NAIC
National Association of Insurance Commissioners

NAIC Financial Analysis Solvency Tools

Financial Analysis Handbook

Health Edition
2009 Annual/2010 Quarterly

2010

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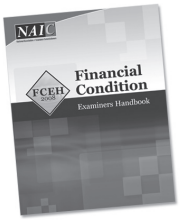
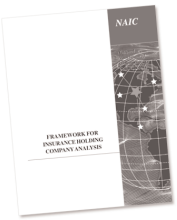
Companion Products

The following companion products provide additional information on the same or similar subject matter. Many customers who purchase the ***Financial Analysis Handbook*** also purchase one or more of the following products:



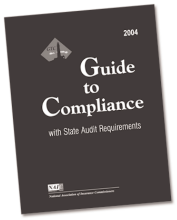
Financial Condition Examiners Handbook

This handbook provides a guide to assist state insurance departments in establishing an effective examination system. It provides an overview of the entire examination process and then offers specific instructions and suggestions for carrying out each individual phase of examination. Updated annually.



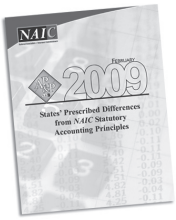
Framework for Insurance Holding Company Analysis

The Framework for Insurance Holding Company Analysis was created to document the best practices of states' efforts in analyzing holding companies and their insurance subsidiaries and in sharing information and coordinating regulatory action. The overall purpose of the Framework is to provide state insurance regulators with the tools and guidance necessary to gain an overall understanding of the holding company structure and the impact its management, business practices and financial condition has on its insurance subsidiaries. Copyright 2002.



Guide to Compliance with State Audit Requirements - As of 2004

This publication is a tool to assist insurers, CPAs and other interested parties in complying with the various state filing mandates for annual audited financial reports and related correspondence. It highlights differences in the states' requirements from the NAIC Model Audit Rule Requiring Audited Financial Statements and provides documentation of each state's rules and regulations. This guide also includes a copy of the AICPA's Statement Position 95-4, "Letters to State Insurance Regulators to Comply with the NAIC Model Audit Rule," as well as examples of various required letters and forms. This guide is also available on CD-ROM, providing instantaneous search capabilities powered by NextPage. Copyright 2004.



States' Prescribed Differences from NAIC Statutory Accounting Principles

The Accounting Practices and Procedures Manual presents a comprehensive basis of accounting that should be followed if not in conflict with state statutes and/or regulations. Should the domiciliary state set forth accounting guidance that differs from the AP&P Manual, disclosures of such must be made. This publication provides information regarding each state's prescribed differences from NAIC statutory accounting principles, including a citation to the respective state statute and/or regulation. Updated annually.

How to Order

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NAIC National Association of Insurance Commissioners & The Center for Insurance Policy and Research

Date: **January 2, 2010**

To: **Users of the NAIC's Financial Analysis Handbook—Health Edition**

From: **NAIC Staff**

This edition of the NAIC *Financial Analysis Handbook* is to be used in conjunction with the 2009 Annual and 2010 Quarterly Financial Statements. The following summarizes the most significant changes since the prior edition:

Level 1 - Analyst Reference Guide and Procedures

Non-Routine Analysis
A new section was added to the Analyst Reference Guide that discusses non-routine analysis related to events or situations that fall outside the normal course of business and may have a material impact on the overall financial condition of an insurer. The discussion includes several examples of the types of non-routine analysis that may be performed.

New Procedures
A procedure was added to address RBC Trend Test failure and a procedure was added within "Assessment of Supplemental Filings" to address communication with the domestic states of affiliated insurers within a group.

Supplemental – Analysts Reference Guide

Audited Financial Reports
Due to the anticipated revisions to the Model Audit Rule effective January 1, 2010, three sections were added to the Analyst Reference Guide to address auditor independence, corporate responsibility, and internal control over financial reporting.

Statement of Actuarial Opinion
The reference guide was significantly modified to provide an overview and enhanced guidance in reviewing the composition of the Actuarial Opinion beginning with the 2009 Annual Statement.

Supplemental – Procedures

Audited Financial Report Procedures
A procedure was added to address whether an insurer has established an audit committee.

Statement of Actuarial Opinion Procedures
The Statement of Actuarial Opinion supplemental procedures were modified to address changes in the Health Actuarial Opinion in Annual Statement Instructions.

If you have questions regarding the *Financial Analysis Handbook Health Edition*, contact Jane Koenigsman, Life/Health Financial Analysis Manager at 816-783-8145 or via Email at jkoenigs@naic.org.

EXAMINATION OVERSIGHT (E) TASK FORCE
FINANCIAL ANALYSIS HANDBOOK WORKING GROUP

SUBMIT TO
NAIC - KC
By June 1, 2010

Financial Analysis Handbook Proposed Revision Form

INSTRUCTIONS	FOR NAIC USE ONLY
1. Complete this form for EACH Handbook proposal. Under "Identification of Item(s) to be Changed", include Section & Page number, Line or Item Identifier. 2. All attachments should be presented in a format wherein new language is underscored and deletions struck through. 3. Please consider whether this revision proposal issue is also addressed elsewhere in the Handbook. 4. All submission forms and attachments must be typed originals. 5. CAUTION: before completing this form, please read additional instructions on reverse side of this form.	DISPOSITION [ ] ADOPTED [ ] REJECTED [ ] DEFERRED [ ] OTHER (SPECIFY) _____
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HANDBOOK SECTIONS TO WHICH PROPOSAL APPLIES

[ ] LIFE/HEALTH [ ] PROPERTY & CASUALTY [ ] HEALTH

[ ] Introductory Chapters
[ ] Financial Analysis Framework
[ ] Analysts Reference Guide
[ ] Specialized Topics
[ ] Quarterly Procedures
[ ] Level 1 Annual Procedures
[ ] Level 2 Annual Procedures
[ ] Level 3 Procedures
[ ] Other (Specify)
[ ] Audited Reports Supplemental Procedures
[ ] Actuarial Opinion Supplemental Procedures
[ ] M D & A Supplemental Procedures
[ ] Holding Company Supplemental Procedures

IDENTIFICATION OF ITEM(S) TO BE CHANGED

REASON OR JUSTIFICATION FOR CHANGE **
(STATE, IN SPECIFIC TERMS, THE BENEFIT TO BE DERIVED FROM THIS PROPOSAL)

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Additional Instructions and Information

The Financial Analysis Handbook Working Group meets via conference call throughout the year to consider proposed changes to the Financial Analysis Handbook (FAH). Suggestions to the FAH should be submitted by **June 1, 2010**. They will be reviewed by the Working Group and considered for adoption and implementation in the next FAH edition. Send proposals to:

National Association of Insurance Commissioners
Insurance Analysis & Information Services Department
2301 McGee Street, Suite 800
Kansas City, MO 64108-260

For questions call the Insurance Analysis & Information Services Department at (816) 842-3600.

Any member of a State Insurance Department is welcome to submit a Proposed Revision Form. The forms will be regarded as submitted on behalf of insurance departments rather than individuals.

Proposed Procedure Revisions

During the Working Group's review, changes proposed via this form will be considered along with an analysis conducted by the NAIC Insurance Analysis & Information Services Department of the effectiveness of procedures. This analysis encompasses the effectiveness of ratio limits as well as the language of procedures. Additionally, the general usefulness of procedures are considered. Specific proposals from states relative to procedures are welcome and should include detailed analysis.

Proposed Revisions for Annual Statement Changes

The Insurance Analysis & Information Services Department also studies adopted changes to the Health Annual Statements and provides revision proposals to the Working Group. The Insurance Analysis & Information Services Department automatically makes changes to the FAH for minor changes, such as for page and line numbers. Specific proposals are welcome. Additionally, please alert the Insurance Analysis & Information Services Department to any overlooked minor annual statement changes.

Proposed Software Revisions

The Life/Health, Property/Casualty and Health Handbooks are automated on I-Site. The FAH is intended to be a dynamic tool. The Working Group is interested in feedback on both analytical and software features. Please contact the NAIC Help Desk at (816) 842-3600 before submitting a form. Many enhancements have been proposed which could not be implemented. Also, some proposals may relate to existing features that the Help Desk may be able to explain.

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Preface

The National Association of Insurance Commissioners (NAIC) consists of insurance regulatory officials from the 50 states, the District of Columbia, and several U.S. territories. One of the primary objectives of an insurance regulator is to identify, as early as possible, insurance companies that may be financially troubled so that corrective action can be taken to protect policyholders, claimants, and creditors from financial loss.

The NAIC's *Financial Analysis Handbook* (*Handbook*) was developed and released by the by the former NAIC Health Entities (E) Working Group with the assistance of outside consultants in 2004 and is maintained by the Financial Analysis Handbook Working Group (FAHWG) of the Examination Oversight (E) Task Force. The purpose of the *Handbook* is to provide a means for insurance departments to more accurately identify insurers experiencing financial problems or that pose the greatest potential for developing financial problems. In addition, the *Handbook* provides guidance for the insurance departments to define and evaluate particular areas of concern in troubled insurers. The overall goal of the *Handbook* is to enable regulators to identify financially troubled insurers earlier, evaluate and understand their problems better, and develop appropriate corrective action plans sooner, thus, potentially decreasing the frequency and severity of insurance company insolvencies.

The information in the *Handbook* is intended to provide concepts and approaches that will enable regulators to perform more effective and efficient analysis of insurance companies. It does not include state specific information or regulations, and does not establish guidelines that insurance companies and departments must follow. Parameters or benchmarks utilized are not regulatory requirements to be complied with by insurance companies. The accreditation standards indicate that the analyst should utilize procedures developed by their Department or Procedures within the *Handbook*.

NOTE: Please note that all references throughout this Handbook to the risk-focused surveillance approach, Insurer Profile Summary, and Supervisory Plan apply only to states that have adopted and implemented the risk-focused surveillance approach. The ownership and responsibility for updates to the Insurer Profile Summary may vary from state to state between the analysis and examination departments.

The Handbook contains the following:

Introductory Chapters
These chapters provide a general overview for the analyst concerning regulatory organization, communication, and prioritization.

Financial Analysis Framework
The framework discusses resources the analyst should utilize throughout the review process. In addition, the steps of the review process are presented.

Analyst Reference Guide
The Analyst Reference Guide should be utilized with the Level 1, 2, 3,and Supplemental Procedures for both annual and quarterly periods. The Analyst Reference Guide provides discussion on the Procedures that could be performed during an analysis of an insurer.

There are three levels of Procedures within the Handbook. In Level 1, the analyst performs an overall review of the health entity. If there is any area of concern, additional procedures from Level 2 should be completed. Level 2 Procedures focus on specific financial areas that assist the analyst in conducting a thorough financial analysis. If continued concerns exist after completion of any Level 2 Procedures, Level 3 Procedures should be completed. Level 3 Procedures are intended to address qualitative issues of a health entity. The Supplemental Procedures assist the analyst in reviewing additional filings from the health entity such as its

Preface

Audited Financial Report, Statement of Actuarial Opinion, Management's Discussion and Analysis, and Holding Company Cnalysis. There are also quarterly Level 1 and 2 procedures.

Guidance for Notes to Financial Statements
The Guidance provides guidelines to assist the analyst in further understanding the reporting requirements of a health entity, which will aid the analyst during the review of the Notes to Financial Statements.

Health Insurance Industry
This narrative discussion section provides an overview of health insurance industry topics and terminology.

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I. Introduction

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B. Interstate Communication and Cooperation

C. External Information

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E. Statutory Accounting Practices vs. Generally Accepted Accounting Principles

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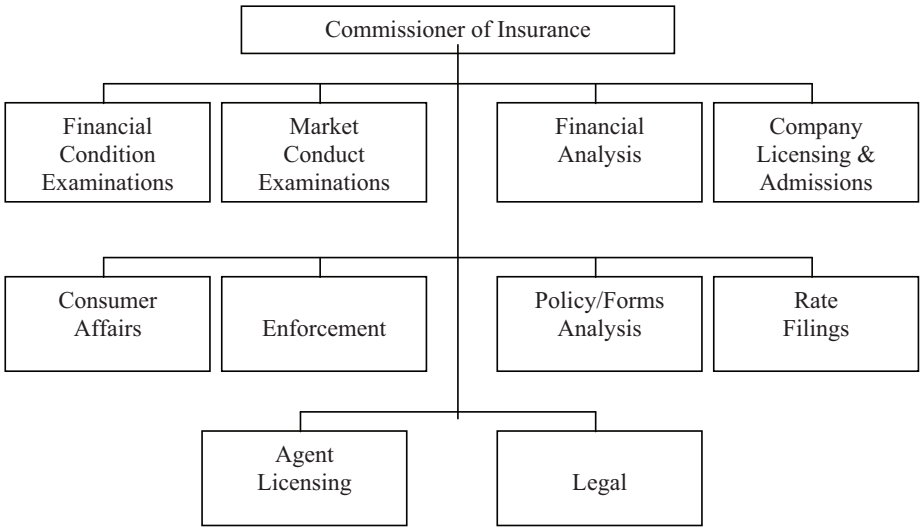
I. Introduction – A. Dept Organization and Communication

Organizational Chart

There is no "typical" state insurance department. The organizational structure will vary from state to state. However, there are several basic functions, which are performed by all departments on health entities, life insurers and property/casualty insurers. It is important for the financial analyst to understand the purpose of each function and the information obtained by each function which may assist the financial analyst in the financial monitoring and solvency surveillance process. The following is a brief discussion of each of the functions of an insurance department. Because of this variance in organizational structure, the chart below depicts typical state department functions rather than trying to highlight a typical organizational structure.

Chart of State
Insurance Department Functional Units



In many states, more than one of the above functions may be performed or supervised by the same individuals. For example, the financial analysts may also perform financial examinations. Financial examiners also frequently perform market conduct examinations. Also, some state insurance departments rely on the Attorney General's office for legal assistance rather than having separate department counsel.

Financial Condition Examinations

The Insurance Code in most states allows the state insurance department to examine health entities as often as the Commissioner deems appropriate, and requires that each health entity be examined at least once every three to five years (the time period varies by state). Financial condition examinations performed by the state insurance departments include full-scope periodic examinations and limited-scope or targeted examinations, which focus on specific accounts and/or issues. The results of a financial condition examination are documented in an examination report that assesses the financial condition of the health entity and sets forth findings of fact (together with citations of pertinent laws, regulations and rules) with regard to any material adverse findings disclosed by the examination. Examination reports may also include corrective actions required to be taken by the health entity and/or recommendations for improvements based on examination results. Through the risk-focused surveillance approach, the department gains knowledge about all aspects of the health entity, including its corporate governance, risk management practices and key business activities, which can be useful to solvency analysis.

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Market Conduct Examinations

The market conduct examination focuses on such areas as sales, advertising, rating and the handling of claims. Market conduct examinations evaluate a health entity's business practices and its compliance with statutes and regulations relating to dealings with policyholders and claimants. The results of a market conduct examination are documented in an examination report, which summarizes examination findings so that the health entity's performance can be assessed. The report may also recommend a corrective action to deal with significant problem areas. Because financial condition and market conduct problems are often interrelated, the examinations are frequently conducted simultaneously. Market conduct examinations are conducted by financial condition examiners in many of the states, usually an impact of the size of the department.

Financial Analysis

Financial analysis provides an in-house desk audit of the Annual Financial Statement and all other supplemental filings made by a health entity. The analyst should refer to other available information as well (including information on the NAIC Financial Data Repository), in order to monitor the health entity's statutory compliance and solvency on a continuous basis in coordination with the periodic on-site field examination process. As part of the risk-focused surveillance approach, the financial analysis unit responsibilities can include monitoring the state's domestic insurers, providing updates to the Insurer's Profile Summary, if applicable, (see Analyst Reference Guide for Level 1 Analysis), providing input for the department's priority score and supervisory plan, and providing department management with timely knowledge of significant events and performing the prospective risk analysis. Refer to the Analyst Reference Guide for Level 1 Analysis for further discussion on prospective risk. As part of the analysis process and the review of the examination report and findings, the analyst should incorporate into his/her analysis information gained about the corporate governance and risk management processes of the health entity. If desired, regulators can request the Insurer's Profile Summary, if applicable, for non-domestic health entities from the domestic or lead state.

As a result of concerns identified during the financial analysis process, the insurance department may take a variety of actions including, but not limited to, contacting the health entity seeking explanations or additional information, obtaining the health entity's business plan, requiring additional interim reporting from the health entity, calling for a targeted or limited scope financial condition examination, engaging an independent expert to assist in determining whether a problem exists, meeting with the health entity's management, obtaining a corrective plan from the health entity and/or restricting, suspending or revoking a health entity's certificate of authority.

Company Licensing & Admissions

A health entity that wishes to obtain a certificate of authority to write business in a state must generally complete an application form indicating the lines of business the health entity wants to write. The application form, along with other information including the most recent Annual Financial Statement, Audited Financial Report, Actuarial Opinion, etc., to support the financial condition of the health entity, is then submitted to the insurance department for review and evaluation. In addition, insurance departments frequently request information supporting the health entity's experience and expertise in writing the applied for lines of business, background information regarding the health entity's management and board of directors, a business plan and a multi-year pro-forma financial projection. After reviewing this information and any other information obtained, the insurance department makes a determination whether to issue a certificate of authority to the health entity.

The Uniform Certificate of Authority Application, also known as the UCAA or Uniform Application, is a process designed to allow health entities to file copies of the same application for admission to numerous states. The National Treatment Working Group currently maintains and updates the UCAA application. Each state that accepts the UCAA is designated as a uniform state. While each uniform state still performs its own independent review of each application; the need to file different applications; in different formats, has been eliminated for all states that

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accept the Uniform Application. The UCAA is available to any health entity in good standing in their domiciliary state, regardless of size. Currently, there are 50 uniform states and the District of Columbia.

Consumer Affairs

Consumer Affairs is responsible for developing and distributing information to consumers regarding insurance products and the insurance industry. Consumer Affairs is also generally responsible for addressing complaints filed with the insurance department by policyholders and claimants against health entities and agents. Detailed statistics regarding complaints (both in number and type of complaint) and their resolution may be maintained as a part of this function. Complaints are recorded on the Complaints Database System, if filed with the NAIC.

Enforcement

Punitive actions taken against companies, agents, and other licensees found to be in violation of the Insurance Code are handled by the enforcement function. This function issues orders and levies fines and other penalties based on the results of investigations performed by other functions within the insurance department. Detailed records are maintained by the department of all regulatory actions taken against companies, agents, and other licensees. In addition, regulatory actions are also recorded on the NAIC Regulatory Information Retrieval System (RIRS) database, if filed with the NAIC.

Policy/Forms Analysis

Most states require a health entity to file policy forms for most lines of business for review and/or approval by the insurance department prior to selling the policies. The primary purpose of this review is to determine statutory compliance regarding policy provisions and benefits.

Rate Filings

Information regarding premium rates, including actuarial rate development assumptions, is generally required to be filed with the insurance department for certain lines of business. Some states are “file and use” states, which allow health entities to begin selling policies at the rates filed as soon as the filing is made. However, in other states, rates must be approved by the insurance department prior to use by the health entity. Rate filings, including the actuarial assumptions, are reviewed for reasonableness and statutory compliance as a part of this function.

Agent Licensing

Agents must be licensed by the insurance department in order to write business in the state. The agent licensing function administers tests for agents, reviews new and renewal applications from agents, and performs background checks on the agents. In addition, many states have continuing education requirements for agents and agent licensing monitors compliance with these continuing education requirements. Detailed records of licensed agents are maintained by agent licensing, including information regarding the health entities for which the agents produce business.

Legal

Legal is generally involved in the review of proposed changes of control of health entities and other holding company transactions and frequently supports the other functions. Legal also may draft statutes and regulations to assist the insurance department in regulating health entities, agents, and other licensees; hold administrative hearings between the Commissioner and health entities, agents, and other licensees; and represent the department in judicial and other proceedings.

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I. Introduction – A. Dept Organization and Communication

Communication

Communication with other divisions or areas within the department (intradepartmental communication) on a timely basis is an important element of effective solvency surveillance and to coordinate the results of the risk-focused surveillance approach. Upon identifying a problem or concern during the financial analysis process, the financial analyst should communicate this information to other divisions within the insurance department. In addition, other divisions within the insurance department should communicate certain information to the financial analyst so that the financial analyst has all of the relevant information available regarding the health entity being analyzed. (Refer to the Insurer Profile Summary in the NAIC *Financial Condition Examiners Handbook*.)

Communication From the Financial Analyst to Other Divisions or Areas

The analyst may identify concerns as a result of the financial analysis process which, when communicated to the financial condition examinations division, may lead to a targeted or limited scope financial condition examination. Also, since the financial analysis and risk-focused examinations are interactive processes, the analyst should be familiar with the health entity's current financial condition, including any changes in its operations since the last periodic financial condition examination. Analysts should actively communicate findings from the analysis process to examiners as this type of communication is beneficial to the financial condition examination staff during the planning of risk-focused examinations and any follow-up. An example of the type of communication may include significant financial variances found in the health entity's business plan projections. Another example may include a material turnover of high-level management positions. Statutory violations identified as a part of the financial analysis process should be communicated to the enforcement division for the issuance of appropriate penalties and/or corrective orders against the health entity. In addition, solvency related concerns, when communicated to the legal division, may result in the restriction, suspension or revocation of a health entity's certificate of authority.

Communication From Other Divisions or Areas to the Financial Analyst

In addition to intradepartmental communication, which originates from the financial analysis division, it is equally important that the insurance department's procedures be designed to ensure that relevant information and data received by the other divisions within the insurance department be directed to the financial analysis division. The following are some examples of information or data that may be received by other divisions within the insurance department (including an indication of the functional unit which would likely have received the information or data), which should be directed to the financial analysis division for consideration as part of the financial analysis process:

1. Financial condition examination reports, which include significant adjustments to the financial information reported to the insurance department, corrective actions required to be taken by the health entity and/or recommendations for improvements based on examination results (financial condition examinations). Communication from financial examination staff may also include significant current events, company conditions and issues, industry conditions impacting the health entity and other financial concerns such as changes in profitability trends, deterioration in asset quality, liquidity or capital adequacy or changes in investment strategies or reinsurance. Moreover, the risk-focused examination may provide information about the health entity's prospective risks and the effectiveness of the health entity's risk management processes.
2. Market conduct examination reports containing corrective actions required to be taken by the health entity as a result of violations in sales, advertising, rating and/or claims practices which might be an indication of financial problems or lead to the risk of financial losses through class action suits or regulatory fines (market conduct examinations).
3. Any relevant information obtained in planning the financial examination stage.

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4. An increase in the number or type of complaints filed by policyholders, claimants, employees, agents or third parties that could indicate liquidity or internal control problems (consumer affairs).
5. Corrective orders and other regulatory actions taken against a health entity and fines and penalties levied (enforcement).
6. New policy form filings or expansion into new lines of business, including high-risk and long-tail lines of business, which might imply planned rapid growth to obtain premiums to improve liquidity or cover prior claims (policy/forms analysis).
7. Requests for significant premium rate increases, which might be an indication of insufficient rates to cover claims and expenses in the past (rate filings).
8. An increase in the licensing of agents, including managing general agents, or third-party administrators, which could indicate planned rapid expansion or relaxed underwriting standards (agent licensing).
9. The increased use of agents, managing general agents, or third-party administrators, which might be an indication that the health entity is not in control of its operations (agent licensing).
10. Information that management personnel of a health entity, including officers, directors or any other persons who directly or indirectly control the operations of the health entity, fail to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the health entity in such position (legal).
11. The unexpected resignation of a health entity's officers, directors or other management personnel, which might indicate internal turmoil or dissatisfaction with the health entity's goals or operating practices (legal).

Intradepartment Communication System

Intradepartment communication in most state insurance departments is primarily informal, due to the size of the insurance department and the location of insurance department personnel. The commissioner may hold periodic meetings with the division heads to discuss current developments and concerns in each division. In addition, in some states, division heads prepare monthly activity reports highlighting current developments, which are circulated to the other divisions within the insurance department. Insurance departments should have a formal structured mechanism to assure appropriate ongoing intradepartmental communication. Adequate controls should be implemented to assure that recommendations, decisions, actions and results are effectively communicated and documented. Among the key objectives of department's intradepartmental communication system are the following:

1. Key insurance department officials should possess all relevant information to permit decisions to be made on a timely basis.
2. The state insurance department should assure that all levels of staff have the appropriate knowledge, information and feedback to effectively perform their assigned functions.
3. Managers within various functional units or divisions should be responsible for the proper internal communication and documentation of decisions and actions taken under their authority.
4. The state insurance department should establish procedures to assure that orders and directives are effectively communicated to the appropriate staff, and that the staff observes such orders and directives.

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I. Introduction – B. Interstate Communication and Cooperation

The operations of some health entities may not be limited to one jurisdiction. Therefore, domestic state insurance departments need to coordinate their regulatory efforts with those of other state insurance departments in which their health entities do business. Similarly, the domestic state insurance department may need to coordinate these types of efforts with a different regulatory agency in some states, such as the state's department of health. The NAIC *Troubled Insurance Company Handbook* states that opportunities to coordinate efforts should be sought throughout the entire process from the monitoring and surveillance of health entities through regulatory actions regarding identified troubled companies. Coordinated activities may take various forms, including: 1) establishment and maintenance of procedures to communicate information regarding troubled companies with other state insurance departments; 2) participation on joint examinations of companies; 3) assignment of specific regulatory tasks to different state insurance departments in order to achieve efficiency and effectiveness in regulatory efforts and to share personnel resources and expertise; and 4) establishment of task forces consisting of personnel from various state insurance departments to carry out coordinated actions. Coordination of actions may also be useful to avoid competing individual state insurance department actions that may be counterproductive. Again, in some cases, the above coordination may be with the state's department of health or another state agency that has financial solvency oversight responsibilities. Additionally, in some cases, coordination on nonfinancial issues may also be necessary. This is quite common when dealing with health entities, because regulatory agencies such as the Center for Medicare and Medicaid Services (CMS), maintain authority in dealing with issues related to Medicare and Medicaid products.

The NAIC Policy Statement on Financial Regulation Standards indicates that a state insurance department should generally follow and observe the procedures set forth in the NAIC *Troubled Insurance Company Handbook*. The NAIC *Troubled Insurance Company Handbook* provides guidance regarding communication with other state insurance departments about domestic companies identified as troubled. The Financial Regulation Standards state:

> State statute should allow for the sharing of otherwise confidential information, administrative or judicial orders, or other action with other state regulatory officials providing that those officials are required, under their law, to maintain its confidentiality. The department should have an established written policy to cooperate and share all information with respect to domestic health entities with other state regulators including committees established by the NAIC which may be reviewing and coordinating regulatory oversight and activities. This policy should also include cooperation and sharing information with respect to domestic health entities subject to delinquency proceedings.

The insurance department should establish and implement procedures to ensure that regulatory actions are reported to the NAIC Regulatory Information Retrieval System (RIRS), that investigative information be reported to the NAIC Special Activities Database (SAD), that summary information on consumer complaints be reported to the NAIC Complaints Database System (CDS) and that the status of regulatory actions be reported to the Global Receivership Information Database (GRID). (These databases are discussed in more detail in Section I.D. NAIC Information.)

Effective interdepartmental action requires timely and effective communication among the various state insurance departments. Insurance departments should develop methods to receive, as well as to communicate, pertinent information regarding troubled health entities promptly to other affected jurisdictions. Good lines of communication may provide additional information to an insurance department to assist in its surveillance, as well as, provide information to other state insurance departments. Such communications should be established to foster cooperation among the various state insurance departments such that each insurance department works toward the satisfactory resolution of all troubled health entity situations, regardless of the health entity's domicile, license or operating status. Communications to other state insurance departments regarding troubled health entities should be made in an atmosphere of appropriate confidentiality. Knowledge by outsiders of actual or contemplated regulatory activities may cause undue negative consequences to the health entity (e.g., cancellation of policies or

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unavailability of reinsurance coverage), and those factors may diminish the health entity's ability to receive assistance or to survive.

The NAIC *Troubled Insurance Company Handbook* indicates that the effects on policyholders in all jurisdictions that may result from the actions of an insurance department should be considered. However, although the insurance department should consider any adverse consequences that possibly could result from making certain information known to other state insurance departments, those possible disadvantages may be outweighed by the advantages gained from sharing information and working with the other state insurance departments.

An insurance department may go beyond routine communications to allow other state insurance departments to participate in decision making activities related to a health entity that operates in more than one jurisdiction. Any such joint action obviously depends on the nature of the decisions to be made and the relative impact on a particular jurisdiction. However, cooperation of this nature can significantly improve communications between state insurance departments, and the resulting increased knowledge of the health entity's condition and circumstances can lead to more effective regulatory action.

