insurance and banking segments. The Group has proven risk mitigation strategies in the insurance companies and has managed those risks well. However, the group is facing new competition in a number of its primary insurance markets as competitors seek to duplicate the group's strong financial performance. While the group appears to be aware of the increased competition and responding to the emerging threats in this area, these threats bear monitoring as a moderate concern. In addition, as discussed above, the one area of risk that is not easy to get a handle on at the group level is its liquidity risk. The ORSA Summary report discusses some aspects (insurance focused) of ERM but it is not sufficiently detailed to assess. See above suggestion regarding liquidity. The group's GCC is assessed as low-risk and stable and is a positive consideration in the overall assessment of strategic risk. The GCC has generally been reasonable and consistent over the past five years as illustrated in the following table. Additionally, refer to the GCC summary for further details.*

	CY	PY	PY1	PY2	PY3
GCC Ratio	*201%*	*207%*	*163%*	*202%*	*197%*

Minimal Concern	Moderate Concern	Significant Concern	Trend
Overall strategic planning			↔
	Competition		↑

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	Liquidity strategy		↔
Group Capital Calculation			↔
Overall Strategic Assessment: Moderate Concern		**Overall Trend: ↔**	

Other: *The most recent Form F report provided by COMPANY 1 indicated that the group is exposed to geopolitical risk and uncertainty related to its investment in COMPANY 9, which is an alien reinsurer operating in Country XX. As the stability of Country XX's government has been weakened due to recent protests related to government corruption, the group's investment in COMPANY 9 is of some concern. However, as the group's total investment in COMPANY 9 ($547 million at Dec. 31, 20XX) represents less than 3% of overall capital and surplus, the situation warrants only a moderate concern at this time.*

Minimal Concern	Moderate Concern	Significant Concern	Trend
	Geopolitical risk (COMPANY 9)		↑
Overall Strategic Assessment: Moderate Concern		**Overall Trend: ↑**	

Overall Conclusion

This section should include the analyst's overall conclusion as to the group's financial condition, discuss key strengths that potentially mitigate the risks assessed above, and highlight any key weaknesses or material concerns the analyst may have with the group'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.).

EXAMPLE:

Based on the branded risk assessments provided above as well as the company's financial results reported in recent periods, the group appears to be financially stable with no major sources of potential contagion risk to the insurance entities identified. However, some of the key weaknesses and material concerns facing the group include increased competition, geopolitical risk to operations in Country XX, overall liquidity planning and the Group's pricing/underwriting of workers' compensation business. These concerns are somewhat offset by company strengths including a conservative investment portfolio, strong reputation and history of strong financial performance. The department meets annually with group leadership with the next meeting scheduled for the first quarter of 20XX to discuss annual results. During the meeting, the department plans to ask about the impact of increased competition on the group as well as liquidity planning.

Supervisory Plan

List any specifically identified items that require further action and/or monitoring by the analyst or specific testing by the examiner. In addition, indicate if the group is or should be subject to any enhanced monitoring, such as monthly reporting, meetings with the department, a targeted examination, or a more frequent exam cycle. Note if any regulatory actions have recently been taken.

EXAMPLE:

Analysis Follow Up

- *Discuss the group's strategy to address increased competition in several of its primary markets as part of the next annual meeting, supervisory college and/or holding company analysis.*

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- *Monitor the situation in Country XX to consider its impact on the group's investment in COMPANY 9. Discuss any significant negative developments with the group's executives.*

Examination Follow-Up

- *Perform a targeted examination on the group's newly developed insurance linked securities in order to understand all aspects of the program including its interaction with other forms of projection, limits, the monitoring used by the company, etc.*
- *Increase the focus on national underwriting procedures and current pricing on workers' compensation during the next coordinated examination.*
- *Increase the focus on the entire group's (including banking) liquidity management program during the next coordinated examination.*

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VI.C.2. Group-Wide Supervision – Non-Insurance Company Grid Template

Non-Insurance Company Grid

NAIC #	FEIN	Name of Securities Exchange if Publicly Traded (U.S. or International)	Name of Parent, Subsidiaries or Affiliates	Domicile	Primary Regulator and Contact	Primary Regulator Email	Description & Purpose of Entity	Business Segment	Inter-Company Guarantee (Yes/No)	Revenue	Net Income	A.M. Best Rating	Moodys Rating	S & P Rating	Prospective Risks

Comments:

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Special Note: The following procedures do not supersede state regulation but are merely additional guidance an analyst may consider useful.

The *Corporate Governance Annual Disclosure Model Act (#305)* and *Corporate Governance Annual Disclosure Model Regulation (#306)* provide a summary of an insurer or insurance group's corporate governance structure, policies and practices to permit the Commissioner to gain and maintain an understanding of the insurer's corporate governance framework.

States should also consider completion of applicable questions within the Operational and Strategic risk repositories of this Handbook based upon the level of concern an analyst may have with management performance and the driving forces behind operations.

Introduction

Models #305 and #306 require an insurer, or an insurance group, to file a summary of an insurer or insurance group's corporate governance structure, policies and practices with the commissioner by June 1 of each calendar year. Model #305 allows the information to be at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. Because most corporate governance is driven at a controlling or intermediate holding company level, this guidance is contained within this section dealing with group supervision. As such, reviewing the corporate governance disclosure of a group is a responsibility of the lead state. In addition to the role of the lead state, other analysts from participating states may also review corporate governance since it is common for most groups to have some level of governance at the individual legal entity level.

Non-Lead State Reliance on the Lead State Analysis of Corporate Governance Annual Disclosure:

Model #305 requires the filing to be made with the lead state; however, non-lead domestic states may request the CGAD filing from the insurer. Because the filing may be made on a group basis or legal entity basis, it may contain group information that applies to all insurers within the group, or it may contain information applicable to a specific legal entity.

Similar to other solvency regulation models, Model #305 contemplates both off-site and on-site examination of the CGAD information, therefore, it may be necessary or acceptable for the lead state to share its work papers with another state during an exam, related to such filing, provided such information is shared in accordance with the confidentiality provisions of Model #305.

The lead state should take primary responsibility for reviewing the CGAD filing, if it is filed on a group basis, and should incorporate any takeaways or concerns into the Group Profile Summary (GPS). Takeaways should be incorporated into the corporate governance summary in the GPS and/or the discussion of various branded risks, as deemed appropriate. There is no requirement or expectation for the analyst to create a separate CGAD checklist or create additional review documentation for sharing with another state or for internal documentation purposes.

If the CGAD highlights any issues that are only relevant to a particular insurance entity in the group, the lead state should notify the domestic state of this issue and share the relevant information from the CGAD with that state in a timely manner.

Internationally Active Insurance Group (IAIG) Considerations:

While the considerations outlined in this chapter are generally applicable to all insurers/insurance groups, depending on the level at which the CGAD filing is made, there are some additional corporate governance assessment considerations applicable to U.S.-based internationally active insurance groups (IAIGs) on an annual basis that are incorporated into this section. It is the responsibility of the group-wide supervisor to ensure that the group meets minimum governance expectations at both the legal entity, for its domestic insurers, and head of the IAIG level. As such, the group-wide supervisor should request and review additional information from the

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head of the IAIG, as necessary, to complete this assessment, which may include requesting information similar to what is provided in a CGAD and/or additional information (e.g., biographical affidavits, conflict of interest statements) at the head of the IAIG level. In addition, the analyst should utilize other filings and resources already available to the department, including holding company filings—i.e., Form B, Form F—Own Risk and Solvency Assessment (ORSA), and any other relevant information (e.g., U.S. Securities and Exchange Commission [SEC] Proxy Statements, voluntary disclosures) to complete this assessment.

PROCEDURES #1 - 2 provides a guide to assist analysts in reviewing the Corporate Governance disclosure for completeness and help guide analysts through each of the major items of information required by Model #306. As noted above, concerns should be documented in the GPS, as there is no requirement or expectation for the analyst to create a separate CGAD checklist or create additional review documentation.

PROCEDURES #3 - 5 provides a guide to assist analysts in summarizing any concerns relative to the insurer or insurance group's corporate governance and its impact.

PROCEDURES #6 - 8 assist analysts in assessing the corporate governance practices of IAIGs on an annual basis.

Compliance with Corporate Governance Disclosure Requirements

The following procedures are intended to guide the analyst through a review of the CGAD. These procedures do not represent a documentation requirement.

1. Does the disclosure provide information regarding the following areas as required by Model #306?
    a. The insurer's or insurance group's corporate governance framework and structure including consideration of the following.
        i. The Board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current Board size and structure; and
        ii. The duties of the Board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the Board's leadership is structured, including a discussion of the roles of Chief Executive Officer (CEO) and Chair of the Board within the organization.
    b. The policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:
        i. How the qualifications, expertise and experience of each Board member meet the needs of the insurer or insurance group.
        ii. How an appropriate amount of independence is maintained on the Board and its significant committees.
        iii. The number of meetings held by the Board and its significant committees over the past year as well as information on director attendance.
        iv. How the insurer or insurance group identifies, nominates and elects members to the Board and its committees. The discussion should include, for example:
            1. Whether a nomination committee is in place to identify and select individuals for consideration.
            2. Whether term limits are placed on directors.
            3. How the election and re-election processes function.
            4. Whether a Board diversity policy is in place and if so, how it functions.

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v. The processes in place for the Board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any Board or committee training programs that have been put in place).

c. The policies and practices for directing senior management, including a description of the following factors:

i. Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:

1. Identification of the specific positions for which suitability standards have been developed and a description of the standards employed.

2. Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.

ii. The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

1. Compliance with laws, rules, and regulations.

2. Proactive reporting of any illegal or unethical behavior. [1]

iii. The insurer's or insurance group's processes for performance evaluation, compensation, and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the Commissioner to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk-taking. Elements to be discussed may include, for example:

1. The Board's role in overseeing management compensation programs and practices.

2. The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid.

3. How compensation programs are related to both company and individual performance over time.

4. Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels.

5. Any "clawback" provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted.

6. Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk- management objectives are met by incentivizing its employees.

iv. The insurer's or insurance group's plans for CEO and senior management succession.

d. The insurer or insurance group shall describe the processes by which the Board, its committees and senior management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:

[1] See additional discussions of conflicts of interest, which could be covered in this section of the CGAD under Assessment of U.S.-Based Internationally Active Insurance Group Corporate Governance below.

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i. How oversight and management responsibilities are delegated between the Board, its committees and senior management;

ii. How the Board is kept informed of the insurer's strategic plans, the associated risks, and steps that senior management is taking to monitor and manage those risks;

iii. How reporting responsibilities are organized for each critical risk area. The description should allow the commissioner to understand the frequency at which information on each critical risk area is reported to and reviewed by senior management and the Board. This description may include, for example, the following critical risk areas of the insurer:

1. Risk management processes (an ORSA Summary Report filer may refer to its ORSA Summary Report pursuant to the *Risk Management and Own Risk and Solvency Assessment Model Act (Model #505)*);
2. Actuarial function
3. Investment decision-making processes
4. Reinsurance decision-making processes
5. Business strategy/finance decision-making processes
6. Compliance function
7. Financial reporting/internal auditing
8. Market conduct decision-making processes

2. If the insurer or insurance group has not disclosed specific information listed in Procedure 1 above, was other information included that adequately describes why such information was not included?

Assessment of Corporate Governance Disclosure

3. Is the analyst aware of any significant and material corporate governance information not reported in the disclosure? If "yes," refer to the Management Considerations section of IV.A. Financial Analysis and Reporting Considerations for additional guidance.

4. Do any of the concerns pose an immediate risk to the insurer's or insurance group's operations, policyholder surplus or capital position?

Assessment of U.S.-Based Internationally Active Insurance Group

Corporate Governance

5. Based on the analyst's review of the CGAD and any additional information received (e.g., biographical affidavits, conflict of interest statements), document any material concerns related to the individual and collective suitability of Board members, senior management and key persons in control functions at the IAIG.

a. In reviewing the information received and assessing suitability, consider whether the IAIG Board has the necessary information and processes in place to understand the group-wide corporate governance framework and structure; activities of the legal entities and associated risks; supervisory regimes applicable to the IAIG; issues that arise from cross-border business and international transactions; and the risk management, compliance, audit, actuarial, and related areas of the group.

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b. In reviewing the information received, consider whether the group-wide corporate governance framework includes policies and processes to identify and avoid, or manage, conflicts of interest that may adversely affect the IAIG as a whole or any of its legal entities.

6. Based on the analyst's review of the CGAD and any additional information received, document any material concerns related to the appropriateness of the corporate governance framework, given the structure, business, and risks of the IAIG, including the risks of its legal entities; and the reporting lines in place between the material legal entities and the head of the IAIG.

   a. Consider what role or influence the head of the IAIG plays in setting corporate governance expectations at the legal entity level, including establishing the "tone at the top."

7. Based on the analyst's review of the CGAD and any additional information received, document any material concerns related to whether the IAIG's group-wide governance structure promotes effective oversight of the group-wide operations independent of day-to-day management.

For the U.S. lead state:

- ❑ Analysts should update the Group Profile Summary and Supervisory Plan with any material information.
- ❑ Analysts should notify the domestic state of any issues that are only relevant to a particular insurance entity in the group and share the relevant information from the CGAD with that state in a timely manner.
- ❑ Analysts should communicate to the examiner-in-charge (EIC) any prospective risks identified in the review of the corporate governance annual disclosure that affects the domestic insurer. In addition, analysts should share information or open items related to group-wide corporate governance assessments with the EIC to facilitate the effective review and follow-up of the analysis during on-site exam activities.

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

For the U.S. lead state that is also the group-wide supervisor:

- ❑ Contact the holding company seeking explanations or additional information
- ❑ Meet with the holding company management
- ❑ Suggest that assessment or follow-up procedures be completed during the next examination
- ❑ Pursue, as appropriate, within an international supervisory college
- ❑ Other (explain)

<u>For the U.S. lead state that is not the group-wide supervisor:</u>

- ❑ Contact the group-wide supervisor, seeking explanations or additional information
- ❑ Pursue, if applicable and as appropriate, within an international supervisory college
- ❑ Other (explain)

<u>For a non-lead state:</u>

- ❑ Contact the lead state, seeking explanations or additional information if questions exist about information noted in the GPS
- ❑ Pursue, if applicable and as appropriate, within an international supervisory college (if applicable)

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Introduction

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

ORSA Summary Report

The NAIC *Risk Management and Own Risk and Solvency Assessment Model Act* (#505) requires insurers above a specified premium threshold, and subject to further discretion, to submit a confidential annual ORSA Summary Report. Model #505 gives the individual insurer and the insurance group discretion as to whether the report is submitted by each individual insurer within the group or by the insurance group as a whole (See the NAIC *Own Risk Solvency Assessment Guidance Manual* (ORSA Guidance Manual) for further discussion).

- **Lead State:** In the case where the insurance group chooses to submit one ORSA Summary Report for the group, it must be reviewed by the lead state. The lead state is to perform a detailed and thorough review of the information and initiate any communications about the ORSA with the group. The suggestions below set forth some possible considerations for such a review. At the completion of this review, the lead state should prepare a thorough summary of its review, which would include an initial assessment of each of the three sections. The lead state should also consider and include key information to share with other domestic states that are expected to place significant reliance on the lead state's review. The lead state should share the analysis of ORSA with other states that have domestic insurers in the group. The group ORSA review and sharing with other domestic states should occur within 120 days of receipt of the ORSA filing.
- **Non-Lead State:** Non-lead states are not expected to perform an in-depth review of the ORSA, but instead rely on the review completed by the lead state. The non-lead states' review of the lead state's ORSA review should be performed only for the purpose of having a general understanding of the work performed by the lead state, and to understand the risks identified and monitored at the group-level so the non-lead state may better monitor and communicate to the lead state when its legal entity could affect the group. Any concerns or questions related to information in the ORSA or group risks should be directed to the lead state.
- **Single Insurer ORSA:** In the case where there is only one insurer within the insurance group, or the group decides to submit separate ORSA Summary Reports for each legal entity, the domestic state is to perform a detailed and thorough review of the information, which would include an initial assessment of each of the three sections and initiate any communications about the ORSA directly with the legal entity. Such a review should also be shared with the lead state (if applicable) so it can develop an understanding of the risks within the entire insurance group. Single insurer ORSA reviews should be completed within 180 days of receipt of the ORSA filing.

Throughout a significant portion of the remainder of this document, the term "insurer" is used to refer to both a single insurer for those situations where the report is prepared by the legal entity, as well as to refer to an insurance group. However, in some cases, the term group is used to reinforce the importance of the group-wide view.

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Similarly, throughout the remainder of this document, the term "lead state" is used before the term "analyst" with the understanding that in most situations, the ORSA Summary Report will be prepared on a group basis and therefore reviewed by the lead state.

Background Information

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

1. To foster an effective level of ERM at all insurers, through which each insurer identifies, assesses, monitors, prioritizes and reports on its material and relevant risks identified by the insurer, using techniques that are appropriate to the nature, scale and complexity of the insurer's risks, in a manner that is adequate to support risk and capital decisions.
2. To provide a group-level perspective on risk and capital, as a supplement to the existing legal entity view.

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

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

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

General Summary of Guidance for Each Section

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

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analyst to consider other aspects of the ORSA Summary Report. This is particularly true of Section I, because as discussed in the following paragraphs, the other two sections have very distinct objectives, whereas the assessment of Section I is broader.

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

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

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

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

Background Information

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

- **Attestation** – The report includes an attestation signed by the chief risk officer (CRO) (or other executive responsible for ERM oversight) indicating that the information presented is accurate and consistent with ERM reporting shared with the board of directors (or committee thereof).
- **Entities in Scope** – The scope of the report is clearly explained and identifies all insurers covered. The scope of a group report also indicates whether material non-insurance operations have been covered. The lead state analyst could utilize Schedule Y, the Lead State report and other related tools/filings to review which entities are accounted for in the filing.
- **Accounting Basis** – The report clearly indicates the accounting basis used to present financial information in the report, as well as the primary valuation date(s).
- **Key Business Goals** – The report provides an overview of the insurer's/group's key business goals in order to demonstrate alignment with the relevant and material risks presented within the report.
- **Changes From Prior Filing(s)** – The report clearly discusses significant changes from the prior year filing(s)

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to highlight areas of focus in the current year review including significant changes to the ERM framework, risks assessed, stress scenarios, overall capital position, modeling assumptions, etc.

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

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

Key Principles:

A. Risk Culture and Governance

B. Risk Identification and Prioritization

C. Risk Appetite, Tolerances and Limits

D. Risk Management and Controls

E. Risk Reporting and Communication

Documentation for Section I

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

A. Risk Culture and Governance

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

- **Roles and Responsibilities** - Roles and responsibilities of key stakeholders in risk and capital management are clearly defined and documented in writing, including members of the board (or committee thereof), officers and senior executives, risk owners, etc.
- **Board or Committee Involvement** – The board of directors or appropriate committee thereof demonstrates active involvement in the oversight of ERM activities through receiving regular updates from management on ERM monitoring, reporting and recommendations.
- **Strategic Decisions** – Directors, officers and other members of senior management utilize information generated through ERM processes in making strategic decisions.
- **Staff Availability and Education** – The insurer maintains suitable staffing (e.g., sufficient number, educational background, and experience) to support its ERM framework and deliver on its risk strategy. Staff is kept current in its risk education in accordance with changes to the risk profile of the insurer.
- **Leadership** – The chief risk officer (CRO), or equivalent position, possesses an appropriate level of knowledge and experience related to ERM and receives an appropriate level of authority to effectively fulfill responsibilities. This includes clear and direct communication channels between the CRO and the BOD or appropriate committee thereof.
- **Compensation** – The insurer demonstrates that incentives, compensation and performance management criteria have been appropriately aligned with ERM processes and do not encourage excessive risk taking given the capital position of the insurer.