The NAIC and its various committees, task forces and working groups may also provide a means for facilitating coordination and communication among the various state insurance departments. For example, the NAIC Financial Condition (E) Committee can participate in coordinating the efforts of various state insurance departments in a troubled company situation. An "association" examination of a health entity may be requested through the NAIC, as described in the NAIC *Financial Examiners Handbook*. The NAIC Financial Analysis Working Group functions as a peer review; they identify companies of national significance that are, or may be, financially troubled, and they determine whether appropriate regulatory action is being taken. The NAIC may also assist in organizing and facilitating other cooperative regulatory efforts, such as the formation of working groups to address specific troubled company situations.

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I. Introduction – C. External Information

There is a considerable amount of information available to assist the analyst in reviewing health entities. The NAIC maintains financial databases developed from the health entity's filings and state insurance department actions, all of which are described in more detail in the next chapter. In addition to the NAIC information, there are a number of external sources of information available from the major rating agencies and industry analysts. The analyst should refer to these sources of information in order to increase his or her knowledge of the health entity's financial position, and to corroborate the financial information filed by the health entity with the NAIC and state insurance departments. These sources of information are all available through direct purchase or subscription order from the rating agencies and/or industry analysts. Following is a discussion of the major sources of external information available to the analyst.

Rating Agencies

There are five major rating agencies that analyze insurance companies. Each has its own unique methodology for assigning ratings. The rating agencies also produce other types of financial information that may be helpful to the analyst. The following paragraphs briefly describe each of the major rating agencies and the types of financial information available.

1. *A.M. Best* - The A.M. Best Company has been rating insurance companies since 1906. The objective of Best's rating system is to evaluate the factors affecting the overall performance of an insurance company to provide its opinion as to the company's relative financial strength and ability to meet its contractual obligations. Best conducts an extensive quantitative and qualitative evaluation of rated insurers based on various sources of information and knowledge of the company accumulated over a long period of time. This knowledge is acquired through frequent contacts with company officials as well as by examining statutory financial statements, special questionnaires and a variety of other sources. Best's ratings encompass five categories of health insurance organizations: Commercial Health Insurers, Blue Cross Blue Shield Companies, HMOs, Delta Dental Organizations and Dental HMOs. The ratings are available through Best's Key Rating Guide and Best's Rating Online. *Best's Managed Care Reports – HMO* provides, in CD-Rom format, five years of key financial data and performance ratios for approximately 700 HMOs operating in the United States. To obtain an A.M. Best rating, a newly rated insurer should have a three to five year business plan, experienced management, $2.0 million in surplus, submit the requested financial information, and pay a fee. The ratings are available through Best's Key Rating Guide and Best's Rating Online. Best also publishes Aggregates and Averages, Company Reports, a Rating and Statistical Guide as well as many other publications, directories, reports and periodicals.

2. *Fitch* – Fitch Ratings was founded as the Fitch Publishing Company on Dec. 24, 1913. Fitch began as a publisher of financial statistics and soon became the recognized leader in providing critical financial statistics to the investment community. In 1924, Fitch introduced the "AAA" to "D" ratings scale along with in-depth analysis that was completed by a staff of investment experts. Fitch's ratings evaluations are qualitative and quantitative. Fitch provides two basic types of ratings, insurer financial strength (IFS) rating and issuer and fixed income security rating. The ratings are obtained via in-depth industry, operational, organization, management, and financial reviews. The ratings are available through Fitch's National Ratings List and Fitch Ratings Online.

3. *Moody's Investors Service* – Moody's Investors Service was founded in 1900. Today, Moody's rates approximately $30.0 trillion of debt securities in approximately 100 countries. Included in these ratings are taxable bonds, structured financings and municipal bonds in the U.S. tax-exempt market. In addition, Moody's rates U.S. Treasury debt, deposits of over 700 banking groups, trillions of dollars of credit risk exposure in derivative markets and insurance claims. In the insurance sector, Moody's has been rating the debt securities of life/health and property/casualty insurance companies since the mid-1970s. Moody's began assigning insurance company financial strength ratings in 1986. Moody's financial strength ratings reflect its opinion as to an insurer's ability to discharge senior policyholder obligations and claims. It seeks to measure "credit risk" (e.g., the risk that an insurer will fail to honor its senior policyholder claims

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in full and on a timely basis). Moody's financial strength ratings are based on qualitative analysis. Moody's disseminates its ratings through various publications. Moody's publishes credit opinions on a semi-annual basis and in-depth analysis, industry outlooks and a statistical handbook on an annual basis. Moody's also publishes insurance financial strength ratings lists and insurance debt lists monthly.

4. *Standard and Poor's* - Standard and Poor's (S&P) has been rating bonds since 1923 and insurance companies' claims-paying ability since 1983. S&P's insurer rating activity draws from its expertise and procedures in rating debt issues and utilizes a similar classification framework, but is conducted by professional analysts whose background, experience and/or training is focused on the insurance industry. S&P sees its role as one of providing risk assessment of insurers to insurance buyers rather than serving as an advisor to insurers to assist them in improving their financial condition and rating. S&P's claims-paying ability rating is an assessment of an operating insurance company's financial capacity to meet its policyholder obligations in accordance with their terms. Claims-paying ability ratings are based on a comprehensive quantitative and qualitative financial analysis using various sources of information, including interviews with company management. S&P insurance ratings are available on Credit Analysis Reference Disk (CARD). The disk is updated twice a month and provides a complete database of global insurance information on CD. Each disk includes interactive and public information, financial strength ratings for approximately 4,000 insurers, and debt ratings on more than 200 insurers. The disk also includes pool affiliations, NAIC codes, key statistics and full analysis on approximately 600 insurers worldwide.

5. *TheStreet.com Ratings*, formerly *Weiss Research*—TheStreet.com Ratings acquired the ratings business from Weiss Ratings, Inc. in August 2006. Martin D. Weiss, founder of Weiss Research, has been publishing newsletters about money markets, interest rates, bank safety, and economic forecasting since 1971. In 1989, Weiss began publishing "safety ratings" of life, health, and annuity insurers. Weiss' methodology and rating scale has generated some controversy within the industry. Weiss' safety rating indicates its opinion regarding an insurer's ability to meet its commitments to its policyholders under current economic conditions. An insurer's rating is determined based on a detailed analysis of numerous factors that are synthesized into a series of indexes such as capitalization, reserve adequacy, profitability, liquidity, and stability. The data for the analysis is obtained from statutory statements filed with the NAIC. TheStreet.com Ratings will continue to be called "Weiss Ratings" and emphasizes that it bases its analysis exclusively on objective, quantifiable information and other financial information provided by the insurers. Unlike other rating agencies, the Weiss Ratings product line does not accept compensation from the companies it rates nor does it allow the rated companies to influence the rating. Weiss supports its insurer rating activities through the sale of its rating information to the public.

Industry Analysts

In addition to the rating agencies, many of the investment houses and stock research firms do considerable research on the insurance industry. The following paragraphs briefly describe several sources.

1. *Investment Houses* - The major Wall Street firms dedicate considerable resources towards researching insurance industry issues. In general, much of this type of research is oriented towards emerging issues facing the industry. Specific insurance company research is also available, but is generally limited to companies with publicly traded debt or equity securities.

2. *Ward's Results* - Annually, Ward Financial Group publishes a financial reference series entitled *Ward's Results*, available in separate life/health and property/casualty editions. The books include financial benchmarks for U.S.-domiciled insurers, including unique peer group benchmarks. The life/health edition groups each company into peer groups that consider the insurer's product mix, asset size and ownership structure. The property/casualty edition groups each company into peer groups that considers the insurer's product mix, premium volume and geographic mix of business. In addition to peer group benchmarks, the books also include top performing stock company and mutual company benchmarks.

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SEC Filings

Insurers that offer debt or equity securities to the public must register with the Securities and Exchange Commission (SEC) and fulfill various reporting requirements. Where applicable, the various SEC filings provide significant background information about the insurer and can assist the analyst in corroborating the information filed by the insurer with the NAIC or state insurance departments. Most of the SEC filings are also available online at no charge. While the SEC filing requirements are quite comprehensive, the following summarizes three of the SEC filing forms that may be of particular of interest to the analyst.

1. *Form 10-K* - The 10-K is the form used to fulfill the SEC's annual reporting requirements. The 10-K must be filed with the SEC within 90 days after the insurer's year-end. Types of information incorporated into the 10-K include:
    a. Item 1 - Business.
    b Item 2 - Properties.
    c. Item 3 - Legal proceedings.
    d. Item 4 - Submission of matters to a vote of security holders.
    e. Item 5 - Market for registrant's common equity and related stockholder matters and issuer purchases of equity securities.
    f. Item 6 - Selected financial data.
    g. Item 7 – Management's discussion and analysis of financial condition and results of operations.
    h. Item 7A – Quantitative and qualitative disclosures about market risk.
    i. Item 8 - Financial statements (which must include the audit report of an independent accountant, management's assessment of internal controls and the audit report on internal controls) and supplemental data.
    j. Item 9 - Changes in and disagreements with accountants on accounting and financial disclosure.
    k. Item 9A – Controls and procedures.
    l. Item 9B – Other information.
    m. Item 10 - Directors and executive officers of the registrant.
    n. Item 11 - Executive compensation.
    o. Item 12 - Security ownership of certain beneficial owners and management.
    p. Item 13 - Certain relationships and related transactions.
    q. Item 14 – Principal accounting fees and schedules.
    r. Item 15 - Exhibits and financial statement schedules.

2. *Form 8-K* - Form 8-K is required after any of the following events occur:
    a. Change in control.
    b. Major acquisition or disposition of assets. For certain acquisitions and dispositions, historical and pro forma financial statements are required.
    c. Bankruptcy or receivership.
    d. Change of independent accountant.
    e. Other events.

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f. Resignation of registrant's directors.

g. Change in fiscal year.

Other External Sources

In addition to the specific sources referenced above, other resources that provide updates about the industry and specific insurers include:

1. Business Insurance.
2. BestWeek.
3. Best Review.
4. National Underwriter.
5. The Wall Street Journal.
6. Bloomberg Financial.
7. Factiva (Reuters Insurance Briefing).

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I. Introduction – D. NAIC Information

In addition to the external information discussed in the previous chapter, there is a considerable amount of information available from the NAIC to assist the analyst in analyzing health entities. Most health entities are required to file Annual Financial Statements and Quarterly Financial Statements with the NAIC. Much of the information available on the NAIC Financial Database Repository is based on data included in these filings. In addition, other NAIC databases include information input by the various state insurance departments regarding regulatory actions taken against health entities, regulatory concerns about health entities or individuals and consumer complaints filed against health entities. Following is a discussion of the more significant information available to the analyst from the NAIC.

Financial Analysis Solvency Tools (FAST)

FAST is a collection of analytical tools within the Insurance Regulatory Information System (IRIS) designed to provide state insurance departments with an integrated approach to screening and analyzing the financial condition of health entities. In addition, FAST assists state insurance departments in allocating resources to those health entities in greatest need of regulatory attention, targeting those specific aspects of a health entity's financial position which could put the health entity at risk of future insolvency.

Scoring System

The Scoring System consists of a series of ratios, calculated on annually and quarterly, for which a health entity scores a given number of points based on certain parameters set for each ratio. There are 16 annual scoring ratios and 13 quarterly ratios calculated for health entities. These ratios focus on a health entity's financial position, results of operations, cash flow and liquidity and leverage. Health entities with the highest scores would generally be considered to be health entities showing a higher risk of future insolvency. The Scoring System is designed so that an analyst can screen on a total score basis or analyze each ratio result separately. Annually, the NAIC Insurance Analysis and Information Services Department, under the direction of the Financial Analysis Research and Development (E) Working Group, ensures that the Scoring System ratios are current, continue to be relevant to solvency monitoring, and that the scoring parameters remain appropriate.

Financial Profile Reports

The analysis component of FAST consists of Financial Profile Reports generated from Annual Financial Statement and Quarterly Financial Statement data. These Financial Profile Reports can be generated to provide either: 1) a quick quarterly or five-year summary of a health entity's financial position; or 2) an in-depth five-year analysis of all aspects of a health entity's operations. Financial Profile Reports can assist the analyst in identifying unusual fluctuations, trends, or changes in the mix of a health entity's assets, liabilities, capital and surplus, and operations. The analysis component also includes the NAIC *Financial Analysis Handbook*.

Analyst Team System

The Analyst Team reviews key financial data from the Annual Financial Statement and ratio results of health entities meeting certain criteria by experienced examiners and analysts from several of the state insurance departments representing all zones of the NAIC. The Analyst Team reviews selected health entities, validates automated level designations assigned and provides brief synopses of their validation findings or comments explaining factors that affect the Company's overall financial condition. Health entities are selected for validation based upon scores, ratios and overall financial condition based on criteria established by the NAIC Examination Oversight (E) Task Force.

Examination Jumpstart

Examination Jumpstart, which is available through I-SITE, was developed by the NAIC to assist examiners in performing financial condition examinations. Using Examination Jumpstart, numerous reports can be generated pertaining to a health entity's reinsurance program and investment portfolio based on the information included in

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the NAIC database from the health entity's Annual Financial Statement. In addition, for property/casualty insurers, loss reserve analysis can be performed. Although Examination Jumpstart was developed to assist examiners in performing financial condition examinations, many of the applications may be of interest to the financial analyst as well. Following is a brief discussion of some of the Examination Jumpstart reports available that may assist the financial analyst in the analysis process.

1. Investment CUSIP Exception/Designation Reports – Attempt to show those CUSIP numbers listed on Schedule D that are not accounted for by the NAIC's Securities Valuation Offices because the CUSIP number does not exist, or it was entered improperly.
2. Investment Market Value Reports – List those investments where the listed value is significantly different than the actual value.
3. Investment Material Holdings Reports – Create reports that show material holdings and designate which holdings you want to include in the report.
4. Designation Reports – Generate a list of investments having one designation.
5. Missing CUSIP – the CUSIP number is not found in the VOS datafile or the FE datafile.

Regulatory Information Retrieval System

The Regulatory Information Retrieval System (RIRS) is a computerized database which contains information regarding formal administrative and regulatory actions taken against health entities, insurers and insurance agents. Information on RIRS includes 1) the health entity or insurance agent against whom formal administrative or regulatory action was taken; 2) the date of the action; 3) the state taking the action; 4) the reason for the action; 5) the disposition; and 6) the amount of monetary penalty levied. RIRS relies on input from the state insurance departments of all final actions taken and is available on-line to all state insurance departments.

Special Activities Database

The Special Activities Database (SAD) is a confidential computerized database that tracks individuals and entities which have been the subject of state insurance department inquiry. SAD is designed to flag entities or individuals of insurance regulatory concern and to provide regulatory contacts for obtaining more detailed information that can be considered in a more critical and subjective fashion. SAD will not provide all the particulars regarding events, dates, or related issues. These particulars should be fully investigated before any further regulatory action is contemplated.

Complaints Database System

The Complaints Database System (CDS) is a computerized database which contains information regarding consumer complaints filed against a firm or individuals in the insurance industry. CDS provides state insurance departments with the ability to evaluate a health entity's comparative performance in the marketplace. CDS generates consumer complaint activity trends by month and year, and complaint counts by reason (e.g., claim payment delays).

Market Initiative Tracking System

The I-SITE application, Market Initiative Tracking System (MITS), tracks information concerning actions state regulators take in investigating the business practices of companies. This system was designed to capture market initiatives that may impact other jurisdictions. These initiatives may include, but are not limited to, any of the options from the continuum of regulatory responses:

- Applied Regulatory Responses or Enforcement Actions
- Interviews with the Company, Correspondence or Information Gathering

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I. Introduction – D. NAIC Information

- Desk Audits, Company Self Audits, or On-Site Audits
- Voluntary Compliance Programs
- Information Sharing
- Investigation
- Target, Comprehensive, and Multi-Jurisdictional Examinations

Global Receivership Information Database

The I-SITE application, Global Receivership Information Database (GRID), allows the regulator to review the status of a receivership (i.e., conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post receivership data, creditor class/claim data, legal data, financial data and reporting data.

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I. Introduction – E. SAP vs. GAAP

Statutory Accounting Principles (SAP) are those accounting principles or practices which are prescribed or permitted by the health entity's domiciliary state insurance department. SAP is prescribed in the insurance statutes, regulations and administrative rules of the various states, and in the NAIC *Accounting Practices and Procedures Manual (AP&P Manual)*, the NAIC *Annual Statement Instructions*, the NAIC *Financial Condition Examiners Handbook*, the *Purposes and Procedures Manual of the* NAIC *Securities Valuation Office*, and NAIC subcommittee and task force minutes. In addition, certain accounting practices are explicitly or implicitly permitted by the various state insurance departments on an issue by issue and/or company by company basis.

Financial statements filed with the state insurance departments are prepared on a SAP basis. Since the primary concerns of insurance regulators are the protection of the policyholders and the solvency of each health entity, SAP places emphasis on the adequacy of statutory capital and surplus. Adequate capital and surplus provides protection against adverse operating results and also permits a health entity to expand its business. In addition, SAP emphasizes the balance sheet, rather than the income statement. Statutory accounting is primarily directed toward the determination of a health entity's financial condition and its ability to satisfy its obligations to its policyholders and creditors as of a certain date.

As stated in the Preamble to the *AP&P Manual*, SAP is based on the concepts of conservatism, consistency and recognition. Each of these concepts is discussed in detail below:

> *Conservatism* – Financial reporting by health entities requires the use of substantial judgments and estimates by management. Such estimates may vary from the actual amounts for various reasons. To the extent that factors or events result in adverse variation from management's accounting estimates, the ability to meet policyholder obligations may be lessened. In order to provide a margin of protection for policyholders, the concept of conservatism should be followed when developing estimates as well as establishing accounting principles for statutory reporting.
>
> Conservative valuation procedures provide protection to policyholders against adverse fluctuations in financial condition or operating results. Statutory accounting should be reasonably conservative over the span of economic cycles and in recognition of the primary responsibility to regulate for financial solvency. Valuation procedures should, to the extent possible, prevent sharp fluctuations in surplus.
>
> *Consistency* – The regulators' need for meaningful, comparable financial information to determine a health entity's financial condition requires consistency in the development and application of SAP. Because the marketplace, the economic and business environment, and insurance industry products and practices are constantly changing, regulatory concerns are also changing. An effective statutory accounting model must be responsive to these changes and address emerging accounting issues. Precedent or historically accepted practice alone should not be sufficient justfications for continuing to follow a particular accounting principle or practice which may not coincide with the objectives of regulators.
>
> *Recognition* – The principal focus of solvency measurement is determination of financial condition through analysis of the balance sheet. However, protection of the policyholders can only be maintained through continued monitoring of the insurance enterprise. Operating performance is another indicator of a health entity's ability to maintain itself as a going concern. Accordingly, the income statement is a secondary focus of statutory accounting and should not be diminished in importance to the extent contemplated by a liquidation basis of accounting.
>
> The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than for fulfilling policyholder obligations, or those assets which may be unavailable due to encumbrances or

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other third-party interests should not be carried on the balance sheet, but rather should be charged against surplus when acquired or when availability otherwise becomes questionable.

Liabilities require recognition as they are incurred. Certain statutorily mandated liabilities may also be required to arrive at conservative estimates of liabilities and probable loss contingencies (e.g., interest maintenance reserves, asset valuation reserves, and others).

Revenue should be recognized only as the earnings process of the underlying underwriting or investment business is completed. Accounting treatments that tend to defer expense recognition do not generally represent acceptable SAP treatment.

SAP income reflects the extent that changes have occurred in SAP assets and liabilities for current period transactions, except changes in capital resulting from receipts or distributions to owners. SAP income also excludes certain other direct charges to surplus which are not directly attributable to the earnings process (e.g., change in non-admitted assets).

Although the Annual Financial Statements, Quarterly Financial Statements and Annual Audited Financial Report filed with the state insurance departments by health entities are prepared on the basis of SAP, financial analysts also review Holding Company Form B filings and Securities and Exchange Commission (SEC) filings which may include financial statements prepared based on generally accepted accounting principles (GAAP). Therefore, the financial analyst must also have a general understanding of GAAP. The Preamble to the *AP&P Manual* presents a brief comparison of GAAP and SAP.

There are two main conceptual differences between SAP and GAAP. First, SAP stresses measurement of ability to pay claims in the future, whereas GAAP stresses measurement of emerging earnings of a business from period to period (e.g., matching revenue to expenses).

The following is a discussion of the more significant specific differences between SAP and GAAP for a health entity:

Health Care Receivables – Under SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans*, detailed admissibility rules determine if health care receivables are admitted assets. Health care receivables that do not meet the conditions set forth in SSAP No. 84 are non-admitted. GAAP does not distinguish between the different types of health care receivables and only requires receivables to be reported net of any allowance for doubtful accounts.

Health Care Delivery Assets – Under SSAP No. 73, *Health Care Delivery Assets – Supplies, Pharmaceuticals and Surgical Supplies, Durable Medical Equipment, Furniture, Medical Equipment and Fixtures, and Leasehold Improvements in Health Care Facilities,* assets which are not used in the direct delivery of health care are non-admitted. Non-admitted health care delivery assets would include: for example, furniture, fixtures and equipment, leasehold improvements used for administration activities, pharmaceutical and surgical supplies such as linens; uniforms; and garments, food and other commodities, housekeeping, maintenance, and office supplies. SAP requires that all health care delivery assets be depreciated over their useful lives, but no more than three years. GAAP does not distinguish between health care delivery assets and other assets and requires health care delivery assets be depreciated over their estimated useful lives.

Claim Adjustment Expenses – Under SSAP 85, *Claim Adjustment Expenses*, Amendments to SSAP 55*, Unpaid Claims, Losses and Loss Adjustment Expenses,* certain claims expenses that actually serve to reduce the number of health services provided or the cost of such services are classified as cost containment expenses. Examples of cost containment expenses include case management expenses, utilization review, detection and prevention of payment for fraudulent requests for reimbursement, and expenses for internal and

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external appeals processes. Examples of other claim adjustment expenses include maintaining records, general clerical and secretarial, office management, supervisory and executive duties and supplies and postage. GAAP does not distinguish between claims adjustment expenses and cost containment expenses.

In addition to the review of Holding Company Form B filings and SEC filings, which include financial statements prepared based on GAAP, the analyst should also consider requesting and analyzing GAAP financial statements as well. Although GAAP financial statements are not required for most health entities that are not publicly traded, many of these health entities do prepare GAAP financial statements for internal analysis. Comparing financial results based on SAP to those based on GAAP for a health entity can provide meaningful information to the analyst regarding the health entity's profitability on a going-concern basis.

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I. Introduction – F. Prioritization of Work

The NAIC Policy Statement on Financial Regulation Standards indicates that a state insurance department's financial analysis process should be priority based to ensure that potential problem health entities are reviewed promptly and that the prioritization scheme should utilize the state insurance department's own regulatory system.

To facilitate the financial analysis process, state insurance departments should establish a system to prioritize or classify health entities according to the health entity's relative stability and the perceived need for analysis. This prioritization system may be either formal, including the assignment of priority designations, or informal in nature. States with a small number of domestic health entities may consider all of their domestic health entities to be priority companies. However, states with a larger number of domestic health entities generally have more formal prioritization systems. In these states, prioritization is necessary because a state insurance department's financial analysts are not able to thoroughly analyze the financial condition of all health entities immediately upon receipt of the Annual Financial Statement, the Quarterly Financial Statement and the supplemental filings.

An insurer's priority level should be reconsidered as the result of each review performed to determine whether the designation is still appropriate. However, changes in priority levels should only be made after approval by senior insurance department personnel.

Although prioritization, to a large extent, is subjective, a state insurance department should establish guidelines to assist in the consistent assignment of priority designations to its health entities. Factors which should be given consideration in the state insurance department's prioritization system include, but are not limited to, the following:

1. Results of the prior year analysis (including the analysis of the Annual Financial Statement, Quarterly Financial Statements and the various supplemental filings)
2. Whether the insurer was a validated "Level A" or "Level B" company in the prior year by the Analyst Team
3. Adequacy of the health entity's capital and surplus
4. Significant changes in the health entity's capital and surplus
5. Negative trends in income and/or cash flow
6. Annual and quarterly Scoring System results
7. Changes in the health entity's management or board of directors
8. Results of the Annual NAIC *Financial Analysis Handbook*, Level 1 Procedures
9. Examination reports issued (financial condition and market conduct)
10. Analysis Performed by the NAIC Financial Analysis Working Group
11. Information from other divisions or areas of the insurance department
12. Independent rating organization ratings and reports
13. Any reports that may be available from the state's Department of Health or other state agencies with financial solvency oversight responsibilities
14. Impact on the public of a health entity's insolvency

As a general rule, financial statements and other materials pertaining to those high priority health entities should be reviewed before lower priority health entities. In addition, the review of high priority health entities might be more in-depth than the review of lower priority health entities.

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II. Financial Analysis Framework

II. Financial Analysis Framework – Overview of Financial Analysis Process

Overview of the Financial Analysis Process

Financial analysis is an on-going process which can be divided into annual cycles, each of which includes the analysis of the Annual Financial Statement, Quarterly Financial Statements and the various supplemental filings including the Statement of Actuarial Opinion, Management's Discussion and Analysis (MD&A), Audited Financial Reports, and Holding Company Filings. The financial analysis process is designed to assist the analyst in reviewing and analyzing health entities throughout the annual cycle in a logical manner, focusing on areas of concern pertaining to the particular health entities being analyzed. The end result of this process is a financial analysis of each health entity specifically tailored to the concerns of that health entity as a result of its unique investments, underwriting, reserving and operations. Some of the financial analysis procedures are to be completed for all domestic health entities, while other procedures will only be completed if concerns are noted.

Procedure Description	Complete for All Domestics	Complete if further concern
Level 1 Annual Procedures , Annual Financial Statement, Annual Scoring, Financial Profile Report	√	
Level 2 Annual Procedures	*	√
Level 3 Procedures		√
Supplemental Procedures:		
Audited Financial Reports	**	√
Statement of Actuarial Opinion	**	√
Mgmt's Discussion & Analysis (MD&A)	**	√
Holding Company Analysis		√
Forms A, B** D, E, & Extraordinary Dividends		
Quarterly Procedures, Quarterly Financial Statement, Quarterly Scoring, Financial Profile Report	√	

* As discussed on the following page, the state should determine, based on the characteristics of its domestic industry, when and to what extent the Annual and Quarterly Level 2 Procedures, or any similar analyses designed to meet the same objectives, should be used. Some Level 2 Annual Procedures or similar analysis should be performed for areas significant to the insurer.

** The completion of Supplemental Procedures or similar analysis is recommended for all multi-state insurers.

The following provides an overview of the Handbook's analysis process for an annual cycle, which focuses on the various documents filed with the insurance department by a health entity. The annual cycle is also presented in flowchart format at the end of the chapter.

NOTE: All references throughout this Handbook to the risk-focused surveillance approach, Insurer Profile Summary, and Supervisory Plan apply only to states that have adopted and implemented the risk-focused surveillance approach. The ownership and responsibility for updates to the Insurer Profile Summary may vary from state to state between the analysis and examination departments.

Annual Financial Statement

A health entity is required to file an Annual Financial Statement with the state of domicile, the NAIC and all states in which the health entity is authorized to transact business by March 1 of each year for the 12 months ended December 31 of the previous year. The Annual Financial Statement information is loaded onto the NAIC database at which time the Annual Scoring System ratios are calculated and the NAIC Annual Financial Profile Reports and Handbook results are generated. All of this information is available to the state insurance departments via I-SITE.

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II. Financial Analysis Framework – Overview of Financial Analysis Process

The analysis of the Annual and Quarterly Financial Statements has been divided into three levels. The Level 1 analysis is to be performed for all domestic health entities. Level 2 and Level 3 analyses may be completed as a result of concerns identified in Level 1 at the department's discretion based on the materiality of the concerns noted and their prior knowledge of the domestic health entity. At any level of analysis, the department may determine there is no further concern, or proceed directly to regulatory action. Following is a detailed discussion of each level of Annual Financial Statement analysis.

Level 1 Annual Analysis

The Level 1 analysis, which is to be performed for all domestic health entities, consists of an overall analysis of the health entity and its operations. As part of the Level 1 analysis, the analyst should review the NAIC's I-SITE Analyst Team System Report, Annual Scoring System Report, and the information included in the Annual Financial Profile Report for the health entity. In addition, the analyst should perform the Level 1 Procedures or any similar analysis designed to meet the same objectives. Level 1 Procedures require the analyst to review the analysis performed during the prior year and to perform an overall review of the Annual Financial Statement, including a review of the General Interrogatories and Notes to the Financial Statements. Other reports to be reviewed are the Audited Financial Report, Statement of Actuarial Opinion, MD&A, and Holding Company Filings, and examination report and findings when they are filed.

The analyst should ensure that those health entities, which have been identified and prioritized as having significant concerns as a result of the Level 1 analysis or other levels, if performed, would be subsequently analyzed on a priority basis for their future filings. The analyst should consider utilizing these prioritization tools: Analyst Team System Report, Annual Scoring System Report and Risk-Based Capital (RBC) report. The analyst should also consider the results of the completion of the Level 1 Procedures, similar analysis or department policy.