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- **Integration** – The insurer integrates and coordinates ERM processes across functional areas of the insurer including human resources, information technology, internal audit, compliance, business units, etc.
- **Assessment** – The insurer's ERM framework is subject to regular review and assessment, with updates made to the framework as deemed necessary.

B. Risk Identification and Prioritization

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

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

C. Risk Appetite, Tolerances and Limits

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

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

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

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

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

D. Risk Management and Controls

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

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

E. Risk Reporting and Communication

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

- **Training** – The importance of ERM processes and changes to the risk strategy are clearly communicated to all impacted areas and business units through ongoing training.
- **Key Risk Indicator Reporting** – Summary reports on risk exposures (i.e., key risk indicators) and compliance with tolerances/limits are maintained and updated on a regular basis.
- **Oversight** – Summary reports are reviewed and discussed on a regular basis by the appropriate members of management, and when appropriate, directors.
- **Breach Management** – Breaches of limits and dashboard warning indicators are addressed in a timely manner through required action by management and, when appropriate, directors.
- **Feedback** – A feedback loop is embedded into ERM processes to ensure that results of monitoring and

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review discussions on key risks by senior management and the board are incorporated by business unit leaders and risk owners into ongoing risk-taking activities and risk management processes.

Overall Section 1 Assessment

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

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

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

Review of Section II - Insurer's Assessment of Risk Exposure

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

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

Documentation for Section II

Prepare a summary and assessment of Section II by identifying and outlining key information associated with the significant reasonably foreseeable and material relevant (key) risks of the insurer per the ORSA Summary Report. Following the documentation on each key risk per the report, the lead state analysts should include an analysis of such risk. In developing such analysis, the lead state analyst is encouraged to use judgment and critical thinking in

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evaluating if the risks and quantification of such risks under normal and stressed conditions are reasonable and generally consistent with expectations. The lead state analyst should be aware that the lead state examiner is tasked to update the assessment by supplementing the lead state analyst's assessment with additional on-site verification and testing. The lead state analyst should direct the lead state examiner to those areas where such additional verification and testing is appropriate and could not be performed by the lead state analyst. Suggested information to be documented on each key risk, including supporting considerations, is outlined below:

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

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

Overall Section II Assessment

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

Review of Section III - Group Assessment of Risk Capital

In reviewing Section III of the ORSA Summary Report, the lead state analyst should recognize this section is generally presented in a summarized form. Although this section requires disclosure of aggregate available capital compared against the enterprise's risk capital (i.e., the amount deemed necessary to withstand unexpected losses

arising from key risks), the report may not provide sufficient detail to fully evaluate the group capital position. As such, the lead state analyst may need to request the assistance of staff actuaries when available in evaluating the reasonableness and adequacy of the stress tests selected, request additional detail from the insurer in order to understand and evaluate the group capital position and/or refer additional investigation to the financial examination function.

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

Documentation for Section III

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

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

The lead state analyst, after completing a summary of Section III, should assess the overall reasonableness of the capital position compared to the group's estimated risk capital. Additionally, the lead state analyst should also consider if any of the information, or any specific conclusions, should be used to update either the GPS or IPS.

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

- **Discussion of Capital Metric(s) Used** – Discuss the method(s) used by the group in assessing group risk capital and their basis for such a decision. Identify the capital metric(s) used to estimate group risk capital, as well as the level of calibration selected. Consider whether the capital metric(s) utilized to assess the group's overall capital target are clearly presented and described. Metrics may consist of internally developed economic capital models (deterministic or stochastic) and/or externally developed models, such as regulatory capital requirements for risk-based capital (RBC) or A.M. Best's Capital Adequacy Ratio (BCAR). In discussing

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calibration, consider both the method used (e.g., Value at Risk, Tail Value at Risk) and its level to evaluate whether the results are calibrated to an appropriate confidence level. Discuss whether the capital metric(s) selected address all key risks of the group. Of particular importance is considering whether the metric used fits the approach used to determine the group's risk appetite. Document the extent to which the lead state analyst believes the approach used by the insurer is reasonable for the nature, scale and complexity of the group and if this has any impact on the lead state analyst's assessment of the insurer's overall risk management.

- **Group Risk Capital - By Risk and in Aggregate** – Provide information on the amount of risk capital determined for each individual key risk and in aggregate. In reviewing the results for each individual risk, evaluate whether all key risks are adequately accounted for in the metric by assessing the amount of capital allocated to each risk. Consider significant changes in group risk capital from the prior filing, the drivers of such change, and any decisions made as a result of such movement.
- **Impact of Diversification Benefit** – Discuss the impact of any diversification benefit calculated by the group in aggregating its group risk capital. Diversification benefit is typically calculated by aggregating individually modeled risk capital and then accounting for potential dependencies among those risks to allow for an offset or reduction in the total amount of required capital (group risk capital). In evaluating the group's diversification benefit, consider whether the benefit is calculated based on dependencies/correlations in key risk components that are reasonable/appropriate.
- **Available Capital** – Provide information on and discuss the amount of capital available to absorb losses across the group, recognizing that there may be fungibility issues relating to capital trapped within various legal entities and jurisdictions for which regulatory restrictions and supervisory oversight constrain the extent and timing of capital movement across the group. Describe management's strategy to obtain/deploy additional capital across the group should the need arise. Determine if there is any double counting of capital through the stacking of legal entities.
- **Excess Capital** – Discuss the extent to which the group available capital amount exceeds the group risk capital amount per the ORSA Summary Report. In evaluating the overall adequacy of excess capital, consider any concerns outlined above relating to the capital metric(s), group risk capital, impact of diversification and available capital. If the level of excess capital or its availability/liquidity is of concern, evaluate the group's ability to remediate capital deficiencies by obtaining additional capital or reducing risk where required. If further concerns exist, contact the group to discuss and communicate with department senior management to determine whether additional investigation or regulatory action is necessary.
- **Impact of Stresses on Group Risk Capital** – Discuss whether additional stress scenarios have been applied to the model results to demonstrate the group's resiliency to absorb extreme unexpected losses. This step is particularly important when reviewing the use of external capital models that may not be tailored to address the enterprise's specific exposures. Evaluate the range and adequacy of any stress scenarios applied and the resulting impact on the group's ability to accomplish its business strategy, provide sufficient liquidity and meet the capital expectations of rating agencies and regulators.
- **Governance and Validation** – Discuss and evaluate the group's model governance process and the means by which changes to models are overseen and approved. Consider whether members of senior management are adequately involved. Discuss the extent to which the group uses model validation (including validation of data inputs) and independent review to provide additional controls over the estimation of group capital.
- **Prospective Solvency Assessment** – Discuss the information provided by the group on its prospective solvency position, including any capital projections. Consider whether the business goals of the insurer and its strategic direction are adequately discussed and incorporated into the prospective solvency assessment. For example, are expected changes in risk profile presented and discussed? Also consider whether prospective solvency is projected across the duration of the current business plan. To the extent the prospective assessment suggests that the group capital position will weaken, or recent trends may result in certain internal limits being breached, the lead state analyst should understand and discuss what actions the insurer expects to take as a result of such an assessment (e.g., reduce certain risk exposure, raise additional capital, etc.).

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Overall Section III Assessment

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

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

Feedback to the Insurer

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

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

Suggested Follow-up by the Examination Team

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

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

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the reasonableness of certain inputs into stress testing from Section II; and reviewing certain inputs, assumptions and outputs from internal capital models).

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

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

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

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

Form F - Enterprise Risk Report

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

Lead State Responsibility for Analysis of Form F

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

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

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Non-Lead State Reliance on the Lead State Analysis of Form F

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

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

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

NAIC Enterprise Risk Report (Form F) Implementation Guide

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

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

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

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

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

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ORSA Review Template

Group/Insurer: _____
Group Code/CoCode: _____
State _____
Valuation Date: _____
Submission Date: _____

General Instructions:

This template is intended to be used to document a review and assessment of the ORSA Summary Report by the lead/domestic state. Regulators should document the results of their annual review of the ORSA and utilize the appendixes to track and communicate feedback to the insurer and procedures for regulatory follow-up. See VI.E. Group-Wide Supervision – Enterprise Risk Management Process Risks Guidance for additional guidance in completing this template.

Prepared/Reviewed By:	Date:

Date of Last Exam:	
Date of Next Exam:	

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Background Information

Summarize and assess background information provided in the report, where available. Key documentation elements are presented below.

1. **Attestation**:

2. **Entities in Scope:**

3. **Accounting Basis:**

4. **Key Business Goals:**

5. **Changes from Prior Filing(s):**

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Section I – Description of the Insurer's Enterprise Risk Management (ERM) Framework

Summarize and assess key information from Section I of the ORSA Summary Report for each of the five principles of a risk management framework.

1. **Risk Culture and Governance:**

2. **Risk Identification and Prioritization:**

3. **Risk Appetite, Tolerances and Limits:**

4. **Risk Management and Controls:**

5. **Risk Reporting and Communication:**

Overall Section 1 Assessment—After reviewing and considering each principle individually, develop an overall assessment of the group's/insurer's risk management framework including any concerns or areas requiring follow-up investigation or communication:

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Section II – Insurer Assessment of Risk Exposures

Prepare documentation summarizing a review and assessment of information provided on the reasonably foreseeable future and relevant material risks of the insurer/group.

THE FOLLOWING TABLE SHOULD BE COMPLETED FOR EACH KEY RISK

Risk Title/Description	
Branded Risk(s)	
Controls/Mitigation	
Risk Limits	
Assessment (QT/QL)	
Normal Exposure	
Stress Scenario(s)	
Stressed Exposure	
Inclusion on GPS/IPS	
Regulator Review & Assessment:	

Overall Section 2 Assessment—After reviewing and considering each key risk individually, develop an overall conclusion regarding the group's/insurer's process to assess key risk exposures including any concerns or areas requiring follow-up investigation or communication:

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Section III – Assessment of Risk Capital and Prospective Solvency

Prepare documentation summarizing a review and assessment of key elements of the risk capital and prospective solvency process as follows.

1. **Discussion of Capital Metric(s) Used:**

2. **Group Risk Capital (GRC) – By Risk and In Aggregate:**

3. **Impact of Diversification Benefit:**

4. **Available Capital:**

5. **Excess Capital:**

6. **Impact of Stresses on GRC:**

7. **Governance and Validation:**

8. **Prospective Solvency Assessment:**

Overall Section III Assessment—After reviewing and considering each of the key elements individually, develop an overall assessment of the risk capital and prospective solvency of the insurer/group including any concerns or areas requiring follow-up investigation or communication:

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Appendix A – Feedback to Insurer

Feedback to the insurer on the ORSA Summary Report is critical for the compliance and effectiveness of future filings. The purpose of this form is to help the lead/domestic state gather and provide constructive and practical feedback to the insurer.

Positive Attributes:

1.
2.
3.

Constructive Feedback:

1.
2.
3.

Requests for Additional Information:

1.
2.
3.

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Appendix B – Recommended Exam Procedures/Areas for Follow-Up Investigation

In completing a review of the ORSA Summary Report, the lead state/domestic regulator should consider whether certain elements could benefit from focused inquiries and review during an on-site risk-focused examination. In some instances, the analyst may want the examiner to determine through limited testing, if the data provided and processes described in the ORSA Summary Report are consistent with the insurer's actual ERM/ORSA operations. Such procedures and issues can be accumulated here for communication and tracking.

Background Information

1.
2.
3.

Section I - ERM Framework

1.
2.
3.

Section II - Risk Assessment

1.
2.
3.

Section III - Risk Capital and Prospective Solvency

1.
2.

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Appendix C – U.S. Based IAIG Risk Management Assessment Considerations

While the considerations provided in this template are generally applicable to all insurers/insurance groups filing an ORSA Summary Report, there are additional risk management assessment considerations for the supervision of Internationally Active Insurance Groups (IAIGs) that have been incorporated into this template. As such, U.S. lead states functioning as group-wide supervisors should document their assessment of specific IAIG risk management practices here, if not already addressed above.

1. Based on the analyst's review of the ORSA Summary Report and any additional information received, assess whether the head of the IAIG ensures that the risk management strategy and framework (whether located at the Head of the IAIG or within another legal entity of the IAIG) encompasses the levels of the head of the IAIG and legal entities within the IAIG, promotes a sound risk culture, and covers:
    - diversity and geographical reach of activities;
    - nature and degree of risks in entities/business lines;
    - aggregation of risks across entities within the IAIG;
    - interconnectedness of entities within the IAIG; level of sophistication and functionality of IT/reporting systems at the group level; and
    - applicable laws and regulations.

2. Assess whether the risk management strategy is approved by the IAIG Board and implemented at the group level; with regular risk management reporting provided to the IAIG Board or one of its committees.

3. Assess whether the risk management function, the actuarial function and the internal audit function are involved in the risk management of the IAIG and which activities they perform.

4. Assess whether the risk management function coordinates and promotes consistent implementation, with any material differences in practices across the group being clearly documented and explained.

5. Assess whether the risk management function is adequately independent from risk taking activities.

6. Assess whether the head of the IAIG reviews, at least annually, the risk management framework to ensure that existing and emerging risks as well as changes in structure and business strategy are taken into account.
    - Assess whether the group-wide risk assessment framework, or components thereof, is independently reviewed[1] at least once every three years, in order to ascertain that it remains fit for the risk profile, structure and business strategy of the IAIG.
    - Assess whether necessary modifications and improvements are made to risk management framework in a timely manner.

[1] Independent review could be performed by internal audit function, if deemed independent from risk management functions of the group

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7. Assess whether the following key elements are appropriately incorporated and addressed within the IAIG's ORSA framework:
    - The ORSA should describe how risks are managed in a cross-border context across the IAIG. These risks should include at least: insurance risk, market risk, credit risk, liquidity risk, concentration risk, operational risk, group risk and strategic risk. The ORSA should also explain how assets are properly diversified and asset concentration risk is mitigated across the IAIG.
    - Mechanisms to keep track of intra-group transactions that have a significant impact on the IAIG, the risks arising from these transactions and the qualitative and quantitative restrictions on these risks.
    - The ORSA framework measures risks using an economic capital model that takes into account the risks faced in different sectors, jurisdictions and economic environments
    - The ORSA shows both the economic and the regulatory capital at the Head of the IAIG level and it includes a discussion of the fungibility of capital and the transferability of asset within the group
    - Risk measurement includes stress testing, including reverse stress testing and scenario analysis, as appropriate for its risk profile
    - Risk measurement demonstrates resilience of the total balance sheet against plausible macroeconomic stresses
    - Risk measurement also includes an assessment of aggregate investment counterparty exposures and analyzes the effect of stress events on those exposures through scenario analysis or stress testing
    - The ORSA reports on the IAIG's management of liquidity risks and assesses its resilience against severe but plausible liquidity stresses to determine whether current exposures are within the liquidity risk appetite and limits
        - The ORSA demonstrates that the IAIG maintains an adequate level of unencumbered highly liquid assets in appropriate locations, as well as a contingency funding plan to mitigate potential stresses
    - The ORSA discusses at a high-level the severe stresses that could trigger a recovery plan and should summarize the recovery options available. The ORSA should also discuss how the management information systems are able to produce information relevant to the recovery plan on a timely basis.

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Special Note: The following procedures do not supersede state regulation but are merely additional guidance an analyst may consider useful.

Compliance with Reporting Requirements

The following procedures are intended to guide the analyst through a review of the Form F. These procedures do not represent a documentation requirement.

1. Does Form F provide information regarding the following areas that could pose enterprise risk [provided such information is not disclosed in Form B – Insurance Holding Company System Annual Registration Statement]?
    a. Material developments regarding strategy, compliance or risk management affecting the insurance holding company system, or internal audit findings.
    b. Acquisition/disposition of insurance entities and/or reallocation of existing financial or insurance entities within the insurance holding company system.
    c. A change in shareholders of the insurance holding company system that exceed (10% or more of voting securities.
    d. Development in investigations, regulatory activities or litigation that may have a significant bearing or impact on the insurance holding company system.
    e. A business plan of the insurance holding company system and summarized strategies for the next 12 months.
    f. Identify material concerns of the insurance holding company system raised by the supervisory college.
    g. Identify capital resources and material distribution patterns of the insurance holding company system.
    h. Identify any negative movement, or discussions with rating agencies that may have caused, or may cause, potential negative movement in credit ratings and insurer financial strength ratings assessment of the insurance holding company system (including both the rating score and outlook).
    i. Corporate or parental guarantees throughout the insurance holding company system and the expected source of liquidity should such guarantees be called upon.
    j. Identify any material activity or development that, in the opinion of senior management, could adversely affect the insurance holding company system.
2. If the registrant/applicant has not disclosed information listed in procedure 1 above, did the registrant/applicant include a statement that, to the best of his or her knowledge and belief, he or she has not identified enterprise risk subject to disclosure?

Assessment of Form F – Enterprise Risk Report

3. Is the analyst aware of any enterprise risk to the insurer not reported in Form F?
4. Based on the analyst's review of Form F and any additional information related to enterprise risk available (e.g., Form B, other filings), document any material concerns regarding enterprise risk to the group.
5. Do any of the risks identified pose an immediate risk to policyholder surplus or risk-based capital position of insurers in the group?
6. Do any of the risks identified result in material impact to the insurance operations of the group? (e.g., changes in writings, licensure, and organizational structure)?
7. Do any of the risks identified result in material impact to the group's balance sheet, leverage or liquidity?

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For the U.S. lead state:

- ❑ Analysts should update the Group Profile Summary and the Supervisory Plan with the risks identified and results from the Form F review.
- ❑ Analysts should notify the domestic state of any issues that are only relevant to a particular insurance entity in the group and share the relevant information from the Form F with that state in a timely manner.
- ❑ Analysts should communicate to the examiner-in-charge (EIC) any prospective risks identified in the review of Form F that affects the domestic insurer.

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

For the U.S. lead state that is also the group-wide supervisor

- ❑ Contact the holding company seeking explanations or additional information
- ❑ Meet with the holding company management
- ❑ Pursue, as appropriate, within an international supervisory college
- ❑ Other (explain)

For the U.S. lead state that is not the group-wide supervisor

- ❑ Contact the group-wide supervisor, seeking explanations or additional information
- ❑ Contact the holding company directly if deemed appropriate by the group-wide supervisor given the Form F is a U.S. only filing
- ❑ Pursue, if applicable and as appropriate, within an international supervisory college
- ❑ Other (explain)

For a non-lead state

- ❑ Contact the lead state, seeking explanations or additional information
- ❑ Pursue, if applicable and as appropriate, within an international supervisory college (if applicable)

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Review of the Group Capital Calculation

Consideration of the Insurance Holding Company System Structure

As the lead state begins to review the annual Group Capital Calculation (GCC) filing for a particular group, it is important for the lead state to do so with consideration of the existing knowledge of both the organizational structure of the group, including changes in the structure from year to year, but more importantly the overall activities of each of the entities in the group which otherwise have the potential to transmit material risk to the insurers within the group. While the GCC will provide additional quantitative information on the entities in the group, the actual activities of the entities are also important in determining the scope of application of the GCC. The lead state is responsible for determining if any of the entities in the holding company structure should be excluded from the calculation, resulting in a smaller "scope of application" for the entities included in the GCC ratio. The filing includes a column for the group to propose what should be excluded as well as an additional column for the final determination made by the lead state. In general, the determination of scope of the application is suggested by the group but made in consultation and agreement with the lead state. This exercise should be undertaken in a manner that yields a clearly documented rationale for excluding entities or subgroups of the larger group. The *Group Capital Calculation Instructions* describes the basis for making this determination and the calculation itself is structured to facilitate this determination, with the inclusion in Schedule 1 of financial data for all entities within the holding company. Related to exclusion from the calculation itself is review of data for cases in which subgroups are completely excluded from the larger group, particularly with regard to Schedule 1; the rationale for the exclusion(s) should be provided in the Group Profile Summary (GPS). The concept is that this Schedule 1 data should be utilized by the lead state in conjunction with its existing knowledge of the group and its activities (obtained from the Schedule Y, ORSA, Forms B/C, Form F, the non-insurance grid, etc.), and therefore likely material risks, to make this determination. To the extent the entities included in Schedule 1 differ from the analyst's knowledge of the group, further discussion and follow-up should be held with the group.