There are five elements of the risk-focused surveillance cycle:

- The first element is Risk-Focused Examination, which addresses the need to identify key functional activities, risks, controls, and establish procedures and conduct an examination.
- The second element is Off-Site Focused Financial Analysis, which includes the use of all financial tools, such as ratio analysis.
- The third element is Internal/External Changes, which reviews any overall modifications to the health entity, such as corporate structure or management changes.
- The fourth element addresses the use of a Priority System to establish a priority of health entity reviews.
- The final element is the Supervisory Plan, which addresses the overall oversight of the health entity.

As part of the risk-focused surveillance approach, the analyst should work with the examination staff to assess the quality and reliability of corporate governance in order to identify, assess and manage the risk environment facing the health entity. This assessment will assist in identifying current or prospective solvency risk areas. Refer to Analyst Reference Guide for Level 1 Analysis for further discussion on prospective risk. By understanding the corporate governance structure and assessing the "tone at the top," the analyst will 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. To assist in this assessment, analysts may utilize:

1) Board and audit committee minutes
2) List of critical management and operating committees, their members and meeting frequencies
3) Examination findings related to the health entity's risk assessment and risk management activities
4) Sarbanes-Oxley filings and similar filings through the NAIC Model Audit Rule, as applicable

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II. Financial Analysis Framework – Overview of Financial Analysis Process

At the conclusion of the Level 1 analysis, the analyst must determine whether to proceed to the Level 2 analysis. This determination should be approved in accordance with departmental procedure. States can make this decision in a variety of ways. For example, in some states, Level 2 analysis may be completed for all domestic health entities. Other states may require certain portions (e.g., investments, reserves and reinsurance) of the Level 2 analysis to be completed for all domestic health entities. Still other states may require Level 2 analysis be completed only for those domestic health entities that meet certain criteria established by the state. The department may also proceed directly to the additional procedures listed in Level 2, Level 3 or other regulatory action authorized or required by state insurance law, regulation or department policy. Alternatively, the analysis may be concluded with only the Level 1 review. The analyst should also document any correspondence or follow-up with the health entity as a result of the Level 1, 2, 3 or Supplemental Procedures. At the completion of the analysis process, including any Level 1, 2, 3 or Supplemental Procedures, the analyst should update the Insurer's Profile Summary, if applicable (see Level 1 Analyst Reference Guide).

Level 2 Annual Analysis

Because of the importance of financial analysis in the state's overall financial regulation and solvency surveillance process, the NAIC recommends that consideration be given to performing some portion of the Level 2 analysis for multi-state domestic health entities. The NAIC believes that the Level 2 analysis (or applicable sections of that analysis) should be performed for multi-state domestic health entities with unresolved concerns identified as a result of prior analysis performed. Other factors, such as the health entity's past regulatory history, accuracy of filing, age of health entity, stability of business plan, and knowledge of company's operations, may affect the extent to which Level 2 procedures are considered necessary.

The Level 2 analysis consists of the completion of Level 2 Annual Procedures. These procedures have been designed to identify potential areas of concern regarding the financial position and operations of the health entity primarily through the use of ratio and trend analysis. The Level 2 Annual Procedures are divided into sections, each of which focus on a key area (e.g., investments, other assets, health reserves, other provider liabilities, income statement and surplus, affiliated transactions, the use of TPAs, IPAs and MGAs, risk transfer, and etc.) and utilize information available from the Annual Financial Statement filed by the health entity. Each section includes one or more procedures focusing on a particular potential concern, and each procedure includes one or more questions designed to assist the analyst in determining whether there is a concern which requires additional analysis in that area. If the analyst has questions regarding procedures included in any of the sections of the Level 2 Annual Procedures, reference should be made to the Analyst Reference Guide for a discussion of the procedures.

At the end of each section of the Level 2 Annual Procedures, the analyst is asked to do the following: 1) develop and document an overall conclusion regarding the section; 2) determine if one or more of the procedures in the Level 3 Procedures for this section should be completed; and 3) describe the rationale for this recommendation or recommend proceeding directly to other regulatory action. The analyst should also document any correspondence or follow-up with the health entity. It may be appropriate that this information be reviewed and approved prior to the analyst completing any of the procedures in the Level 3 Procedures. In addition, at the conclusion of an analysis, a management report should be prepared and distributed to senior personnel, which summarizes the results of the analysis performed, including the priority level assigned to each insurer, should be prepared and distributed to senior personnel.

Level 3 Annual Analysis

For those areas where concerns are identified as a result of the completion of the Level 2 Annual Procedures, Level 3 analysis could be performed. The Level 3 analysis consists of the completion, by the analyst, of one or more procedures in the Level 3 Procedures for those areas where concerns exist. The suggested procedures for the analyst to consider are keyed to specific concerns identified as a result of completion of procedures in the Level 2 Annual Procedures and are designed to assist the analyst in focusing on those areas. If the analyst has questions

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regarding procedures included in any of the Level 3 Procedures, reference should be made to the Analysts Reference Guide. Some of the procedures in the Level 3 Procedures require the analyst to obtain additional information from the health entity that is not available from the filed Annual Financial Statement. Therefore, it is important that the procedures that the analyst proposes be discussed with and approved by the analyst's supervisor prior to completion of the procedures. At this time, consideration of more substantive regulatory action may be warranted or a more efficient utilization of department resources.

At the end of the Level 3 Procedures for each area, the analyst is asked to develop and document an overall conclusion regarding the area and to indicate recommendations for further action, if any. Recommendations for further action might include contacting the health entity seeking explanations or additional information, obtaining the health entity's business plan, requiring additional interim reporting from the health entity, referring concerns to the examination section for a targeted examination, engaging an independent expert to assist in determining whether a problem exists, meeting with the health entity's management, obtaining a corrective plan from the health entity, etc. At the conclusion of the Level 3 Procedures, a management report should be prepared and distributed to senior insurance department personnel. As discussed above, the management report should summarize the results of the analysis performed, any recommendations for further action and any adjustment to the priority level.

It is important for the analyst's supervisor to be actively involved in each level of the financial analysis performed on the Annual Financial Statement. It is also important that the review and supervision be performed on a timely basis.

Quarterly Financial Statements

A health entity is required to file Quarterly Financial Statements for the first, second and third quarters with the state of domicile, the NAIC and, in most instances, all states in which the health entity is authorized to do business by May 15, August 15 and November 15, respectively. The Quarterly Financial Statement is loaded onto the NAIC database, at which time the Quarterly Scoring System ratios are calculated and the Quarterly Financial Profile Report is generated. This information is available to the state insurance departments via I-SITE.

The Quarterly Financial Statement Level 1 analysis is to be completed for all domestic health entities. As part of the Quarterly Level 1 analysis, the analyst should review the Annual Financial Statement Level 1, Level 2 and Level 3 Procedures that were prepared and any quarterly procedures, which had previously been completed for the health entity. In addition, the analyst should review the NAIC Quarterly Financial Profile Report, Quarterly Scoring System Report, and the Quarterly Financial Statement. The Quarterly Level 1 Procedures are designed to identify potential areas of concern regarding the financial position and operations of the health entity primarily through the use of ratio and trend analysis to indicate significant fluctuations from the prior quarter, prior year quarter, or prior year-end. The analyst will make the same determinations for the Annual Level 1 Procedures whether to proceed with additional analysis or other procedures.

The Level 2 Quarterly Procedures are divided into sections, each of which focuses on a key area for more in-depth review (similar to the Annual), and utilizes information available from the Quarterly Financial Statements. Each section includes one or more procedures designed to assist the analyst in determining whether there is a concern in a particular area which requires additional in-depth analysis and a determination similar to those required in the Level 2 Annual Procedures. If the analyst has questions regarding procedures included in any of the sections of the Level 2 Quarterly Procedures, references should be made to the Analyst Reference Guide (See Section III).

As part of the risk-focused surveillance approach, the analyst should work with the examination staff to assess the quality and reliability or corporate governance as discussed in the Annual Financial Statement section above.

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II. Financial Analysis Framework – Overview of Financial Analysis Process

At the end of each section of the Level 2 Quarterly Procedures, the analyst is asked to: 1) develop and document an overall conclusion regarding the section; 2) recommend whether one or more of the procedures in the Level 3 Procedures for this section should be completed (if not completed during the annual analysis); and 3) describe the rationale for this recommendation or recommend other substantive regulatory action. The analyst should document any correspondence or follow-up with the health entity. It may be appropriate that this information be reviewed and approved prior to the analyst completing any of the procedures in the Level 3 Procedures. The analyst should document any correspondence or follow-up with the health entity. For a discussion of the completion of the Level 3 Procedures, refer to the discussion of the Annual Financial Statement Level 3 Analysis above. In addition, at the conclusion of an analysis, a management report should be prepared and distributed to senior personnel, which summarizes the results of the analysis performed, including the priority level assigned to each health entity.

Audited Financial Report

Virtually all health entities are required to file, as a supplement to the Annual Financial Statement, an Audited Statutory Financial Report completed by an independent auditor, the auditor's letter of qualifications and, if applicable, a report of significant deficiencies in the health entity's internal control structure with the state of domicile, the NAIC and all states in which the health entity is authorized to do business by June 1 of each year and for the 12 months ended December 31 of the previous year.

The Audited Financial Report review is to be completed for domestic health entities if the Level 1 analysis indicated further procedures were necessary. The analyst should review any Level 2 and Level 3 Annual Procedures performed and complete the Audited Financial Report Supplemental Procedures. The Audited Financial Report Supplemental Procedures are designed to assist the analyst in reviewing the Audited Financial Report, CPA's letter of qualifications and other reports filed to determine that they meet the requirements of the *Annual Financial Statement Instructions*, that amounts per the Audited Financial Report agree with the Annual Financial Statement filed with the insurance department, and to identify significant information and explanatory language included in the CPA's opinion or the Notes to the Audited Financial Report.

At the end of the Audited Financial Report Supplemental Procedures, the analyst is asked to develop and document an overall conclusion and to indicate recommendations for further action. Recommendations for further action might include contacting the health entity seeking explanations or additional information from either the health entity or the independent CPA, obtaining the health entity's business plan, requiring additional interim reporting, referring concerns to the examination section for a targeted examination, meeting with the health entity's management or obtaining a corrective plan.

Statement of Actuarial Opinion

Virtually all health entities are required to file, as a supplement to the Annual Financial Statement, a Statement of Actuarial Opinion with the state of domicile, the NAIC and all states in which the health entity is authorized to transact business by March 1 of each year covering the reserves as of December 31 of the previous year. The Statement of Actuarial Opinion must be completed by a qualified actuary.

The Statement of Actuarial Opinion review is to be completed for all domestic health entities as part of the Level 1 analysis and, if indicated, the analyst should complete the Statement of Actuarial Opinion Supplemental Procedures. If the Level 1 analysis indicates further procedures are necessary, the analyst could review the reserves and reinsurance sections of the Level 2 and 3 Annual Procedures. The Statement of Actuarial Opinion Procedures have been designed to assist the analyst in reviewing the Statement of Actuarial Opinion to determine that it meets the requirements of the *Annual Financial Statement Instructions*, that reserve amounts per the Statement of Actuarial Opinion agree with the reserve amounts per the Annual Financial Statement filed with the

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insurance department, and to identify significant information and explanatory language regarding the health entity which has been emphasized by the qualified actuary.

At the end of the Statement of Actuarial Opinion Supplemental Procedures, the analyst is asked to develop and document an overall conclusion and to indicate recommendations for further action. Recommendations for further action might include contacting the health entity seeking explanations or additional information, obtaining the health entity's business plan, requiring additional interim reporting from the health entity, referring concerns to the examination section for a targeted examination, consulting with an in-house actuary, engaging an independent actuary to assist in determining whether a problem exists, meeting with the health entity's management or obtaining a corrective plan from the health entity.

Management's Discussion and Analysis

A health entity is required to file, as a supplement to the Annual Financial Statement, an MD&A with the state of domicile, the NAIC and all states in which the health entity is authorized to do business by April 1 of each year. The purpose of this narrative document is to assist the analyst in understanding the health entity's financial position, prospective information, material changes, liquidity (i.e., asset/liability matching and capital resources), loss reserves, off-balance sheet arrangements, participation in high yield financings, highly leveraged transactions or non-investment grade loans and investments, and preliminary merger/acquisition negotiations.

The MD&A review may be completed for all domestic health entities if Level 1 analysis indicated further procedures were necessary. The analyst should review the Level 2 and 3 Annual Procedures, if completed, and complete the MD&A Supplemental Procedures. The MD&A Procedures are designed to assist the analyst in reviewing the MD&A to determine that the information included meets the requirements of the *Annual Financial Statement Instructions* and to identify concerns.

At the end of the MD&A Procedures, the analyst is asked to develop and document an overall conclusion and to indicate recommendations for further action. Recommendations for further action might include contacting the health entity seeking explanations or additional information, obtaining the health entity's business plan, requiring additional interim reporting, referring concerns to the examination section for a targeted examination, meeting with the health entity's management or obtaining a corrective plan from the health entity.

Flow Charts

The following flow charts illustrate the annual cycle of the financial analysis process. The flow chart generally indicates that a "Yes" response results in further analysis. However, if a health entity's RBC is below 200 percent, a state insurance department may determine it is necessary to take the required legal action immediately, prior to any further analysis.

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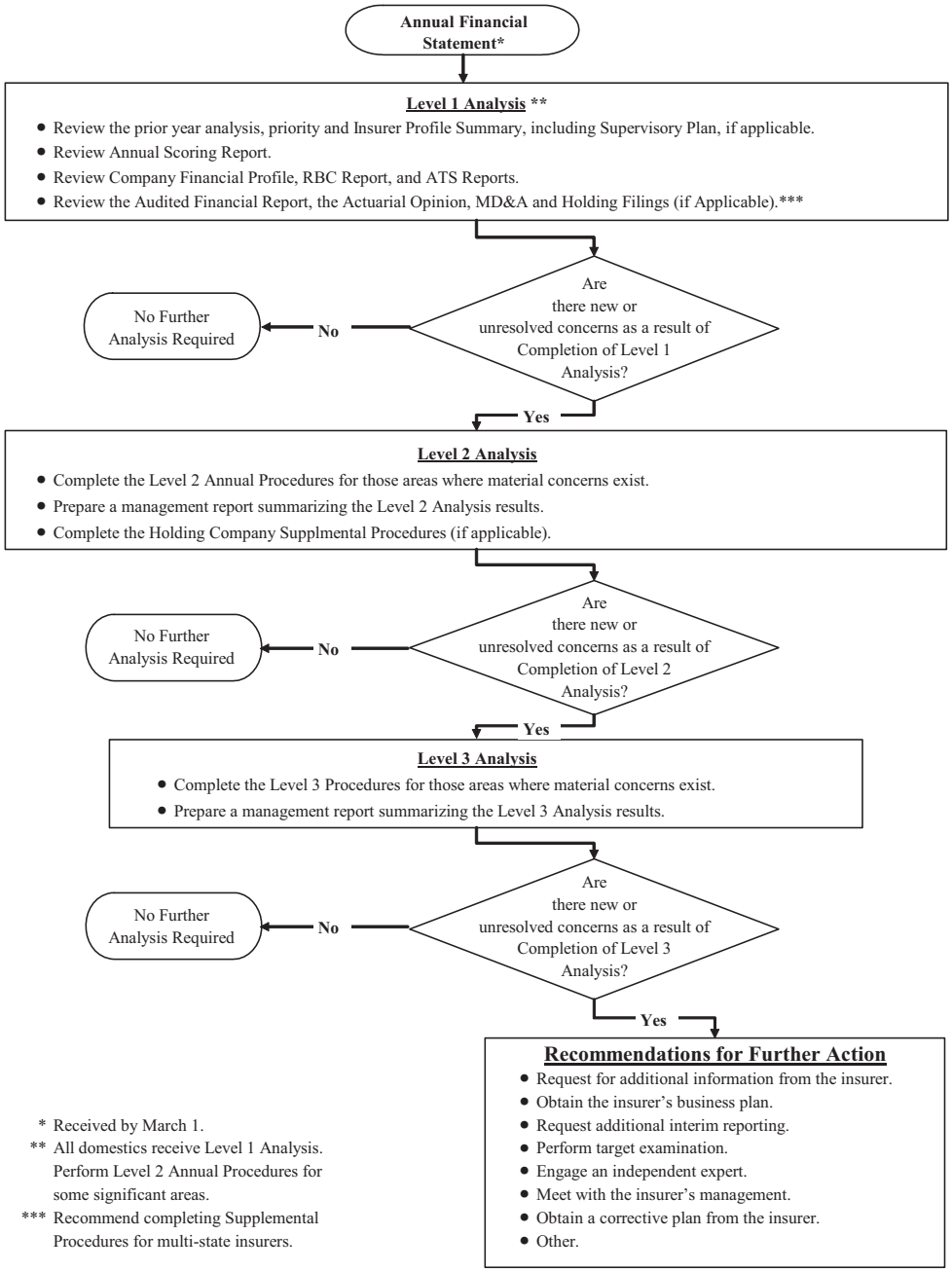
II. Financial Analysis Framework – Overview of Financial Analysis Process



* Received by March 1.
** All domestics receive Level 1 Analysis. Perform Level 2 Annual Procedures for some significant areas.
*** Recommend completing Supplemental Procedures for multi-state insurers.

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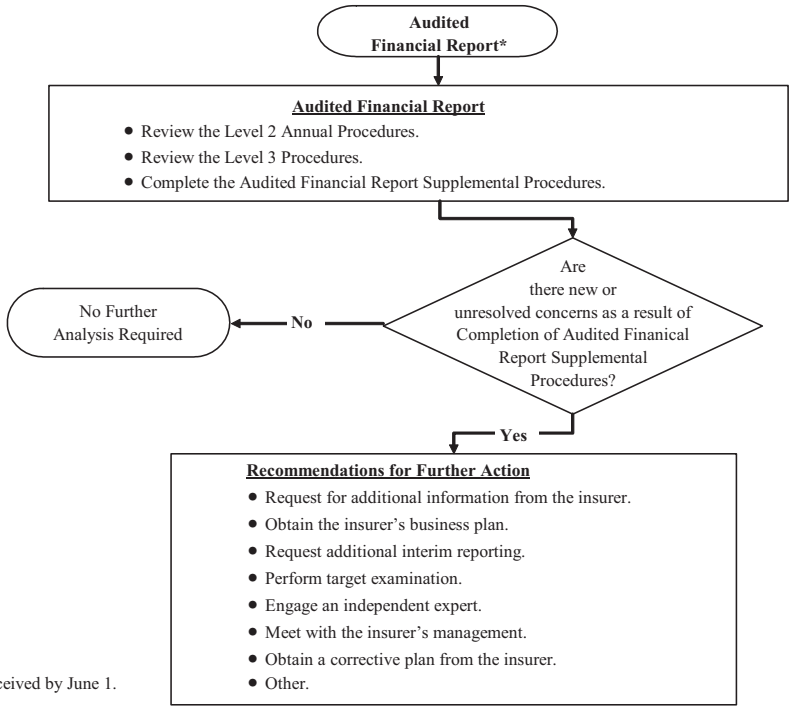
II. Financial Analysis Framework – Overview of Financial Analysis Process



* Received by June 1.

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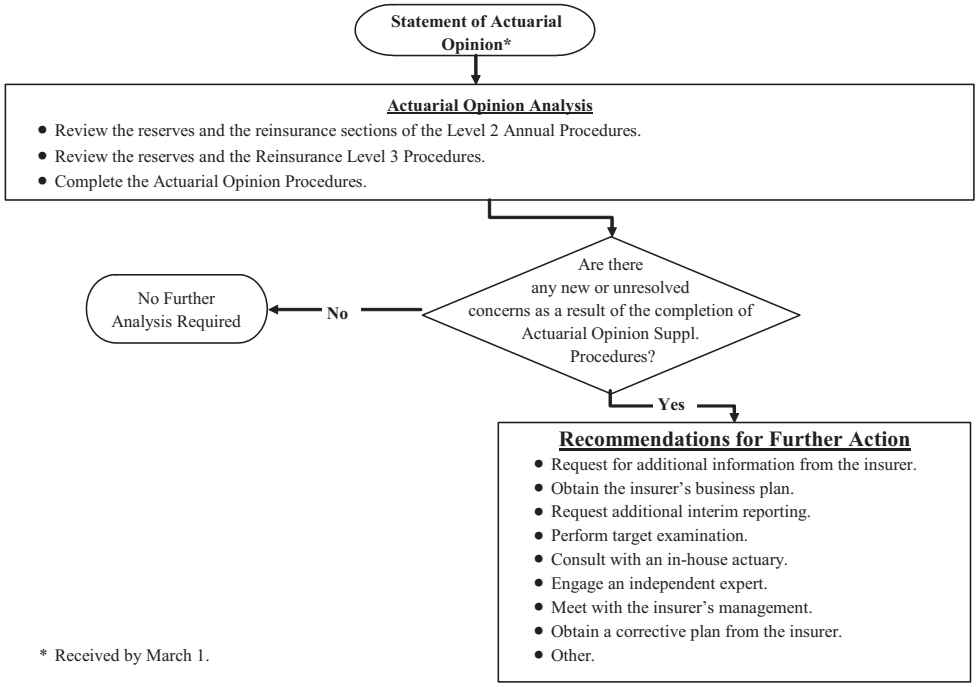
II. Financial Analysis Framework – Overview of Financial Analysis Process



* Received by March 1.

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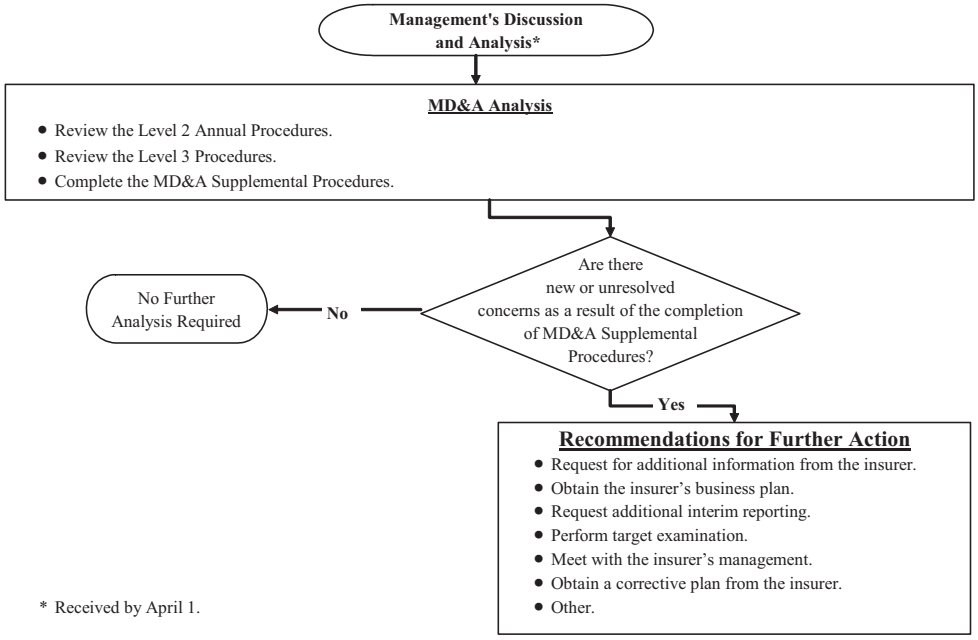
II. Financial Analysis Framework – Overview of Financial Analysis Process



* Received by April 1.

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Other Financial Procedures

The Holding Company Analysis Supplemental Procedures review may be completed for domestic insurers if Level 1 Analysis indicated further holding company analysis was necessary. The Holding Company Analysis Supplemental Procedures encompass the following analysis areas:

- Understanding the holding company structure
- Lead state and interstate communication
- Financial condition of the holding company

Depending on the level of concern, the Holding Company Analysis Supplemental Procedures may need to be completed in part or in total.

The following checklists are included within the Holding Company Analysis Supplemental Procedures.

Forms A, D, E 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
The Form A review is to be completed for all acquisitions, mergers or changes in control. Form A is filed with the domestic state of each insurer in the group. The analyst should review the transaction and all applicable documents and complete the Form A Procedures, when necessary.

Form B
The Form B review is to be completed for all insurers that are members of a holding company system if Level 1 analysis indicated further procedures were necessary. The analyst should review the affiliated transactions section of the Level 2 and Level 3 Annual Procedures, if completed, and complete the Form B Procedures. The Form B Procedures are designed to assist the analyst in reviewing Form B to determine that the appropriate information has been filed and whether concerns exist regarding the financial position of the ultimate controlling person or any of the affiliated transactions or agreements.

Form D
The Form D review is to be completed for all prior notices of material transactions. Form D must be filed with the domestic state. The analyst should review the transaction and all applicable documents and complete the Form D Procedures, when necessary.

Form E or Other Required Information on Competitive Impact
The Form E or other review of competitive impact is to be completed for all pre-acquisition notifications regarding the potential competitive impact of a proposed merger or acquisition by a non-domiciliary insurer doing business in the state or by a domestic insurer. Form E or other required information must be filed with the domestic state. The insurer may also be required to file documents with the Federal Trade Commission under the Hart-Scott-Rodino Act. The analyst should review the transaction and all applicable documents and complete the Form E Procedures, when necessary.

Extraordinary Dividends/Distributions
The extraordinary dividend review is to be completed for any domestic insurers planning to pay any extraordinary dividend or make any other extraordinary distribution to its shareholders. Such dividends and distributions must receive proper prior regulatory approval. The analyst should review the transaction and all applicable documents and complete the Extraordinary Dividends Procedures, when necessary.

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II. Financial Analysis Framework – Overview of Financial Analysis Process

At the end of the Holding Company Analysis Supplemental Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the information reviewed and to indicate recommendations for further action, if any, based on the procedures performed. Recommendations for further action might include contacting the insurer seeking explanations or additional information, obtaining the insurer's business plan, requiring additional interim reporting, referring concerns to the examination section for a targeted examination, meeting with the insurer's management, or obtaining a corrective plan from the insurer.

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III. Analysts Reference Guide

Level 1

A. Level 1 Annual Procedures

Level 2 & 3

B.1. Investments

B.2. Other Assets

B.3. Health Reserves and Liabilities

B.4. Other Provider Liabilities

B.5. Income Statement and Surplus

B.6. Risk-Based Capital

B.7. Cash Flow and Liquidity

B.8. Risk Transfer Other Than Reinsurance

B.9. Reinsurance

B.10. Affiliated Transactions

B.11. TPAs, IPAs and MGAs

Supplemental

C.1. Audited Financial Reports

C.2. Statement of Actuarial Opinion

C.3. Management's Discussion and Analysis

C.4. Holding Company Analysis

III. Analysts Reference Guide – A. Level 1 Annual Procedures

Financial Analyst Role

During the risk-focused surveillance approach, the financial analyst role is to provide continuous off-site monitoring of a health entity's financial condition, monitor internal/external changes relating to all aspects of the health entity, maintain a prioritization system and work with the examination staff to develop an ongoing Supervisory Plan as well as update the Insurer Profile Summary, if applicable.

Overview of Level 1 Procedures

The objective of the Level 1 Procedures is to perform a sufficient level of analysis of all domestic health entities in order to derive an overall assessment that highlights areas where a more detailed analysis, as found in the Level 2 Procedures, may be necessary. As part of the Level 1 Analysis, the analyst will review the health entity's Annual Scoring System Report, Analyst Team Validated Level, RBC results, and the information included in the Financial Profile Report. The Level 1 Procedures require the analyst to review the prior year's analysis of the health entity and to perform a general review of the current year's Annual Financial Statement, along with an assessment of supplemental filings, including the Audited Financial Report, Statement of Actuarial Opinion, Management's Disscussion and Analysis (MD&A), and the varous holding company filings (e.g., 10-K, Form A, etc.).

The analysts should have a firm understanding of the following risk classifications:

- **Credit -** Amounts actually collected or collectible are less than those contractually due.
- **Market -** Movement in market rates or prices—such as interest rates, foreign exchanges rates or equity prices—adversely affects the reported and/or market value of investments.
- **Pricing/Underwriting -** Pricing and underwriting practices are inadequate to provide for risks assumed.
- **Reserving -** Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.
- **Liquidity -** Inability to meet contractual obligations as they become due because of an inability to liquidate assets or obtain adequate funding without incurring unacceptable losses.
- **Operational -** Operational problems such as inadequate information systems, breaches in internal controls, fraud or unforeseen catastrophes resulting in unexpected losses.
- **Legal -** 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.
- **Strategic -** 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.
- **Reputational -** Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.

A prospective risk is a residual risk that impacts future operations of a health entity. These anticipated risks arise due to assessments of company management and/or operations or risks associated with future business plans. Types of risks may include underwriting, investments, claims, and reinsurance. The analyst's understanding of the above nine risk classifications includes an assessment of the level of that risk and the ability of the health entity to appropriately manage the risk during the current period and prosepctively. These prospective risks require assessment and identification of how they may evolve related to the health entity's overall risk profile. Understanding how risks that may or may not appear urgent now will potentially impact future operations, and how management plans to address those risks is key to prospective risk analysis. The assessment of these nine risk classifications both currently and prospectively should be part of the quantitative and qualitative analysis completed within the Level 1, 2, 3 and Supplemental procedures. The *Financial Condition Examiners Handbook* provides guidance on prospective risks within Exhibit O—Examples of Risks and Exhibit V—Prospective Risk Assessment.

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At the conclusion of the Level 1 Procedures, the analyst is asked to document an overall summary and conclusion regarding the financial condition of the health entity, as well as the health entity's strengths and weaknesses, determine whether the health entity is considered a priority company, and whether one or more of the procedures in the Level 2 Procedures should be completed. Because some items, such as the Audited Financial Report and the various holding company filings are not required to be filed until after most of the annual review is completed, the analyst will document a conclusion based on the Level 1 Procedures and the current analysis of the health entity. The Audited Financial Report and the various holding company filings should be reviewed upon receipt and, if additional concerns are noted, the conclusion or the first quarter conclusion should be revised to reflect the most recent information. Similarly, as the analyst completes the Level 2 Procedures, the Level 1 conclusion should be reviewed and revised as necessary with any follow-up information or similar updates made to the first quarter conclusion. At the completion of the analysis process, including any Level 1, 2, 3 or Supplemental Procedures, the analyst should update the Insurer Profiles Summary, if applicable, and communicate with financial examination staff.

Insurer Profile Summary

The Insurer Profile Summary is a "living document" maintained by the state of domicile to "house" summaries of risk-focused examinations, financial analysis, internal and external changes, priority scores, supervisory plans, and other standard information.

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 health entity. The analyst should work with the examination staff to update the Insurer Profile Summary, including the Supervisory Plan, if applicable. The Supervisory Plan should be developed using the most recent examinations and annual and quarterly analysis results. 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 health entity under its jurisdiction). The Supervisory Plan should include the type of surveillance planned, the resources dedicated to the oversight, and the coordination with other states.

Continual Review Process

The above-mentioned review of the Audited Financial Report and the Holding Company Analysis Procedures highlights the importance of a continual review process. This ongoing review process is obvious in these cases but is also necessary in other areas. For example, to the extent that an analyst completes the Level 1 Procedures for a health entity and has concerns with its non-invested assets, the analyst would complete the Level 2 Procedures for Other Assets. Upon completion of the Level 2 Procedures, the analyst may have additional concerns and would complete the Level 3 Procedures for Other Assets. This analysis may result in questions posed to the health entity and additional information being supplied to the analyst.

In some cases, the state may choose to perform a more in-depth analysis of the health entity's receivables, such as a targeted examination. This is just one of the many recommendations that could result from the ongoing analysis of a health entity. Other recommendations include: 1) requesting additional information from the health entity; 2) obtaining the health entity's business plan; 3) requesting additional interim reporting; 4) engaging an independent expert; 5) meeting with the health entity's management; and 6) obtaining a corrective action plan from the health entity. These specific recommendations are included in the Financial Analysis Framework section of the *Handbook* and represent just a few of the potential actions that could result from the ongoing analysis of a health entity.

Regardless of the final outcome, the results of the ongoing analysis should be documented in the appropriate level of the analysis, including the Level 1 conclusion, if applicable.

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Financial Examination Assessment

In performing the procedures related to financial examinations, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments is crucial during the consideration of these procedures. The analyst 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 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 should be structured and written to communicate to regulatory officials examination findings of regulatory importance. This type of communcation includes management letter comments and performace audit comments, where approproiate.

These comments are similar to management letter comments frequently made by CPA firms as a result of their audit. Many insolvencies have been caused by mismanagement. When examiners identify systems, or operational or management problems that exist, performance audit comments are an opportunity to alert management and other readers of the financial examination report to problems that, if left uncorrected, could ultimately lead to insolvency.

Performance audit comments generally contain the following information: 1) a concise statement of the problem found; 2) the factors which caused or created the problem; 3) the materiality of the problem and its effect on the financial statements; 4) the financial condition of the health entity or the health entity's operations; and 5) the examiner's recommendation to the health entity 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 domiciliary state insurance department. Periodically, after a financial examination report has been issued, inquiries should be made to the health entity to determine the extent to which corrective actions have been taken on report recommendations and criticisms. Because the examiners have usually moved on to another examination, many states utilize the financial analysts to perform this function. A lack of satisfactory corrective action by the health entity may be cause for further regulatory action.

Risk-Focused Examinations

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 which are anticipated to arise or extend past the point of completion of the examination. Risks in addition to the financial reporting risks may be reviewed as part of the examination process.

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—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.

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- Phase 4 – Determine Residual Risk—Once this risk is determined, the examiner can determine where to focus resources most effectively.
- Phase 5 – Establish/Conduct Examination Procedures—Upon completion of risk assessment, determine nature and extent of the examination.
- 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 Based on Findings—Incorporate into the examination report and management letter the results and observations noted during the examination.

The goals of the risk-focused examinations are to:

- Assess the quality and reliability of corporate governance to identify, assess and manage the risk environment facing the health entity 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 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. To assist in this assessment, examiners may utilize board and audit committee minutes; list of critical management and operating committees, their members and meeting frequencies; and Sarbanes-Oxley filings and initiatives, as applicable.
- Assess the risk that a company's surplus is materially misstated.

Discussion of Level 1 Annual Procedures

Level 1 Annual Procedures are designed to identify potential areas of concern. As noted above, the principal areas of focus in the Level 1 Annual Procedures include the overall analysis of the health entity and its operations. The following provides a brief description of the purpose of each procedure.

Background Analysis

Procedure #1 provides guidance to the analyst in determining if any conclusions reached in the prior year analysis of the health entity should be considered in the work to be completed for the current year. Areas of concern noted in the prior year should be reviewed carefully in the current year. Health entities who were classified as priority companies in the prior year, either by the state's priority designation, the Scoring System results, the Analyst Team System Validated Level, or the RBC Ratio, should be reviewed carefully in the current year. The analyst should review the Insurer Profile Summary, including the Supervisory Plan, if applicable, for any concerns or risks that may require additional attention during the current analysis being performed.

Procedure #2 alerts the analyst to review all inter-departmental communciation, as well as communication with other state insurance departments and the health entity. Internal communication may include departments such as examination, licensing and admissions, consumer affairs, rate filings, policy/forms analysis, agents' licensing, legal, and market conduct. It may be necessary to communicate with other state departments if a multi-state domestic health entity writes a significant amount of business in other states. Additional communciation with the health entity throughout the year should be reviewed to identify any items or areas that may require special attention during the analysis process. Refer to the Introductory Chapters for further discussion on internal and external communication.

Procedure #3 directs the analyst to determine whether the health entity was a party to a merger or consolidation, which can have a significant impact on the ongoing operations of the health entity. While organizational changes alone may not indicate a problem, knowledge of the change may help the analyst understand the health entity's future plans and goals. Additionally, the analyst should verify that Form A or additional filings have been approved.

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Procedure #4 requires the analyst to review General Interrogatories, Part 1, #6.1 and #6.2, to determine whether the health entity had any Certificates of Authority, licenses or registrations (including corporate registration if applicable) suspended or revoked by any governemental entity during the reporting period and investigate the reason(s) for the action(s).

Procedure #5 directs the analyst to identify if there are recent changes in the state's statutes and regulations that could have an impact on the health entity's financial results or business profile. If so, to the extent that information is available regarding the new statute or regulation, the analyst should determine if the health entity has complied with any new state statutes and/or regulations that have been enacted during the period.

Procedure #6 requires the analyst to review the most recent rating agency report. In many cases, a rating agency downgrade may have an impact on the health entity's ability to generate new business or to retain existing business. The significance of the impact of a downgrade is generally dependent upon the type of product sold by the health entity and the level of the rating given by the agency.

Procedure #7 directs the analyst to review any industry reports, news releases or any emerging issues that have the potential to negatively impact the health entity. An example might include regulatory or media scrutiny of certain insurance lines of business, whether related to market conduct or financial issues. Another example would be changes in the economic environment that may negatively impact investment returns or result in material capital losses.

Procedure #8 directs the analyst to review the business plan of the health entity if it is available from recent surveillance activity, such as previous analysis or examinations, and if a review of the busienss plan is considered necessary based on the health entity's priority designation and financial condition. If reviewed, the analyst should assess if the plan is consistent with current operations and expectations of projected results. For example, consider if the health entity is writing more or less premium or different lines of buiness than outlined in the plan, Consider if the plan is consistent with changes in the makets or geographical areas where business is being written, or new licenses obtained to write business. The analyst should assess significant variances in the business plan through review of the plan and/or through communication with the health entity. If a business plan is not available or current and, based on the analysis performed, the analyst feels it is necessary to request a business plan and recommend further analysis in this area, a procedure exists at the end of Level 1 within the "Recommendations for Further Analysis" section.

Management Assessment

Procedure #9 assists the analyst in determining if changes in the health entity's management or board of directors have occurred. Changes such as these can have a significant impact on the ongoing operations of the health entity and management philosophy. Changes in the board of directors may also indicate changes in the audit committee. When assessing management, the analyst should take into consideration not only the changes in management but also the analyst's and examiner's knowledge about the current management team and any concerns that may exist regarding management. While management changes alone may not indicate a problem, knowledge of these changes may help the analyst understand other potential problems.

With regard to corporate governance, there are many aspects that require consideration, such as: adequate competency; independent and adequate involvement of the Board of Directors; multiple channels of communication; code of conduct between the Board and management; sound strategic and financial objectives; support from relevent business planning; reliable risk management processes; sound principles of conduct; reporting of findings to the Board; adoption of Sarbanes-Oxley provisions; and Board oversight and approval of executive compensation and performance evaluations.

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The analyst should review the Biographical Affidavit for any new officers, directors, or trustees; follow up on any unusual items or areas of concern; and consider whether changes identified will alter management philosophy. The analyst should pay close attention to responses regarding any suspensions, revocations, or non-approval of licenses; conflicts of interest; civil actions; or criminal violations, and follow up on any areas of concern. Communication with other state insurance departments may be necessary if the officer previously worked for a health entity domiciled in another state.

Balance Sheet Assessment

Procedure #10 directs the analyst in identifying significant changes in a health entity's assets, liabilities, and capital and surplus. Significant changes identified in procedure #7 should be explained, to the extent possible. The procedure also assists the analyst in determining if the overall amount of capital and surplus continues to meet Risk Based Capital (RBC) requirements. RBC creates a minimum standard for capital and surplus. Generally, an analyst should be careful not to extend the use of the RBC beyond its intent. For example, a health entity with a 600 percent RBC ratio is not necessarily stronger than a health entity with a 500 percent RBC ratio.

Operations Assessment

Procedure #11 assists the analyst in identifying significant changes in a health entity's Statement of Income. Shifts in net income could indicate a change in premium earned, a change in benefits incurred, or other more complex issues that require further investigation. For this reason, it is critical that the analyst understand material changes within each income and expense category.

Procedure #12 requires the analyst to review the supplemental filings, Medicare Supplement Insurance Experience Exhibit (filed March 1st), the Long-Term Care Experience Exhibit Reporting Form (filed April 1st) and the Accident and Health Policy Experience Exhibit (filed April 1st). These supplemental filings provide added information, and may assist the analyst in understanding inforce, premium, and claims for certain lines of business.

Procedure #13 assists the analyst in identifying unusual results in a health entity's Cash Flow. During the review of the cash flow statement, the analyst should understand shifts in cash inflows and cash outflows that impact cash from operations. The analyst should also investigate investment acquisitions and dispositions, the health entity's investment strategies, and the origin of other sources of cash.

Procedure #14 requires the analyst to identify material ceded reinsurance as reported in Schedule S, Part 3—Reinsurance Ceded, and review all General Interrogatories and Notes to Financial Statements pertaining to reinsurance. The analyst should understand the health entity's reinsurance programs and identify any credit risks. In addition, the analyst should be aware of the types of collateral held for reinsurance with unauthorized reinsurers.

Investment Practices

Procedure #15 assists the analyst in identifying unusual investment management practices of the health entity. These steps are specifically designed to assist the analyst in determining if the health entity has proper control over its investments.

Procedure #16 requires the analyst to review the Summary Investment Schedule to determine if the health entity uses any unusual methods for valuing its invested assets. The Summary Investment Schedule provides a comparison between the gross investment holdings, as valued in accordance with the *AP&P Manual*, and the admitted assets, as valued in accordance with the state of domicile's basis of accounting. This schedule should be reviewed in conjunction with Note #1 of the Annual Financial Statement, *Summary of Significant Accounting Policies*, Section A.

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Procedure #17 requires the analyst to review the Supplemental Investment Risks Interrogatories to determine whether the health entity's investment portfolio is adequately diversified with the appropriate level of liquidity to meet cash flow requirements.

Procedure #18 assists the analyst in determining the amount of assets held as deposits with the states. These deposits are placed with the states to secure the settlement of the health entity's obligations to policyholders, claimants, and others. Health entities with greater than 10 percent of its assets held as deposits with states may hold greater liquidity risk in certain situations.

Review of Disclosures

Procedure #19 requires the analyst to review the Notes to Financial Statements to assist in identifying any relevent quantitative and qualitative information.

Procedure #20 requires the analyst to review the General Interrogatories to assist in identifying any unusual responses.

Assessment of Latest Examination Report and Results

Procedures #21, 22, and 23 assist the analyst in gathering specific information related to the health entity's most recent financial examination. During a review of the examination report, the analyst should note any items or areas that indicate further review is necessary. This might include such things as internal controls issues, risk management, information technology or other issues that could impact the health entity's priority. The analyst should also review the management letter comments which may include risks or progress on issues that the analyst should give attention to the current analysis being performed. Effective communication between the analyst and the examination staff can be very important in developing a good understanding of the health entity's management and financial position. As an example, the examination staff may have specific information on the reliability of the health entity's financial reporting. In addition, the analyst may want to utilize the Exam Tracking System on I-SITE. The analyst should consider the impact, if any, of the Financial Examination Report findings on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (i.e., complete additional supplemental procedures).

Assessment of Results From Prioritization and Analytical Tools

Procedure #24 requires the analyst to review and comment on the Annual Scoring System ratio results of the health entity, which can assist in identifying any unusual financial results.

Procedure #25 requires the analyst to review and understand the assigned Analyst Team System Validated Level, documented within the ATS Report and the ATS Validated Level Report on I-SITE. In addition, the analyst can reference the ATS Procedures Manual and ATS Level Definitions documents on I-SITE. The Analyst Team typically completes the validation process by mid-April.

Procedure #26 requires the analyst to review the Annual Financial Profile Report, which can assist in identifying unusual trends and results.

Procedure #27 alerts the analyst to review communication they have engaged in with the market analysis unit of the Department, including the results of market conduct exams, as well as information drawn from the review of market analysis tools available on I-SITE. Market analysis tools available on I-SITE include Market Analysis Profile (MAP), Examination Tracking System (ETS), Market Analysis Review System (MARS), Regulatory Information Retrieval System (RIRS), Special Activities Database (SAD), Market Initiative Tracking System (MITS) and the Complaints Database. Analysts should review any market conduct issues identified by market analysis staff or I-SITE tools and consider the financial implications those issues may have on the health entity. For example, large fines levied by states, suspensions or revocations of licenses, market conduct exam settlements

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(whether financial or other), or other regulatory actions taken based on market conduct violations may have a material impact on the financial solvency of the health entity.

Assessment of Supplemental Filings

Procedure #28 requires the analyst to review the Statement of Actuarial Opinion to assess the adequacy of the health entity's reserves. See the Statement of Actuarial Opinion Supplemental Procedures for additional guidance in this area.

Procedure #29 requires the analyst to review the MD&A, which can provide additional information to the analysis of the health entity. See the MD&A Supplemental Procedures for additional guidance in this area.

Procedure #30 requires the analyst to review the Audited Financial Report, which helps to assess the reliance placed on the validity of the health entity's financial statements. The Audited Financial Report also contains additional financial information that is generally not included in the Annual Financial Statement and can be helpful to the analyst. See the Audited Financial Report Supplemental Procedures for additional guidance in this area.

Procedure #31 requires the analyst to review the most recent financial statement of the holding company, as filed in the SEC 10-K Report. In addition, the analyst should review Forms A, B, D, E and Extraordinary Dividends/Distributions, if available. If there are affiliated insurers within the holding company group, the analyst should document communication with the domestic departments of insurance for those affiliated insurers.

Discussion of Level 1 Quarterly Procedures

The Level 1 Quarterly Procedures are designed to help the analyst perform a general review of the health entity and its operations. The quarterly procedures are similar to the annual procedures because they are mostly broad-based questions; however, the quarterly procedures include questions that focus primarily on changes from the prior year. At the conclusion of the quarterly Level 1 Procedures, the analyst is asked to do the following: 1) develop and document an overall conclusion regarding the financial condition of the health entity; 2) determine whether the health entity be considered a priority company; and 3) indicate whether one or more of the Level 2 Quarterly Procedures should be completed. As with the annual review, the Level 1 conclusion should be reviewed and revised, as necessary, when subsequent procedures and follow-up with the health entity are completed.

Discussion of Non-Routine Analysis

The Handbook contains procedures that assist an analyst in deriving an overall assessment of the insurer's financial condition; however, situations may exist when it is necessary to perform additional procedures and analysis not contained in the Handbook for one or more insurer.

On occasion events or situations outside of the normal course of business occur that may have a material impact on the overall financial condition of an insurer. During these occasions state insurance regulators may need to perform non-routine analysis, which may require additional reporting from a specific insurer or from a group of insurers. A few examples of these occasions may include significant financial events such as material investment defaults, credit market stress, or catastrophic events. Non-routine analysis may also be appropriate and necessary in situations impacting a single insurer, group, or a small group of insurers. For example, when permitted practices are granted, there may be a need to perform follow-up analysis of the situation requiring the permitted practice, including assessing the realizablity of deferred tax assets. The state may conduct this analysis themselves or enter into an agreed upon procedures audit with CPA firm to assist in the assessment and analysis of the projected future deferred tax assets and the impact to surplus.

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III. Analysts Reference Guide – A. Level 1 Annual Procedures

The following are a few examples of types of non-routine analysis that may be appropriate in an economic downturn, investment defaults, and changes in the credit markets. (Note some or all of these may be applicable in other non-market or investment-related situations as well.)

- Focused analysis on asset quality where insurers hold higher amounts of riskier assets. The analyst should not only consider exposure to individual default events but also aggregate exposure. Additional review or explanation from the insurer may be requested when high amounts of other-than-temporary impairments, unrealized losses and/or large variances between book and market value are reported. The analyst should review the value of affiliated investments and assess indirect exposure to economic events that may result in the decline in the affiliated holdings. Analysts may consider other sources of analysis or information to assist in the review of investments. For example, an analyst may consider requesting a Portfolio Analysis Memorandum from the NAIC Securities Valuation Office.
- Analysts should consider the impact of tightened short-term credit markets on insurers or groups who have dependency on commercial paper, overnight repos, dollar repos, etc. Another area that could be impacted by changes in credit markets is the insurer's ability to obtain letters of credit (LOC) provided for XXX (life reserves) or other reinsurance reserves, and the costs of those LOCs for insurer dependent on LOCs.
- If the insurer engages in securities lending, the analyst may consider requesting detailed information about the program to review the types of assets (risk and duration match) within the program, gain an understanding of the structure and terms of the program and, if material, monitor monthly changes in the program.
- Certain insurance products may be impacted more than others in an economic downturn. The analyst should consider the impact to an insurer that writes a material amount of products that are more likely to be accelerated (e.g. funding agreements, guaranteed interest contract–GICs) or where the liability can be accelerated (e.g., variable annuities, living benefit/death benefit on variable annuities).
- The analyst should consider the level of sensitivity of the insurer to ratings downgrades and the possible impact on the insurer or the group. For example, its ability to market new business or the impact of rating downgrades on any debt covenants. If an insurer is downgraded, the analyst may consider monitoring surrenders, new business sales as well as any changes in the insurer's business plans.
- Where liquidity is a concern, the analyst may also consider requesting interim reporting from the insurers on areas of risk specific to that insurer. For example, surrender activity, high risk investment exposures, GICs, capital and surplus, available liquidity, available credit facilities and capital losses.
- Where significant concerns exist, the state may consider requesting the insurer to perform stress testing on the possible future impacts of additional equity losses, defaults, or other areas relevant to the situation.

Examples of types of non-routine analysis that may be appropriate in catastrophic events.

- Implement disaster reporting requests to appropriate insurers and monitor claims exposure during future periods following the event.
- Identify insurers and reinsurers with material exposure.
- Implement appropriate procedures to identify fraudulent activities.
- Perform an in-depth analysis of liquidity to ensure timely payment of claims.
- Engage legal staff to ensure appropriate claims payment practices.

Additional Reference Sources

1. *Financial Condition Examiners Handbook*, NAIC.

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III. Analyst Reference Guide – B.1. Investments

Overview of Investments

Health entities receive premiums from policyholders today in exchange for a promise to pay covered claims 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 they are needed to pay claims. Although most health entities tend to operate with a fairly liquid investment philosophy compared to other insurers, state insurance laws are still in place to regulate a health entity's investments and prescribe the types of investments that may be acquired by health entities. These laws also generally provide limitations on investments by type and issue. However, in most states, a large amount of the health entity's assets may be invested at the discretion of management or the board of directors within the statutory limits. A health entity 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.

As previously mentioned, 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. Their liquidity philosophy may be driven by their 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 HMDIs, may be able to maintain sufficient liquidity while holding some long-term investments. A significant portion of most health entity's invested assets is maintained in cash and short-term investments. Most health entities also hold the majority of their remaining invested assets in investment grade bonds with somewhat short-term maturities. Although most health entities will maintain a fairly liquid asset mix, the analyst 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's 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, 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. In some cases, management may use strategies to maximize investment yields when losses are higher than anticipated at the time the products were priced. Higher investment yields generally involve higher risk. A shift to higher yield investments may result in the ownership of investments with questionable quality or value.

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.

The principal areas of concern to the analyst in reviewing a health entity's investment portfolio are these: 1) diversification, 2) liquidity, 3) quality, and 4) valuation. First, under most circumstances, a health entity's investment portfolio should be adequately diversified to prevent an undue concentration of investments by type or issue. In order to determine whether diversification is in order, the analyst should take into account both the amount of concentration and the quality of the various types of investments in the portfolio. 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 health entity's benefit commitments as they become due. Generally, cash holdings and scheduled investment maturities should be adequate to fund anticipated net cash outflows. To accommodate unanticipated outflows, 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

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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 preferred stocks which are valued at their fair value. However, the analyst should track investments that may need to be written down to fair value due to impairments in the market.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 of directors.

The nine procedures included in the Investments section of Level 2 Annual Procedures are designed to identify potential areas of concern. As noted above, the principal areas of concern regarding a health entity's investment portfolio are diversification, liquidity, quality and valuation. Most of the procedures are designed to assist the analyst in identifying undue concentrations of investments by type or issue and investments that have been improperly valued in the Annual Financial Statement. As stated in the discussion above, health entities generally hold cash, short-term securities and investment grade bonds. However, a review of all types of potential investments should be performed for health entities. Health entities that also write long-tail business may hold other riskier and/or less liquid securities.

Procedure #1 assists the analyst in determining whether the health entity's investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type or issue. The ratios within the procedure are a measure of diversity of the health entity's investment portfolio by type of investment. The results of these ratios may also provide some indication of the health entity's liquidity. Ratios are included for most types of investments except for government and agency bonds and cash and short-term investments, which are generally very liquid. In addition, the ratio of the investment in any one issue or issuer to total admitted assets is a measure of the diversity of the health entity's investment portfolio.

Procedure #2 assists the analyst in determining whether concerns exist regarding the level of investment in certain types of investments that tend to be riskier and/or less liquid than publicly traded bonds, stocks, cash, and short-term investments. Although most health entities tend to invest primarily in publicly traded bonds and stocks and short-term securities, there are some health entities that may have a significant concentration of riskier investments. In addition to the steps for the types of investments included in procedure #2, the analyst should review procedures #3 and #4 in the Affiliated Transactions section of the Level 2 Annual Procedures and Level 3 procedure #3 in the Level 3 Procedures for Affiliated Transactions for procedures regarding investments in affiliates.

Procedure #2a assists the analyst in determining whether concerns exist due to the level of investment in non-investment grade bonds. Bonds that have NAIC designations of 3, 4, 5 or 6 by the Securities Valuation Office (SVO), are considered non-investment grade bonds and represent a significantly higher credit or default risk to the health entity than do investments in investment grade bonds. In addition, the prices of non-investment grade bonds are frequently more volatile than the prices of investment grade bonds. The NAIC has adopted a Model Regulation on Investments in Medium Grade and Lower Grade Obligations. The Model Regulation establishes limitations on the concentration of non-investment grade bonds because of concerns that changes in economic conditions and other market variables could adversely affect health entities having a high concentration of these types of bonds. While most states have adopted this Model, not all states include all health entities in the scope of the regulation.

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Procedure #2b assists the analyst in determining whether concerns exist due to the level of investment in multi-class securities. Multi-class securities include the following: 1) loan-backed bonds, 2) multi-class residential mortgage-backed securities, and 3) other multi-class securities. Of the multi-class securities, multi-class residential mortgage backed securities are generally the most complex and volatile. Multi-class residential mortgage backed securities convert a pool of mortgage loans into a series of securities that have expected maturities that vary significantly from the underlying pool as a result of slicing the pool into numerous tranches with different repayment characteristics. They are either issued or backed by the United States government, carry very little credit risk, and the health entity will most likely receive par value. As a result, many have been designated category 1 by the SVO. However, the credit rating does not consider the prepayment or interest rate risk inherent in these investments. If the underlying mortgage loans are repaid by the borrowers faster or slower than anticipated, the repayment streams will be affected and the expected durations will either contract or extend. Thus the cash flows on these investments are much more unpredictable than those for more traditional bonds and for mortgage pass-through certificates. If the prepayments are significantly faster than anticipated and the health entity had paid a large premium when it was acquired, the health entity could experience a significant loss on the investment even though the par value was received. In addition, cash flows are harder to match with corresponding payments on losses. This leads to the risk that prepayments may not be able to be reinvested in instruments earning comparable yields.

Procedure #2c assists the analyst in determining whether concerns exist due to the level of investment in privately placed bonds. While Rule 144 and 144A securities are reasonably liquid, most private placement bonds are illiquid. Significant investments in illiquid privately placed bonds may cause the analyst to have concerns regarding the health entity's liquidity because many of these types of investments cannot be resold, while those that can be resold frequently have restrictions as to whom they can be sold. There is no structured market for privately placed bonds like there is for publicly traded bonds. Therefore, even if the privately placed bonds can be sold, it may be difficult to find a willing buyer. Health entities commonly purchase these debt obligations in order to avoid the uncertainties of the market, to engage in private negotiations, and avoid the Securities and Exchange Commission (SEC) restrictions.

Procedure #2d assists the analyst in determining whether concerns exist due to the level or quality of investment in real estate and mortgage loans. These investments are less liquid than many other types of investments. In addition, the analyst may also have concerns regarding the fair value of the real estate whether it is the underlying investment or the collateral for a mortgage loan. Real estate in certain parts of the country has experienced significant declines in fair values from time to time. Most states restrict mortgage loan investments to first liens on property, with some states allowing second liens in instances where the health entity also owns the first lien. Second liens are more risky because, in the event of default, the holder of the first lien would be repaid out of any proceeds from the sale of the underlying property prior to the holder of the second lien.

Procedure #2e assists the analyst in determining whether concerns exist due to the level of investment in other invested assets (Schedule BA). The types of investments included in Schedule BA include collateral loans, limited liability companies, joint ventures and partnerships, oil and gas production, and mineral rights. Joint ventures and partnerships typically involve real estate. These types of assets tend to be fairly illiquid and may contain significant credit risk.

In addition to the steps for the types of investments included in procedure #2, the analyst should review procedures #3 and #4 in Level 2 Annual Procedures for Affiliated Transactions, along with procedure #3 in Level 3 Procedures for Affiliated Transactions.

Procedure #3 assists the analyst in determining whether the purchases and sales of investments were approved by the health entity's board of directors and whether all securities are owned December 31 of the current year, over which the health entity exclusive control, and are in the health entity's possession. Most states require investment

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transactions to be approved by the health entity's board of directors or a subordinate committee. General Interrogatory #14 indicates whether this has been done. General Interrogatories #22.1 and #22.2, indicates whether the stocks, bonds or other securities, of which the health entity has exclusive control (defined by the NAIC as the exclusive right by the health entity to dispose of an investment at will, without the necessity of making a substitution therefore) are in the actual possession of the health entity. If the health entity owns securities, which are not in its possession, they should be held by a custodian under a properly executed custodial agreement in order to be considered admitted assets. General Interrogatories #23.1 and #23.2 indicates whether any of the stocks, bonds or other assets of the health entity are not exclusively under its control. Assets which are not under the health entity's control might not meet the state's requirements to be considered admitted assets.