In the initial year(s) of a GCC filing, to help the analyst get comfortable with the Inventory and Schedule 1 process, consider the following:

- Gather appropriate background information for your group(s) (e.g., GPS, ORSA, RBC Reports, Schedule Y).
- Determine that all Schedule Y entities are listed in schedule 1 or in the Schedule BA list in the other information tab or that an entity's omission is understood / explained.
- Evaluate requests for exclusion of non-insurance/non- financial entities without material risk to determine if you agree with exclusion.
- Confirm that all insurers and financial entities are de-stacked in the inventory tab.
- Determine if grouping has been properly applied.
- Evaluate the level of risk assigned by the filer to financial entities without regulatory capital requirements.
- On a sample basis, check that the numbers reported in Schedule 1 and Inventory Tab look reasonable, especially for the insurers. A sample check should be sufficient.

The holding company structure and activities should also be utilized by the lead state in determining how to understand the GCC ratio. More specifically, information on structure can help in understanding the flow of capital used by the group among entities within the holding company structure. Also, understanding the following can assist in evaluating the flow of capital resources:

- Domestic insurance operations.
- International insurance operations.
- Banking or other financial services operations subject to regulatory capital requirements.
- Financial and non-financial operations not subject to regulatory capital requirements. *

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*The GCC instructions provide examples of financial versus non-financial entities in this category. All financial entities should be included in the scope of application of the GCC. However, there can be a broad array of entities that could be considered financial. The lead state should document the rationale for cases in which it concludes that an entity that may be financial in nature can nonetheless be classified in the group's GCC filing as "non-financial" and thus excluded from the scope of the group for the GCC.

The GCC is intended to be used as an input into the GPS. The expectation is that the GCC summary section will help to document a high-level summary of the analyst's take away of the GCC, as well as the Strategic branded risk. The manner in which the analyst determines what else should be documented beyond the GCC Summary and the Strategic branded risk should be based upon the following steps, since these steps contemplate the previously mentioned concept that the existing evaluation of the financial condition should be used in evaluating the depth of review of the GCC.

The GCC is a new analytical tool for use by regulators, and it will take a number of years before there is both: 1) sufficient data for any given group to provide the trend identification ultimately anticipated for the GCC; and 2) experience by regulators with its use. Analysts should be mindful that any stated threshold in the following procedures is for analysis purposes only and DOES NOT constitute a trigger for regulatory action. Rather, the stated threshold should be used as an opportunity for an analyst to understand issues and concerns that may be emerging and address them with the group, if needed. Nonetheless, the following procedure steps provide analysts with a framework to consider the GCC results in conjunction with other data and tools at their disposal, and to begin to gain and benefit from experience in utilizing the GCC as a new analytical tool.

- Procedure Step 1 suggests that a review of the components of the GCC is appropriate when the GCC ratio is trending downward.
- When Procedure Step 1 identifies the need to look further, Procedure Step 2 suggests determining, at a high level, the drivers of any decreases in the total available capital pursuant to the GCC. While there are numerous benefits of the GCC over consolidated approaches, the ability to drill down on the drivers is one of the more significant benefits and is consistent with the states' approach to not just looking at capital, but to the drivers of capital issues.
- When Procedure Step 1 identifies the need to look further, Procedure Step 3 suggests determining, at a high level, the driver of any increases in operating leverage, which is typically what drives insurance capital requirements up, be it asset risk/leverage or writings leverage. Similar to drivers of capital decreases, the GCC has detailed information on financial figures and ratios that can be used to isolate the issues.
- When either Procedure Step 2 or Step 3 identify the need to understand the situation better, Procedure Step 4 is similar in that it utilizes detailed information on capital allocation patterns used by the group over time that are necessary for the analyst to understand if there are any future negative trends in the GCC.
- When Procedure Step 2, Step 3 and Step 4 together identify the need to understand the situation better, Procedure Steps 5, helps understand the steps the group/company is already taking or plans to take in order to address the issues they feel are appropriate, if any, considering existing capitalization levels may drive the group's evaluation and therefore when steps may not be necessary.
- The guidance in these procedures is not intended to be exhaustive, but rather should give the analyst a starting point in better understanding the various issues.
- If the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document their understanding of the material risks of the group observable from the GCC (as well as the required information to be included in all GPS from the GCC), the rational for this determination should be documented by the analyst in any workpapers deemed appropriate by the state In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner and judgement based upon and existing understanding of the group and existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that decision.

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Procedure Step 1 – Understand the Adequacy of Group Capital

1. Determine if the group capital position presents a risk its insurance subsidiaries based upon its recent trends and/or current measures in the GCC ratio.

	Branded Risk	*Benchmark*
a. Has there been a decrease in the GCC ratio over last two or more years? If "yes", determine the cause(s) of the decline.	ST	a. <-10% (this is not a point change)
b. Has there been a decrease in the GCC total available capital from prior year? If "yes", determine the cause(s) of the decline.	ST	<-10%
c. Has there been a negative trend in the GCC ratio over the past five years suggesting an overall pattern of declining capital?	ST	N/A

If the answer to any of the above questions is "yes", but it is obvious that the negative trend is caused by something such as a restriction on the allowable debt, or a change in a corporate tax rate, or some other factor external to the group's operations, note as such but do not proceed to Procedure Step 2. In addition, if it is obvious that the negative trend is clearly driven from one entity in the group, understand the cause and document as such but do not proceed to Procedure Step 2. However, in all other cases if the answer to any of the above questions is "yes", then the analyst should proceed with Procedure Step 2, understand decreases in total GCC available capital and/or procedure step 3, understand increases in operating leverage to determine the cause(s) of the negative trends.

Procedures Step 2 – Understand Decreases in Total Available Capital

2. Determine the source(s) of decreases in the GCC ratio or the GCC total available capital.

Recognizing that not all declines in capital ratios are necessarily "negative", i.e., they may be the result of sound capital management and Enterprise Risk Management (ERM) to more efficiently utilize capital, approved changes in the scope of application, or changes in underlying authority requirements, the intent of Procedure Step 2 (and Step 3) is to determine the actual source of the negative issues. In most cases, this equates to pinpointing the legal entity(ies) driving any negative trends. The analyst should proceed to Procedure Steps 4 and 5, to understand more fully the actions the group, or the legal entity(ies) driving the negative trends, are already taking or plan to take to address the issues identified in Procedure Step 2 that the group believes is needed. However, the analyst may already have a deep understanding of any such plans, and as a result, in some cases, it is possible that no further follow-up with the group will be necessary and that the lead state should simply update the GPS to be certain the main understanding of the issues is known to all regulators utilizing the GPS.

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	Branded Risk	*Benchmark*
a. Review the ratio of available capital to calculated capital from each of the reported entities and compare to the same ratio from the prior year. Determine which entities may have led to the negative trends.		<-10%
b. If the change in the GCC is not driven from a legal entity, and instead the change in allowable debt, note as such.	ST	N/A
c. Review the levels of profitability for each of the reported entities in the GCC in the current and prior years (as reported in the GCC) to determine if there are particular entities showing losses or signs of material decreasing profitability, which may eventually lead to future decreases in the GCC ratio or total available capital.	OP, PR/UW	<-10%
d. For each of the reported entities showing either 1) a meaningful decrease in the GCC due to a decrease in the total available capital, or 2) material negative profitability trends, request information that identifies the issues by inquiring of the legal entity regulator first or the group itself (e.g., non-insurance company), if applicable.	OP, PR/UW, ST	N/A
e. If due to pricing or underwriting issues, understand if the issues are the result of known pricing policies that are currently being modified or if the business is in runoff, whether new product lines have been developed, geographic or other concentrations, volume/growth business strain, or other issues. When considering pricing that is being modified, include those products for which the price is adjusted through crediting rates.	PR/UW	N/A
f. If due to reserve issues, understand the reserve development trends, whether reserve and pricing adjustments have been made and changes in business strategy apart from those products.	RV, ST	N/A
g. If due to market risk issues—i.e., capital losses—understand not only why the losses occurred, but also the likely near-term impact given current and likely prospective economic conditions. Market issues include not only changes in equity prices, but also impact/exposure to interest rates and other rates such as foreign currency exchange rates or rates on various hedging products used by the group.	MK, CR	N/A
h. If due to strategic issues such as planned growth, planned decline in writings or changes in the investment strategy, utilize the business plan from the Form F to better understand the anticipated changes and how the actual changes compare. Understanding the variance from the business plan is important in assessing the ongoing risk either in projected future profitability or in some cases the investments.	ST, PR/UW, OP	N/A

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i. If due to negative reputational issues, for example, that have adversely affected new business or retention of existing business, understand the issues more closely, whether potential ongoing changes in stock prices or financial strength ratings that may further affect market perception, or what the group is doing to address the potential future impact be it sales projections or access to the capital markets.	RP	N/A
j. If due to credit losses, understand the current and future concentration in credit risks, be it investments, reinsurance, or other source of credit losses.	CR, MK	N/A
k. If due to operational issues, such as extremely large catastrophe events, information technology (IT) or cybersecurity events or relationships, understand the current and prospective impact.	OP, ST	N/A
l. If due to legal losses, understand the underlying issues and degree of potential future legal losses.	LG	N/A
m. If due to non-insurance reported entities in the group, understand the relationship of the non-insurance operations to the insurance entities and the potential impact to the insurance operations (i.e., intercompany agreements, services, capital needs, etc.).	ST, OP	N/A

Procedure Step 3 – Understand Increases in Operating Leverage

3. Determine the source(s) of any decreases in the GCC ratio due to increases in leverage.

Like Procedure Step 2, the intent of Procedure Step 3 is to determine the actual source of the negative issues. The difference between step 3 and step 2 is simply the types of issues. Procedure Step 2 is focused on issues that have resulted in negative capital trends. Step 3; however, is focused on the issues that affect the risk being considered in the GCC. In most cases that risk is either from the asset side or from the liability side where in both cases there has been an increase in such risk that has not been offset by a corresponding or equal increase in capital. In general, this is referred to as operating leverage, where this risk can manifest itself either through increased insurance writings (e.g., the ratio of premiums to capital or liabilities to capital), or through increased assets that also carry risk. The expectation is that other regulated entities also have capital requirements that increase as these different types of risks increase, similar to how the NAIC RBC considers different types of products and assets that carry more risk. It is also possible to have increased leverage outside of the insurance companies and other regulated entities. However, similar to other items noted in this document, such increases do not necessary represent negative trends; the analyst should further understand the drivers of such. In most cases, this equates to pinpointing the legal entity(ies) driving any negative trends. Similar to Procedure Step 2, using an understanding of items in Procedure Step 4, to understand more fully the actions the group, or the legal entity(ies) driving the negative trends already being taken or planned to be taken by the group to address the issues identified in Procedure Step 2 that the group believes is needed.

	Branded Risk	*Benchmark*
a. Review the ratio of available capital to calculated capital from each of the reported entities and compare to the same ratio from the prior year. Determine which entities may have led to	MK, CR, RV, ST, OP, RP	<-10%

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the negative trends based upon corresponding increases in leverage (e.g., writings/capital ratios or liability to capital ratios).		
b. Review the levels of operating leverage for each of the reported entities in the GCC as well as the same for the prior years as reported in the GCC to determine if there are particular entities showing signs of increasing operating leverage which may lead to future decreases in the GCC ratio or total available capital.	MK, CR, RV, ST, OP, RP	<-10%
c. For each of the reported entities contributing to a meaningful decrease in the GCC due to an increase in operating leverage, request information that identifies the issues by inquiring first from the legal entity regulator or the group itself (e.g., non-insurance company), if applicable.	MK, CR, RV, ST, OP, RP	N/A
d. If operating leverage has increased, consider if growth may have resulted from underpriced products or a change in underwriting. Specifically inquire to determine if pricing was reduced to increase sales, or whether the growth is in new product lines or new geographic focus where the group may not have expertise. When considering pricing being modified, include those products that the price is adjusted through crediting rates.	PR/UW, OP, ST	N/A
e. If operating leverage has increased, consider if reserving risk has also increased, through potential underpricing that ultimately manifests itself into reserve adjustments. To do so, obtain current profitability information on the products leading to the increased leverage.	RV	N/A
f. If operating leverage has increased, obtain current information on the asset mix to be certain that there is a corresponding decrease in riskier assets to mitigate the otherwise likely increase in market and credit risk.	CR, MK	N/A

The analyst should proceed to Procedure Step 4 and Procedure Step 5 to understand more fully the actions the group, or the legal entity(ies) driving the negative trend, is already taking or plan to take to address the issues identified in Procedure Step 3, if that is not already clear from the information obtained in Procedure Step 3. However, in some cases, it is possible that no further follow up with the group will be necessary, and that the lead state should simply update the GPS.

Procedure Step 4 – Understand the Capital Allocation Patterns

4. Determine the capital allocation patterns to determine if some entities may put pressure on other legal entities.

Procedure Step 2 and Procedure Step 3 are critical in understanding the issues faced by the group and in identifying the source of negative trends. While additional follow up with the group is expected, before proceeding to Procedure Step 5, the lead state should understand the historical capital allocation patterns within the group and the future capital allocation actions that may be needed by the group if negative trends continue. The GCC includes data on historical capital allocation patterns (e.g., contributed capital

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received/paid or dividends received/paid), which help to illustrate which entities have historically needed more capital and which entities have capital that they have provided other entities in the group. While these patterns do not necessarily repeat themselves from one period to the next, there is often consistency in terms of entities that need capital or have excess capital, which may or may not be driven by losses, or by a change in strategy (e.g., increased writings at one company over another) by the group. These trends can also assist in discussions with the group about where capital may come from as a result of a future unexpected material event. Where similar information is also disclosed in Form F, the detail in the GCC may confirm what is already known by the analyst in this area and in some cases may provide greater detail.

	Branded Risk	*Benchmark*
a. Review the underlying data from the GCC Analytics tab to determine the historical capital allocation patterns within the group and summarize the result of this analysis.	ST	N/A
b. Using this data, as well as any recent information on net losses, or likely expected funding, determine if there may be an impact on the capital available to the insurance entities (either through the likelihood of higher dividends or through less capital being available for infusions).	OP, ST	N/A

Procedure Step 5 – Consider the Need for Company Discussions for Reductions in Risk

5. Determine the group's plans for addressing source(s) of any meaningful decreases in the GCC ratio or total GCC available capital. Please note, that in some cases, the plan may be as simple as actions designed by the group to reverse a single negative trend.

Procedure Step 5 is designed to assist in understanding the group's plans for addressing any meaningful decreases in the GCC ratio or total available capital that were not intended by the group (i.e., that are not the results of capital management so as to efficiently utilize capital while still maintaining sufficient levels for ERM needs). The specific plans of the group may or may not fully address all the issues but to the extent the group believes they have addressed what is needed, ultimately what is most important is that such information and the regulators plan for evaluating and monitoring the situation are known to the other regulators. There is a multitude of possibilities, and this guidance is not intended to address all of those. This includes the possible actions by the group and its legal entities. This also includes the possible actions to be taken by the regulators of the individual legal entities, which may include regulators choosing to put their legal entity into supervision, conservation, or some other form of receivership (which, by necessity and intent, would presumably be done based upon existing legal entity authority since there is no authority provided under the GCC). Similar to other areas, where similar information is also disclosed in Form F, further information may already be known in this area.

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	Branded Risk	*Benchmark*
a. Obtain a copy of the group's most recent business plan and compare it to the prior year plan for variances. (See Additional Procedures below for additional follow-up analysis).	ST	N/A
b. Request information from the group on how it intends to address the issues or negative trends (those that are not planned or due to approved changes to the GCC scope of application or the result of changes in underlying legal entity capital requirements) identified in Procedure Steps 1-3. More specifically, determine how the group intends to decrease risk, and by what means.	ST	N/A
c. Based on information received in Procedure Step 5.b., determine the group's capacity to reduce risks or raise additional capital.	ST	N/A
d. Where the remaining capital is adequate, document the findings in the GPS (or another document) and make available to the supervisory college and or domestic states with the presumption no further action is deemed necessary.	ST	N/A
e. Consider whether the collective information suggests that any of the U.S. legal entity regulators should deem the legal entity to be in a "Hazardous Financial Condition" and take appropriate action to address based upon the facts and circumstances and the provisions of the state's law (similar to the *Model* Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition #385).	N/A	N/A
f. Where appropriate, consider holding a meeting of the supervisory college or of all the domestic states to fully understand the group's plans. Where appropriate, require the group to present its plans to the supervisory college or all the domestic states.	N/A	N/A
g. Where appropriate, determine if the plans proposed by the group are considered inadequate by any of the legal entity regulators, and more specifically if any are considering taking action over their applicable legal entity. If this is the case, hold a meeting of the supervisory college or of all the domestic states to provide this information.	N/A	N/A
h. Where appropriate, consider holding a broader meeting of all impacted jurisdictions in which the group is selling insurance. Where appropriate, require the group to present its plans to all such regulators and for the regulators to announce their plans.	N/A	N/A

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

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Purpose of the Group Capital Calculation (GCC) in Holding Company Analysis

The following information is intended to provide background and context concerning the issues/considerations for analysts when utilizing the NAIC group capital calculation (GCC) for an insurance holding company group (hereafter referred to as "group") completing the GCC where required. The GCC is a tool to quantitatively understand the group's capital and the mathematically calculated risks within the group. The GCC framework is built on the risk-based capital (RBC) model. However, while RBC, as a capital requirement, has triggers in states' laws to take formal actions, the GCC is not designed for that purpose and is instead designed as an analytical tool.

Background Information

In 2008, the NAIC Solvency Modernization Initiative (SMI) began to consider whether there were any lessons learned from the financial crisis that would cause the solvency framework to be modified. The NAIC determined that changes should be made in the area of group supervision, starting with the new annual requirement for the lead state of each group operating in the U.S. to complete a written holding company analysis. Since that time, other changes to state laws have been made to further enhance group supervision (e.g., Form F, Own Risk and Solvency Assessment (ORSA), and Corporate Governance reporting). All of these new tools are inputs into the previously mentioned holding company analysis, which is now summarized into a consistent tool used by all states that is known as the Group Profile Summary (GPS).

Benefits of the GCC and Methods to Achieve Them

The GCC instructions describe the background, intent, and calculation for the GCC in detail. As stated in the GGCC instructions, the GCC and related reporting provides more transparency about a group's structure and related risks to insurance regulators and makes those risks more identifiable and more easily quantified. In this regard, this tool is intended to assist regulators in better understanding the risks that the non-insurance entities may pose to the group and ultimately regulated insurance entities, how capital is distributed across an entire group, and whether and to what degree insurance companies' capital may be put at risk from the operations of non-insurance entities, potentially undermining the insurance company's financial condition. An analyst is not expected to understand non-insurance industries represented within the group but is expected to understand through this calculation if a non-regulated entity could place pressure on or provide relief to a regulated entity.