Procedure #4 assists the analyst in determining whether the securities owned by the health entity have been valued in accordance with the standards promulgated by the SVO. Beginning in 2004, the provisional exemption (PE) identifier in the NAIC *Purposes and Procedures Manual of the SVO (SVO P&P Manual)* was changed to filing exempt (FE). This change expands the exemption to preferred stocks and all NAIC equivalent designations and removes several of the optionality requirements. In conjunction with this change, the SVO compliance certificate was changed to a general interrogatory in the investment section. According to NAIC requirements, all securities purchased that are not filing exempt per the *SVO P&P Manual* should be submitted to the SVO for valuation within 120 days of the purchase. In accordance with the *NAIC Annual Financial Statement Instructions*, if the SVO provides an NAIC designation or price, that designation or price should be utilized. Health entities are required to complete the general interrogatory on compliance filing requirements of the *SVO P&P Manual* and list exceptions as a component of the Annual Financial Statement. This interrogatory should indicate the following: 1) all prices or NAIC designations for the securities owned by the health entity that appear in the Valuations of Securities (VOS) product have been obtained directly from the SVO, 2) all securities previously valued by the health entity and identified with a "Z" suffix (which indicates that the security is not filing exempt, does not appear in the SVO's *Valuations of Securities* Publication *(VOS)* or has not been reviewed and approved in writing by the SVO) have either been submitted to the SVO for a valuation or disposed of, and 3) all necessary information on securities which have previously been designated NR (not rated due to lack of current information) by the SVO have been submitted to the SVO for a valuation or that the securities have been disposed. In addition, the analyst should review Schedule D - Part 1 - Bonds and Schedule D - Part 2 - Preferred Stocks and Common Stocks to determine whether it appears that the health entity is complying with the requirement to submit securities to the SVO for valuation. There should be no securities which were acquired prior to the current year that have a "Z" suffix after the NAIC designation.

Procedure #5 assists the analyst in determining whether the book/adjusted carrying value of bonds and redeemable preferred stocks is significantly greater than their fair value. General Interrogatory Part 1, #28 shows the aggregate book/adjusted carrying value and the aggregate fair value of bonds and preferred stocks owned and requires the health entity to indicate how the fair values were determined. If the book/adjusted carrying value of bonds and redeemable preferred stocks is significantly greater than their fair value, the health entity could realize significant losses if it were forced to sell these investments to cover unexpected cash flow needs due to larger than anticipated losses.

Procedure #6 assists the analyst in determining whether the fair value of common stock is significantly greater or less than the actual cost. The analyst should review Schedule D - Part 2 - Section 2 - Common Stocks Owned December 31 of Current Year, to determine what the aggregate fair value position is in relation to the aggregate actual cost of common stock. The analyst should also review individual stock issues to determine if the fair value is significantly above or below actual cost. If the fair value of a stock issue is significantly below cost (unrealized loss) the health entity may incur a loss upon disposition. However, since common stock is carried on the balance sheet at fair value, this unrealized loss is already reflected in statutory net worth and, therefore, there is no additional reduction in net worth at disposition. On the other hand, if the fair value of an individual stock is significantly greater than the actual cost (unrealized gain) the health entity may be reflecting an unrealized gain

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that might not be realized at disposition. However, the analyst should be careful about drawing conclusions from an unrealized gain. The implications of the gain may depend upon such things as how long the stock has been held or how the purchase price compares to the historical price range of the stock. A significant unrealized gain that has accumulated over a long holding period may simply represent the expected return on the stock, rather than indicating high volatility. In the contrary case, if a volatile stock was purchased at the beginning of its run-up in price, it might have accumulated a very significant unrealized gain, which could disappear later if the fair value decreases. However, if the same stock was purchased near its peak, there might have been little or no unrealized gain, but the stock would have been subject to the same loss in value. Therefore, whenever there are significant holdings of common stock, the analyst should conduct a more in-depth analysis.

Procedure #7 assists the analyst in determining whether concerns exist due to significant purchases or sales of securities near the beginning and/or end of the year. The analyst can identify significant purchases or sales of securities by reviewing Schedule D - Part 3 - Long-Term Bonds and Stocks Acquired During Current Year, Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or otherwise Disposed of During Current Year and Schedule D - Part 5 - Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed of During Current Year. If significant purchases or sales of securities occurred near the beginning and/or end of the year, the health entity might have “rented securities" or engaged in “window dressing” of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring the same or similar lower quality investments after year-end) in an attempt to avoid additional regulatory scrutiny which would have occurred with the health entity’s lower rated investment portfolio.

Procedure #8 assists the analyst in determining whether concerns exist due to the level of investment turnover. The analyst can identify significant turnover by reviewing Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or otherwise Disposed of During Current Year, and Schedule D - Part 5 - Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed of During Year. The turnover ratio represents the degree of trading activity in long-term bonds, preferred, and common stock investments that has occurred during the year. Investment turnover is an indication of whether a buy-and-hold or sell based on short-term fluctuation strategy is utilized. A high turnover of investments generally leads to greater transaction costs, operating expenses and the acceleration of realized capital gains. Sales result from securities reaching a price objective, anticipated changes in interest rates, and changes in creditworthiness of issuers or general financial or market developments.

Procedure #9 assists the analyst in determining whether concerns exist due to the level of investment in derivative instruments. A derivative instrument is a financial market instrument that has a price, performance, value, or cash flow based primarily on the actual or expected price, performance, value, or cash flow of one or more underlying interests. Derivative instruments (which consist of options, caps, floors, collars, swaps, forwards, and futures) are used by some health entities to hedge against the risk of a change in value, yield, price, cash flow, or quantity or degree of exposure with respect to its assets, liabilities, or anticipated future cash flows. Health entities generally do not invest in derivative investments. If a health entity invests in derivative instruments, it is important for the analyst to understand the impact that these derivative instruments have on the investment portfolio of the health entity. For health entities with significant investments in derivative instruments, this will probably require the analyst to obtain the assistance of an actuary.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for the investments section are designed to identify the following: 1) whether the health entity’s investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type or issue, 2) whether the health entity has a significant portion of its assets invested, or has significantly increased its holdings since the prior year-end, in certain types of investments that tend to be riskier and/or less liquid than publicly traded bonds and stocks and cash and short-term investments, 3) whether the health entity has significantly increased its holdings since the prior year-end in certain types of derivatives that tend to be riskier and/or less liquid than publicly traded bonds and stocks and cash and short-term investments, 4)

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whether any of the health entity's assets have been loaned or otherwise made available for use by another person during the quarter, and 5) whether the health entity has complied with the requirements of the *SVO P&P Manual*, which requires all securities to be valued in accordance with standards promulgated by the SVO.

Discussion of Level 3 Procedures

The Level 3 Procedures for Investments are designed to assist the analyst in further investigating potential problems and concerns that are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate further and how far to probe.

Procedure #1 suggests additional steps the analyst may perform if there are concerns regarding whether the health entity's investment portfolio is adequately diversified to avoid concentration of investments by type or issue. The analyst should consider determining whether the health entity's investment portfolio is in compliance with the investment limitations and diversification requirements per the state's insurance laws. The analyst might also review the Percentage Distribution of Assets in the Financial Profile Report for significant shifts in the mix of investments owned during the past five years. The analyst should compare the health entity's distribution of invested assets to industry averages to determine significant deviations from the industry averages. In addition, the analyst might also want to request a copy of the health entity's formal adopted investment plan. This should be evaluated to determine if the plan appears to result in investments that are appropriate for the health entity based on the types of business written and its liquidity and cash flow needs and to determine whether the health entity appears to be adhering to its plan. The analyst might also review Schedule D - Part 1A - Quality and Maturity Distribution of All Bonds Owned and consider the liquidity of the health entity's investments to help determine whether the health entity's investment portfolio appears reasonable based on the types of business written. If the analyst has concerns regarding liquidity or cash flows, he or she should consider having a cash flow analysis performed by an actuary.

Procedures #2 through #6 suggest additional steps the analyst may perform if there are concerns regarding the level of investment in certain types of investments which tend to be riskier and/or less liquid than publicly traded bonds and stocks and cash and short-term investments. In addition to the steps for the types of investments included in procedures #2 through #6, the analyst should consider reviewing procedures #3 and #4 in Level 2 Annual Procedures for Affiliated Transactions and procedure #3 in Level 3 Procedures for Affiliated Transactions regarding investments in affiliates.

Procedure #2 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in non-investment grade bonds. The analyst should consider reviewing Schedule D - Part 1A - Section 1 - Quality and Maturity Distribution of All Bonds Owned and compare the health entity's holdings of non-investment grade bonds to the limitations included in the *NAIC's Investments in Medium Grade and Lower Grade Obligations Model Regulation* by NAIC designation. The health entity should have a plan for investing in non-investment grade bonds that has guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, and geographic location. The analyst might consider requesting a copy of this plan from the health entity to determine whether the health entity appears to be adhering to its plan for investing in non-investment grade bonds. For the more significant non-investment grade bonds, the analyst might also consider requesting from the health entity audited financial statements and a rating agency report for the issuer of the bonds to assess the health entity's current financial position and ability to repay its debt.

Procedure #3 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in multi-class residential mortgage backed securities. The analyst should consider reviewing the multi-class securities categories in Schedule D - Part 1 – Long-Term Bonds Owned for bonds with a book/adjusted carrying value significantly in excess of par value, which could result in a loss being realized if bond prepayments occur faster than anticipated. The analyst should also consider reviewing a listing of the effective yield on each of

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the health entity's multi-class securities. The effective yield on most debt securities is generally linked to its credit risk and duration. However, significant prepayment risk can also increase the effective yield.

There are many different types of multi-class residential mortgage backed securities, each of which have different characteristics and inherent risks. Therefore, the analyst might consider requesting information from the health entity regarding the amount of each type held (e.g., Planned Amortization Class (PACs), support bonds, interest only (IO) and principal only (PO)) to help evaluate the riskiness of the portfolio. A glossary of various commercial mortgage obligation terms is available within the link "Detailed Discussion of CMOs" at the top of the Financial Analysis Handbook Reports page on I-SITE. The document is "An Investors Guide to CMO's."

The analyst might consider requesting information from the health entity regarding estimated prepayment speeds on its multi-class residential mortgage backed securities. Several standardized forms of calculating the rate of prepayments of a mortgage security exist in the market. The Constant Prepayment Rate (CPR) and the Standard Prepayment Model of the Bond Market Association (PSA curve) are the most common methods used to measure prepayments. For further discussion of prepayments speeds and other items that impact the interest rate risk and valuation risk of a mortgage backed security, see the "Mortgage Backed Securities" document included in the "Detailed Discussion of CMOs" link at the top of the Financial Analysis Handbook Reports page on I-SITE. The analyst should consider further analysis in those instances that prepayment risk appears high.

Procedure #4 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in privately placed bonds. The analyst should consider reviewing Schedule D - Part 1A - Section 1 - Quality and Maturity Distribution of All Bonds Owned and Schedule D - Part 1A - Section 2 - Maturity Distribution of All Bonds Owned December 31 by Major Type and Subtype to determine the amount, issue type, NAIC designation, maturity distribution of privately-placed bonds, and the amount of privately-placed bonds which are freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A. For the more significant privately-placed bonds, the analyst should also consider requesting from the health entity current audited financial information regarding the issuer to evaluate the issuer's financial position and ability to repay its debt.

Procedure #5 suggests additional steps the analyst may perform if there are concerns regarding the level or quality of investment in real estate and mortgage loans. If there are concerns regarding real estate owned, the analyst should consider reviewing Schedule A - Part 1 - Real Estate Owned to determine whether updated appraisals should be obtained for any of the properties owned based on the location of the property, the book/adjusted carrying value and reported fair value of the property, and the year of the last appraisal. In addition, for those properties with book/adjusted carrying values in excess of fair value, the analyst might consider whether the asset should be written down. The analyst should also consider investigating any instances where a property has a book/adjusted carrying value in excess of its cost and requesting information from the health entity regarding any increases in book/adjusted carrying value during the year. If there are concerns regarding mortgage loans, the analyst should consider reviewing Schedule B - Mortgages Loans Owned to compare the book/adjusted carrying value of each loan to the value of the land and buildings mortgaged. The analyst should determine whether the mortgage loans are adequately collateralized and whether any of the mortgage loans are to officers, directors or other affiliates of the health entity. For those loans that have had an increase in book/adjusted carrying value during the year, the analyst might consider requesting information from the health entity regarding the increase to determine whether the increase should be considered an admitted asset.

Procedure #6 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in other invested assets. The analyst should consider reviewing Schedule BA - Part 1 – Other Long-Term Invested Assets to determine the amount and types of other invested assets owned and to determine whether they are properly categorized as other invested assets. Information might be requested from the health entity to support any increases by adjustment in book/adjusted carrying value during the year. In addition, the analyst

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should consider requesting current audited financial statements and other documents (e.g., partnership agreements) necessary to support the book/adjusted carrying value of the health entity's investment in partnerships and joint ventures and information to support the book/adjusted carrying value of significant other invested assets (e.g., other than partnerships and joint ventures). For investments in collateral loans the analyst may want to compare the fair value of the collateral to the amount loaned to determine whether the loan is adequately collateralized.

Procedure #7 suggests additional steps the analyst may perform if there are concerns regarding investment approval or control and possession. If there are concerns regarding investment approval, the analyst should consider requesting a copy of the health entity's formal adopted investment plan to determine who is authorized to purchase and sell investments and what approvals are required for investment transactions. If there are concerns regarding investments which are held by someone other than the health entity, the analyst should consider reviewing General Interrogatory #22 in more detail to determine the reason the securities are not in the health entity's possession and who holds the securities in order to evaluate whether they qualify as admitted assets of the health entity under the state insurance laws or whether there are concerns regarding the health entity's ability to have access to the securities when needed. If there are concerns regarding investments which are not under the health entity's exclusive control, the analyst should consider reviewing General Interrogatory #23 in more detail to determine the reason the assets are not under the health entity's exclusive control (e.g., loaned to others, subject to repurchase or reverse repurchase agreements, pledged as collateral, placed under option agreements) and who holds the assets in order to evaluate whether they qualify as admitted assets for the health entity under the state insurance laws or whether there are other concerns.

Procedure #8 suggests additional steps the analyst may perform if there are concerns regarding whether securities have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office. The analyst should consider reviewing Schedule D - Part 1 - Bonds to determine whether all bonds with an NAIC designation of 3, 4, 5 or 6 (non-investment grade bonds) have been valued at their fair value and all other bonds have been valued at their book/adjusted carrying value in accordance with the NAIC *Accounting Practices and Procedures Manual (AP&P Manual)*. The analyst should also consider reviewing Schedule D - Part 2 - Preferred Stocks and Common Stocks to determine whether sinking fund preferred stocks have been valued at their cost and all other stocks have been valued at their fair value in accordance with the NAIC *AP&P Manual*. For those securities listed in Schedule D - Part 1 - Bonds or Schedule D - Part 2 - Preferred Stocks and Common Stocks with a "Z" suffix after the NAIC designation, the analyst might request verification from the health entity that the securities are filing exempt or have been submitted to, and subsequently valued by the SVO. The analyst should compare the price or designation subsequently received from the SVO to that included in the Annual Financial Statement for significant securities. The analyst should also consider using Examination Jumpstart investment analysis (available in I-Site) to compare the CUSIP number, NAIC designation, and fair value for each of the securities listed in Schedule D - Part 1 – Bonds, Schedule D - Part 2 – Preferred Stock and Common Stocks, and Schedule DA – Short-Term Investments to information on the SVO master file.

Procedure #9 suggests additional steps the analyst may perform if there are concerns regarding the significance of any excess of the book/adjusted carrying value over the fair value of bonds and sinking fund preferred stocks. The analyst should consider reviewing Schedule D - Part 1 - Bonds and Schedule D - Part 2 - Preferred Stocks and Common Stocks or requesting information from the health entity to determine which individual bonds and redeemable preferred stocks have a book/adjusted carrying value significantly in excess of their fair value. The analyst should be aware that the fair value for those securities with an "AV" (amortized value) designation in the rate used to obtain the fair value column in Schedule D does not represent a true fair value for the securities. For those securities with a book/adjusted carrying value significantly in excess of their fair value, the analyst might consider verifying the NAIC designation assigned and determine whether it has recently been reviewed by the SVO, determine the current rating by a nationally recognized statistical rating organization, and evaluate whether there has been a permanent impairment in fair value. For bonds and redeemable preferred stocks with permanent

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impairments, the analyst should also consider whether the investment should be written down to its fair value to properly reflect its investment. If the health entity has experienced negative cash flows or has other liquidity problems, the analyst should consider requesting information from the health entity regarding investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of their fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

Procedure #10 suggests additional steps the analyst may perform if there are concerns regarding the significance of any excess of cost over fair values of common stocks owned. The analyst should consider reviewing Schedule D - Part 2 - Section 2 - Common Stocks to determine which individual common stocks have a cost significantly in excess of their fair value. The analyst should also determine whether the stock is listed on a national exchange and verify the price per stock and the total fair value listed in the statement. If the NAIC designation of the stock is "A," (unit price of the share of common stock is determined analytically by the SVO) determine when the price per share was last analyzed by the SVO. The analyst should also consider whether the common stock is permanently impaired by the market. The analyst should consider requesting the Audited Financial Statement and other documents necessary to support the value of the common stock. The analyst should also consider requesting information from the health entity regarding investment strategies and short-term cash flow needs.

Procedure #11 suggests additional steps the analyst may perform if there are concerns regarding significant purchases or sales of securities near the beginning and/or end of the year. The analyst should consider reviewing Schedule D - Part 3 - Long-Term Bonds and Stocks Acquired During Current Year, Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or otherwise Disposed Of During Current Year, and Schedule D - Part 5 - Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed Of During Current Year to determine the types of securities purchased and sold at or near the beginning and the end of the year, the vendors used for investment purchases and the purchasers of investments sold. This information can then assist the analyst in determining whether the health entity might have engaged in "window dressing" of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring lower quality investments after year-end) in an attempt to avoid additional regulatory scrutiny which would have occurred with the health entity's lower rated investment portfolio.

Procedure #12 suggests additional steps the analyst may perform if there are concerns regarding investment turnover. The analyst should consider reviewing Schedule D - Part 3 - Long-Term Bonds and Stocks Acquired During Current Year, Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or otherwise Disposed Of During Current Year, and Schedule D - Part 5 - Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed Of During Current Year to determine the types of securities purchased and sold. This information can assist the analyst in determining the types of securities sold and acquired, as well as the length of time each security was held and the quality of the security. The analyst should also review realized capital gains from the sale of securities to determine any reliance on these gains. The analyst should also consider having a specialist review the health entity's investment program. The analyst should also review the Statement of Actuarial Opinion and memorandum to determine whether any concerns about investment turnover are noted.

Procedure #13 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in derivative instruments. The analyst should consider obtaining a comprehensive description of the health entity's hedge program in order to obtain an understanding of the health entity'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 health entity's assets, liabilities or expected cash flows. The hedge program could be evaluated to determine whether it appears to result in hedges that are appropriate for the health entity based on its assets, liabilities, and cash flow risks and whether the health entity appears to be adhering to the hedge program. For significant derivative instruments that are open at year-end, the analyst should consider requesting and reviewing a description of the methodology used by the health entity 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

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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* have been met. The analyst might also consider having the health entity's derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.

Additional Reference Sources

1. *Accounting Practices and Procedures Manual*, NAIC
2. *Annual Statement Instructions - Health*, NAIC
3. *Purposes and Procedures Manual of the NAIC Securities Valuation Office*, NAIC

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III. Analyst Reference Guide – B.2. Other Assets

Overview of Other Assets

Health entities are authorized to report a number of assets in their Annual Financial Statement. According to SSAP No. 4, *Assets and Nonadmitted Assets* (SSAP 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.

1. 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 6), which also requires that premiums owed by agents should be reported net of commissions and are nonadmitted under a 90-day rule. Remaining amounts that are determined to be uncollectible 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 (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 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

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nonadmitted *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 collectibility 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, collectibility 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 uncollectible premiums. Uncollected premium balances on non-government business that are over 90 days due are nonadmitted under SSAP 6. On all business, an evaluation of any remaining asset balance is required to be made to determine any impairment. Amounts deemed uncollectible 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 collectibility 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 nonadmitted 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. The analyst 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 6 for further discussion of uncollectible premiums and SSAP No. 54, *Individual and Group Accident and Health Contracts* (SSAP 54).

2. 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 collectibility of health care receivables should be monitored by the health entity, as it could become a source of future problems if write-offs of uncollectible receivables become material.

Pharmaceutical Rebate Receivables

According to SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP 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 amounts can be material, SSAP 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

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Receivables. The analyst 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 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 #27 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 VII. Guidance for Notes to Financial Statements, for guidance on reviewing Note #27.

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 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, the analyst 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, the analyst 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 84 provides that these loans and advances can only be reported as admitted assets in certain circumstances, the analyst 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 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 uncollectible 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 25. This includes financing arrangements with providers of health care services with whom the health entity periodically contracts. Again, the analyst 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 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 provider. To qualify as admitted assets under SSAP 84, among other things, the advances must be made under

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the terms of an approved provider services contract in anticipation of future services and must not exceed one month's average capitation payments.

SSAP 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 84.

Despite these requirements, and the requirement that the collection of risk-sharing receivables be made quarterly, the analyst should closely monitor the balance of this asset. The analyst should use the information from Note #27, 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 Other Provider Liabilities section for further discussion of risk-sharing arrangements and Guidance for Notes to Financial Statements section for guidance on reviewing Note #27.

Government Insured Plan Receivables

Government plan receivables may be included in either uncollected premiums or under health care receivables. The analyst 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 in Force,* are admitted assets. However, the collectibility of these amounts must be periodically evaluated even though the 90-day past due rule does not apply. Any amounts deemed uncollectible must be written off and charged to income in the period the determination is made. See SSAP 84 for further discussion.

3. Amounts Receivable Relating to Uninsured Accident and Health Plans

SSAP No. 47, *Uninsured Plans* (SSAP 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 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

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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 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 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. The analyst 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 VII. Guidance for Notes to Financial Statements, for guidance on reviewing Note #18.

4. Furniture and Equipment

Furniture and equipment includes not only administrative furniture and equipment but also health care delivery assets such as furniture, medical equipment and fixtures, pharmaceuticals and surgical supplies, and durable medical equipment.

SSAP No. 73, *Health Care Delivery Assets-Supplies, Pharmaceuticals and Surgical Supplies, Durable Medical Equipment, Furniture, Medical Equipment and Fixtures, and Leasehold Improvements in Health Care Facilities* (SSAP 73) describes health care delivery assets as those assets that are used in connection with the direct delivery of health care services in facilities owned or operated by the health entity. SSAP 73 further provides that these types of assets shall be admitted provided they meet the definitions of health care delivery assets as set forth in the SSAP. As a result of this accounting guidance, it is possible that a health entity with these types of assets will have a much different mix of assets than other health entities that do not use these types of assets in their operations. It should be noted that the depreciation period for health care delivery assets is limited to three years, which varies from the depreciation period for similar assets that are nonadmitted.

Analysis of these assets should consist primarily of ongoing monitoring of the balances, their relative change, and the relationship of that change with what is expected based upon other trends/activity within the health entity.

5. Electronic Data Processing Equipment and Software

As discussed in SSAP No. 16, *Electronic Data Processing Equipment and Software* (SSAP 16) electronic data processing (EDP) equipment and operating system software are admitted assets to the extent they conform to the requirements of SSAP 4. The admitted asset is limited to three percent of capital and surplus; adjusted to exclude any EDP equipment and software, net deferred tax assets and net positive goodwill. However, SSAP 16 provides that non-operating system software is a nonadmitted asset. EDP equipment and software depreciated for a period not to exceed three years using methods detailed in SSAP No. 19, *Furniture, Fixtures and Equipment; Leasehold Improvements Paid by the Reporting Entity as Lessee; Depreciation of Property and Amortization of Leasehold Improvements* (SSAP 19).

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EDP assets generally are subject to various state specific limitations, such as a minimum amount that can be capitalized as an asset, a maximum depreciable life, and/or limits that may be admitted as a percentage of total admitted assets or capital and surplus. These limitations are put in place to avoid undue concentrations of assets that have less marketability than other admitted assets and rapid technological obsolescence. Because of this, the amount reported by a health entity is generally limited to an amount that is not significantly material to the health entity's financial position. It is also common to find that the health entity reports no EDP assets. In these cases, the health entity often relies upon a parent or an affiliated company to provide EDP services with a resultant charge back through a management or service agreement.

Analysis of EDP assets should consist primarily of ongoing monitoring of the balances, their relative change, and the relationship of that change with what is expected based upon other trends/activity within the health entity.

6. Miscellaneous Assets

Health entities may report miscellaneous assets not listed above. To qualify for admission, assets must comply with the provisions of SSAP 4 and any applicable state statutes. Examples may include amounts not received within 15 days of the end of the period that are due from brokers when a security has been sold, but the proceeds have not yet been received; the cash value of corporate owned life insurance (COLI), including amounts under split dollar plans; non-invested assets not included in other categories; intangible assets and goodwill where permitted; guaranty funds receivable or on deposit; deposits in suspended depositories; loans unsecured or secured by assets that do not qualify as investments; cash advances to or in the hands of officers or agents; travel advances; non-bankable checks; trade names and other intangible assets; automobiles, airplanes and other vehicles; and the company's stock as collateral for a loan.

To the extent the health entity has reported material write-in assets, the nature of the write-ins should be carefully reviewed to determine if the health entity has properly accounted for and reported the item being reviewed. Because most of the items specifically identified in the AP&P Manual are included in the Annual Financial Statement Instructions, most admitted assets should be included in a specific line. Other items that are not specifically identified in the AP&P Manual should be nonadmitted, unless the health entity's state of domicile has issued a permitted or prescribed accounting practice allowing the asset to be admitted.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 procedures included in the Other Assets section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The purpose of this section is primarily to assist the analyst in identifying those entities with issues related to admissibility, collectibility, valuation, or reporting.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for Other Assets are intended to identify whether admissibility, collectibility, valuation, and reporting issues associated with Other Assets would have a potential impact on the health entity's

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solvency and if significant changes in Other Assets have occurred since the prior year Annual Financial Statement.

Discussion of Level 3 Procedures

The procedures included in Level 3 Procedures for Other Assets are designed to assist the analyst in further investigating potential problems and concerns that are identified in either the Annual or Quarterly Level 2 Procedures as emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate, and how far to probe. The procedures suggest additional steps the analyst may perform if there are concerns regarding the admissibility, collectibility, valuation, or reporting of Other Assets.

Additional Reference Sources

1. *Accounting Practices and Procedures Manual,* NAIC
2. *Annual Statement Instructions –Health,* NAIC

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Overview of Health Reserves and Liabilities

Health reserves are intended to (1) cover claims payments for claims that have been incurred prior to the valuation date and have not yet been paid or (2) to retain a portion of current revenues to cover future incurred claims that the company anticipates it will be obligated to pay. The NAIC *Annual Financial Statement Instructions* and the NAIC *Accounting Practices and Procedures Manual* (*AP&P Manual*) contain specific guidance for distinguishing between certain types of claim liabilities. Specifically, SSAP No. 54, *Individual and Group Accident and Health Contracts* (SSAP 54) and SSAP No. 55, *Unpaid Claims, Losses and Loss Adjustment Expenses* (SSAP 55) differentiate between claims that have accrued costs (claim liabilities) and claims that may have been incurred but for which costs will be accrued in the future (claim reserves). For this handbook the term reserve will be used in its broader sense to include items denoted as reserves as well as other items called liabilities.

When there are reserves and liabilities for claim amounts to be paid in the future there will also be expenses associated with paying these claims. The liability for the administrative expense associated with paying these claims is entered in "Unpaid Claims Adjustment Expenses".

The incurred date of a claim is the first date on which the company has an obligation to pay for a contracted benefit. The incurred date of a claim depends on the type of product and the contract language. Some examples of incurred date determination would include:

- Hospital claims are incurred on the date of admission.
- Some claims related to one diagnosis may be grouped together and are considered incurred on the first date of service.
- Maternity claims are incurred on the date of the first service related to the maternity.
- Other medical, dental and vision services are incurred on the date of service.
- Disability income claims are incurred on the date of disability.
- Long term care claims are incurred on the date of eligibility for benefits or date of first service, depending on the reserving method.
- Stop loss claims are incurred based on the contract specifications.

Other reserves are associated with provider contracts and experience rating contracts with employer groups. Provider contracts often result in funds being held for future payment based on claims experience for the members assigned to a provider group. Similarly some contracts with employer groups result in future premium due or premium refunds owed based on actual claims experience.