The manner in which the GCC achieves some of these intentions varies. For example, with regard to understanding how capital is distributed across an entire group, this can be seen in two ways. One is by viewing the tab titled Input 4-Analytics for the display of the "Ratio of Actual to Required Capital". The other is by viewing the same tab for the display of "Required Capital" in a separate column. The degree of capital movement can also be seen in the Input 4-Analytics tab, with the display of the columns as follows: 1) Capital Contributions Received/(Paid); and 2) Net Income. While one year of information can provide insights, a better understanding will be obtainable after further years of the GCC are reported within the template. Once five years of data are displayed in this Input 4-Analytics tab, it will allow the analyst to better understand the financial condition of the group as a whole as well as the risks posed by non-insurance entities in the group. Of course, such conclusions can only be made once the analyst sees the data and understands from the group what is occurring that is leading to such figures.

Recognizing that legal entity supervision and related tools (e.g., RBC) are the primary means to address inadequate capital, the GCC may provide an additional early warning signal to regulators regarding risks or activities of non-insurers within the group that may pose material risk to the insurance operations. This early warning signal can be seen with the trending of the financial information in the Input 4-Analytics tab, as well as through the application of sensitivity analysis in the Input 5 tab and inclusion of other relevant information in the Input 6 tab. However, the analyst should also understand that other qualitative tools, such as the Form F, are capable of also providing early warning signals if properly reported by the group. In addition, since most holding company systems may have a larger percentage of their operations in the insurance businesses, the insurance trends for the U.S.

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insurers in the group should already be known and made available to the lead state by the legal entity regulator(s) of the insurer(s). However, in the context of added policyholder protection, this may largely come into play with respect to the added quantitative data about non-insurers.

The GCC is an additional reporting requirement with important confidentiality protections built into the legal authority to require such reporting. State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to provide regulators with further insights to allow them to make informed decisions on both the need for action and the type of action to take as to the regulated entity, or additional requests for information from other entities. That said, the GCC and its related provisions in the Insurance Holding Company System Regulatory System Regulatory Act (#440) and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group's GCC. Regulators will use other existing tools and authorities to take action, primarily at the legal entity level.

While the new information from the GCC may offer new insights, it is equally important to understand that it will be up to the analyst to work with the insurance group to actually understand what is leading to the figures reported in the GCC, and from that perspective, especially in the early years of the GCC, it will require learning by both the analyst and the group to really be able to utilize the GCC in a manner as suggested in these introductory paragraphs.

Other Considerations When Considering Such Benefits

Unforeseen events and economic conditions (e.g., pandemic, recession, etc.) may also create stresses on a group, reinforcing the value of the quantitative data included in the GCC. Some stresses are similar to those experienced during the financial crisis, and others are more unique. However, because the GCC is based upon a methodology that gets its inputs from individual legal entities, the capital calculated for each legal entity certainly can only capture the allowed capital resources of the legal entities in the group. While such an aggregation-based methodology is an appropriate group-level capital measure, until experience is gained with the GCC, it is not known how the GCC will behave in response to business cycles and various risk events, in part because it only recognizes limited diversification benefits among entities in the group except for the diversification embedded in existing entity specific regulatory capital requirements. And while the GCC is not meant to be used in a way that compares groups to each other, it is also true that it is unknown how it will behave across groups, peers, and even sectors. This is true because of its limited diversification benefit, the differences between group types (mutual vs. stock holding company), grouping of entities, and scope of entities included in the calculation. It is also true because application of jurisdictional accounting principles and use of scalars could have an impact on this as well via the foreign insurer profile of the group. The quantitative data collected in the GCC will evolve as state insurance regulators and groups increase their understanding of the impact on available capital and calculated capital.

The following guidance on the GCC is intended to be utilized in a manner that allows the GCC to enhance group-wide financial analysis and to be used as an additional input into the GPS. The GCC provides the quantification of risk within the group and when combined with the information from the ORSA on the amount of capital needed to run the company's current business model and related risk appetite, it puts the regulator in a much better position to understand the available capital and calculated capital within a group, as well as the financial condition of the group. Both are complementary tools to each other. The ORSA provides management's internal approach to capital management and an understanding of the economics of the group. The GCC provides a standard model that can better enable the analyst to understand where the entire group stands with respect to existing legal entity requirements, as well as broad measures of risk for non-insurers. Analysts should be mindful of the differences between the ORSA and the GCC. For example, in the case of a group with predominantly U.S. operations, the GCC will largely be based on the standard model/RBC of the U.S. subsidiaries. However, the ORSA is not constrained by a standard model and will reflect management's internal approach to capital management

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and may utilize or benefit from an economic capital model, other internal models, stress testing and other means. As a result, while the GCC is an additional input into the GPS, it may provide data and signals that do not align with the risk measures within the ORSA.

Overall Theme of Remaining Guidance

The previous information describes the purpose for considering the GCC within the context of the state's holding company analysis and corresponding GPS. In general, the remainder of this guidance provides more depth to the specific information to be included in the GPS, and it provides the analyst with a basic understanding of the GCC, including why the entities included within the GCC may be a subset of those entities that are within the holding company structure; whether the trends within the GCC suggests questions should be raised with the group's management; whether the underlying data suggests trends exist that should likewise be raised with the group or with the respective legal entity's supervisor; whether the information in the GCC filing is generally aligned with other information available to the analyst, and if not, why not; and whether that evidences other questions or concerns that should be addressed, or how they may already have been resolved. Notably, the purpose of the GCC is NOT to trigger regulatory action. Thus, even though the GCC is intended as a group-wide measure and provides insights as to capital adequacy and risks across the group, any regulatory action would have to result from other information made available to the regulator and based on legislative authority.

Utilization of the Group Capital Calculation in the Lead State's Responsibilities

The lead state is responsible for completing the holding company analysis and documenting a summary of that analysis in the GPS. The depth and frequency of the holding company analysis will depend on the characteristics (i.e., sophistication, complexity, financial strength) of the insurance holding company (group) system (or parts thereof), and the existing or potential issues and problems found during review of the insurance holding company filings.

Similarly, in the analysis of the GCC, the depth of the review in the "five-step process" and specific inquiries will vary based on each group's unique situation. For example, in some groups, little if any work (inquiries of the group) will be done after the first step due to generally positive trends of the ratio over time. In other groups, the analyst may need to proceed through each of the five steps. Exactly how the analyst proceeds through the guidance will be dictated by a multitude of factors and requires judgement. As a result, the steps and sub-procedures should not be used as checklist, but rather as a guide in how to utilize the GCC to increase the analyst's understanding of the group.

GCC Construction That Also Affect its Utilization and Review

Some decision points may be addressed prior to the submission of a GCC template. These include: the scope of application (e.g., whether segments of the holding company system (group) should be excluded for financial conglomerates); whether a limited filing will be allowed (as permitted in Model #440 and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions [#450]); and whether subgroup reporting (as defined in the GCC instructions) of a foreign insurance group will be required. In general, the analytics provided by the GCC will be similar for all entities included in the template. See the primer on the GCC Formula) at the end of this section to better understand these points.

These factors are also a consideration in determining the depth of the analysis of the GCC and subsequent correspondence with the group. Refer to chapter VI.B. – Roles and Responsibilities of Group-wide Supervisor/Lead State for details on responsibilities for completing the GPS.

The utilization of the GCC can be summarized as an additional input into the GPS. More specifically, once the analyst completes their review of the GCC and trend of the ratio, a summary should be incorporated into the GPS to help support the assessment of strategic risk.

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Documentation of Review of the GCC in the Group Profile Summary

The purpose of these procedures is to explain how to document the GCC into the GPS. The following provides an example of a GCC summary that represents the minimum expected input of the GCC into the GPS, with new information reported within the strategic branded risk classification. The other purpose of this section is to determine if more follow-up with the group should be performed and, if so, to assess the information obtained from that additional review. The following is intended to assist in documenting the analyst's understanding of the group's GCC in the GPS.

Group Capital Calculation Summary
Summarize your assessment of the GCC both quantitatively and qualitatively, including any such items as may not be applicable to a branded risk category. For example, it may be appropriate to indicate "*The review of the group's GCC indicated the scope of the application is consistent with the lead state's determination*" and if possible, to summarize succinctly, the general scope of the GCC. For example, "*the GCC includes all U.S. and Bermuda operations, but excludes ABC non-insurance operations in South American countries"*. It may also be appropriate to identify key drivers of risks for the group within the GCC that are discussed later in the branded risk categories, as those risks supplement existing risk assessments derived from holding company analysis or are new risks that warrant further review. "*The group's GCC of 201% in the current year was impacted by a decline in total available capital of $X which is related to group's non-insurance operations in Bermuda and as well as the negative impact of market risks in the U.S. insurance legal entity ratio components, which based on further analysis has resulted from the recent financial market volatility*".

Branded Risk Assessment
Strategic: *The group's GCC is assessed as low-risk and stable and is a positive consideration in the overall assessment of strategic risk. The GCC has generally been reasonable and consistent over the past five years as illustrated in the following table. Additionally, refer to the GCC summary for further details.*

	CY	***PY***	***PY1***	***PY2***	***PY3***
GCC Ratio	*201%*	*207%*	*163%*	*202%*	*197%*

GCC Summary and Strategic Branded Risk Documentation:

The above information documented in a summary section of the GPS and into the strategic branded risk classification is expected to be the primary type of information that is always documented into the GPS. The GCC provides a capital measurement of the group and, consistent with the branded risk categories, should be reported in the strategic risk section. Similar to how RBC for an individual insurance entity is helpful in allowing the analyst to better understand other potential issues, given capital represents a relative measure of cushion for adverse risks, the GCC (and its inclusion in the GPS) helps regulators to understand the same, relative to a group. While the GCC is not a capital requirement, with specified ladders of intervention, each of the insurance legal entity figures are relative to individual company requirements. Therefore, the GCC can provide a relative measure of risks in terms of the minimum capital levels of the insurers.

Other Branded Risk Documentation:

To the extent the GCC ratio is trending negatively, or GCC available capital is decreasing, the analyst may choose to include more information in the strategic branded risk section of the GPS that summarizes any key drivers of such findings if they did not fall into one of the branded risk categories. Those drivers of the change might be documented in other specific branded risk categories – for example pricing/underwriting if driven by group-wide weak insurance underwriting, or reserving if the group-wide drivers were reserve deficiencies, etc. References to other branded risk categories may also be appropriate. However, this may not always occur or be possible for the

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analyst to pinpoint given the multitude of risks within any insurer's regulatory capital requirement formulas. This guidance is simply meant to suggest that if the GCC does in fact appear to show particular trends that are noteworthy on specific risks, further documentation into that (applicable) branded risk may be appropriate.

A determination for when documentation of risks from the GCC into other branded risk categories may be appropriate is driven by whether any of the thresholds in Procedures 1 were met, and by the rest of the GCC information as described in Procedures 2 - 4. The GCC summary is intended to be high-level. Therefore, other more detailed observations from reviewing the GCC should generally not be documented into the GPS unless they are specifically insightful, add to a high-level understanding of the group's financial condition, or are specific to a branded risk category as stated.

Other Considerations:

In addition to the broad guidance provided herein on the documentation of the GCC in the GPS, the analyst should also understand the following more general points that could affect the GCC result for a particular group. Judgement is required when considering these points:

- Asset-liability accounting or economic mismatches may lead to volatility within components of the GCC ratio, and potentially in the GCC ratio as a whole. For instance, if an entity is in a market-based regime, and if economic risks are unhedged, the entity's solvency ratio may fluctuate with economic conditions. As another example, if an insurance entity's liabilities are subject to U.S. RBC and statutory valuations, and if associated hedging is subject to a market-based valuation, volatility may result due to accounting mismatches. The factors that create volatility will be significantly influenced by the accounting standards used in each applicable regime.
- Regime changes may lead to noticeable changes in the GCC ratio that are not necessarily reflective of changes in the entity's underlying business. Regime changes can include changes in valuation, RBC, available capital, tax rates, or the use/discontinuation of permitted or prescribed practices. In some jurisdictions a regime change could involve the use/discontinuation of an "internal model" or "partial internal model," which is a tailored set of risk charges and/or risk correlations and is intended to align insurer and regulatory perspectives of risk and capital.
- The GCC provides a means for analysts to identify non-insurance operations outside of the insurance group and to determine the extent of risk they may pose to the insures within the group. However, in doing so, analysts should understand that findings from review of Form B, Form D and Form F might be equally valuable in these situations.
- When understanding capital requirements for non-insurer financial entities that are not subject to regulatory capital requirements, consideration should be given to the appropriateness of the GCC's capital charge for a specific entity's financial operations (e.g., an entity conducting a large volume or large dollar of complex transactions but with little net revenue or equity).
- When understanding capital requirements for non-insurer/non-financial entities, consideration should be given to the appropriateness of the level of risk assigned to specific entities.

Detailed Observation Documentation:

More detailed observations shall be documented separately from the GPS and in a form not dictated by this handbook. As in all holding company analysis, the level of documentation is determined by the lead state insurance department and is dependent on the characteristics and complexity of the group and its risks. These detailed observations generally need to only note the drivers of trends and/or actions being taken by the group to mitigate risks. In some cases, these points can be easily summarized into the GPS. In other cases, they are too detailed and should be documented instead within a separate document not dictated in form by this handbook. The analyst should not spend time documenting either subtle changes within the GCC or individual company

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movements that do not create a trend at the group level or identify a growing weakness in the group. However, judgment is required to make this determination. For example, a 10% (not point change) decrease in an RBC ratio of one of the smaller insurers within the group generally would not be documented. By contrast, a 10% decrease (not point change) in an RBC ratio in one of the larger insurers in the group that causes, either alone or jointly with other insurers, a 10% decrease in the GCC should be noted. However, it should be understood also that this 10% threshold is not intended to be a used as a "bright-line." In fact, it is possible the 10% is not necessarily indicative of any negative trends at all. This could be the case when for example there was a change in the regulatory capital requirement. Therefore, again, judgement is required in making these determinations and this, as well as other thresholds used in this guidance, are not meant to be bright lines. As the GCC is used more, both by the individual analyst and by the various states, using judgement around these thresholds is expected to become easier as the judgement is informed by experience.

Specific Procedures for Completing Review and Understanding of the GCC

The following procedures should be used by the analyst in their review and documentation of results of the GCC. However, if the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document the material risks of the group observable from the GCC (as well as the required information to be included in the GPS from the GCC), this should be documented by the analyst in any workpapers deemed appropriate by the state along with the general reasons supporting that conclusion. In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner, and judgement based upon existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that decision.

Procedures Step 1

The purpose of Procedures Step 1 is to assess the GCC level, and to identify the drivers of any changes in the GCC, in order to summarize and to document that overall assessment in the GPS and its strategic risk category, which is the minimum expected input of the GCC into the GPS. However, the analyst should understand that in the early years of the GCC, a limited amount of prior year(s) comparative data will be available, therefore requiring more judgement in determining if or where further analysis is warranted. Such judgement may need to be based upon various factors, including but not limited to, other known information regarding the applicable group obtained from other sources (ORSA, Form F, Form B, etc.).

Procedure 1 is also intended to help the analyst determine if more follow-up review work should be performed. However, if the answer to any of the questions in Step 1 is "yes", the analyst should proceed with Step 2, Understand Decreases in Total Available Capital and/or Step 3, Understand Increases in Operating Leverage to determine the cause(s) of the negative trends. In the example provided above, the trends are positive with no decreases in the base ratio except in PY1; presumably, the analyst may have performed some level of inquiry to the holding company to understand the driver of the drop.

Procedures Step 2a - 2m

Unlike Step 1, the intent of Step 2 (and Step 3) is to determine the actual source of the negative issues and where they should be documented in the GPS. Procedure Step 2a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at the ratio of actual-to-required capital for the legal entity insurers over the available years reported. The following sample of a table from the GCC calculation completed by the group from the data in Schedule 1 can be helpful in determining the source of the issues.

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Insurance Capital Table Template Groupings		Ratio of Actual to Required Capital				
		2025	2025	2023	2022	2021
		[1]	[2]	[3]	[4]	[5]
RBC Filing U.S. Insurer (P/C)	[1]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Life)	[2]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Health)	[3]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Captive)	[4]	XXXX	XXXX	XXXX		
Non-RBC Filing US. Insurer	[5]	XXXX	XXXX	XXXX		
Canada - Life	[6]	XXXX	XXXX	XXXX		
Canadian – P/C	[7]	XXXX	XXXX	XXXX		
Bermuda - Other	[8]	XXXX	XXXX	XXXX		
Bermuda - Commercial Insurers	[9]	XXXX	XXXX	XXXX		
Japan - Life	[10]	XXXX	XXXX	XXXX		
Japan - Non-Life	[11]	XXXX	XXXX	XXXX		
Solvency II - Life	[12]	XXXX	XXXX	XXXX		
Solvency II -- Composite	[13]	XXXX	XXXX	XXXX		
Solvency II - Non-Life	[14]	XXXX	XXXX	XXXX		
Australia - All	[15]	XXXX	XXXX	XXXX		
Switzerland - Life	[16]	XXXX	XXXX	XXXX		
Switzerland - Non-Life	[17]	XXXX	XXXX	XXXX		

Procedure Step 2b recognizes that the GCC does allow some debt to be included in capital up to a predetermined limit and can drive the overall GCC ratio. The following sample table taken from the GCC calculation using the data in Schedule 1 can be helpful in making this determination. Cases where debt is issued to address risk-driven reductions in the GCC ratio may not offset those reductions. This data metric may not be available in the case of a "limited filing".

Debt/Equity Table Template Groupings		Debt/Equity ($)				
		2025	2024	2023	2022	2021
		[1]	[2]	[3]	[4]	[5]
Total	[8]	XXXX	XXXX	XXXX	0	0

Procedure Step 2c recognizes that profitability (e.g., net income/net loss) is generally one of the biggest drivers of changes in capital, and utilizing the following table from the GCC can assist in identifying if there are entities reporting net losses that may be driving the decreases in capital. The following table taken from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues.

Income & Leverage Table Template Groupings		Net Income ($)					Return on Capital				
		2025	2024	2023	2022	2021	2025	2024	2023	2022	2021
		[1]	[2]	[3]	[4]	[5]	[1]	[2]	[3]	[4]	[5]
US Ins	[1]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Non-US Ins	[2]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Non-Financial Entities	[3]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Bank	[4]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Asset Manager	[5]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		

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Other Financial with Capital Requirement	[6]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Financial Entities without Capital Requirements	[7]										
Total	[8]	XXXX	XXXX	XXXX	0	0	XXXX	XXXX	XXXX		

If the source of the issues is the insurers, the following sample from a table from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues among the insurers.

Core Insurance Table 1		**Net Income ($)**					**Return on Capital**				
Template Groupings		**2025**	**2024**	**2023**	**2022**	**2021**	**2025**	**2024**	**2023**	**2022**	**2021**
		[1]	[2]	[3]	[4]	[5]	[1]	[2]	[3]	[4]	[5]
RBC Filing U.S. Insurer (P/C)	[1]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Life)	[2]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Health)	[3]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Captive)	[4]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Non-RBC filing US. Insurer	[5]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Canada - Life	[6]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Canadian – P/C	[7]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Bermuda - Other	[8]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Bermuda - Commercial Insurers	[9]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Japan - Life	[10]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Japan - Non-Life	[11]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Solvency II - Life	[12]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Solvency II -- Composite	[13]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Solvency II - Non-Life	[14]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Australia - All	[15]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Switzerland - Life	[16]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Switzerland - Non-Life	[17]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		

Procedure 2d is focused on requesting more specific information from the legal entity regulator or the group to better identify the source of the issue(s). Procedures 2e - 2l simply contemplates that if the source of the issues can be identified into one of the branded risk categories, it should be documented in the detailed workpapers and into the appropriate branded risk category of the GPS. However, it is recognized that the source of issues may be in multiple branded risk categories, in which case documentation of each of the sources into the detailed workpapers is still appropriate. However, documentation into one of the single branded risk categories of the GPS is only appropriate if that risk category is a material driver of the negative trends. Procedure 2m is intended to identify if the source of the issues is related to non-insurance operations. The GCC is intended to provide for more consistent analysis of risks to an insurer that may originate from non-insurance entities within the holding company system.

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Procedures Step 3a - 3f

Procedure 3a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at indicators of leverage, e.g., leverage ratios, where this risk may manifest itself either though increased writings or exposure, or through increased balances relative to capital and surplus. The following sample of a table from the GCC calculation using the data in Schedule 1 can be helpful in determining the source of the issues.

Insurance Leverage Table		Net Premium Written ($)					Liabilities ($)/Capital & Surplus				
Template Groupings		2025	2024	2023	2022	2021	2025	2024	2023	2022	2021
		[1]	[2]	[3]	[4]	[5]	[1]	[2]	[3]	[4]	[5]
RBC Filing U.S. Insurer (P&C)	[1]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Life)	[2]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Health)	[3]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Captive)	[4]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Non-RBC filing US. Insurer	[5]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Canada - Life	[6]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Canadian - P&C	[7]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Bermuda - Other	[8]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Bermuda - Commercial Insurers	[9]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Japan - Life	[10]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Japan - Non-Life	[11]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Solvency II - Life	[12]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Solvency II -- Composite	[13]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Solvency II - Non-Life	[14]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Australia - All	[15]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Switzerland - Life	[16]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Switzerland - Non-Life	[17]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Hong Kong - Life	[18]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Hong Kong - Non-Life	[19]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Singapore - All	[20]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Chinese Taipei - All	[21]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
South Africa - Life	[22]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
South Africa - Composite	[23]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
South Africa - Non-Life	[24]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Mexico	[25]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
China	[26]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
South Korea	[27]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Malaysia	[28]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Chile	[29]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		

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Brazil	[30]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
India	[31]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
Other Regime	[32]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		
TOTAL	[33]	XXXX	XXXX	XXXX			XXXX	XXXX	XXXX		

Procedure 3b is more forward-looking by suggesting the analyst look at the same leverage ratios used in Procedure 3a to determine if the trends might continue and lead to further decreases in the GCC ratio. Procedure 3c simply requests the analyst use the leverage information to target questions to the group to better identify the drivers. Procedure Steps 3d - 3f are all questions designed to help the analyst consider whether the changes in leverage will lead to greater underwriting risk, reserving risk, or market and credit risk. Procedures 3d - 3f provide general inquiries for additional information for the analyst. However, these inquiries may also appropriately provide a basis for the analyst to hold conversations with the group on the same topics to understand how the group views these topics and how the group is managing and monitoring these risks. For groups filing an ORSA, see also documentation within the ORSA report for additional information on the identified risks and the group's monitoring of risks, as well as consistency of the discussion with management and management's observations in the ORSA Summary report.

Procedures Step 4a - 4b. Procedure Step 4a is intended to help the lead state understand the historical capital allocation patterns or the likely future needed capital allocation patterns by simply documenting those in the detail analysis workpapers. This includes, for example, noting that there is consistency in the entities generating net income and distributing it further through the group, in some cases, this may require distribution through other insurers, which in the U.S. often requires approval if considered extraordinary. Procedure 4a is intended to utilize that knowledge, along with other planned actions of the group, to understand whether problems with repaying debt or other obligations in the group could occur. The intent is to be in a better position for discussions with the group on where the group may expect capital to come from to support future expected activity or future unexpected material events. The following sample of tables from the GCC calculation using data in Schedule 1 can be helpful in determining the source of the issues.

Insurance Capital Table		**Capital Contributions $ Received/(Paid)**				
Template Groupings		**20254**	**2024**	**2023**	**2022**	**2021**
		[1]	[2]	[3]	[4]	[5]
RBC Filing U.S. Insurer (P/C)	[1]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Life)	[2]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Health)	[3]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Captive)	[4]	XXXX	XXXX	XXXX		
Non-RBC filing US. Insurer	[5]	XXXX	XXXX	XXXX		
Canada - Life	[6]	XXXX	XXXX	XXXX		
Canadian – P/C	[7]	XXXX	XXXX	XXXX		
Bermuda - Other	[8]	XXXX	XXXX	XXXX		
Bermuda - Commercial Insurers	[9]	XXXX	XXXX	XXXX		
Japan - Life	[10]	XXXX	XXXX	XXXX		
Japan - Non-Life	[11]	XXXX	XXXX	XXXX		
Solvency II - Life	[12]	XXXX	XXXX	XXXX		
Solvency II -- Composite	[13]	XXXX	XXXX	XXXX		
Solvency II - Non-Life	[14]	XXXX	XXXX	XXXX		
Australia - All	[15]	XXXX	XXXX	XXXX		
Switzerland - Life	[16]	XXXX	XXXX	XXXX		
Switzerland - Non-Life	[17]	XXXX	XXXX	XXXX		

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Insurance Capital Table Template Groupings		Intragroup Dividends $ Received/(Paid)				
		2025	2024	2023	2022	2021
		[1]	[2]	[3]	[4]	[5]
RBC Filing U.S. Insurer (P/C)	[1]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Life)	[2]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Health)	[3]	XXXX	XXXX	XXXX		
RBC Filing U.S. Insurer (Captive)	[4]	XXXX	XXXX	XXXX		
Non-RBC filing US. Insurer	[5]	XXXX	XXXX	XXXX		
Canada - Life	[6]	XXXX	XXXX	XXXX		
Canadian – P/C	[7]	XXXX	XXXX	XXXX		
Bermuda - Other	[8]	XXXX	XXXX	XXXX		
Bermuda - Commercial Insurers	[9]	XXXX	XXXX	XXXX		
Japan - Life	[10]	XXXX	XXXX	XXXX		
Japan - Non-Life	[11]	XXXX	XXXX	XXXX		
Solvency II - Life	[12]	XXXX	XXXX	XXXX		
Solvency II -- Composite	[13]	XXXX	XXXX	XXXX		
Solvency II - Non-Life	[14]	XXXX	XXXX	XXXX		
Australia - All	[15]	XXXX	XXXX	XXXX		
Switzerland - Life	[16]	XXXX	XXXX	XXXX		
Switzerland - Non-Life	[17]	XXXX	XXXX	XXXX		

Procedures Step 5a - 5h. Procedures 5a-5h are designed for those uncommon situations where the group believes they need to reduce risk because raising capital may be unlikely (see the appendix for further discussion on that topic). Before performing this procedure, Procedure Step 2 (Evaluating Decreases in Total Capital) and Procedure Step 3 (Evaluating Increases in Operating Leverage) will have already been performed to determine whether capital is decreasing, or operating leverage is increasing. As such, after considering information that may already be available to the regulator on the business plan, Procedure 5b is largely focused on better understanding directly from the group the group's reaction to the apparent negative trends. The analyst should understand that some of these trends may have already been known, through, for example, the ORSA review and discussions of the ORSA by the lead state. In fact, the key takeaways may already be documented in the GPS and, therefore, the remaining procedures in this section may be irrelevant and could be skipped if recently considered and understood. In addition, such trends from Procedure Step 2 and Procedure Step 3 may suggest no additional information is necessary. It is for this reason that the first procedure is focused on the group's existing business plan as it is possible these trends may have been expected. Further, Procedure Step 5a is based on the belief that reducing risk by the group may have been previously incorporated into the group's latest business plan, which may have been obtained from the Annual Form F Filing.

Procedure Step 5b, on the other hand, contemplates that the manner to address any unexpected negative trends may not have been incorporated into the latest business plan and thus further contemplates that the analyst speaks with the group or identified insurer causing the negative trend to understand how the issue is to be addressed. However, it should be recognized that some trends that may appear to be "negative", e.g., a decline in the reported GCC, may be due to the result of a conscious decision by the group to more efficiently deploying capital while remaining at sufficient levels from an enterprise risk management (ERM) perspective. This procedure is not meant to suggest action **must** be taken by a regulator, but only to help the analyst understand whether a trend is in fact "negative" or not, and if so, what the group has already decided or plans on doing to address the issue, if anything, and appropriately document. Some of what the group is currently doing may already be known by the lead state, either through the ORSA, the Form F, or a periodic meeting with the group that some states conduct annually. However, the procedure provides an opportunity for the analyst to ensure they understand the drivers and what, if anything, the group is already doing to address the underlying issues as the group thinks is appropriate. To be clear, increases in operating leverage are often planned, and often come with expected future

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actions by the group, such as capital injections or future transactions that may reduce risk. On the other hand, decreases in capital sometimes are not expected, and may not result in immediate action, but it is possible that they may lead the group to contemplate future actions to take. Therefore, these discussions would allow these potential actions to be better understood by the analyst and documented.

Procedure Step 5c contemplates assessing if the group has the ability and resources to either reduce its risks or to raise additional capital. See the section below for further considerations of the group's capacity to raise capital. This procedure is not intended to suggest the analyst has the capacity to make this determination on their own, but rather to question the reasonableness of the possibility. Further, the GCC and related provisions in Model #440 and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group's GCC; regulators will use other existing tools and authorities to take action, primarily at the legal entity level.

Procedure Step 5d contemplates that the group or legal entity may believe no action is necessary because it believes current capital is adequate to meet its business plan, which is more likely to be the case when a one-time reduction of capital as opposed to a growth in leverage that may continue. Procedure 5e is for the rare situation where the legal entity insurers have been strained or face impending pressure contemplated within the *Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition (#385)* that would suggest one or more of the insurers may be in a hazardous financial condition. Procedure Step 5f is designed to suggest the analyst bring the collective supervisors of the legal entity insurers together for a supervisory college to fully understand what is occurring and the identified legal entity's plans for addressing the underlying issues. Procedure Step 5g is an extension of Procedure Step 5f as it contemplates the regulators discussing whether the proposed actions from the legal entity(is) in the group are adequate. This action could represent something either informally done before an insurer is in a regulatory action level, or formally once an insurer is in a regulatory action level. Procedure Step 5h is similar to the other actions contemplated within a supervisory college or, for example, to address a troubled insurance company under accreditation requirements regarding communication with other states.

Additional Procedures – Business Plans

While there is a multitude of possibilities that are beyond the scope of this guidance to address, the following provides some of the related issues that may be helpful to the analyst to consider.

Group's Business Plan (or collective legal entities):

Planning Process:

- Understand the overall planning process (who is involved, how frequently it occurs, etc.) and how the overall initiatives are determined.
- Understand the estimate of the impact of the proposed actions on financial results.
- Review the plan's assumptions for reasonableness. Consider the likelihood of variations in the assumptions and the resulting impact on the future financial results.
    - Consider subcategories of changes including:
        - Overall potential changes in investment strategy.
        - Overall potential changes in underwriting strategy or risk concentrations.
        - Overall impact on financing matters (e.g., debt, requirements, etc.).
        - Overall impact on derivatives to mitigate economic conditions.

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- Overall changes in governance or risk management procedures.
- Increased ceded reinsurance transactions (common approach to reducing risk/increasing surplus):
    - Details regarding the revised strategy.
    - Specifics on types of coverage such as assumption reinsurance, loss portfolio transfers.
    - Transfer of risk considerations.

Variances to Projections:

- Consider the history of explanations regarding variances in projected financial results and the insurer's actual results. If analysts determine the goals of the business plan are not attainable and/or projections are unreasonable, a revised business plan may be requested.
- Identify any internal or external issues not considered in the plan that may affect future financial results. Examples of such issues include the following: 1) the existence of competitors to limit future sales levels; 2) recent state legislation restricting the company's product designs; or 3) the loss of key marketing personnel.

Evaluating a Business Plan:

Analysts should consider further detail where necessary in evaluating the proposed revised business plan but also monitor, on a periodic basis, the insurer's progress in achieving the initiatives included in the group's plan. Assuming that the analyst has determined that a decline in the GCC is material and considered a negative event, i.e., it was not the result of capital management and planning to more efficiently utilize capital while staying within sound levels to achieve ERM objectives, the goal of the plan would then be to address the underlying causes that led to the issues and an improvement in subsequent GCC ratio results. Detail considerations for improving the plan may include the following (where considered inadequate):

- Trending comparative measures of targeted risk exposures including (where applicable):
    - Asset mix by detailed types.
    - Credit risk by detailed types.
    - Business writings/ratios by detailed product.
- Impacts on financing items:
    - Projected cash flow movements for ongoing principal and interest payments on debt.
    - Impact on debt interest coverage ratio, other debt covenants, and rating agency ratings.
    - Discussion of impact on parental guarantees and/or capital maintenance agreements.
    - Expected source and form of liquidity should guarantees be called upon.
- Impact of reasonable possible stress scenarios
- How the individual legal entities' capital will be maintained at required levels.

Consultation with Other Regulators

- Consult with members of the supervisory college (if applicable) or other domestic states for input in evaluating the revised business plan.

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Considerations Regarding Ability of the Entities in the Group to Raise Capital

The following is designed simply as a reminder of considerations the lead state would contemplate when discussing the group system response to the issues identified in this section. More specifically, in most situations a group will first consider ways to reduce risk. In limited situations, it may consider trying to raise additional capital. While this is typically not an option for a group that is currently not performing as it anticipated, in some situations, alternative sources of capital may be raised if the holders of the newly issued equity securities are given rights that are attractive to the holder. In addition, in some cases, the group may have the ability to issue other forms of capital (e.g., debt), which can be used to inject into the insurance subsidiaries. While these facts are not unique to the utilization of the group capital calculation, they are worth a reminder along with relevant other related details.

New Equity Considerations

Public Holding Company
While no two groups are the same, issuing public stock may be limited for the reasons previously identified. In addition, regulators are reminded that a public holding company may be obligated to pay dividends in order to maintain the expectations of their shareholders, making the reduction of risk a more viable action under the circumstances.

Private Holding Company
While no two groups are alike, a private company has some of the same characteristics as a public company in terms of owners' expectations, but usually such expectations differ from a public company, and it may be more feasible for a private company given their access to specific individuals that may have a higher interest in additional capital rights.

Mutual Insurance Company
A mutual insurer is limited in terms of its access to capital because it cannot issue new stock, but it can issue surplus notes.

Mutual Holding Company
Because mutual holding companies have characteristics of both public companies and mutual companies, there are implications of how such a structure affects its operations.

Non-profit Health Company
Insurers that are non-profits are generally charitable organizations, and it is not uncommon for some types of insurers, particularly those that provide health insurance, to have some history as a non-profit. It may be helpful to understand these types of dynamics when considering a group structure.

Fraternal Associations
Regulators often find similarities between a fraternal benefit society and a mutual insurer because both can be limited in terms of their ability to raise additional funds, but they can issue surplus notes. If allowed within state law and the charter, the fraternal could assess members or adjust members policy values.

Reciprocal Exchanges
Regulators often find similarities between reciprocal exchanges and fraternal benefit societies and mutual insurers because they can be limited in terms of their ability to raise additional funds. Although this is a general consideration for the regulator when evaluating the group system, there is generally much more that must be understood because in some cases, the reciprocal may be able to assess policies that can serve a similar purpose as raising capital.

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New Debt Considerations

Through discussions with the group, understand the potential impact of any new debt on the group system, including specifically the extent of future additional reliance on the insurance operations and whether those insurers have the capacity for such. Also consider an updated review of the following:

- Total debt service requirements.
- Revenue streams expected to be utilized to service the debt.
- Any new guarantees for the benefit of affiliates.
- Any new pledge of assets for the benefit of affiliates.
- Any new contingent liabilities on behalf of affiliates.

General Holding Company Considerations

International Holding Company Structure

This section is applicable only to those international groups that are required to complete the GCC, which may be relatively few considering many international holding companies have a non-U.S. groupwide supervisor and are exempt from the GCC. Those foreign groups that are required to complete the GCC will generally file a "subgroup" GCC that includes insurance entities that are part of the group's U.S. operations. In those situations, the analysts should understand the structure to determine if it has any impact on this analysis. Analysts should direct any regulatory concerns to the appropriate organization contact to ensure a prompt reply or resolution. In some organizations, the appropriate organization contact will often be associated with the U.S. insurance operations, while in others, an advisory board may have been established to communicate with regulators.

Capital/Operational Commitment to U.S. Operations

Some holding companies may consider their U.S. insurance enterprises non-core and may be less invested in their ongoing business operations or financial support. Analysts should be aware of a holding company's stated commitment to ensure the continued stability of U.S. insurance operations. This commitment may include a written or verbal parental guarantee.

Primer on the Group Capital Calculation Formula

The National Association of Insurance Commissioners (NAIC) began development of the GCC in late 2015 following extensive deliberation on potential measurement models and methodologies. The GCC uses a bottom-up aggregation approach, accounting for all available capital/financial resources, and the required regulatory capital based on the measurement of assets and liabilities of the various corporate entities, including insurers, other financial entities, and non-financial businesses.

The Group Capital Calculation Aggregation Methodology

As illustrated in the sample tables above, the proposed GCC is an aggregation or grouping of the available financial resources and calculated capital of all legal entities that potentially could pose material risk to the insurers in the group. The GCC allows some discretion in determining what entities are under common control but outside of the defined insurance group may be excluded from the scope of application in the GCC. When reviewing a group's choice of entities to be excluded from application of the GCC, the following points should be considered:

- The regulatory evaluation should be based on the criteria for material risk (e.g., structural separation, no history of cross subsidies, or other criteria as defined in the GCC instructions).
- Group requests for reducing the scope of application of the base GCC should be based on supporting information and a rationale provided by the group.
- Information on excluded entities should be made available upon request from the analyst.

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The GCC includes the following types of entities (listed with the general approach of calculated capital toward each):

U.S. Insurers – The available capital of U.S. domiciled insurers is determined by Statutory Accounting Principles (SAP) as defined by state law and the NAIC Accounting Practices and Procedures Manual, which defines assets, liabilities, and net available capital/financial resources, sometimes referred to as policyholder surplus. The calculated capital for these insurers is subject to state law that requires these insurers to maintain minimum capital based on the applicable NAIC RBC formula at 200% x Authorized Control Level.

Non-U.S. insurers – Similar to the available capital and calculated required capital of U.S. insurers, the available and calculated capital of non-U.S. insurers is determined by reference to the home jurisdiction's basis of accounting and capital requirements converted to U.S. dollars. While most non-U.S. jurisdictions do not possess the same level of industry specific technical guidance as included in the NAIC AP&P Manual, all jurisdictions have established accounting standards that insurers are required to follow to determine available capital/financial resources. In some cases, this represents local Generally Accepted Accounting Principles (GAAP), which may or may not be consistent with International Financial Reporting Standards (IFRS).