Health reserves and methods used for their estimation are discussed in detail in the NAIC *Health Reserve Guidance Manual*. The analyst should be familiar with the information addressed in that manual and should use it as a reference when looking for guidance about a particular item under review. Before contacting a company or a company's actuary, the analyst should review the NAIC *Health Reserve Guidance Manual* to become more familiar with the terms and techniques for reserve estimation.

Due to the variety of types of health policies issued and the complexity of determining the aggregate reserves and liabilities for health policies, most health entities rely on actuaries or individuals with actuarial training to assist in estimating these liabilities. Although some health entities do not use actuaries to actually set the health reserves, health entities are required to annually obtain an opinion regarding the reasonableness of the established health reserves by a qualified actuary. Therefore, qualified actuaries are involved in setting and/or reviewing the health reserve liabilities established for virtually all health entities.

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There are eight categories of health reserves and liabilities:

1. Unearned premium reserves
2. Claim reserves
3. Reserves for future contingent benefits
4. Claims or claim adjustment expense liability
5. Contract reserves
6. Premium stabilization reserves
7. Provider liabilities
8. Premium deficiency reserves

1. Unearned premium reserves

The unearned premium reserve is the amount of paid premium covering future periods. For example, an annual premium paid on January first is 75 percent unearned at the end of the first quarter. Health products often have monthly premiums that do not require unearned premium reserves if coverage is from the first of the month to the end of each month (typically the case for employer-based coverage).

If a premium is paid before it is due it is considered an advanced premium. For example, if January's monthly premium is paid on December 15 of the prior year it is advanced premium. Advanced premiums are entered in premiums received in advance on the Annual and Quarterly Financial Statements. See SSAP 54 for further guidance on this distinction.

2. Claim reserves

Claim reserves are intended to cover claims that have been incurred, but have not been paid. They can be further divided into three categories based on where the claim is in the process of being reported, approved and paid. The allocation among these categories is usually based on past statistics and they are usually not estimated separately. In general, incurred claims are estimated using one of the techniques described in the NAIC *Health Reserve Guidance Manual* and paid claims are deducted from the incurred claims to get a claim reserve. Other methods may be used for non-medical lines of business.

Claim reserves can fluctuate as a percentage of incurred claims. A possible reason for this fluctuation is a large increase or decrease in the health entity's claims inventory. This often happens when a new claims system is installed. Other reasons for fluctuations in claims inventory can include a larger than normal turn over in claims processors, changes in the percentage of claims submitted electronically, changes in provider agreements such as moving to or from capitation arrangements, and adding large amounts of new business. One concern may be that a change in the ratio of claim reserve to incurred claims could indicate that reserves are being lowered to improve profits or raised to justify rate increases.

a. Claims reported and in process of adjudication:

   Claims reported and in process of adjudication may be waiting for additional information or may be ready for payment. States have different laws and regulations concerning the maximum number of days between the time that a claim is received and paid or otherwise adjudicated. An average backlog can be very roughly estimated by comparing the Reported in Process of Adjustment in the Underwriting and Investment Exhibit Part 2A to the average daily-incurred claims amount (incurred claims divided by 365).

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i. Due and unpaid claims:

These are claims that have been received, approved and adjudicated, but have not yet been paid. They generally represent a very small part of the claim reserve compared to the incurred-but-not-reported liability. Typically claims are considered paid when the check is issued.

ii. Claims in course of settlement:

These are claims that have been received by the company, but have not been paid. They are often claims that are waiting for some additional information before they can be adjudicated and approved for payment.

b. Incurred but not reported (IBNR) claims:

Although claim reserves are often called IBNR, technically the only part of the reserve that is IBNR is the part that represents claims that have NOT been reported to the company. This is almost always the largest part of the claim reserve.

Historically, physician claims take longer to be reported than hospital claims, but electronic filing of claim information is shortening the lag between the date of service and the date that a claim is submitted to the health entity.

The amount of claim reserve per member or per incurred claim dollar differs significantly between types of companies. If a company pays most of its claims on a capitated basis, its claim reserve will result only from services that are not covered by the capitation. Claims not covered by the capitation generally include claims for out-of-area emergencies and claims for referrals to non-capitated specialists. Also, because some companies pay a budgeted amount to the largest hospitals providing services to their insureds with a periodic reconciliation for actual claims, there are additional reporting rules for these payments. SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP 84), defines these payments as advances or loans to providers and distinguishes between advances to hospitals and advances to non-hospital providers. Regarding advances to hospitals, as long as a reconciliation is performed within the strict parameters set forth in SSAP 84, these advances are admitted assets up to the estimated amount of incurred claims still unpaid to the hospital (includes IBNR). For non-hospital providers, and when the advances to a hospital do not meet the specific reconciliation requirements of SSAP 84, the admitted asset is limited to the amount of claims due and unpaid or in course of settlement (does not include IBNR) to that particular provider. The claim reserve is not to be reduced in either situation. Accounting guidance found in SSAP No. 25, *Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties* (SSAP 25), should be followed for loans and advances to related party providers.

When companies contract with providers on a capitated basis, they may consider it appropriate to include an amount in the IBNR reserve for the contingency that the provider group becomes insolvent and is not able to perform under its contract. For example, if a capitation has been paid to a provider group for medical services and the provider group becomes insolvent and does not have the funds to pay member doctors, then the company may have to pay doctors directly for services rendered to members.

Claim reserves are estimated with some level of conservatism based on the health entity's and the actuary's determination of the amount of margin needed for potential adverse experience. Factors affecting the need for conservatism in reserve estimates include (1) statistical fluctuation in incurred claims, (2) data problems due to system changes or inadequate data reporting, (3) new or growing product lines and (4) changes in plan design or provider arrangements that may affect claims payment patterns. Conservatism can be achieved by using a tabular method based on a conservative table, by using

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conservative assumptions and/or by adding explicit margins to reserve estimates. The conservatism of past claim reserve estimates can be observed by comparing Claims Incurred in Prior Years with the Estimated Claim Reserve and Claim Liability December 31 of the Prior Year in the annual statement from the Underwriting and Investment Exhibit Part 2B.

c. Disabled life reserves:

Disabled life reserves are reserves for individuals who are currently eligible for claim payment on coverage such as disability income and long-term care. These claims will continue to be paid even if the contract ends until the individual is no longer eligible for claim payments due to an improvement in health status. More guidance can be found in SSAP 54 under claim reserves.

3. Reserves for future contingent benefits:

In some situations and for some types of products, benefits resulting from an incurred claim can extend beyond the valuation date and may extend even beyond the end of the contract period. For a hospitalization that extends past the end of the contract period, either the contract itself or state law may require payment of charges up to a specific time past the end of the contract period. Maternity claims may also result in a reserve for future contingent benefits, if the delivery is covered even if the contract is terminated. The federal Health Insurance Portability and Accountability Act (HIPAA) places restrictions on pre-existing condition exclusions resulting in new policies being responsible for continuing hospitalizations and maternity benefits, thus reducing the need for future contingent benefit reserves, but under state laws the prior carrier may still remain liable for the claim. A contingency benefit reserve may still be needed since there may be no replacement policy or the replacement policy may not cover all of the benefits of the old policy. Company experience and tabular methods are used to calculate these types of reserves.

Future benefits for disability income and long-term care claims are included in disabled life reserves rather than as reserves for future contingent benefits.

4. Claims or Loss Adjustment Expense Liability:

When incurred claims have not been paid as of the valuation date and a reserve is set up for their future payment, there will generally be an expense to process and pay the claims. This expense, although paid in the future, is associated with claims incurred prior to the valuation date. To achieve consistent financial reporting a liability is set up for the future claims payment expense.

Also, when provider contract provisions require a payment at the end of the contract period for financial and/or operational performance, there will be a cost of determining and paying the contingent payment. A liability should be included for the expense of processing the provider liability.

5. Contract Reserves:

Contract reserves are in addition to claim and premium reserves. A contract reserve is a reserve set up when a portion of the premium collected in the early years is meant to help pay for higher claim costs arising in later years. The reserve is calculated using actuarial assumptions and techniques, and in general, equates to the amount that the present value of future benefits exceeds the present value of a consistent portion of future premiums (the portion of the “gross premium” used for contract reserves is called the “net premium”).

Contract reserves are needed when premiums are collected in the early years of a policy and are intended to offset increasing claims in later years. This is usually seen when premiums are level over the life of a policy, but can occur when premiums are structured to increase, but still are not proportional to expected claims. Issue age rated policies often fall into this category where premiums can increase, but the ratio of expected

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claims to premiums are lower in early durations, by design, in order to avoid rate increases at later durations (or at least reduce their size).

The types of products that generally require contract reserves include (1) individual disability income (if premiums are not based on attained age), (2) long-term care, and (3) issue age rated medical policies (including those for specified diseases). Issue age rated medical policies are rare except for issue age Medicare Supplement and some issue age hospital indemnity policies. Many other types of health policies (accident coverage or AD&D coverage) may not need contract reserves because the likelihood of claims is the same for each age. Those contracts (most employer-based coverage) that are re-rated each year to cover the expected claims for the year do not need contract reserves.

Contract reserves may be needed for policies with multi-year rate guarantees. Many medical policies with multi-year rate guarantees have built in rate increases to cover anticipated increases in claims cost, but if premiums are level, contract reserves will be needed.

Appendix A-010, *Minimum Reserve Standards for Individual and Group Health Insurance Contracts*, (Appendix A-010) of the *AP&P Manual* prescribes the minimum standards used in determining the health policy reserves and specify some of the assumptions to use such as morbidity tables, maximum interest rate and valuation method. Health entities may establish health policy reserves that equal or exceed these minimum standards. The analyst should review that all changes to contract reserve assumptions for in force policies have been approved in accordance with State regulations.

6. Premium stabilization reserves:

These are reserves set aside to reduce the potential for large rate increases and smooth out the underwriting cycle. They are often associated with retrospectively rated contracts that require additional premium if claims are more than a specific percentage over expected or a premium refund if claims are less than a specific percentage of expected claims. The use of premium stabilization reserves due to retrospectively rated contracts is described in SSAP No. 66, *Retrospectively Rated Contracts* (SSAP 66).

There are other experience rating arrangements besides retrospectively rated contracts that build up premium stabilization reserves. These reserves are used in years of higher than expected claims cost and result in a smoothing effect on premiums since premiums will not have to be increased to compensate for one year of poor experience.

Most premium stabilization reserves are determined by contract, but a company may use a similar concept on a block of business. Care should be taken to insure that positive reserves from one contract are not used to offset material claims on other contracts that should be recognized. The reserve would be used to smooth out the need for large rate increases by building up a reserve in years when claims are less than expected and then drawing it down in years of larger than expected claims.

7. Provider liabilities:

There are many types of provider contracting arrangements in the marketplace today. Many of these arrangements base some portion of the amount paid to the provider on financial and/or operational goals that are measured periodically. Under these types of arrangements, payment for reaching goals is not dependent on any specific service, but rather is based on overall performance. As of the valuation date, a payment for performance under a provider contact may have been earned, but not paid. This payment must be set up as a liability to the company.

If a contract period has ended and there has not been a final settlement, any potential settlement with respect to provider liability should be included. If the valuation date occurs during a contract period, then an

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appropriate liability should be determined that represents the time period from the beginning of the contract period through the valuation date. When provider risks are minimized using stop-loss arrangements that take large claims out of the calculation, the effect of the stop-loss coverage should be estimated and included in the claim reserve calculation. In some situations, the provider contracts may allow for an additional provider payment to the company. These payments, which may be determined in a similar manner should be separated (not netted against the company's liability) and may be admitted if recorded in accordance with SSAP 84.

Some conservatism for adverse fluctuations should be included when estimating provider liabilities. The level of conservatism depends on the variability of the liability, time period being estimated, and the quality of the data being used. Please note, conservatism that increases the claim reserve estimate and anticipates 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.

For more information see the Risk-Transfer Other Than Reinsurance section.

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. The analyst 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. The analyst should refer to SSAP No. 5, *Liabilities, Contingencies and Impairments of Assets* (SSAP 5), 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, the analyst 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

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- 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 the analyst should refer to SSAP 54 and the *Health Reserve Guidance Manual*.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 two procedures included in the Health Reserves and Liabilities section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The purpose of this section is primarily to assist the analyst in identifying those health entities that might have understated their health reserve liabilities.

Procedure #1 assists the analyst 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 percent, a 33 percent understatement of its health reserves would eliminate its entire surplus.

The effect of a reduction in capital and surplus of 10 percent 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 percent. A 200 percent RBC ratio is the Company Action level of concern according to the NAIC Risk-Based Capital for Health Organizations Model Act. A ratio below 200 percent indicates a health entity must file an RBC plan with the domiciliary state.

In evaluating these leverage ratios, the analyst 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 as a health entity that has just begun writing health business, even if both entities have the same leverage ratio results.

Procedure #2 assists the analyst in determining whether health policies appear to have been adequately reserved. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary. Therefore, the analyst should review the results of the Actuarial Opinion General Checklist procedures to determine whether any concerns were noted regarding 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*.

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.

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Part 2B of the Underwriting and Investment Exhibit provides information that allows the analyst 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 percent.

Part 2C 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. The analyst 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.

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 the analyst should investigate if material changes occur.

The analyst 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.

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. The analyst 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.

Other steps included in this procedure include the 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, which resulted in a decrease in health reserves in an amount greater than 5 percent of capital and surplus.

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.

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Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for Health Reserves and Liabilities section 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 #1 is similar to procedure #1 in the Level 2 Annual Procedures.

Procedure #2 assists the analyst in determining whether health policies appear to have been adequately reserved. A change in reserves of greater than 10 percent 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 premium were 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.

Other items in procedure #2 are similar to the Level 2 Annual Procedures.

Discussion of Level 3 Procedures

The procedures included in Level 3 for Health Reserves and Liabilities are designed to assist the analyst in further investigating potential problems and concerns that are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate, and how far to probe.

Procedure #1 suggests additional steps the analyst may perform if there are concerns regarding whether health policies have been adequately reserved. The analyst 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. The analyst should also consider 1) reviewing 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) reviewing 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, the analyst 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.) The analyst 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 the analyst to consider in Level 3 procedure #1 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 and 2) if the ratio appears unusual, the analyst 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. If the adequacy of claim liabilities is a concern, the analyst might want to request information from the health entity regarding claims paid after year-end which were incurred

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prior to year-end in order to test the reasonableness of the year-end claim liabilities established by the health entity.

Additional Reference Sources

1. *Accounting Practices and Procedures Manual*, NAIC
2. *Annual Statement Instructions – Health,* NAIC
3. *Accounting Practices and Procedures Manual Appendix A-010,* NAIC
4. *Health Reserve Guidance Manual,* NAIC
5. *Risk-Based Capital for Health Organizations Model Act,* NAIC

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III. Analysts Reference Guide – B.4. Other Provider Liabilities

Overview of Other Provider Liabilities

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 information, see the health reserve and liabilities section and for further accounting guidance, see SSAP No. 55, *Unpaid Claims, Losses, and Loss Adjustment Expenses* (SSAP 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 provider 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, *Certain Health Care Receivables and Receivables Under Government Insured Plans*. In the situation where the provider contract requires payments from, as well as, to the provider, the health entity should separate ultimate

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results into the liability entry and the receivable entry (see Other Assets section of this *Handbook* for further discussion).

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. For further information, see the health reserve and liabilities section of this reference guide.

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.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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.

There are very few tests that can be made to verify that provider liabilities are appropriate. Provider contracts are changing dramatically from year to year, making comparisons meaningless. These liabilities build up over the contract period and then are paid, decreasing the liability to zero. Contract periods for different providers may cover different periods so that wide fluctuations can be seen from period to period.

Procedure #1 assists the analyst in determining if the health entity's use of bonus and withhold arrangements are significant. Since health entities use these arrangements to different degrees, it is important to determine the significance of their use by the health entity under review. This procedure determines if the amount of bonus and withhold liabilities and expenses compared to the total hospital and medical expense is significant.

Procedure #2a and 2b assists the analyst in verifying that information that is reported in the financial statement for the health entity is consistent with what is reported in the health entity's RBC filing. Since withholds and bonuses are reported both in the Annual Financial Statement and in the RBC filing, they should not appear in one and not the other.

Procedure #2c assists the analyst in determining if a significant amount of the prior year's withholds and bonuses available were not paid during that reporting year. Withholds and Bonuses Available represent the total amount that could have been paid in withholds and bonuses. (This information is provided in the RBC filing page

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XR016). The amount paid compared to the amount available provides the analyst with a rough indication of how well provider groups were able to meet their contract goals. Further analysis may be necessary in order to determine whether the provider group is able to meet its financial or operational goals in its contracts with the health entity, currently and going forward. Provider groups not being able to meet their financial and operational goals and thus not earning all of their withholds in one year can result in higher claims costs than anticipated and/or less favorable contracts in the next contracting cycle.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for Other Provider Liabilities are designed to identify significant use of these types of arrangements. Arrangements such as these are subject to significant estimate and if liabilities for these arrangements are materially misstated, it can result in material misstatement of the financial statements taken as a whole.

Discussion of Level 3 Procedures

The procedures included in Level 3 Procedures for Other Provider Liabilities are designed to assist the analyst in further understanding any potential problems or concerns with the health entity's use of these types of arrangements.

If the level of these arrangements is significant it is important to determine if any actual risk is being transferred. Potentially, these arrangements could be used to create the appearance of capitated risk transfer when in fact the bonus and withholds result in no actual risk transfer. Since these arrangements reduce Risk-Based Capital, capital requirements could be understated. Some health entities have many types of contracts with providers, but it is possible to request that a health entity provide the primary contracts with its largest contracting providers.

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

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

Additional Reference Sources

1. *Annual Statement Instructions Health*, NAIC
2. *Health Insurance Reserves Model Regulation*, NAIC
3. *Health Reserve Guidance Manual*, NAIC
4. *Actuarial Standards of Practice*, Actuarial Standards Board
5. *Accounting Practices and Procedures Manual,* NAIC
6. *Health Risk-Based Capital Report, Overview and Instructions,* NAIC

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III. Analysts Reference Guide – B.5. Income Statement and Surplus

Overview of Income Statement and Surplus

Statutory accounting principles emphasize the balance sheet because statutory accounting is primarily directed toward the determination of a health entity's financial condition on a specific date. However, the income statement is also important and should be reviewed as an integral part of the financial analysis process. Ultimately, most problems encountered in maintaining adequate levels of capital and surplus within a health entity are first revealed in the income statement. Income statement analysis primarily focuses on the operating performance of a health entity. 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 profit margin and return on capital and surplus are very general measures of a health entity's profitability. Although these ratios generally do not allow an analyst to determine the primary source of profits or losses, they provide an overall measure of profitability that the health entity's ultimate parent is likely to monitor in evaluating the performance of its strategic business units. Measures such as the combined ratio, the medical loss ratio and administrative expense ratio provide the analyst with more specific measures of the health entity's source of profits or losses and are an important part of the Level 2 Annual Procedures for this section. 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. Ratios will not reveal those issues.

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.

Prior to completing the Level 2 Annual Procedures for income statement and surplus, the analyst should consider the results of the initial review performed in the Level 1 Analysis, including the review of the health entity's Annual Financial Statement, the Annual Scoring Results, and the Annual Financial Profile. In reviewing these items, the analyst should determine the overall risk associated with the health entity's operating statement. This would include noting the primary lines of business written by the health entity and the general operating results of the health entity. If based on this initial review, the analyst determines that a more thorough analysis of the operations is necessary; the Level 2 Annual Procedures would be completed.

In completing and reviewing the Level 2 Annual Procedures, the analyst should keep in mind the information obtained regarding the health entity's lines of business. This is critical in evaluating the health entity's operating ratios from the Level 2 Annual Procedures. The operating ratios that may be impacted the most by the lines of business include the medical loss ratio, the administrative expense ratio and even the investment yields. These ratios can be significantly different if the health entity writes long-tailed business such as disability or long-term care. This is because the suggested Annual Financial Statement thresholds of 85 percent, 15 percent, and between 2 percent and 6 percent, respectively, are based upon health entities that write only "comprehensive health products." As discussed in the Health Insurance Industry section of this *Handbook*, medical loss ratios on long-term care insurance are generally much lower than the 85 percent threshold used in the Level 2 Annual Procedures. Meanwhile, the administrative expense ratio and the investment yield usually tend to be much higher for a health entity that writes this line of business compared to one that just writes "comprehensive health." Different distortions will occur if the health entity writes small amounts of specific disease plans, student accident, etc. However, a health entity typically writes primarily "comprehensive health products." Therefore, the

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percentage of revenue that represents other health business will be small, but the effect on the ratios may be significant.

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.

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

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

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

In assessing financial condition, considerable emphasis is placed on the adequacy of a health entity's capital and surplus (See section III.B.6. for a detailed discussion of Risk-Based Capital (RBC)). Capital and surplus provides protection (or "cushion") for policyholders against adverse underwriting results, inadequate reserve levels and fluctuations in the value of assets. In addition, capital and surplus provides underwriting capacity and allows a health entity to expand its business. The RBC formula is designed to calculate a minimum threshold measure of capital and surplus adequacy based on each health entity's unique mix of asset risk, insurance risk, and business risk. Refer to the RBC section of the *Handbook* for discussion on RBC.

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III. Analysts Reference Guide – B.5. Income Statement and Surplus

The components of capital and 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 capital and surplus for health entities. 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 health entity. In addition, the RBC requirements must also be met in states that have implemented health RBC.

Health entities 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," "contribution certificates," or subordinated debt) have the characteristics of both debt and equity. Surplus notes resemble debt in that they are repayable with interest and sometimes (depending upon 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. 41, *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 Annual Financial Statement Notes to Financial Statements. Surplus notes are considered subordinate to all other liabilities of the health entity.

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.

Health entities may also issue capital notes, which are reported as a liability by the health entity and are therefore treated as debt instruments. In liquidation, they rank with surplus notes and are subordinate to the claims of policyholders, claimants and general creditors. Capital notes are included in the health entity's total adjusted capital for RBC calculations.

Capital notes are repayable with interest and include maturity dates and/or repayment schedules. However, payments 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, similar to surplus note interest payments that have not been approved.

Capital and surplus notes may have the effect of enhancing surplus or providing needed funds. The holder of the capital or surplus note may expect repayment on a scheduled basis and may exert pressure on the health entity to generate cash in order to be able to make the payments. As a result, the analyst should be aware when reviewing health entities that rely heavily on these notes. Capital and surplus notes are not inherently bad. They may provide a source of capital to health entities whose surplus levels are deemed inadequate to support current operations and that do not have access to traditional equity markets.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst should also consider the health entity's corporate governance which includes the assessment of the risk

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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 procedures included in the Income Statement and Surplus section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The purpose of this section is primarily to assist the analyst in reviewing and analyzing the health entity's operating performance, with emphasis on basic operating ratios and the change in those ratios, and the level and change in the health entity's premiums. In addition, separate focus is given to the change to and quality of a health entity's capital and surplus.

Procedure #1 assists the analyst in determining whether concerns exist regarding the health entity's income statement or operating performance. Each of these ratios is designed to provide the analyst with an overall assessment of the health entity's profitability. The profit margins in the health insurance industry have traditionally been fairly low. As a result, the threshold for this ratio is established at less than 0 percent or greater than 10 percent. A profit margin ratio less than 0 percent indicates the health entity has experienced a net loss and operating problems may exist. With continued losses, the health entity's capital cushion to support the business is likely to be diminished. Conversely, a profit margin greater than 10 percent is unusual in the health insurance industry and should be investigated.

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

Procedure #2 assists the analyst in determining whether concerns exist regarding changes in the health entity's operations. As previously mentioned, an increase in a health entity's medical loss ratio may indicate a loss of control in the health entity's underwriting or pricing processes. An increase in the administrative expense ratio may indicate escalating costs or an expense structure that no longer supports the health entity's premium volume. Changes may also be the result of a change in the health entity's business mix. As previously mentioned, a health entity's entrance into new lines of business or sales regions might result in financial problems if the health entity does not have expertise in these new lines of business or regions. All of these items should be further investigated to further assess the risk to the health entity.

Procedure #3 assists the analyst in identifying other potential areas of concern. The items contained in this procedure are generally not primary operating indicators for most health entities. However, they do impact the

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overall financial position of the health entity and in some cases may materially impact some health entities. Specifically, the investment yield is an indicator of the profitability of the health entity's invested assets. Generally, this indicator is not heavily weighted because most health entities are concerned with maintaining high liquidity and low risk within their asset portfolio. In other words, a health entity, which generally writes short-tailed business, will invest in short term investment assets (which need to be highly liquid to satisfy short term obligations). However, if a health entity writes a considerable amount of long-tailed business, which usually does not require short-term obligations, the health entity will invest in long-term investment assets. This method of investing is known as the "matching principle." As a result, in comparison to a life insurer and even a property/casualty insurer, most health entities have a much shorter average maturity on their bonds and hold much more in cash and short-term investments. Typically, short-term investments usually offer lower interest rates, lower investment yields and, if any, lower capital gains and losses. However, some health entities take a more aggressive investment approach and do have a fair amount of asset risk. The analyst should review the health entity's investment yield and its investment gains and losses to better assess the extent to which the entity relies upon their investment returns. Refer to the Investments section of the *Handbook* for discussion on investments.

Procedure #4 assists the analyst in determining the business stability. As previously discussed, a significant increase in premiums and enrollment may indicate rapid growth, which can present many different types of problems to a health entity or can also be an indication of the health entity's entrance into new lines of business or sales regions. Significant increases in premiums might also be an indication that the health entity is attempting to increase cash inflow to cover current benefit payments, particularly if the health entity primarily writes longer tail insurance.

Procedure #5 assists the analyst in determining whether the health entity is excessively leveraged due to its volume of business. Capital and surplus can be considered as underwriting capacity. The ratios of net premiums and risk revenue to capital and surplus measures the extent to which that capacity is being utilized and the adequacy of the health entity's capital and surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A net premium and risk revenue to capital and surplus ratio greater than 10 to 1 (8 to 1 for non-HMOs) may indicate that the health entity is excessively leveraged. Special attention should be given to the type of coverage provided and the extent to which the health entity is able to transfer some of the risk from the business to another entity. Two health entities both with a 10 to 1 ratio may have different leverage depending on the type of coverage that they write. For example, to the extent the health entity has written primarily comprehensive business for many years in the same region, and is able to capitate some of its business, it may not be as risky as a health entity which has just begun writing Medicare business in a new region and is unable to transfer any of its risk. Even if both of these health entities have the same leverage ratio results, the one starting Medicare Risk coverage will have a riskier financial position. The analyst should also specifically consider if a significant portion of the premium is written on longer tail lines. On these lines, the ultimate experience may not be known for some time, thereby increasing the risk of reserve understatement. The analyst should also determine whether there has been an increase in the writings ratio or an increase in the amount of long-tail business that is being written, to assist in identifying future trends.

Procedure #6 assists the analyst in determining whether concerns exist regarding the pricing of the health entity's products. To the extent the health entity's premium per member per month (PMPM) has not increased by an amount that approximates the expected increase in health care costs PMPM, this may be an indication that the health entity's premium rates may not be able to keep pace with the health entity's medical inflation. Although this ratio is a measure of what has occurred since the prior year, it can be used as a gauge in evaluating whether a health entity may be exposed. The ratio is also limited since it can't be applied at the product level using Annual Financial Statement information. However, the purpose of the ratio is to provide the analyst some sense of how the entity's premium rate changes compare with medical inflation in general. The analyst should also use the ratio of change in claims PMPM to change in premium PMPM. A result greater than zero indicates that claims increased from the prior year at a faster rate than premiums have increased from the prior year. A result less than

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zero would indicate that premiums have increased from the prior year at a faster rate than claims have increased from the prior year. The use of PMPM allows the ratio to be broken down to a more meaningful comparison. One other item that the analyst should consider is the health entity's use of multiple year provider contracts. Multiple year provider contracts allow a health entity and a provider to lock in agreed upon rates for an extended period of time. Although not necessarily an indication of underpricing, clearly it is much more difficult to predict the cost of health care three years out than it is one year out. As a result, multiple year contracts by their nature lend themselves to greater pricing risk. The analyst should be aware of the use of these contracts and the extent to which they are used.

Procedure #7 assists the analyst in evaluating the underwriting performance of the Medicare Part D Prescription Drug coverage. The procedures utilize data in the Medicare Part D Coverage Supplement and calculates the loss ratio, expense ratio and combined ratio. If the results are outside the benchmarks, the analyst should consider if the insurer writes an enhanced benefit plan that may contain more exposure to losses. While Medicare business is funded through contracted government rates, risk exists when utilization and benefit costs exceed that which was anticipated in the contract. If the insurer is reporting unusual results, the analyst should consider if any delays in payments from the Centers for Medicare and Medicaid Services (CMS) are impacting results.

Procedure #8 assists the analyst in evaluating a health entity's capital and surplus. The RBC formula is designed to calculate a minimum threshold of capital and surplus based on each health entities' unique mix of asset risk, insurance risk and business risk. The level of, and changes in, premiums (procedure 3 above) and reserves must be considered in evaluating the amount of a health entity's capital and surplus. The net change in capital and surplus measures the improvement or deterioration in the health entity's overall financial condition from the prior year. Even increases in the change in capital and surplus ratio, when significant, may indicate instability or mask financial problems attributable to fundamental changes in the health entity. Another step is designed to assist the analyst in identifying dividend payments or declarations, to determine if any necessary approvals were obtained.

Other steps in procedure #8 are designed to assist the analyst in identifying significant amounts of capital and surplus notes and write-ins for special and other than special surplus funds, which don't carry the same level of quality as unassigned surplus. Also, significant changes in capital and surplus due to changes in 1) reserve valuation basis, 2) net unrealized capital gains/losses, 3) foreign exchange capital gain/loss, 4) net deferred taxes, 5) nonadmitted assets, 6) the liability for unauthorized reinsurance, 7) surplus notes, or 8) change in accounting principle are reviewed. This step is designed to assist the analyst in identifying other activity during the year related to the health entity's overall capital and surplus.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for Income Statement and Surplus are designed to identify the following: 1) operating problems based upon primary operating ratios, 2) significant changes in the primary operating ratios from the prior year, 3) significant changes in the primary operating ratios from the prior year quarter, 4) operating problems based upon other financial indicators, 5) significant changes in the volume of premiums or the health entity's mix of business (lines of business written and/or geographic location of premiums written), 6) signs of excessive leverage, 7) signs of potential underpricing, or 8) any changes in capital or surplus notes that have occurred or dividends paid to stockholders since the prior year Annual Financial Statement or prior Quarterly Financial Statement.

Discussion of Level 3 Procedures

The procedures included in Level 3 Procedures for Income Statement and Surplus are designed to assist the analyst in further investigating potential problems and concerns that are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate further, and how far to probe.

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Procedure #1 suggests additional steps the analyst may perform if there are concerns regarding the health entity's primary operating ratios. The analyst should obtain a greater understanding of where the losses have occurred by reviewing the Analysis of Operations By Line of Business page. The analyst should also consider the need to compare the line of business gains and losses with industry averages. A comparison to industry average combined ratios can assist in this matter. However, the analyst should consider not only those problematic lines of business, but also those in which the health entity has been successful. These procedures will assist the analyst in assessing the current operating performance of the health entity. The analyst should also assess the health entity's current performance against prior periods to determine where fluctuations or trends have occurred. The analyst should consider comparing the primary operating ratios with prior periods to assist in this matter. The analyst should also make the same type of comparison with specific lines on the profile report. This process may help pinpoint specific problems that are not obvious from reviewing the period-to-period ratios. A further analysis of the lines of business information may be helpful and the analyst should consider comparing the current year combined ratios by line of business with the prior year combined ratios by line of business to assist in this analysis. The analyst should also consider comparing the health entity's actual experience with its projections.

Procedure #2 suggests additional steps for the analyst to perform to assess the impact that other items can have on the health entity's overall operating income. Consideration should also be given to the size and type of health entity. Although the profit margin ratio generally considers the impact of all income and expense items, a review of investment income and capital gains and losses may not typically be considered part of the primary operating figures within a health entity. As discussed above, the investment results of a health entity are typically secondary to its underwriting results and most health entities maintain a fairly conservative asset base to increase their liquidity. However, the analyst should consider the need to review the investment yield over a period of time for unusual fluctuations as well as against the industry average. This review and other items may indicate a need to perform a detailed review of the source of the income and the source of any investment gains or losses to determine if there are any particular assets that are not providing an adequate return. Similarly, the analyst may need to perform a more detailed review of write-in lines, which impact the profit margin, but not the other primary operating ratios of a health entity. Generally, most write-in lines are not material to the health entity, but in cases where they are, they should be reviewed for their reasonableness.

Procedure #3 suggests additional steps the analyst may perform if there are concerns regarding the financial impact that changes in the volume of premiums or changes in the health entity's mix of business (lines of business written and/or geographic location of the premiums written) could have on its financial position. The analyst should consider comparing any significant changes in premiums to the health entity's most recent projections and business plan. Variances could suggest that consumers have responded to the health entity differently than anticipated. As previously discussed, growth can have a material impact on the operations of a health entity, and the analyst should gain more information from the health entity when this has occurred, including how current and future growth is expected to be supported. However, decreases in premium can also place some pressure on the health entity through forced expense reductions. The analyst should attempt to understand how decreases in premiums are expected to impact this issue. If new lines of business are being written or if premiums are being written in new regions, the analyst should review the health entity's Managements Discussion and Analysis for related information. Otherwise, information may be requested from the health entity showing operating results vs. projections for the new lines of business or territories, and describing any changes in implementation strategy or revisions in financial projections for future periods. The analyst should also consider determining if, as a result of increases in sales regions, how the health entity prices its products, the contracts used with providers and any future expected changes in the health entity's business. The business of health insurance is very localized and the health entity must have a reasonable understanding of that market to be successful.

Procedure #4 suggests additional steps the analyst may perform if there are concerns regarding whether the health entity may be excessively leveraged due to its volume of business. Generally, the threshold for health business on

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

Procedure #5 suggests additional steps the analyst may perform if there are concerns that one or more of the health entity's products may be underpriced. Although it may be difficult to determine if any specific products are underpriced, one procedure the analyst may want to consider is the level of losses on the individual statutory lines of business. To the extent the health entity had a combined ratio of greater than 105 percent on any line of business, it may be an indication that the product is underpriced. To the extent a health entity has underpriced a product, the financial impact could be significant depending upon the health entity's leverage and the type of product. The analyst should also consider the need to determine if the health entity has established a premium deficiency reserve on a line of business. As discussed in the Health Reserves and Liabilities section, this reserve is established when future premiums and current reserves are not sufficient to pay future claims and expenses. This type of reserve is established because it meets the definition of a loss contingency and should therefore be considered in evaluating the current financial position of the health entity. The analyst should use the information, along with any information from the health entity, to better assess the current financial position of the health entity. Other information could include a monthly assessment from the health entity on the adequacy of the current deficiency reserve based upon updated information. Since the reserve is essentially an estimate of the expected losses from one or more contracts, updated information can assist in assuring the reserve continues to be adequate and that the health entity's financial position has not materially deteriorated.

Procedure #6 suggests additional steps the analyst may perform if there are concerns regarding the Medicare Part D business. Medicare Part D business is contracted with CMS. The contract sets a fixed income from CMS for the period of one year. The insurer may also offer enhanced benefit plans that fill coverage gaps that exist in basic plans. If the policyholder's utilize more benefits than were projected in the contract, the insurer may experience losses since the income from CMS is set for a full year. The analyst should consider obtaining and reviewing information on the contracted benefits, premium and cost sharing with CMS. The analyst should also evaluate a comparison of premiums, reserves, expected utilization and benefit costs to actual experience on each plan.

Procedure #7 suggests additional steps the analyst may perform if there are concerns regarding the amount of the health entity's capital and surplus. If there are concerns regarding the adequacy of the health entity's capital and surplus, the analyst should consider reviewing the procedures in the Risk-Based Capital Level 2 Procedures. If the health entity has issued surplus notes, which are significant, the analyst should consider reviewing the information regarding the surplus notes in Note to Financial Statements #13. If surplus notes were either issued or repaid or if interest was paid during the year, the analyst should determine if the domiciliary state insurance department approved these transactions. In addition, if surplus notes represent a significant portion of capital and surplus, the analyst should consider recalculating important ratios excluding the surplus notes to determine their affect on the ratio results. If the health entity has issued capital notes which are significant, the analyst should consider reviewing the information in Note to Financial Statements #11 for pertinent information such as repayment, redemption price or interest features. Other steps to consider in procedure #7 include the review of the detail of unrealized gains or losses and the review of other components of capital and surplus for reasonableness.

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Additional Reference Sources

1. *Accounting Practices and Procedures Manual*, NAIC
2. *Annual Statement Instructions - Health*, NAIC

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III. Analysts Reference Guide – B.6. Risk-Based Capital

Overview of Risk-Based Capital

Beginning with the 1998 Annual Financial Statement, health entities became subject to a new Annual Financial Statement requirement that they calculate and report an estimated level of capital needed for financial stability, depending upon the health entity's risk profile, known as Risk Based Capital (RBC). The RBC ratio is defined as the ratio of Total Adjusted Capital divided by Authorized Control Level Risk-Based Capital. States that enact the Risk-Based Capital for Health Organizations Model Act (the Model Act) are required to take regulatory action when this ratio falls below specified levels. Historically, minimal capital requirements were imposed on health entities by various state laws. Those minimums frequently were arbitrary, generally low, varied widely from state to state, and generally did not consider the risk profile of the health entity. The Model Act supplements the system of absolute minimums and considers the risk profile of each individual health entity.

The RBC formula and Model Act were the result of several years of work by the American Academy of Actuaries, insurance regulators, and representatives of HMOs and other health entities. The formula is detailed and lengthy, but in concept is simple. There are five major categories of risk requirements: 1) asset risk-affiliates, 2) asset risk-other, 3) underwriting risk, 4) credit risk, and 5) business risk. A health entity's RBC requirement is calculated by applying risk factors to various asset, premium, claims, and expense items, where the factor is higher for those items with greater underlying risk and lower for those items with lower underlying risk. Total RBC is then calculated using a "covariance" formula, which adjusts the total based on the fact that these risks are generally statistically independent of each other. If the RBC is distributed among the five categories rather than concentrated in one or two, then the total RBC is significantly less than the sum of the RBC calculated for each of the categories.

Historically, underwriting risk constitutes the largest portion of the aggregate RBC. One of the primary determinants of the underwriting risk is the managed care discount factor, which is based upon the type of managed care arrangements the health entity uses. The health entity's asset size is also a major factor that impacts the RBC calculation. Although most HMOs do not carry significant asset risk, as the asset size becomes larger, the risks tend to increase. Generally, this has impacted HMDIs and larger HMOs the most.

The information in this overview should provide a sense of typical levels of RBC and the RBC ratio. Some entities are not typical, in which case this information will give a sense of how these entities differ from more typical entities.

Each risk category is summarized below.

1. **Asset Risk-Affiliates (H0)**

   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 percent 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 are included in this risk component and include non-controlled assets, guarantees for affiliates, and contingent liabilities. Refer to the Affiliated Transactions section of the Handbook for more discussion on transactions with affiliates.

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

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2. Asset Risk-Other (H1)

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. Refer to section III.B.1.—Investments for more discussion on concentration of investments.

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

3. Underwriting Risk (H2)

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 reduce the fluctuation of incurred claims relative to fee-for-service arrangements. Note that 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 under-pricing 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 purchased stop-loss reinsurance and are liable for less than $750,000 per claim, the minimum requirement is reduced to reflect their lower liability.

Refer to the Income Statement and Surplus and Health Reserves and Liabilities sections for more discussion.

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 percent and 75 percent (before covariance), while HMDI's have less net underwriting risk, but still have between 45 percent and 55 percent of RBC (before covariance) in net underwriting risk.

4. Credit Risk (H3)

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. Refer to the Other Assets, TPAs, IPAs and MGAs, and Reinsurance sections for more discussion.

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

5. Business Risk (H4)

Business risk includes the risk of loss on the health entity's non-insurance business such as Administrative Services Only (ASO) agreements, and the risk associated with growth in the RBC that exceeds growth levels of the health entity's premiums. Refer to the Risk Transfer Other Than Reinsurance section for further discussion of non-insurance business.

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

The covariance formula is applied to the RBC results for the individual risk categories. Total Adjusted Capital is divided by Authorized Control Level Risk-Based Capital to arrive at the RBC ratio. The Model Act then defines several action levels of RBC depending on the level of the ratio. The description of each level includes a brief summary of what happens if a health entity's RBC ratio is below that level. For example, one of the levels is called the "company action level," because a health entity must take action if its RBC ratio falls below that level. The various levels are related to one another by fixed percentages. The levels, which are the ratio of Total Adjusted Capital to Authorized Control Level Risk-Based Capital, are as follows:

1.	**≥ 300%**	**No Action Level**
2.	**> 200% to < 300%**	**Trend Test Level**
3.	**≥ 150% to < 200%**	**Company Action Level**
4.	**≥ 100% to < 150%**	**Regulatory Action Level**
5.	**≥ 70% to < 100%**	**Authorized Control Level**
6.	**< 70%**	**Mandatory Control Level**

Every health entity that does business in a state that has adopted the Model Act, regardless of the level in which it falls, is required to file an RBC report. For states that have adopted this Act, the Regulatory Action Level is also triggered when the health entity fails to file an RBC report by March 1st, unless the health entity has provided an explanation for such failure, which is satisfactory to the commissioner and has cured the failure within 10 days after March 1st. The report shows the calculation of the Total Adjusted Capital and the calculation of the RBC levels. A health entity that falls within or below the trend test level and has a combined ratio greater than 105 percent may trigger an action level. A health entity whose Total Adjusted Capital is greater than or equal to 200 percent of the Authorized Control Level Risk-Based Capital is in the No Action Level. Other than filing the RBC report, no further action is required by the health entity.

A health entity whose Total Adjusted Capital is greater than or equal to 150 percent but less than 200 percent of the Authorized Control Level Risk-Based Capital is in the Company Action Level. That health entity must file an RBC plan with the domiciliary state. The plan must include proposals for corrective steps by the health entity. The Model Act provides that the plan is confidential. A health entity whose Total Adjusted Capital is greater than or equal to 100 percent but less than 150 percent of the Authorized Control Level Risk-Based Capital is in the Regulatory Action Level. The required actions by the insurance commissioner are to perform whatever examination of the health entity is deemed necessary and issue an order specifying the corrective steps to be taken

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by the health entity. A health entity whose Total Adjusted Capital is greater than or equal to 70 percent but less than 100 percent of the Authorized Control Level Risk-Based Capital is in the Authorized Control Level. The commissioner may seize the health entity if that step is deemed "to be in the best interests of the policyholders and creditors of the health entity and of the public." A health entity whose Total Adjusted Capital is below 70 percent of the Authorized Control Level Risk-Based Capital is in the Mandatory Control Level. The commissioner must seize the health entity; however, that step may be forgone if there is "a reasonable expectation" that the circumstances causing the health entity to be in that level will be eliminated within 90 days.

Although most health entities fall into the "no action level," the analyst should not assume that health entities that fall into this level are in strong financial condition. Health entities may be in weak condition but have not triggered one of the regulatory action levels. The RBC calculation utilizes risk components that have been established to focus on the areas of the health entity's business that pose the highest risk to the health entity. These components and the risk factors used in the calculation of risk charges have been pre-established over time and are generally based on industry experience, statistical models or other data. While the impact of each risk component applies to all health entities using the formula, some health entities' risk levels may differ from the industry. When reviewing the RBC report, the analyst should consider those areas where the health entity's risk factors could be greater than the industry's. The analyst should also consider items that could impact the health entity's future capital and surplus levels when reviewing the RBC report. This type of review will allow the analyst to identify potential issues surrounding the health entity's capital adequacy based upon factors not reflected in the calculation.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 procedures included in the Risk-Based Capital section of the Level 2 Annual Procedures are designed to identify potential areas of concern regarding RBC.

Procedure #1 assists the analyst in identifying whether the current RBC Ratio is near Company Action Level. 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 percent 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. The procedure also identifies significant changes in the RBC Ratio components compared to the prior year. The analyst should document the leading underlying causes for the changes in the authorized control level and total adjusted capital.

Procedure #2 determines for the analyst whether the health entity failed the RBC Trend Test. A health entity that falls below an RBC Ratio of 300% (the Trend Test level) and has a combined ratio greater than 105 percent may trigger an action level.

Procedure #3a directs the analyst to obtain and review a copy of the health entity's RBC plan. If applicable in your state, the analyst may participate in the review and approval process of the RBC plan. The RBC plan is a comprehensive financial plan which is described in the Model Act, and:

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1) Identifies the conditions in the health entity that contribute to the Company Action Level event.
2) Contains proposals of corrective actions that the health entity intends to take and that would be expected to result in the elimination of the Company Action Level event.
3) Provides projections of the health entity's financial results in the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. 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 health entity's projections and the sensitivity of the projections to the assumptions.
5) Identifies the quality of, and problems associated with, the health entity'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, if any, in each case.

The analyst reviewing the plan should take the following steps:

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

Procedure #3b directs the analyst to monitor, on a periodic basis, the health entity's progress in achieving the initiatives included in the RBC plan and the impact of those initiatives on the 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 a subsequent RBC Ratio that will remove the health entity from Action Level status.

Additional Reference Sources

1. *Annual Statement Instructions—Health*, NAIC
2. *Risk-Based Capital for Health Organizations Model Act*, NAIC
3. *Health Risk-Based Capital Report, Overview and Instructions*, NAIC

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III. Analyst Reference Guide – B.7. Cash Flow and Liquidity

Overview of Cash Flow and Liquidity

The Statement of Cash Flow is one of several core financial statements presented in the Annual Financial Statement of every health entity. It provides information about the primary sources of cash (inflow) and applications of cash (outflow). The Statement of Cash Flow is organized to readily identify the net cash flow from operations separately from the net cash flow from investments and financing. Sources and applications of cash within financing are shown, such as dividends to stockholders and borrowed money received. The net change in cash and short-term investments as reflected on the Statement of Cash Flow reconciles to the change in the balance sheet accounts of cash and short-term investments for the year.

While the Statement of Cash Flow provides information about historical sources and applications of cash, the analyst should analyze the liquidity of the balance sheet in order to evaluate the health entity's ability to fund policyholder benefits and other demands for cash in the future. There are several procedures that an analyst can perform to measure a health entity's liquidity. One of the most common ways of accomplishing this is to compare the total liabilities of the health entity to its total liquid assets available to fund those liabilities. Variations of this comparison focus on which assets are available to fund the liabilities.

There are a number of situations that can elevate the risk of a negative impact on a health entity's cash flow and liquidity including the credit risk of receivables, the level of borrowed money and other liabilities, and dividends to shareholders. For example, if a health entity relies heavily on risk transfer arrangements with provider groups and the parties involved in the arrangements are unable to meet their obligations, the collectibility of those obligations could negatively impact the liquidity of the health entity. Credit risk is a concern for other receivables as well, including amounts due from affiliates and reinsurance receivables. An analyst should be aware of the domiciliary state's requirements for downstream risks such as provider groups and reinsurance. Other situations involve significant increases in liabilities such as unpaid claim reserves or borrowed money, which can increase the health entity's short-term cash requirements. Additional cash would also be needed in order for the health entity to pay dividends to a parent company or other shareholder.

Health entities have a shorter benefit payout period than other insurers, and consequently understanding the need for liquidity is an important issue for management. Because a health entity writes short-tail business, it will generally have a shorter average maturity on its bonds and hold more cash and short-term investments than other insurers. The key liquidity risks to a health entity include substantial decline in enrollment and also include underpricing and spikes in claims. If this were to occur, the entity's cash outflows for claims payments would exceed its inflows from newly received premiums. However, a health entity with a relatively stable enrollment and claims experience within expectations may feel it can safely accept some durational mismatch between its assets and liabilities, and may invest in more long-term invested assets in order to increase its investment yield. Those health entities writing long-tailed business may also own long-term invested assets to support those lines' liabilities.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 procedures included in the cash flow and liquidity section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. One concern relates to the liquidity of the health entity's balance

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sheet in terms of its ability to fund future liabilities. Other concerns relate to situations where negative cash flows from operations are being generated or where cash outflows from certain types of non-operating activities are significant.

Procedure #1 assists the analyst in evaluating the health entity's overall balance sheet liquidity. The primary method of accomplishing this is to compare the health entity's liabilities with its liquid assets available to fund such liabilities in the future. However, as previously mentioned, various other comparisons can be used to help assess liquidity or potential liquidity concerns. Liquid assets in this calculation include all bonds but exclude affiliated investments.

Procedures #1a and *1b* assist the analyst in determining a health entity's ability to pay maturing obligations with cash and invested assets. A significant increase in the liabilities to liquid assets ratio could indicate the health entity's growing inability to satisfy its financial obligations without having to sell long-term investments. Liquid assets in this calculation include all bonds but exclude affiliated investments.

Procedure #1c alerts the analyst to fluctuations in total liquid assets. A significant increase in total liquid assets could indicate that the health entity has been unable to collect on receivables. If the change is significant, an analyst may consider a more detailed review of the change in the asset mix from the prior period to determine the cause of the fluctuation.

Procedures #1d and *1e* measures the health entity's ability to pay current obligations with current assets including marketable securities. Results of less than 200 percent may not pose a serious threat to the health entity if it has access to other assets that can be liquidated. This ratio excludes non-investment grade bonds and affiliated investments but includes certain receivables not included in the two procedures above.

Procedure #1f measures the extent to which capital and surplus relies on assets that are due from affiliated entities. Affiliated investments are often illiquid. Excessive affiliated investments and receivables may indicate the health entity has invested heavily in affiliated stock and bonds instead of cash or short-term investments and may also indicate an affiliate's inability to pay current amounts due. The analyst may consider reviewing and understanding the financial statement of the affiliate. Refer to the Affiliated Transactions section for more guidance on affiliated transactions.

Procedures #1g and *1h* measures a health entity's average number of days of unpaid claims. When the time it takes to pay claims lengthens, the liability for unpaid claims generally increases. An analyst should consider also reviewing the health entity's liability for unpaid claims balances, since an understatement of these liabilities could overstate the results of procedures 1a, 1c and 1d. An increase in current liabilities increases the health entity's current cash requirements. A longer claims payment period could indicate the health entity is holding cash for other purposes.

Procedures #2a and *2b* assists the analyst in identifying situations where the health entity's operations are generating negative cash flow, or the potential for future negative cash flows. Cash outflows from operations can result in decreases in the overall liquidity of the health entity. If a health entity already maintains low liquidity, cash outflows from operations can have significant implications. It is important for the analyst to focus on specific components of the health entity's operations to determine what is causing the cash outflows.

Procedures #2c, 2d and *2e* compare the relationship of other cash provided from financing to capital and surplus and cash from operations. Since other cash provided (applied) contains miscellaneous changes in assets and liabilities, it may be difficult for an analyst to determine the true source of this cash flow item.

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III. Analyst Reference Guide – B.7. Cash Flow and Liquidity

Procedure #2f assists the analyst in determining the impact of benefit payments on cash flow. Changes in liabilities for unpaid claims reserves are included in the medical loss ratio however, by calculating the benefits to premiums ratio from the cash flow statement, the analyst may be able to determine if the loss ratio matches the health entity's benefit payment ratios. The analyst should be aware however that variations in this ratio can occur due to the changes in the health entity's volume of business resulting from the lag between claim incurral and claim payment. For example, if the volume of business is declining, this ratio will typically be higher than the medical loss ratio. If the volume of business is increasing, this ratio will typically be lower than the medical loss ratio.

Procedure #2g offers the analyst an additional procedure to assess how the health entity's liquidity results compare to industry averages (some ratios included in the Financial Profile) and peer companies that have similar business mix and asset composition.

Procedure #3 requires the analyst to review the Z-Score analysis included in the Annual Financial Profile. The Z-Score is a way to measure and monitor financial performance by analyzing specific ratios over a period of time. If a result of less than 2.6 occurs, the analyst should consider reviewing the individual ratios within the Z-Score. An unstable trend of the Z-Score or a low Z-Score may indicate increased risk to the solvency of the health entity and the analyst should take a closer look at each of the ratio results in the Financial Profile. There are four ratios in the Z-Score; however, the Z-Score places the most emphasis on working capital and earnings. The following briefly explains each ratio within the Z-Score, although more detail is available in the link to the *Z-Score Document* on I-SITE.

- *Working Capital to Total Assets* measures the ability of a health entity to manage working capital, which is fundamental for all business. While a health entity may have sufficient surplus, they may have insufficient working capital to pay claims due to related party transactions and other non-liquid long-term investments. Analysts should also consider that while working capital may be above the threshold, it may still not provide a sufficient cushion for significant unexpected losses. Refer to the discussion of procedure #1d above.
- *Retained Equity to Total Assets* reflects the age of the business and the philosophy of management. This assumes that a more mature business would normally have more capital and surplus. Companies that have been in business fewer years and have insufficient management experience tend to have higher failure rates.
- *Earnings Before Interest & Taxes (EBIT) to Total Assets* measures a health entity's earnings performance. This ratio is weighted the highest for several reasons including the following: 1) significant shifts in earnings may indicate a highly risky industry with unstable cash flows, 2) health entities must balance consumer demands with cost management, and 3) Medicare & Medicaid programs and other outside factors can have a significant impact on the health entity's financial condition.
- *Capital and Surplus to Total Liabilities* is the leverage measure within the Z-Score and is the inverse of the traditional debt to equity ratio.

Procedure #4 requires the analyst to review cash flow and liquidity information, which may be found in sources available to the analyst, such as the Management Discussion & Analysis and the asset adequacy analysis in the Statement of Actuarial Opinion. The analyst should determine if any information disclosed in these filings cause concern regarding cash flow and liquidity. An asset adequacy analysis is generally not required for a health entity; however, for companies filing the health blank that also write life business, this may be required. Refer to the Actuarial Opinion section, for more discussion on asset adequacy analysis.

Procedure #5 assists the analyst in determining if the health entity is exposed to greater than normal liquidity risk with respect to special deposits. Special deposits are segregated into two sections, "for the benefit of all policyholders" and "not for the benefit of all policyholders." Deposits for the benefit of all policyholders are deposits held by individual states but are aggregated on one summary line. Deposits not held for the benefit of all

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policyholders must be itemized by security. The assets comprising these deposits are held on the various investment schedules in the financial statement. However, the assets are not held in custody of the health entity and restrictions are placed on their disposal. In a situation of a rehabilitating or troubled health entity, these restrictions on assets may cause concerns, particularly those not held for the benefit of all policyholders.

Additional steps the analyst may perform are intended to assist the analyst in determining if the domiciliary state may have difficulty in calling deposits which are deemed "not for the benefit of all policyholders." These procedures specifically apply when the level of deposits not for the benefit of all policyholders as a percentage of total assets is high or in cases when the health entity has been determined to be troubled. The analyst may consider this assessment necessary in either of those cases because once the health entity is moved into rehabilitation, the cash flow position of the health entity may deteriorate rapidly.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for Cash Flow and Liquidity are intended to identify significant changes in cash flow and liquidity that have occurred since the prior year Annual Financial Statement, or the prior Quarterly Financial Statement.

Additional Reference Sources

1. *Annual Statement Instructions—Health*, NAIC

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III. Analysts Reference Guide – B.8. Risk Transfer Other Than Reinsurance

Overview of Risk Transfer Other Than Reinsurance

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 mis-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

The risk transfer to reinsurers is discussed in the Reinsurance section.

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-insurance 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. 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

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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 percent 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, health entity and policyholder agree to set premiums at a lower level than determined by the health entity, e.g., 80 percent level, with a provision that an additional retrospective premium may be required, up to the 100 percent level, if claims experience is unfavorable. An individual stop-loss arrangement is typically included in these plans, so as 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 is treated as a non-admitted asset. At any time, if it is probable that the additional retrospective premium is uncollectible, 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.

A modification to the retrospective premium arrangement is where the full 100 percent 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 line 4, with a corresponding entry to premiums. Accounting

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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. The analyst should see Section D for more information on other risk-transfer techniques that do not explicitly appear in the financial statements.

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. See the TPA, IPA, MGA section for more detail on payment arrangements.

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. The amount paid in bonuses and withholds associated with capitations is not included on Exhibit 7. Withholds and bonuses are discussed in the Other Provider Liabilities section.

If capitation arrangements are significant, the analyst 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.

Receivables from provider contracts are subject to the analysis and reporting requirements of SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans*. In the situation where the

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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. For additional discussion see the Other Assets section.

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. For further information see the Health Reserves and Liabilities section.

Special payment arrangements to provider groups can include fee schedules, discounts, and DRG payments to hospitals. See the Health Reserves and Liabilities section for a discussion of how these arrangements affect risk transfer, liabilities, and reserves.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 procedures included in the Risk Transfer Other Than Reinsurance section of the Level 2 Annual Procedures are designed to identify potential areas of concern with the reporting of provider contracts, minimum premium contracts or ASO and ASC arrangements to the analyst.

The materiality of uninsured plans is determined by reviewing claims volume and the magnitude of uninsured receivables. Relationships of ASO/ASC claims payments are made to hospital and medical expenses to determine the relative volume of uninsured payments. Uninsured receivables are compared to capital and surplus and changes in receivables is reviewed.

The materiality of experience rated arrangements is determined by comparing the amount due from groups (from write-in for other than invested assets) and the amount due to groups (from reserve for rate credits or experience rating refunds on the Underwriting and Investment Exhibit Part 2D, Line 4) to total hospital and medical benefits paid.