DRAFTING NOTE: While the GCC utilizes the available capital and home jurisdictions' capital requirement, for jurisdictions where data is available, the use of appropriate scalars is currently being explored to produce more comparable measures for risk that can be aggregated into the group-wide measure. One such scaling methodology is included as part of a sensitivity analysis in the GCC template. That scalar methodology uses aggregated data from the U.S. and other jurisdictions at the first intervention level to recognize that (for example) state regulators often have much higher reserve requirements, incorporating amounts that are required to be carried as capital in other jurisdictions. For jurisdictions where the data is not available, the full jurisdictional requirement at the first intervention level is used.

U.S. Insurers Not Subject to RBC – Some types of U.S. insurers are not subject to an RBC formula (e.g., Financial Guaranty Insurers, Title Insurers). For these entities, the available capital/financial resources are determined by reference to state law and the NAIC AP&P Manual. However, since an RBC formula does not exist, calculated capital is determined by reference to the minimum capital requirements set out in state law (or 300% of reserves for Title insurers). For U.S. captive insurers, available capital is determined based upon the states accounting requirements, but the calculated capital is required to be calculated using the applicable RBC formula even if RBC does not apply to that entity in its state of domicile.

Banking or Other Financial Service Operations Subject to Regulatory Capital Requirements – Non-insurers such as banks are subject to their own regulatory valuation methods (typically GAAP with tiering of available capital) and their own regulatory capital requirements (e.g., Office of the Comptroller of the Currency (OCC), Federal Reserve, Federal Deposit Insurance Corporation (FDIC), or other requirements for banks). These regulatory values are used for the GCC.

- Financial and non-financial operations not subject to regulatory capital requirements – In general, financial entities (as defined in the GCC instructions) are subject to a higher capital charge in the GCC than the non-financial entities. However, the GCC does require available capital/financial resources and calculated capital to be gathered for all such entities that pose a material risk to insurers. In both cases, the GCC will utilize the valuation used by such legal entities (typically U.S. GAAP) and a calculated capital based upon a risk factor. All entities within the defined insurance group (definition included in GCC instructions) must be included.
- All financial entities (definition included in GCC instructions) must be included.
- The level of risk (low/medium/high) and associated capital calculation assigned to a financial entity will be selected by the group and evaluated by the lead -state reviewer.

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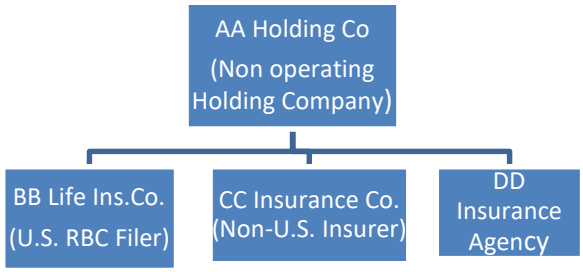
- Non-financial entities that are subsidiaries of U.S. insurers, foreign insurers, or banks where a capital charge for the non-financial entity is included in the regulated parent's capital formula will remain with the Parent and will not be inventoried. Regulators already have access to the financials of these entities if needed (if causing unrealized losses within the insurer).

Eliminations - The GCC uses an aggregation and elimination approach, where each of the above legal entities' available capital/financial resources and calculated capital are combined, and then eliminations are utilized to prevent any double counting of available capital/financial resources or calculated capital. The following example illustrates the use of eliminations for both available capital/financial resources and calculated capital. However, in practice, the GCC only requires the foreign insurers and other financial entities owned by an insurance company to be "de-stacked", so if AA Holding Company was a U.S. insurer (e.g., AA Insurance Company), the capital required and calculated capital for DD Insurance Agency as a nonfinancial entity would remain in the values of AA Insurance Company and not be de-stacked.

EE Insurance Group (EEIG)



EEIG Financial Information

Entity	Total Available Capital	Minimum Regulatory Capital
AA Holding Company	50.0 million	0[2]
BB Life Insurance Company	30.0 million	3.0 million[3]
CC Insurance Company	6.0 million[1]	1.6 million[3]
DD Insurance Agency	2.0 million[1]	0[2]

Calculation of ARC

Entity	TAC	Less: Subs' TAC	Adjusted TAC
AA Holding Co.	50.0M	(38.0M)[1]	12.0M
BB Life Insurance Co.	30.0M	0	30.0M
CC Insurance Co.	6.0M	0	6.0M
DD Ins. Agency	2.0M	0	2.0M
ARC (EEIG Group Total)			**50.0M**

[1] Amount of TAC for Subs as follows: (30.0M + 6.0M + 2.0M)

[1] For non-RBC filers this is regulatory available capital or stockholder equity
[2] There is no regulatory capital for these entities when owned by a non-regulated entity. Calculated capital is added @ 10.5% x stand-alone ARC
[3] Authorized Control Level (ACL) RBC or Prescribed Capital Requirement for non-U.S. insurers

Calculation of MRC

Entity	ACL or Calculated Capital[1]	Less: Subs' Calculated Capital	Adjusted Calculated Capital	Multiply by 2.0[3]	MRC
AA Holding Co.	6.07M	(4.81M)[2]	1.26M	NA	1.26M
BB Life Ins. Co.	3.0M	0	3.0M	6.0M	6.0M
CC Insurance Co.	1.6M	0	1.60M	NA	1.6M
DD Ins. Agency	0.21M	0	.21M	NA	0.21M
MRC Total					**9.07M**

[1] Estimated post covariance factor of 10.5% @ CAL x ARC per GCC added for AA Holding Co. and DD Ins. Agency
[2] Amount of Calculated Capital for Subs as follows: (3.0M +1.6M + .21M)
[3] Applies to U.S. insurer only to increase level to Company Action Level (CAL) RBC

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In the above example, available capital/financial resources are referred to as available regulatory capital (ARC) and total authorized capital (TAC1), and minimum calculated capital is referred to as minimum regulatory capital (MRC) and authorized control level (ACL2). The GCC will allow non-insurance/non-financial entities owned by RBC filers in the group to remain within the available capital and calculated capital of the parent, so no eliminations are required for these entities. As shown, since AA Holding Company owns each of the other business entities in the organizational chart, $38 million (which is the amount of available capital/financial resources in the subsidiaries of AA) is eliminated from the TAC column since accounting methods include those as an asset on AA Insurance Company's balance sheet. Also, the GCC includes capital calculations for AA Holding Company and DD Insurance Agency as part of the MRC in addition to the regulatory capital already included for the insurance subsidiaries. The MRC of the subsidiaries is eliminated from the parent's (AA Holding Company) calculated capital. Therefore, in this example, $4.81 million of calculated capital is eliminated from the MRC. Finally, the MRC of U.S. insurance subsidiary is multiplied by 2 in order to reflect Company Action Level (CAL) RBC as required in the GCC.

Debt – It is important to note that the available capital used in deriving the GCC recognizes a portion of the group's senior and hybrid debt as capital. This allowance recognizes that debt that is not already recognized as available capital/financial resources under all known accounting principles (SAP, U.S. GAAP, or IFRS) may have some value to the group under the U.S. insurance regulatory requirements where debt proceeds are contributed down to the insurance companies and where extraordinary dividends must be approved by the state. Qualifying debt along with limitations thereon are described in the GCC instructions as is the calculation for the additional available capital. In addition to looking at the group's debt leverage, consideration should be given to how the allowance for additional capital from debt interacts with changes in available capital and capital requirements from year to year. The impact of procyclical changes in the allowance for debt as capital should be assessed.

Other Information Included in the GCC – The GCC includes selected financial information (net income, premiums, liabilities, debt, etc.) that is captured in Schedule 1 and in the "Analytics" tabs of the GCC, which is meant to be used to help isolate potential strengths and weaknesses of the group and more specifically where such exist among the entities in the group. Some important information related to other features in the GCC also should be considered and are discussed below. Schedule 1, a simplified version of the Inventory tab, and most analytics are required in the case of a limited filing. However, data is not required for the Capital Instruments, Sensitivity Analysis, and Other Information tabs in a limited filing.

Grouping - The GCC separately allows certain financial entities (e.g., asset managers) and non-financial entities included in the GCC to have their values and capital calculation combined (grouped) for more efficient reporting and analysis. Although the GCC instructions set parameters for such grouping, the general expectation is that regulators will work with each applicable GCC filer in determining where grouping is and is not appropriate outside of what is allowed within the GCC instructions. Grouping should be viewed in the context of materiality. A single entity conducting a given activity may not be material, but when all entities conducting the same activity are combined, they may then be material.

Excluded Entities – The GCC provides two mechanisms for the exclusion of non-financial entities in Schedule 1 and in the Inventory tab at the discretion of the lead state. State regulators should consider whether any of the information collected in the GCC template should be collected for an entity or group of similar entities that would otherwise be excluded from the GCC ratio calculation. Regulators should separately monitor increases in the level of activity of an "excluded" entity or group of similar entities for purposes of materiality and potential subsequent inclusion in the GCC.

Sensitivity Analysis – A tab devoted to sensitivity analysis is included in the GCC. These informational items provide the regulator with impact of discretion in excluding listed entities and alternative perspectives on risk

[1] Terminology used in RBC for available capital/financial resources.
[2] Terminology used in RBC for calculated regulatory capital.

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charges for non-financial entities and foreign insurers. Monitoring these items can help the regulator identify areas where the GCC may be improved, or where capital calculations may be adjusted in the future. One item included in the sensitivity analysis is a "sensitivity test" that increases the overall calibration of the calculated capital in the GCC from its normal 200% x ACL RBC calibration to 300% x ACL RBC.

Accounting Adjustments - The impact of accounting adjustments and related detailed information is collected in the GCC template in the Inventory tab and in the Other Information tab, respectively. Such adjustments can be material during the de-stacking process. For example, a consolidated holding company may include GAAP values for entities that would otherwise be valued under regulatory accounting rules (e.g., SAP) on a stand-alone basis. When the regulated entity is de-stacked the difference between the GAAP values and SAP values will be removed from the group's available capital. These "lost" values can result in a material reduction in the inventoried available capital compared to consolidated available capital. Understanding the impact and the components of this adjustment can help the regulator when considering the impact of issuing new debt or when evaluating the allowance for debt as capital calculated in the GCC template.

Intangible Assets – Acquisitions, mergers, and reorganization often can create significant intangible assets at a holding company level or possibly at an operating company (other than a regulated entity) level. The GCC template collects information on intangible assets held by inventoried entities in the Other Information tab. The available capital associated with the value of entities whose assets are materially comprised of intangible assets should be evaluated in the context of fungible resources and in assessing the adequacy of the capital calculation assessed on such entities.

Dividend Pass-Thru (Gross View of Dividends) – Schedule 1D collects information on dividends paid and received within the group. It also includes a column that indicates whether dividends were declared but not yet paid, as well as cases where dividends received were retained or "passed through" to another affiliate or paid out in dividends to shareholders. This information will assist the regulator in evaluating the movement of capital within the group to fund strategic insurance and non-insurance operations or activities (e.g., expansion of activities) or to fund entity specific capital shortfalls. It also provides a window to capital leaving the group (e.g., debt repayment, stock repurchase, or dividends to shareholders).

Considerations When Exempting Groups – As stated elsewhere within this guidance, the GCC and its related provisions in the Model #440 and Model #450 are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group's GCC. Rather, the GCC is intended to be a tool to better understand the risks of the group, mostly through the trending of the financial information in the "Input 4-Analytics" tab. However, specific to the provisions of the Model #440 and Model #450, the Group Capital Calculation (E) Working Group did believe that the GCC might be more helpful for some groups and not as much for others when it developed criteria within Model #440 and Model #450 for exemptions. On this point, the Working Group believed that in general the GCC would be more helpful for those groups that had 1) non-U.S. insurers within the group; 2) a bank within the group, or 3) a more material degree of non-insurers. Specific to the point regarding non-U.S. insurers or banks, the GCC is based upon the premise that the most relevant measure of capital is the actual legal entity requirements of capital from the applicable regulator. On this point, the required capital, as well as the trending of information on these particular legal entities might be the most valuable, particularly if the relative operations and assets of these entities compared to the U.S. RBC filers is material. Similarly, while the calculated capital on the non-insurance entities may not be as relevant as required capital on regulated insurers or banks, if the operations and assets of non-insurers relative to those of U.S. RBC filers are material, the GCC may provide greater value to such types of groups.

To these points, Model #440 and Model #450 contain possible exemptions for groups that have less than $1 billion in premium and that do not possess any of the three characteristics just described. The possible exemptions exist after the GCC has been filed once, because without seeing the completed GCC at least once for a group, it may be

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difficult for the lead state to determine if the GCC has value. However, it should also be understood that these three criteria of non-U.S. insurer, bank, or non-material non-insurers are not the only situations where the GCC would be valuable to the lead-state. As a reminder, all states are required to assess the sufficiency of capital within the holding company structure; prior to the GCC, this was done using various methods (e.g., debt to equity ratios, interest coverage ratios, existing RBC ratios and relative size of insurance). The GCC is expected to enhance a state's ability to make this assessment more easily. Therefore, in deciding if a group should be exempted, the lead state will need to consider a number of factors, including how easily it can make this assessment without the GCC. For small groups where the U.S. RBC operations and assets are much larger than the non-insurance operations, it is likely the GCC would provide a smaller degree of value and exempting from the GCC may be appropriate. However, the analyst should also consider the fact that the simpler the holding company structure, the more easily the GCC can be completed. Specifically, given all of the data included in the GCC is existing data and, therefore, readily available to the company, a smaller and simple structured group should be able to accumulate into the GCC template in a short period of time. Also worth considering is that if such operations are contained within a number of different U.S. insurers where it is difficult to determine the degree of double counting of capital, the GCC may provide more value.

To be clear, these are not the only situations where the GCC might be helpful even with a relatively small group. This is because the value may come from figures the GCC requires that the state may have otherwise not been aware of. Specifically, the GCC may identify non-RBC filers who may be experiencing some level of financial difficulties. This possible identification of information the lead state was not otherwise aware of is the primary reason the Working Group suggested the GCC be filed once before deciding on whether a group should be exempted. While the NAIC Accreditation program may not require a state to have such authority to have the GCC filed once before exempting, this background information provided herein is intended to encourage the state to consider such possibilities before deciding on exempting a group, particularly since it may be difficult to stop an exemption in any given year once it is provided.

In summary, as with everything else described in this documentation, the GCC requires judgement on behalf of the analyst and the lead state based upon multiple factors including the lead-state's existing knowledge of the group. The same applies when considering whether a group should be exempt.

Special Consideration for Risk Retention Groups When Exempting Groups

Risk retention groups (RRGs) often have unique structures that impact how they are regulated, how risks are assessed, and their potential sources of capital. For RRGs in a holding company system, the type of entities in the group, as well as the amount of information readily available for the other entities in the group, play a key role in regulatory oversight, including granting exemptions from the GCC calculation.

The following are some examples of unique circumstances/structures and related procedures that should be considered for RRGs when granting exemptions from the GCC. There may be other examples when evaluating RRGs, and the regulator should clearly document the justification if an exemption is granted.

- RRG is affiliated with a commercial carrier, and the RRG is not the controlling entity in the holding company:
  - The lead state of the commercial carrier will determine whether the GCC is required.
  - The commercial carrier will prepare GCC, which will include RRG results.

- Closely held RRG:
  - Obtain and review the sponsoring organization's audited financial statements to assess the ability to infuse capital if needed and consider any other impacts to the RRG.
  - Check the sponsoring organization's website and/or perform internet research for news headlines to learn of any current changes to the sponsor structure, such as mergers, acquisitions, or any other significant occurrences that could impact the RRG. This would be done periodically/quarterly to anticipate changes requiring a Form D filing.

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  - Review the RRG's balance sheet for the asset receivable from parent, subsidiaries, and affiliates, as well as the liability payable to parent, subsidiaries, and affiliates to determine whether there are concerns with the level of affiliated receivables/payables.

- RRG with affiliated offshore reinsurer:
  - Obtain and review the most recent audited financials for the affiliated reinsurer.
  - Ensure compliance with credit for reinsurance requirements.

- RRG itself is the ultimate controlling entity, has one or more non-insurance subsidiaries, and no one policyholder owns or controls 10% or more of the RRG:
  - Through review of RRG policies and procedures, corporate documents, subscription agreements, and policy provisions, determine the RRG's access to capital in the event a capital infusion would be needed. Consider the need to obtain financial information of policyholders. However, where no one policyholder owns or controls 10% or more of the RRG, it is not contemplated that the state would routinely collect financial information of the RRG's individual policyholders.
  - Obtain and review the most recent financials for the subsidiaries.

In addition to structure, factors consistent with the above guidance for all holding company groups should be considered when exempting an RRG from the GCC. Factors to consider include how easily the information necessary to understand the group's capital situation can be obtained without the GCC and whether the state already has a process to obtain and review the information needed to easily assess the sufficiency of capital within the holding company system.

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Special Note: The following procedures do not supersede state regulation but are merely additional guidance an analyst may consider useful.

The following is intended to demonstrate the type of potential questions a lead state may want to consider when it conducts a periodic meeting with the group. To the extent a lead state chooses to consider asking particular questions, as opposed to simply engaging in a conversation, it is recommended that these NOT be used in a checklist manner and instead be tailored to fit the situation of the group. Tailoring should be based on sophistication, complexity and overall financial position of the group. Again, this list is intended to simply demonstrate the type of questions that may be appropriate.

Financial Performance and Related Indicators

Suggested Items for Discussion:

1. Group's most recent profitability results by comparing such results (e.g., return on equity (ROE), return on revenue (ROR) or other internal (group) measures against the prior year plan, and the adequacy of the group's results over a five-year period compared to the industry as a whole, peers and shareholder/other stakeholder expectations over the same time period.
2. The drivers of weaknesses within the profitability results and the action the company is taking to improve the results either on a short-term basis in terms of specific products/investments, or a long-term basis in terms of any movement to new products/investments. Discuss the time frame for such actions and when either is expected to affect future trends.
3. Actions being taken by the group to capitalize on strengths in the profitability results and trends such a position. Discuss any risks to such approaches and any risk management techniques the group is using to minimize the downside risk. Are any of these actions expected to put any strain on the group's leverage or overall capital position?
4. Impact of the current year results on the group's overall financial position. Include in that discussion a request to address: 1) the current equity levels of the group compared to the prior year plan, and long-term plan; 2) its adequacy in relation to the group's internal targets; 3) any external targets for the current business plan from rating agencies, banks, or other lenders.
5. The extent to which the current year equity levels are sufficient to absorb any material spike in losses that may have been experienced by the insurance operations, or a particular non-insurance segment or entity.
6. Internal measures used by the group to measure leverage and consider the extent to which such measures are increasing or decreasing over the past five years.
7. The extent the group has introduced any new products, or has become subject to any new obligations, discuss the basics of such products/obligations and any measures taken by the group to mitigate any material downside risk.
8. Changes in the group's liquidity program and the internal measures used by the group to measure such adequacy.
9. Changes in the group's investment strategy or any market changes that are shifting the group's general approach.

Other Group Risks

Suggested Items for Discussion:

10. Top five to 10 risks the Chief Financial Officer (CFO) and/or Chief Risk Officer (CRO) have identified within the group and how such risks are mitigated.

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11. Group's non-insurance entities, as well as any risks they originate and could pose to the group.
12. Group's use of derivatives and other instruments to mitigate risk and how the group measures any risk that such programs pose to the group.
13. Group's most recent results/position compared to any corresponding covenants the group is required to meet.
14. Impact that the current economic environment is having on the ability to execute the group's business plan both on a short-term basis and a long-term basis.
15. Strategy for meeting any short-term debt or other similar material non-insurance company payments (source of cash and anticipated movement within the group structure).
16. Group's capital allocation methodology including specific levels of capital that are maintained within specific companies and the basis for such allocation (multiple of RBC, multiple of rating agency capital, etc.) and the extent to which excess capital is fungible throughout the group.
17. Internal discussion the group has had with respect to any potential rating agency downgrades and the impact that such a downgrade could have on the group's financial flexibility.
18. Any proposed acquisitions that the group is pursuing, and/or a current strategy associated with acquisitions that meet a particular need. Similarly, discuss whether there are any proposed divestures or operations that may be discontinued and any current strategy the group is considering for possible future transactions.
19. Group's approach for managing its non-insurance entities, as well as the non-uniform requirements of regulated entities and the impact these two distinct variations have on the management of the group's financial condition.
20. Any other events that are affecting the group's strategy or ability to execute its strategy.

Summary, Conclusion and Recommended Follow-Up

- Develop and document an overall summary and conclusion regarding the periodic meeting.
- Analysts may want to consider documenting any questions that were asked during the meeting.
- Analysts should communicate to the examiner-in-charge (EIC) any prospective risks identified.
- Provide a copy of such questions and answers to the examiner to help prevent any duplication of questions. However, in some cases, asking some of the same questions on an examination may be helpful to provide an update on particular issues, and would often be used in an examination year to replace the periodic meeting with the group.
- Analysts should update the Insurance Holding Company System Analysis, Branded Risk Assessments and Supervisory Plan in the Group Profile Summary for risk and other information obtained through meetings with the group.

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Special Note: The following procedures do not supersede state regulation but are merely additional guidance an analyst may consider useful.

The following provides examples of potential risk areas where the lead state, or group-wide supervisor for internationally active insurance groups (IAIGs), may want to perform certain limited examination procedures as part of the continual risk assessment process. However, analysts should be aware that in some years, it is highly possible that no risks or changes in risks rise to the level of requiring a specific targeted examination. In addition, certain risks and examination procedures may not be deemed urgent enough to warrant a targeted or limited-scope examination and could therefore be deferred until the next scheduled examination of the group.

The general purpose of a targeted on-site examination is to focus resources on a particular risk. Such procedures would generally be driven by any change in risks or any weaknesses or concerns. Performing such procedures through an on-site inspection can provide assurances that cannot be provided through off-site monitoring. In some cases, such procedures will focus on collecting information that will provide assurances that the risks that have been portrayed by the group can be relied upon. On-site examinations can also be more effective in understanding the risks of a group that are not easily understood with a regulatory filing, be it through a physical inspection of the group's process or through inspection of supporting documentation. The following provides examples of different risk areas where such assurances can be provided through tailored procedures. However, these are only examples and, again, what should be considered more than anything is the risk or changes in risk of the group and the assurances that can be provided through such an on-site inspection relative to such risks.

Prospective Risks (See Exhibit V – Overarching Prospective Risk Assessment of the Financial Condition Examiners Handbook for a more detailed listing of examples.)

1. New products, or recently developed products that have become more material or that create unique risks to the group. Consider reviewing the process to develop and price the product, as well as monitor its results compared to pricing.
2. New investment vehicle either recently acquired or that recently became more material to the portfolio. Consider reviewing the process by which the investment vehicle became available, the diligence performed to consider its risks, and the process to monitor its results before more monies are invested into the strategy.
3. Risk arising from the group's governance. (See Section VI.D. Corporate Governance Disclosures Procedures for a detail of such procedures) or risk management process (see Section VI.E. Enterprise Risk Management Process Risks Guidance for a detail of procedures to apply to groups submitting an Own Risk and Solvency Assessment (ORSA)).

Information Obtained from Filings, etc.

4. Information that supports representations regarding significant investors' expectations.
5. Current and historical consolidating financial statements used to validate information obtained regarding non-insurers.
6. Internal management reports that provide product detail on operations that, when accumulated are supported in total by audited statements.
7. Supporting documentation of internal and external equity target levels, including information from rating agencies, banks or other lenders.
8. Copy of the most recent liquidity strategy and walkthrough of daily monitoring process.
9. Copy of the most recent investment strategy and walkthrough of recent acquisitions or sales made in

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connection with strategy.

10. Documentation supporting risk management strategy as presented to internal risk committee or board of directors.
11. Copy of group derivatives use plan and walkthrough of daily monitoring process.
12. Copy of debt covenants and internal quarterly calculations.
13. Copy and walkthrough of projected future capital management plans.
14. Copy of any due diligence work performed on potential acquisition and key metrics for the board's consideration.

Internationally Active Insurance Group Considerations (See Additional Discussion in *Financial Condition Examiners Handbook* Section 1.I.F)

15. Risks arising from the holding company's status as an IAIG, including evaluations of the head of the IAIG's corporate governance (see Section VI.D. Corporate Governance Disclosure Procedures), risk management (see Section VI.E. Enterprise Risk Management Process Risks Guidance), and/or internal control (see Section VI.C. Insurance Holding Company System Analysis Guidance) frameworks.

Summary and Conclusion

- ❑ Develop and document an overall summary and conclusion regarding the targeted examination.
- ❑ Analysts should update the Insurance Holding Company System Analysis and Supervisory Plan in the Group Profile Summary.

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Special Note: The following procedures do not supersede state regulation but are intended to provide guidance and best practices for Supervisory Colleges; but also, to identify some specific minimum procedures to be used by all U.S. lead states and/or group-wide supervisors when leading a Supervisory College.

Overview

Background Information

A Supervisory College is a mechanism that intends to foster cooperation, promote common understanding, communication and information exchange, and facilitate coordination for group-wide supervision. Potential benefits of Supervisory Colleges include:

- Improving all the relevant regulators' understanding of the group and its risks
- Building relationships between relevant regulators, sharing regulatory approaches, and promoting cooperation and consensus
- Interacting more effectively with a group's management to gain insights into the group and to reinforce regulatory messages

As the business of insurance has expanded globally, insurance regulators worldwide have determined that increased levels of communication, coordination and cooperation among regulators at Supervisory Colleges is vital to understanding risk trends that could adversely impact policyholder protection and solvency oversight in an increasing global insurance market. As a result, the overall objective is to further information exchange, cooperation and coordination amongst relevant regulators as a key component for enhancing the supervision of cross-border financial institutions.[i]

In the U.S., the *Insurance Holding Company System Regulatory Act* (#440) provides the commissioner with the authority to participate in a Supervisory College for any domestic insurer that is part of an insurance holding company system with international operations. The powers of the commissioner with respect to supervisory colleges include, but are not limited to, the following:

- Initiating the establishment of a Supervisory College.
- Clarifying the membership and participation of other supervisors in the Supervisory College.
- Clarifying the functions of the Supervisory College and the role of other state insurance regulators, including the establishment of a group-wide supervisor.
- Coordinating the ongoing activities of the Supervisory College, including planning meetings, supervisory activities, and processes for information sharing.
- Establishing a crisis management plan.

In addition to U.S. guidance, the International Association of Insurance Supervisors (IAIS) has developed guidance for state insurance regulators in conducting and participating in Supervisory Colleges, which are primarily presented in Insurance Core Principle (ICP) 25 – Supervisory Cooperation and Communication, as well

[i] The statement from the G-20 Summit on Financial Markets and the World Economy, held in Washington, DC, in November 2008, states the following: "Supervisors should collaborate to establish Supervisory Colleges for all major cross-border financial institutions, as part of efforts to strengthen the surveillance of cross-border firms."

[ii] "Report of the Financial Stability Forum on Enhancing Market and Institutional Resilience," Financial Stability Forum, April 2008.

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as additional considerations and best practices in the IAIS's Application Paper on Supervisory Colleges.[ii] Information from these sources has been utilized in developing this chapter, and state insurance regulators are encouraged to reference the source documents, as necessary, to gather additional insight. However, IAIS materials are not deemed authoritative and should not be viewed as official NAIC guidance if they are not directly incorporated into this chapter.

ICP 25 provides among other things, the following guidance related to Supervisory Colleges that is hereby incorporated into this chapter:

- "Supervisors of the different insurance legal entities within an insurance group with cross-border activities should coordinate and cooperate in the supervision of the insurance group as a whole."
- "Supervisors may draw upon several supervisory practices to facilitate cross-border cooperation and coordination. These practices include the identification of a group-wide supervisor and the use of coordination arrangements, including supervisory colleges."
- "The procedures for systematic or ad hoc information exchange should be agreed with the other involved supervisors. The sharing of information by the group-wide supervisor and the other involved supervisors should be subject to confidentiality requirements."
- "Once identified, the group-wide supervisor should be responsible for coordinating the input of insurance legal entity supervisors in undertaking group-wide supervision as a supplement to the existing insurance legal entity supervision. Responsibilities of the group-wide supervisor should include chairing of the supervisory college (where one exists) or consider establishing one if not in place yet."
- "The group-wide supervisor, in cooperation and coordination with other involved supervisors, should consider establishing a supervisory college where, for instance: the nature, scale and complexity of the cross-border activities or intra-group transactions are significant and associated risks are high; group activities or their cessation could have an impact on the overall stability of the insurance markets in which the insurer operates; and the insurance group has significant market share in more than one jurisdiction."
- "The group-wide supervisor sets out the coordination arrangements in a written coordination agreement and puts such arrangements in place."
- "A written coordination agreement should cover activities including information flows between involved supervisors; communication with the head of the group; convening periodic meetings of involved supervisors; conduct of a comprehensive assessment of the group, including the objectives and process used for such an assessment and supervisory cooperation during a crisis."

Structure

The guidance contained in this, and the following sections apply generally to all Supervisory Colleges of insurance groups involving foreign jurisdictions. Additionally, colleges for insurance groups that meet the IAIG criteria are subject to additional expectations that are separately outlined towards the end of the chapter.

Organizational Procedures Performed Before Conducting a Supervisory College

Although there is no international legislation that provides that the group-wide supervisor has any authority over the sovereign authority of the jurisdiction, insurance regulators across the world have agreed that having one group-wide supervisor that is responsible for coordination and communication among supervisors within the group strengthens the global insurance regulatory system.

[ii] Located on the IAIS website: https://www.iaisweb.org/home

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Supervisory College Membership

Supervisory College members are generally the states/jurisdictions where the largest insurance entities within a group are domiciled, premium underwritten and key corporate decision-makers in the organization are located. However, also worth considering is the materiality that the group has for a particular jurisdiction. The group-wide supervisor or U.S. Lead State should consider who the appropriate invitees to the college should be; recognizing that determining the materiality of a group to a particular jurisdiction may be difficult. Ultimately, it is the responsibility of the group-wide supervisor, in cooperation with other involved supervisors, to determine which jurisdictions participate in the college and to review membership on a regular basis to reflect changing circumstances in the insurance group.

While there is a need to include as many members as possible, it must be balanced with the need to maintain a manageable, operational Supervisory College. In this regard, it may be appropriate to establish a tiered membership approach. This approach suggests that regulators that attend a Supervisory College be referred to as "Tier 1 or Tier 2" jurisdiction. If jurisdictions have primary authority (e.g., state/country of domicile) for insurers that have direct or gross premium greater than 5 percent of the entire group it may be appropriate for this tier 1 cutoff. The state insurance regulator should also consider requesting feedback from the insurance group regarding who it believes should be included in the "Tier 1," because they will have more specific data on the premiums written in each jurisdiction. In most cases, this type of approach will limit the number of jurisdictions involved. However, it may also be appropriate to place a limit on the total number of individuals participating from each jurisdiction. Some state insurance regulators suggest a maximum of 75 regulators attending a Supervisory College and believe that 50 is a more manageable number to maximize the effectiveness of the college.

In some cases, trying to maintain a specific size may result in some smaller jurisdictions that may be small to the group, but whose market is materially impacted by the group, being excluded from the actual college meeting. However, the group-wide supervisor must determine a means for such jurisdictions to be involved with the college through other means (e.g., follow up correspondence with all jurisdictions after a college meeting has taken place which could include the use of different secure IT tools).

States that are group-wide supervisors should consider developing, or requesting the group to develop, a map of all of the entities within the group and the corresponding jurisdiction for each entity. This mapping can be further enhanced by providing additional information that identifies the actual primary contact for each jurisdiction, as well as other participants from the same jurisdiction, and various contact information. When developing such a list, it's important to consider branches or other aspects of the group that may not be included on an organizational chart. All of this information should be kept up to date at all times, and made available through correspondence to all college members, and may be more easily distributed through a secure IT tool.

The use of such tools is becoming more common, and in addition to requiring confidentiality of data and controls around the sharing and updating of information, they must also allow for the permanent storage of data, and they must be efficient to administer. Similar issues may exist as it pertains to other forms of communication, such as conference calls.

Coordination and Information-Sharing Agreements

One of the most critical and lengthy tasks undertaken by the group-wide supervisor is drafting, distributing, and obtaining executed coordination and information-sharing agreements from the participating supervisory college membership. U.S. group-wide supervisors have experienced significant delays in getting information-sharing agreements drafted and completed with college members, which can span a period of months. Therefore, sufficient lead time is absolutely critical to ensuring that all agreements are obtained prior to the distribution of any materials for the college meeting. Consequently, this activity should be initiated at the outset of planning and organizing a supervisory college.

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A written coordination agreement should cover activities including:

- Information flows between involved supervisors.
- Communication with the head of the group.
- Convening periodic meetings of involved supervisors.
- The conduct of a comprehensive assessment of the group, including the objectives and process used for such an assessment.
- Supervisory cooperation during a crisis.

In addition, the coordination agreement may also include information on membership of the college, the process for appointing a supervisor to chair, the roles and functions of the college and its members, the frequency and location of meetings, and the scope of activities of the college.

The group-wide supervisor is responsible for the regular information collected by the Supervisory College and any notifications that should be made to it (from supervisors and the group). The Supervisory College should agree to the frequency of which information is provided and any information gathering should be coordinated in a way so as to avoid duplicative requests and to reduce the burden on a group. State insurance regulators should understand the difficulty and the amount of time it may take to get these agreements in place. This difficulty can lead to significant delays in beginning a new Supervisory College; therefore, state insurance regulators should take action to complete these information sharing agreements as soon as possible. The group-wide supervisor must recognize however that such agreement is needed not only for college meetings, but also correspondence that may be made available to all college members (sometimes a wider group than the jurisdictions attending the meetings) subsequent to a meeting.

A written information-sharing and confidentiality agreement between the involved supervisors must be agreed upon and entered into by all parties prior to participating in the Supervisory College, which may be covered through a broader coordination agreement. This information-sharing and confidentiality agreement can be achieved in various ways, such as: 1) through bilateral memorandums of understanding (MOU) among all of the jurisdictions involved; 2) through a Supervisory College-specific agreement; or 3) through the IAIS multilateral memorandum of understanding (MMOU), which establishes a formal basis for cross-border cooperation and information exchange amongst supervisors around the world to enhance supervision of internationally active insurance groups (IAIGs). The Department should note that in selecting the best agreement to utilize, while the NAIC Master Information-Sharing and Confidentiality Agreement (Master Agreement) addresses the sharing of information between state insurance departments, it does not include information sharing with other functional regulators, such as federal or international regulators, that may be participating in Supervisory Colleges.

The objective of the Mamou is for a signatory authority[iiii] to be able to request from and provide to any other signatory authority having a legitimate interest, information on all issues relevant to regulated insurance companies (including licensing, ongoing supervision and winding-up where necessary) and to other regulated entities such as insurance intermediaries, where appropriate. The MMoU is essentially designed as an alternative vehicle for having every jurisdiction sign a bilateral confidentiality agreement with every other jurisdiction. Further, it facilitates the exchange of confidential information in the Supervisory College context. If all members of a Supervisory College are also signatory authorities of the IAIS MMoU, it would effectively eliminate the need for every Supervisory College member to enter into a bilateral agreement with every other Supervisory College member and/or the drafting of a Supervisory College specific agreement in order to ensure

[iii] A "signatory authority" is defined in the IAIS MMOU Article 2 as "any insurance industry supervisor who is an IAIS member or is represented by an IAIS member [reference made here to the NAIC per the IAIS Bylaws Article 6 No. 2(b)] and following a successful qualification procedure has acceded to the MMOU by its signature." Each U.S. state insurance regulator, as an IAIS member or represented by an IAIS member (the NAIC), is eligible to be a signatory authority.

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that confidential information can be freely exchanged between Supervisory College members. This mechanism has the potential to significantly improve and expedite the cross-border exchange of information between supervisors. The execution of a memorandum of understanding on either a bi-lateral or multi-lateral basis does not supersede state or federal law governing disclosure of information. The legal obligations and regulatory requirements concerning information sharing and disclosure placed on state insurance regulators remain in effect.

Chairing the Supervisory College/other Supervisory Duties

As previously noted, it is generally expected that the group-wide supervisor will serve as the chair of all Supervisory Colleges. In addition to serving as the leader for the college, the chair is expected to complete a number of activities prior to and subsequent to each college. The following lists some of these activities:

- Set the date for the meeting.
- Conduct a group-wide supervisory review of the IAIG, including a group-wide risk assessment, and communicate the results to members of the Supervisory College and, as appropriate, concerns or areas of focus to the head of the IAIG to assist in college planning.
- Set the agenda for the meeting in coordination with other involved supervisors and distribute it in advance. The potential list of agenda topics and company presenters should be discussed with the insurer for input to help maximize the effectiveness of the college.
- Record outcomes that are achieved at each meeting including points arising from the meeting (specifically, the individual to whom each task is assigned and the deadline when an action should be complete) to allow the college to track individual items to make sure that the necessary action has been carried out.
- Liaison with insurer's designated college coordinator in obtaining information, their participation in the college and any related correspondence.
- Develop a preliminary crisis management plan.
- Consider for larger colleges preparing and updating a coordinated work plan. Consider using U.S. Supervisory Plan as starting point.
- Prepare, update, and circulate as changes occur, a contact list of members.
- Require a periodic self-assessment of the effectiveness of the college.
- In addition to these items, it is important to recognize that other expectations may exist from regulators and the US state should determine how to address such expectations. The following may be common examples of such other expectations of the group-wide supervisor:
- Set reporting requirements for the college, including specifying frequency (e.g., annual, quarterly, etc.) and type (technical provisions, issues raised as a result of on-site inspections, intra-group transactions, outsourced activities)
- Analyze data received from the group.
- Promote willingness to work together with other regulators.
- Provide guidance to other regulators on particular issues.
- Improve college effectiveness not within the group-wide supervisor's purview. Therefore, it may be appropriate to encourage maximum participation from all members of the college.
- Allow college members to submit written comments prior to the college meeting if they are unable to attend due to resource constraints, timing of the meetings, language barriers, or any other reason, even though regulators of entities that are significant to the group are generally expected to attend.

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- Draft minutes or action points for approval by the members
- Circulate presentations and other materials for the meeting once information sharing-agreements are obtained from all college participants.

Key Functions of the Supervisory College Including Coordination Agreements/Terms of Reference and Work Plan

One of the primary purposes of Supervisory Colleges is to facilitate coordination and communication between regulators. Consequently, one of the key functions of the college is to create the means to facilitate communication. Making this happen begins with the actions of the group-wide supervisor. As previously stated, state insurance regulators should be aware that other regulators may have other expectations when it comes to the group-wide supervisor. Specifically, Article 248 of the *European Union Solvency II Directive* indicates that the group-wide supervisor has a significant planning and coordination role, but also a more defined supervision review and assessment role and significantly more decision-making capacity. State insurance regulators should understand and be aware of these possible differences and seek to establish agreed upon expectations with the other involved supervisors. Understanding the specific expectations may be communicated through conference calls by the college members. These expectations once documented are often referred to as a "Coordination Agreement" or "Terms of Reference." A Coordination Agreement can serve as defining the expectations of the members of the purpose of the college and can include clarification on why a particular supervisor was determined to be the lead supervisor(s), group membership, agreement on frequency and location of meetings and finally, the role and responsibilities of the group-wide supervisor.

Different Approaches to College Structures

In general, the majority of colleges that states attend and lead are known as inclusive colleges. Under an inclusive college, there are no differences for the group-wide supervisor and other college members regarding participation in college work or access to information. More specifically, under this approach, the college would not use sub-colleges (e.g., regional colleges) or topical colleges where only certain members are invited to participate. This approach does not preclude the use of joint examinations between jurisdictions where two or more jurisdictions believe that they have a similar issue that applies to their legal entities. Other approaches can include a tiered approach, where there may be a US regional college, or a European college, or some other regional, with a separate world college. In these situations, the group-wide supervisor may be expected to attend each of these, or at least that has become the practice. Consequently, this may be more demanding. Finally, in some cases there may be core colleges that only involve the college members most significant to the business of the group. These may be useful in targeting discussions but may also create additional work for communicating the results back to other members of the world college. States should also be careful to consider the ramifications of these types of approaches on the existing information sharing agreements, as they may require additional more inclusive agreements if jurisdictions carry that opinion.

College Expectations – As the Group-Wide Supervisor

College Requirements for U.S. States Determined to be the Group-Wide Supervisor

The following sets forth examples of regulatory procedures to be used by U.S. lead states when leading a Supervisory College. States that act as group-wide supervisors are encouraged to develop additional internal processes for meeting planning and logistics to supplement these procedures.

Initial College Procedures (most likely not applicable after first college meeting)

- ❑ Begin to plan all of the relevant logistical items that are important to a successful college, including considering the schedule of other Supervisory Colleges as posted to the Supervisory College Calendar on iSITE+.
- ❑ Identify the entities that would fall within the scope of the group, either based upon information from annual holding company filings or through direct communication with the group, or both.

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- ❑ Determine through various means if your jurisdiction may be considered the group-wide supervisor and proceed under this assumption.
- ❑ Make initial contact with other regulators that may also be considered the group-wide supervisor and informally suggest your state may be the group-wide supervisor. If there are no objections, proceed to planning the first Supervisory College.
- ❑ Develop and execute information sharing agreements necessary for the protection of confidential information that will be shared among college members Acceptance of the wording of these agreements and the protections they provide are key to the insurer releasing college materials.
    - Consider establishing and maintaining a confidential information-sharing tool or portal, with an appropriate level of access controls and monitoring in place, to collect and share information among college members that have entered into a Coordination/Information-Sharing Agreement.
- ❑ At the college, present an initial Coordination Agreements/Terms of Reference document that summarizes various important aspects of the college collected prior to the college meeting, then discuss and adjust as deemed appropriate by members.
- ❑ At the college, present an initial Crisis Management Plan for discussion then adjust as deemed appropriate by members.
- ❑ At the college, direct a short discussion by each jurisdiction of their respective legal entity(ies), and the impact it (they) may have on the group. This type of discussion is not to be repeated after the initial meeting unless the impact is material, or if it is from the perspective of what is driving particular performance for the group as a whole.
- ❑ Develop a preliminary Supervisory Work Plan based on information gathered at the college with input from the college members.

Initial and Ongoing College Meetings

- ❑ Send to all of the appropriate jurisdictions, initial information regarding the potential for a Supervisory College meeting approximately six to nine months before the intended date (two to three months each conference calls) and modify the date to fit the needs of as many regulators as possible. Use of conference calls to discuss specific issues raised regarding the insurer will enable the regulator-to-regulator meeting immediately preceding the college meeting to be more efficient.
- ❑ Develop a tentative agenda and distribute it eight weeks before the college to all other regulators who plan to attend, asking for changes in order to ensure each jurisdiction's needs are met. Refine the agenda as needed and redistribute to all regulators four weeks prior to the college.
    - The agenda should be focused on a regulator shared view of the primary risks of the group. At the end of the meeting, college members should reach consensus upon the updated shared view of the primary risks of the group.
        - The primary risks of the group will vary but will require the same general understanding of the group's business strategy, risk management and governance processes, in addition to its financial, legal, and regulatory position. Therefore, initial colleges should have an agenda that develops this same general understanding of each of these items. Primary risks can be determined prior to such an understanding, but such a list is expected to be modified over time as the college gathers more information each meeting.
    - The agenda should include presentations from the group regarding those topics selected by the regulators when voting on the agenda (either to the entire group, or breakout sessions on more specific topics). This can include things such as the following:

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- Strategic and financial overview
- Material changes to the group since last meeting
- Material plans and projects for the coming year
- Governance and risk management
- Identification of key risks
- Capital planning and management
- Stress testing
- Interconnectivity
- Non-regulated entities
- Succession planning

- The meeting should include targeted discussions on the primary risks of the group, or trends that suggest a modification to such a list. The group-wide supervisor should consider utilizing a Group Profile Summary, or a similar document to meet this objective and summarize the results of their group-wide risk assessments. This specifically includes a document that would focus on the branded risk classifications of the group.
  - Exchange/discuss qualitative and quantitative information and data either prepared by the regulator or by the group. The information shared should be based upon the regulators shared view of the primary risks of the group, including any evolving or new potential material risks identified by any member. Discuss at each college if the information is adequate or if further information is appropriate for ongoing review of the group.
  - The group should present on the implications and readiness of the group for work adopted within various jurisdictions (e.g., ORSA, reporting or model development for Solvency II, etc.)

- ❑ After the agenda topics/insurer presenters are identified by the college participants, contact the insurer's designated college coordinator to make certain the key personnel are available for the appropriate portions of the college meeting before finalizing the date.
- ❑ Discuss and agree on feedback to the group and where appropriate, solo/legal entities.
- ❑ Update and reach consensus upon a modified Coordination Agreements/Terms of Reference document.
- ❑ Update and reach consensus upon a modified Crisis Management Plan.
- ❑ Update and agree upon a modified Supervisory Work Plan including updates to risks and identification of individuals and the jurisdiction to whom each task is assigned and the deadline or frequency when an action should be completed. The updated Supervisory Work Plan should be updated and distributed to all members of the college.
- ❑ Record a summary of each meeting, documenting decisions that were reached. Distribute the summary to the participants following each college meeting.
- ❑ Distribute an updated contact list of members following each college meeting, or something more flexible if that is agreeable to college members.
- ❑ Have each member of the college meeting discuss the effectiveness of the college and the need for any changes, and have each member complete a survey of its effectiveness.

With regard to agendas, the above tries to capture the need for agendas that are focused on the risks of the group, which can be different from one group to the next. However, as Supervisory Colleges are intended to

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employ best practices because participating members are expected to attend other colleges, emphasis should be placed on asking all jurisdictions to provide suggestions to draft agendas.

Group Risks Perspective from Each Supervisory College Member

As discussed previously, the Coordination Plan/Terms of Reference document is intended to capture the specific expectations of each member of the Supervisory College. Understanding each member's expectation is critical to having a successful college. In order to meet the majority members expectations, it is suggested that the group-wide supervisor requests input from other college members, as necessary, to identify group risk exposures and tailor the college agenda and supervisory workplan, as necessary, to address concerns.

Crisis Management Plan – (Note: Sample Plan is available within iSITE+ – FAH Report Links)

Many regulators believe that Supervisory Colleges are most effective when mutual cooperation and mutual trust is achieved. This attribute proves most beneficial and perhaps needed in times of financial difficulties or financial distress for the company. Although regulators take steps to encourage companies to avoid financial trouble and distress, they must all be prepared for such situations to occur. To that end, the Supervisory College should engage in a conversation about the issue and how the college will work in these situations. The intent is for these discussions to occur at the inception of the college itself, and then be documented and approved formally as early as possible. Such plans should attempt to be flexible and should consider the need to adapt to the particular individual company situation.

College Expectations – As the Lead State but Not the Group-Wide Supervisor

The following are suggestions relating to the role of the U.S. lead state to function as the U.S. contact for parent holding companies domiciled in other countries.

- Communicate on a consistent basis with applicable international regulators
- Attend Supervisory Colleges and for informal conference calls
- Provide consistency in who participates in the Supervisory College for continued building of international relationships

The U.S. lead state plays a key role in coordinating communication to and from the international holding companies to the non-lead states.

The U.S. lead state also provides a financial review of the international holding companies, and must:

- Have a good understanding of the holding company organizational structure
- Keep current of the financial review of the ultimate controlling person's financial statements and those of key subsidiaries
- Keep current of the significant events that impact the holding company system (e.g., financial, market, stock, catastrophic, etc.)
- Maintain contact with the international holding companies and the international regulators
- Coordinate the sharing and requesting of information where appropriate

After participating in a Supervisory College session, the U.S. lead state is encouraged to:

- ❑ Develop and document an overall summary and conclusion regarding the college
- ❑ Describe structure of college, attendees, key risks identified, etc.
- ❑ Identify key observations and risk noted during the Supervisory College

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- ❑ Coordinate and communicate follow-up on key takeaways to relevant regulators, including in-house state departments (such as examination, actuarial, rates and forms, etc.)
- ❑ Update the Holding Company System Analysis if there are observations from the college that have a material impact on the view of the group.
- ❑ Update the Group Profile Summary and Supervisory Plan if there are observations from the college that have a material impact on the view of the group.

U.S.-Based Internationally Active Insurance Group Considerations

While the guidance included in this chapter is generally applicable to all Supervisory Colleges, there are some specific considerations and requirements for IAIG Supervisory Colleges that should be followed by U.S. group-wide supervisors, as summarized below. For additional background information and best practice suggestions, please see ICP 25.

- **Frequency of College Sessions** – IAIG college sessions are expected to be conducted at least annually, in-person or via conference/video call, with the first session taking place in a timely manner after the identification of the IAIG.
- **Initial College Session** – Priorities for the initial Supervisory College meeting should include:
  - Confirming the group-wide supervisor and the structure of the Supervisory College.
  - Describing the scope of group-wide supervision, including an explanation from the group-wide supervisor on the scope of group supervision and any entities excluded.
  - Discussing proposed coordination agreements.
- **Ongoing College Sessions** – The group-wide supervisor should ensure that the IAIG's Supervisory College discusses the most relevant elements of the group-wide supervisory process and the supervisory plan by coordinating with other involved supervisors. The agenda set by the group-wide supervisor should provide for discussion of at least the IAIG's:
  - Corporate governance framework.
  - Enterprise risk management (ERM).
  - Main risks and intra-group transactions.
  - Financial position.
  - Regulatory capital adequacy and compliance with supervisory requirements.
  - Coordination of ongoing supervisory oversight activities and examinations, if appropriate.
- **Communication and Information Exchange** – The members of the IAIG's Supervisory College should communicate and exchange information on an ongoing basis—i.e., in conjunction with and outside of formal college sessions—in accordance with information-sharing and confidentiality agreements.
- **Review and Assessment of Group Capital** – The members of the IAIG's Supervisory College should obtain, discuss, and assess group capital information from the IAIG, including information provided in the group capital calculation (GCC) and ORSA Summary Report. In addition, a discussion of group capital may include information provided through the Aggregation Method (AM), or the Reference Insurance Capital Standard (ICS) as reported to the IAIS, if applicable and available.
  - The discussion by group-wide supervisors and Supervisory Colleges could include: 1) a comparison of GCCs, current or under development, to the Reference ICS; 2) the extent to which material risks of the IAIG are captured; 3) the appropriateness and practicality of the calculations required; and 4) any difficulties in implementing the GCCs by the IAIG or the group-wide supervisor.

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- **Crisis Management Group**[iv] – The group-wide supervisor establishes a crisis management group (CMG) for the IAIG, with the objective of enhancing preparedness for, and facilitating the recovery and resolution of, the IAIG.
  - There should be clear membership conditions, and members should include the group-wide supervisor, other relevant involved supervisors, and relevant resolution authorities, if possible.
  - The CMG should keep under active review the process for sharing information within the CMG and with host resolution authorities not represented, the processes for recovery and resolution planning for the IAIG, and the resolvability of the IAIG.
  - The group-wide supervisor, in consultation with the CMG, should determine whether to require that the IAIG develop a formal recovery plan[v] to establish in advance the options to restore the financial position and viability of the IAIG in a crisis, as well as how and when the plan should be updated on an ongoing basis. The role, priorities, and approach of any CMG should be proportional to each group's organization, capital structure, characteristics, and financial condition.
    - The recovery plan should be utilized by the CMG and the IAIG to take actions for recovery if the IAIG comes under severe stress.
    - It is recommended that the group-wide supervisor consider the IAIG's nature, scale, and complexity when setting recovery plan requirements, including the form, content, and detail of the recovery plan and the frequency for reviewing and updating the plan.
    - The head of the IAIG should maintain management information systems that are able to produce and communicate information relevant to the recovery plan on a timely basis.
    - Regardless of whether a formal recovery plan is required, the ORSA Summary Report should discuss at a high level the severe stresses that could trigger a recovery plan and the recovery options available.
  - Resolution plans[vi] are put in place at IAIGs where the group-wide supervisor and/or resolution authority, in consultation with the CMG, deems necessary. Where a resolution plan is required, the group-wide supervisor and/or resolution authority, in coordination with the IAIG CMG, should:
    - Determine whether a resolution plan is necessary, including consideration of factors such as the size and complexity of the IAIG.
    - Require relevant legal entities within the IAIG to submit necessary information for the development of resolution plan.
    - The head of the IAIG should maintain management information systems that are able to produce and communicate information relevant to the resolution plan on a timely basis.
    - Regularly undertake resolvability assessments to evaluate the feasibility and credibility of resolution strategies, in light of the possible impact of the IAIG's failure on policyholders and the financial system and real economy in the jurisdictions in which the IAIG operates.

[iv] For additional guidance, refer to the *Receiver's Handbook for Insurance Company Insolvencies* [insert chapter/appendix reference] and the *Troubled Insurance Company Handbook* (regulator only publication) [insert chapter/appendix reference].

[v] Refer to ICP CF 16.15 and the IAIS Application Paper on Recovery Planning for more background information and possible best practice guidance regarding governance, monitoring, updating the recovery plan, and key elements of a recovery plan (e.g, stress scenarios, trigger frameworks to identify emerging risks, recovery options, communication strategies, and governance). (https://www.iaisweb.org/home)

[vi] Refer to ICP CF 12.2 and 12.3 and the Application Paper on Resolution Powers and Planning for more background information and possible best practice guidance, including the approach to determining if resolution plans are needed and key elements of a plan (e.g., resolution strategies, financial stability impacts, governance, communication, and impact on guaranty fund systems). (https://www.iaisweb.org/home)

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- Require the IAIG to take prospective actions to improve its resolvability.

- The group-wide supervisor puts in place a written coordination agreement between the members of the IAIG CMG, which covers the following:
  - Roles and responsibilities of the respective members of the IAIG CMG.
  - The process for coordination and cooperation, including information sharing among members of the IAIG CMG.

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Schedule A
(Supervisory College Members)

as a part of the

Terms of Reference
for the COMPANY Supervisory College

Tier I Members:

1. COUNTRY
2. COUNTRY
3. UNITED STATES – STATE
4. UNITED STATES - STATE

Tier II Members:

1. COUNTRY
2. UNITED STATES - STATE

Tier III Members:

1. COUNTRY
2. UNITED STATES - STATE

EXAMPLE

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The following guidance on assignment of group code was adopted by Financial Condition (E) Committee in 2014.

- NAIC Group Codes are assigned by NAIC staff to add efficiency and effectiveness to the oversight functions performed by NAIC members and their financial regulatory staff. Similar to the concept of statutory accounting and reporting which is designed to meet the needs of regulators but is also used by non-regulators, the NAIC Group Code is designed for regulatory needs but is available to non-regulators. The NAIC Group Code allows for quick and easy identification of related companies, their electronic statutory financial statement results in the NAIC Financial Data Repository (FDR) database, and their automated prioritization and analysis tool results that are generated from the electronic statutory financial statement filings and provided to regulators through iSite+.
    - These benefits are useful to regulators in all states in which the particular insurer or insurers in a specific insurance holding company system are licensed and writing business, not just the domiciliary state(s).
- To respond to mergers, acquisitions and dispositions, NAIC staff will make changes in existing NAIC Group Codes based upon information received from insurance groups and their regulators. However, if any questions or disagreements arise for a particular change in the NAIC Group Code, NAIC staff will seek direction from the collective states which are expected to make their decisions as to which US based insurers should be included in an NAIC Group Code based upon the definitions of "Insurance Holding Company System," "Control," "Affiliate," "Subsidiary," and "Person" from the NAIC *Insurance Holding Company System Regulatory Act* (#440).
    - The "Control" concept in Model #440 includes a process whereby presumption of control (presumed to exist with ownership/control of 10% or more of the voting securities of an entity) can be rebutted (Section 4.K.). Per this section, a "disclaimer of affiliation" must "fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation."
    - Similarly, the "Control" concept in Model #440 establishes the authority for the commissioner to determine control exists, "after furnishing all persons in interest notice and opportunity to be heard," even when a presumption of control does not exist (Section 1.C.).
- For these issues, all states in which the subject insurer is currently licensed, as well as the domiciliary states of affiliates of the subject insurer, are the collective states able to raise questions or disagreements with any proposed change to the NAIC Group Code.
- Upon receipt of a question or disagreement, NAIC staff will work with the domiciliary state regulator of the subject legal entity insurer to set up a call with these states, and any applicable international supervisors and/or sectoral regulators, to discuss the question or disagreement. As a best practice, the subject legal entity insurer should communicate with the collective states to facilitate this process.
- The NAIC Group Code will be changed based upon the consensus view of the domiciliary states of the subject legal entity insurer and its affiliates. If a consensus view is not reached, NAIC staff will pursue direction from the NAIC Financial Condition (E) Committee. NAIC staff will formally notify the Chief Financial Regulators, and any applicable international supervisors/sectoral regulators, of the change in the FDR database and its effective date.

As stated above, the collective domestic states decide which U.S based insurers should be included or excluded in an NAIC Group Code. The following are a few best practices and considerations for establishing a change in the Group Code.

- Group Code changes should not be impacted by insurance companies within the respective group.
- Group Code decisions should not be based on intentions that results in allowing groups to avoid U.S. state, federal or international regulation (e.g., ORSA group premium criteria).

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- If a decision is made to exclude an insurer from a group code, regulators should consider whether any interconnectedness between the insurer and the group will still be transparent in public disclosures.

The following examples provide unique organizational situations that may require analysts to gain a clearer understanding of the group relationships during the review of group code changes or during subsequent holding company analysis.

- Attorney-in-fact: The amount of fee charged to the insurer for services provided by the attorney-in-fact and the overall financial impact on the insurer.
- Limited Partnerships & Hedge Funds:
  - A Master Limited Partnership (LP) where the only management and employees in the LP consist of two individuals who were appointed and paid by a hedge fund.
  - Hedge funds that own stakes in several insurance groups or serve as asset managers for the insurance groups.
- Family Ownership Structures: Family members collectively own the largest percentage shares in multiple insurers.
- Boards of Directors: Common and multiple seats on Boards of Directors of different insurance groups, however the common board members do not have voting rights on the Board, therefore under SEC rules there is no control.

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