The significance of capitation payments and bonuses and withholds is determined by comparing their total to hospital and medical benefits paid. Also, the percent of capitation being paid to intermediaries or "other providers" is reviewed to determine if there is a disproportionate amount being paid to these entities and the proportion of bonuses and withhold payments is reviewed for appropriateness.

Discussion of Level 2 Quarterly Procedures

The Procedures included in the Risk Transfer Other Than Reinsurance section of the Level 2 Quarterly Procedures are intended to identify whether significant changes in alternate risk transfer arrangements have occurred since the prior year Annual Financial Statement.

Discussion of Level 3 Procedures

The procedures included in Level 3 Procedures for Risk Transfer Other Than Reinsurance are designed to assist the analyst in further investigating potential problems and concerns that are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate, and how far to probe. The procedures suggest additional

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steps the analyst may perform if there are concerns regarding the health entity's alternate risk transfer arrangements.

The procedures compare RBC filing and year-to-year Annual Financial Statements to determine if there may be a problem in reporting. The analyst is also asked to make some judgments concerning the potential inaccuracy of some Annual Financial Statement reporting. The purpose of this section is primarily to assist the analyst in identifying those entities with issues related to alternate risk transfer mechanisms.

Additional Reference Sources

1. *Annual Statement Instructions - Health*, NAIC
2. *Accounting Practices and Procedures Manual,* NAIC

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III. Analyst Reference Guide – B.9. Reinsurance

Overview of Reinsurance

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 percent of health entities have no ceded reinsurance premiums. Health entities that are not licensed as insurers are often not authorized to assume reinsurance. Over 95 percent of health entities have no assumed reinsurance premiums. This section is primarily designed to assist an analyst when reviewing a health entity with more significant use of reinsurance. However, this section can still be used in cases where the use of reinsurance is less pervasive and the analyst determines that only certain procedures apply.

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 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 and Associations Including Intercompany 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 presented 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.

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III. Analyst Reference Guide – B.9. Reinsurance

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.

1. 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.

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.

2. 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.

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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.

1. 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.

2. 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.

3. 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 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.

4. 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 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

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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 continue 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.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 procedures included in the reinsurance section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. While there are many legitimate business uses for reinsurance, it can be used to mask a health entity's financial problems or expose the health entity to significant collectibility, or credit risk.

Procedure #1 assists the analyst in determining whether the health entity has a reinsurance program in place that adequately supports its overall risk profile.

Procedure #2 assists the analyst in determining whether significant errors exist relating to the accounting for reinsurance. Generally, the major concern will relate to the manner in which the health entity accounts for credits, or reductions in, the liability for reserves relating to recognition of estimated reinsurance recoverables. SSAP No. 61, *Life, Deposit-Type & Accident and Health Reinsurance* (SSAP 61), defines the specific circumstances when the health entity can record such a credit, or reduction in, the liability for claim reserves. In summary, a credit for reinsurance can be recorded when the assuming insurer is authorized (i.e., licensed or approved by the ceding health entity's state of domicile, or accredited). When the assuming insurer is unauthorized (i.e., neither licensed or approved by the ceding health entity's state of domicile, nor accredited), then a credit for reinsurance may only be recorded when adequate security exists in the form of trust accounts, letters of credit, etc. Another accounting issue may involve the treatment of disputed amounts. Occasionally, a reinsurer will question whether an individual claim is covered under a reinsurance contract or may even attempt to nullify an entire treaty. A ceding health entity, depending upon the individual facts, may or may not choose to continue to take credit for such disputed balances. The ceding health entity may not take credit for reinsurance recoverables in dispute with an affiliate.

Procedure #3 assists the analyst in determining whether reinsurance recoverables are significant and if so, whether the amounts involved are collectible. For example, for stop-loss reinsurance, only after claims have been paid beyond the retention level can the primary company seek reimbursement from a reinsurer for its share of paid claims. As a result, evaluating the collectibility of the recoverables, as well as the overall credit-worthiness of the reinsurers, is a key concern. Evaluating the collectibility of reinsurance recoverables in general requires an understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented towards the type of reinsurer from whom the reinsurance was obtained. Reinsurance is generally obtained from one of the following categories of insurers:

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III. Analyst Reference Guide – B.9. Reinsurance

1. Professional Reinsurers - The main business of professional reinsurers is assuming reinsurance from non-affiliated insurers. In general, the large and well-capitalized professional reinsurers will not pose a serious collectibility concern.
2. Reinsurance Departments of Primary Insurers - Many insurers assume reinsurance from non-affiliates, but also write significant business on a direct basis. These types of insurers may pose a larger collectibility concern than professional reinsurers since the specialized reinsurance expertise may not be as strong.
3. Alien Insurers - Reinsurers domiciled in another country generally pose the most significant collectibility issues; however, health entities typically obtain reinsurance from U.S. domestic reinsurers.

Procedure #4 assists the analyst in identifying whether reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another. 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. 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 affiliates can be used effectively in lieu of moving capital in cases where there is capital capacity in affiliated companies that does not exist in the health entity. However, affiliate reinsurance can present opportunities for manipulation and potential abuse where excess capital in a health entity is removed from the regulators jurisdiction. 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.

Procedure #5 assists the analyst in highlighting whether any transactions or agreements with reinsurance intermediaries exist. While some professional reinsurers are direct marketers, intermediaries (brokers, managers, or managing general agents) may arrange reinsurance agreements between a ceding company and a reinsurer in exchange for commissions or fees. The intermediary bears no financial risk in the event of under priced or poor underwriting or placement with a troubled reinsurer. But, poor performance by an intermediary can affect both ceding health entities and reinsurers. Refer to the TPAs, IPAs & MGAs section for more discussion on managing general agents.

Procedure #6 assists the analyst in highlighting 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 health entity in form and in fact, against loss or liability relating to the original policy in order for the health entity to account for it as a reinsurance recoverable. Determining whether a contract involves the transfer of risk requires a complete understanding of the contract between the health entity and the reinsurer. All contractual features that limit the amount of insurance risk to the reinsurer or delay the timely reimbursement of claims by the reinsurer should be thoroughly understood. A 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.

Although not common in health entities, the analyst should also be alert to unusual types of transactions such as commutations, portfolio transfers, bulk reinsurance, assumption reinsurance agreements and surplus relief. A commutation is a transaction, which results in the complete and final settlement and discharge of all present and future obligations between parties to a reinsurance agreement and is more prevalent in property/casualty lines of business. A loss portfolio transfer is an agreement, applied retroactively, in which the ceding company transfers a portfolio of claims (i.e., claim reserves) to another company along with consideration for assuming such claim reserves. Bulk reinsurance is when a health entity 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 approval. Assumption reinsurance agreements occur when the health entity transfers, with the consent of the policyholder, responsibility for policyholder obligations to another health entity. Surplus relief, or financial reinsurance, is a method of accelerating future profits on a block of insurance business, whereby the reinsurer

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normally returns the majority of the profits on a block of business, less a fee, to the health entity through an experience refund. Since surplus relief transactions merely represent a financing arrangement, SSAP 61 does not allow a credit to surplus until the risk has been transferred.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for Reinsurance are intended to identify 1) whether amounts recoverable are significant or 2) were any unusual reinsurance transaction completed during the quarter.

Discussion of Level 3 Procedures

The procedures included in Level 3 Procedures for Reinsurance are designed to assist the analyst in further investigating potential problems that are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate further and how far to probe.

Procedure #1 suggests additional steps the analyst may perform if there are concerns that the reinsurer's risk profile is not adequately supported by its reinsurance program. A particularly helpful source of information in this regard is the supporting reinsurance information the health entity prepares for the rating agencies. While this information is not a required filing to the insurance department, the major rating agencies generally require it in connection with the rating process. For example, if the health entity has elected to apply for an A.M. Best rating, a detailed questionnaire on reinsurance must be prepared. This questionnaire requires the health entity to describe each major reinsurance contract, and provide other extensive information. Questions such as these can provide excellent background information to the analyst.

Procedure #2 suggests additional steps the analyst may perform if there are concerns regarding the health entity's accounting treatment of ceded reinsurance. The analyst should consider reviewing the largest reinsurers as well as a random selection of the remaining reinsurers to determine that reinsurers are classified correctly.

Procedure #3 and selected aspects of some of the remaining supplemental procedures, suggest additional steps the analyst may perform if collectibility concerns exist. The fundamental issue involved with evaluating collectibility is an assessment of the financial stability of the underlying reinsurers. To evaluate the collectibility of reinsurance recoverables, the analyst should consider the need to collect as much financial information as possible about the reinsurers, including various regulatory and governmental filings, rating agency reports and financial analyses available from industry analysts.

The I-SITE application, Global Receivership Information Database (GRID), allows the regulator to review the status of a receivership (i.e., conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post receivership data, creditor class/claim data, legal, financial and reporting data. Receivables and recoverables due from companies in liquidation proceedings may be partially collected; however, collection will likely be delayed. It is practically certain that balances due at the time a liquidation is closed (the last action date that may be entered in GRID) will never be collected. Evaluating the collectibility of reinsurance recoverables requires understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented towards the type of reinsurer from whom the reinsurance was obtained.

Procedure #5 assists the analyst in determining whether pyramiding exists. The chain of reinsurance does not end once a health entity cedes business to a reinsurer. Since a reinsurer purchases reinsurance for the same reasons as a health entity, the reinsurer may, in turn, retrocede a portion of its assumed reinsurance business to another reinsurer. Each ceding company may rely on many reinsurance agreements with multiple reinsurers participating in each agreement. Therefore, retrocessions further complicate assessing how reinsurance affects a health entity's

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financial condition. While a health entity remains liable for all claims filed by its policyholders before seeking reimbursement from its reinsurers, a health entity's continued solvency may be impaired if the reinsurance chain fails.

Procedure #7 assists the analyst in evaluating significant or unusual reinsurance transactions or agreements, such a commutation, portfolio transfer, bulk or assumption reinsurance, and surplus relief or financial reinsurance. The analyst should review these types of transactions and agreements closely to determine whether a transfer of risk has been consummated. Even when transfer of risk has been consummated, the analyst should evaluate the impact of the transaction on future financial performance of the health entity.

Additional Reference Sources

1. *Troubled Insurance Company Handbook*, NAIC
2. *Annual Statement Instructions - Health*, NAIC
3. *Accounting Practices and Procedures Manual*, NAIC
4. *Model Law on Credit for Reinsurance*, NAIC
5. *Financial Examiners Handbook*, NAIC
6. *Disclosure of Material Transactions Model Act*, NAIC
7. *Fronting Disclosure and Regulation Act*, NAIC
8. *Reinsurance Intermediary Model Act*, NAIC
9. *Managing General Agents Act*, NAIC

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III. Analysts Reference Guide – B.10. Affiliated Transactions

Overview of Affiliated Transactions

SSAP No. 25, *Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties* (SSAP 25), defines an affiliate as an entity that is within the holding company system 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 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 shall be presumed to exist if a reporting entity and its affiliates directly or indirectly, own, control, hold with the power to vote, or hold proxies representing 10 percent or more of the voting interests of the entity. An analyst may also refer to the NAIC *Insurance Holding Company System Regulatory Act* for additional guidance. Not all states have incorporated health entities into the requirements of the *Holding Company System Regulatory Act*.

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 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 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 (See the Risk Transfer section). 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.

Transactions between affiliates and other companies within the same holding company system shall be fair and reasonable. Premiums shall be billed, claims paid, and expenses allocated so as to clearly maintain the identity of affiliated entities. 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 arms length transaction that results in the transfer of risks and rewards of ownership and represents a consummated act. An arms length transaction is defined as one in which willing parties, each being reasonably aware of all relevant facts and neither under compulsion to buy, sell or loan, would be 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.

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

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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 the analyst 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.

Another holding company issue would be determining that the risks and rewards of ownership have been transferred to the buyer. This requires an examination of the underlying facts and circumstances. Although these are frequently less of an issue in dealing with most health entities, the matter should still be considered. The following circumstances from SSAP No. 25 may raise questions about the transfer of risks.

1. 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.
2. 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.
3. Repayment of debt that constitutes the principal consideration in the transaction dependent on the generation of sufficient funds from the asset transferred.
4. Limitations or restrictions on the purchaser's use of the asset transferred or on the profits from it.
5. 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.

Health entities may rely on surplus notes from affiliates as a source of capital within a holding company structure. Such notes are often the method of choice for not-for-profit health entities. Surplus notes are discussed further in the Income Statement and Surplus section.

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 health entity. A bonafide business purpose would not exist if the transaction were initiated for the purpose of inflating (deflating) a particular health entity's financial statement, including effects on the balance sheet or income statement.

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

1. Economic-based transfers between affiliates should be recorded at prevailing fair values at the date of the transfer.
2. Non-economic-based transfers between affiliated health entities should be recorded at the lower of existing book/adjusted carrying values or prevailing fair values at the date of the transfer.
3. Non-economic-based transfers between a health entity 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 health

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entity or its affiliates should be recorded at the prevailing fair value at the date of the transfer. However, to the extent that the transfer results in a gain, that gain should be deferred until such time as permanence can be verified.

4. Transactions that are designed to avoid statutory accounting practices shall be included as if the health entity continued to own the assets or to be obligated for a liability directly instead of through a subsidiary.
5. Assets may be valued on a different basis if held by a health entity versus a life insurer. Therefore, the regulator must take this into consideration when using the general guidelines.
6. 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.

In addition to the above valuation requirements, reporting of affiliated balances must follow the requirements set forth in SSAP No. 64, *Offsetting and Netting of Assets and Liabilities*, which provides that netting of balances can only be used when certain conditions are met.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 Procedures included in the "Affiliated Transactions" section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The challenge to the analyst in this area is to understand, in substance, the various transactions between affiliates and recognize those transactions that are intended to circumvent existing regulations. Many of the procedures may require a prior knowledge of the health entity or a past knowledge of the holding company structure. A review of the health entity's holding company files may assist in this regard.

Procedure #1 assists the analyst in understanding the health entity's corporate structure. Significant changes in corporate structure may materially impact the health entity's future financial condition and generally require prior regulatory approval. The analyst should closely analyze changes in corporate structure in order to understand the motivation for the change. By understanding the corporate structure in which the health entity operates, the analyst may be able to foresee future problems and take appropriate action. For example, a common corporate structure the analyst may encounter involves a holding company whose only significant asset is the stock of the health entity. The holding company may have financed the acquisition of the health entity through bank financing or other debt where the debt service by the holding company is completely dependent upon dividends paid by the health entity. This type of corporate structure warrants close attention by the analyst to ensure that dividends are valid and in compliance with your state's applicable dividend restrictions, and that any other payments by the health entity to the holding company are legitimate, rather than dividends in disguise. The analyst should also be alert to a corporate structure that includes affiliated brokers or intermediaries that may be recording unusual or significant levels of commissions and fees. When a corporate structure is involved that includes multiple tiers of affiliates where significant levels of surplus are comprised of investments in affiliates, the analyst should focus on the level of real surplus that exists on a consolidated basis. The analyst should also be aware of corporate structures that include a hospital organization. As previously mentioned, the operations and financial condition of the health entity may be secondary to other missions of the corporate structure when a hospital or other type of medical provider is involved.

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Procedure #2 assists the analyst in understanding and evaluating the summary of transactions reported in Schedule Y, Part 2. Eight major types of affiliated transactions are reported in Schedule Y, Part 2 and explanatory comments are provided in Note to Financial Statements No. 10, Information Concerning Parent, Subsidiaries and Affiliates. The analyst should refer to both sources of information in order to develop an understanding of the underlying affiliated transactions.

The following briefly describes the key concerns to the analyst for several of the major affiliated transactions.

- For **shareholder dividends**, the major concern relates to whether the level of dividend is within the regulatory guidelines, and whether the dividend should be considered extraordinary, and therefore requires prior regulatory approval.
- For **capital contributions** from the health entity to another affiliate, the analyst should determine that such contribution does not substantially impact the financial condition of the health entity.
- For **non-cash capital contributions** into the health entity, the analyst should determine that the infusion is recorded at fair value so as to not arbitrarily inflate surplus.
- In the case of **purchases, sales, or exchanges of loans, securities, real estate, mortgage loans, or other investments**, the concern to the analyst is primarily one of valuation. These types of transfers should be at arms length and recorded at fair value.
- The analyst should also be alert to possible abuses regarding the **transfer of assets** between insurance affiliates merely to impact the Risk-Based Capital calculation of the affiliates.
- For **management agreements and service contracts**, the main concerns to the analyst relate to the type of service being performed and the reasonableness of the cost or allocation basis. The contract should also specify the frequency of review and adjustment of the cost or allocation basis. This is a common area for abuse when parent companies desire to withdraw funds from the health entity, but do not want to, or would not be permitted to classify it as a shareholder dividend. The analyst should understand why the parties were motivated to enter into such contracts and particularly the benefit to the health entity.
- For **guarantees by the health entity** for the benefit of an affiliated entity, the analyst should be aware that if the affiliated entity is unable to perform, it could be subject to material contingent liabilities. The analyst should review Notes to Financial Statements No. 10 to determine if the health entity is subject to this type of potential exposure. For **guarantees by an affiliate** (usually a parent) for the benefit of the health entity, the analyst should understand the nature of guaranty. Parental Guarantees are not counted as capital, but regulators often rely on them as additional security during the development period of health entities or during implementation of impairment restoration or RBC action plans. Such guarantees should include specific provisions as to triggers and timing of capital infusions. The analyst should review the department's internal files to obtain a better understanding of the guarantees. In reviewing the guaranty, the analyst should consider the impact that an all purpose long-term guaranty may have on the market or competing health entities. However, the analyst should be most concerned about the ability of the guarantor to meet the requirements of the guarantee if needed.

Procedures #3 and *#4* assist the analyst in determining whether investments in affiliates are significant 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 investment may be substantially overvalued.

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Procedure #5 assists the analyst in evaluating all other affiliated transactions. The analyst's primary objective in this area is to understand the substance of the transactions and to determine whether they are economic-based. The analyst should closely monitor other affiliated transactions to ensure that the health entity is not exposed to significant collectibility risk.

The analyst should review the information obtained in Exhibits 5 and 6, which contain detailed information on amounts due from affiliates and amounts due to affiliates, respectively. The analyst can use the detailed information on amounts due from affiliates to help assess whether the health entity may be experiencing collectibility problems. Similarly, the analyst can use the detailed information on amounts due to affiliates to help assess whether the health entity may be experiencing some liquidity problems.

The analyst should also review the information obtained in Exhibit 7 to determine if transactions with affiliated providers are significant. Non-arm's length transactions with affiliated providers could present a potential material area of abuse and special attention should be given if there is reason to believe the amounts paid to these particular providers are not reasonable.

The analyst should review Schedule E-Part 1-Cash, to determine if any open depositories are institutions that are affiliates of the health entity. Affiliated open depositories can present additional access and control risk to the health entity that are not present in unaffiliated open depositories.

If the health entity is included in a consolidated federal income tax return and a significant asset for Federal Income Tax Recoverable is recorded on the financial statements of the health entity, the analyst should closely review the financial statements of the parent to determine the parent's ability to repay the receivable.

The analyst should review the extent of transactions with officers and directors to ensure that the transactions are at arms length and are not detrimental to the financial condition of the health entity. General Interrogatories #15 and #16, as well as, Schedule SIS, Stockholder Information Supplement should be studied to determine if there is a potential problem.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for Affiliated Transactions are intended to identify 1) significant changes in the corporate structure; 2) whether affiliated transactions that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement are economic-based; 3) whether the transactions are significant, legitimate and properly accounted for; or 4) other significant or unusual transactions with affiliates.

Discussion of Level 3 Procedures

The procedures included in Level 3 Procedures for Affiliated Transactions are designed to assist the analyst in further investigating potential problems that are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate further and how far to probe.

Procedure #1 suggests additional steps the analyst may perform if the health entity's corporate structure elevates concerns about affiliated transactions. The primary objective is to understand the financial position of the parent company. By understanding the financial commitments of the parent, the analyst will be able to better understand the parent's motivation for entering into transactions with the health entity or other affiliates. Financial statements of affiliates may reveal unauthorized transactions in progress.

Procedures #2 and *#4* suggest additional steps the analyst may perform when there are concerns that transactions with affiliates may not be economic-based or at arms length. For those services provided by an affiliate where a

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market already exists, such as data processing, actuarial, or investment management, an effective way for the analyst to determine whether an arms length transaction exists is to contact one of the vendors and request a proposal or fee estimate for a similar service.

Procedure #3 suggests additional steps the analyst may perform when investments in affiliates are significant and the valuation of such investments is a concern. In particular, the analyst should review the level of return on the investment in affiliate, including the source of the investment income (i.e., cash or merely an increase in the accrual). The analyst should not only be alert to the level of investments in affiliate, but also the level of accrued interest relating to investments in affiliate.

The I-SITE application, Global Receivership Information Database (GRID), allows the regulator to review the status of a receivership (i.e., conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post receivership data, creditor class/claim data, legal, financial and reporting data. Receivables and recoverables due from companies in liquidation proceedings may be partially collected; however, collection will likely be delayed. It is practically certain that balances due at the time a liquidation is closed (the last action date that may be entered in GRID) will never be collected. Evaluating the collectibility of reinsurance recoverables requires understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented towards the type of reinsurer from whom the reinsurance was obtained.

Additional Reference Sources

1. *Annual Statement Instructions –Health*, NAIC
2. *Accounting Practices and Procedures Manual*, NAIC
3. *Accounting Practices and Procedures Manual Appendix A-440, Insurance Holding Companies,* NAIC
4. *An Act Concerning Insider Trading of Domestic Stock Insurance Company Equity Securities*, NAIC
5. *Regulation Regarding Proxies, Consents, and Authorizations of Domestic Stock Insurers*, NAIC
6. *Stockholders Information Supplement Schedule (Schedule SIS)*, NAIC
7. *Insurance Holding Company System Regulatory Act,* NAIC

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III. Analysts Reference Guide – B.11. TPAs, IPAs and MGAs

Overview of TPAs, IPAs and MGAs

The importance of understanding the contractual relationship between a health entity and a subcontractor cannot be overstressed or underestimated. Health entities can utilize third party administrators (TPAs) and managing general agents (MGAs). In addition, Individual Practice Associations (IPAs) or other provider-based organizations are utilized to perform similar services, and also can add the element of risk transfer (discussed in detail in section III.B.8.). These organizations are often referred to as Risk Bearing Entities (RBEs) (discussed in section VIII.). An analyst must become familiar with the various methods that health entities employ in their subcontracting arrangements. Also, the terminology used for the multiple types of subcontracting arrangements is continually changing and may vary from state to state. Each individual state, as a general rule, has approached the regulation of delegation of services and business risk differently. Therefore, regulatory attention to the transfer of various types of business functions from health entities to subcontractors is one of the most complex and serious challenges currently faced by regulators.

The NAIC Model Third-Party Administrator Statute (*NAIC Model Statute*) defines a TPA as any person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from or adjusts or settles claims in connection with life or health insurance coverage, annuities or workers' compensation insurance. However, the *NAIC Model 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, licensed adjusters whose activities are limited to the adjustment of claims, and MGAs.

The NAIC Model Managing General Agents Act (*NAIC Model Act*) defines an MGA as any person who 1) manages all or part of the business of a health entity (including the management of a separate division, department or underwriting office) and 2) acts as an agent for such health entity, 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 percent of the health entity's surplus in any one quarter or year and either adjusts or pays claims or negotiates reinsurance on behalf of the health entity. However, the *NAIC Model Act* exempts certain persons from being considered MGAs for purposes of the Act, including employees of the health entity and underwriting managers under common control with the health entity whose compensation is not based on the volume of premiums written.

MGAs produce or solicit business for some health entities and can also provide one or more of the following services: underwriting, premium collection, enrollment changes, claims adjustment, claims payment and reinsurance negotiation. MGAs can be used by health entities 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. Although this may help a health entity 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.

TPAs can serve this function as well, but are more typically used in the processing or preauthorization of claims, or the administration of particular types of health business. 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 health entity 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 health entity 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. IPAs, which include other provider-based organizations, can act like TPAs but also add the element of risk transfer. In all of these arrangements it is important to identify how much of the claims cost or underwriting risk is being assumed by each entity.

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The more authority that is delegated to TPAs, IPAs and MGAs, the greater the potential impact of mismanagement making it more important for the health entity to provide active ongoing oversight into the MGAs or TPAs operations. If the health entity relinquishes too much control, management may not be able to effectively guide and monitor the entity's operations. TPAs, IPAs and MGAs may have priorities or needs that conflict with those of the health entity. When MGAs are compensated based on the volume of business written, there may be incentive to write as much business as possible, without adequate 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. These types of conflicts have played a significant part in the failure of several health entities. Alternatively, when TPAs or IPAs preauthorize or process claims, they can cause problems for health entities 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 health entity retains the responsibility if regulatory requirements are not met. In some cases, these problems can result in sizable penalties imposed on the health entity. 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 health entity 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.

It is important that the health entity actively supervises and monitors the financial impact that TPAs, IPAs and MGAs have on the entity, on an ongoing basis, to ensure their adequate performance. To effectively monitor TPAs, IPAs and MGAs, health entities should obtain and review annual independent financial examinations and financial reports of the TPAs, IPAs and MGAs utilized. In addition, the NAIC model acts regarding MGAs and TPAs require health entities to periodically perform on-site reviews of the underwriting and claims processing operations of each MGA and TPA utilized and these requirements should be applied to health entities. The health entity should also review membership administration and customer service processes, if they are delegated to the TPA, IPA or MGA.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 of directors.

The procedures in the TPAs, IPAs and MGAs section of the Level 2 Annual Procedures are designed to assist the analyst in identifying those health entities that may have problems due to significant reliance on TPAs, IPAs and MGAs. The two procedures in the TPAs, IPAs and MGAs Annual Financial Statement Supplemental Procedures are designed to determine the extent to which TPAs, IPAs and MGAs are used to write and administer business written by the health entity. The Annual Financial Statement contains information regarding the MGAs and TPAs utilized, the types and amount of direct premiums written by each, and the types of authority granted to each by the health entity. The Annual Financial Statement and Health Risk-Based Capital (RBC) reports also contain information relative to capitated arrangements in Annual Financial Statement Exhibit 7, Part 1 – Summary of Transactions With Providers and RBC report page XR015 that can be used as a starting point to determine whether IPAs are processing claims. The Annual Financial Statement also contains information on health care receivables, which can also be indicative of TPA arrangements, particularly with regard to pharmaceutical claims.

Procedure #1 assists the analyst in determining whether a significant amount of the health entity's direct premiums are being written through MGAs and TPAs. While the amount of direct premiums written by MGAs and TPAs is not necessarily an indication of a problem or concern, this procedure provides an indication to the

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analyst of the health entity's exposure to potential abuse by MGAs and TPAs. MGAs and TPAs who had been delegated significant authority without health entity oversight have played a major role in the insolvency of several large health entities.

Procedure #2 assists the analyst in determining whether a significant proportion of the health entity's claims are being pre-authorized or processed by TPAs and IPAs. While the proportion of claims processed by TPAs or IPAs is not necessarily an indication of a problem or concern, this procedure does provide the analyst with the health entity's possible exposure to potential regulatory penalties, unpaid claim reserve misstatement, and other financial exposures to TPAs and IPAs that can affect the solvency of the health entity.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for TPAs, IPAs and MGAs are intended to identify any significant changes regarding the terms of any agreements with MGAs or TPAs that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.

Discussion of Level 3 Procedures

The procedures included in Level 3 Procedures for TPAs, IPAs and MGAs are designed to assist the analyst in further investigating potential problems and concerns regarding TPAs, IPAs and MGAs, which are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate further and how far to probe.

Procedure #1 suggests additional steps the analyst may perform if there are concerns regarding the health entity's use of MGAs and TPAs. The analyst should consider reviewing the information in Note to Financial Statements No. 19 - Direct Premiums written by Managing General Agents/Third-Party Administrators in more detail than was done as a part of the Level 2 Annual Procedures review to determine which MGAs and TPAs are being utilized (and whether any of the MGAs or TPAs are affiliated with the health entity), the types and amount of direct premiums written by each, and the types of authority granted to each by the health entity.

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

To evaluate the health entity's oversight of significant MGAs and TPAs, the analyst should consider requesting from the health entity copies of its contracts with the MGAs and TPAs to determine compliance with the minimum contract provisions per the NAIC Model Managing General Agents Act and the NAIC Model Third-Party Administrator Statute and/or the applicable provisions of the Insurance Code. The analyst should also consider requesting from the health entity copies of financial statements for the significant MGAs and TPAs and documentation supporting the health entity's periodic (at least semi-annual) review of the underwriting and claims processing systems. If there are concerns regarding the business placed with the health entity by an MGA or TPA,

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the analyst should consider determining if other health entities are utilizing the same MGA or TPA and comparing the contract between the health entity and the MGA or TPA with the contracts between the other health entities and the MGA or TPA to determine whether they are similar (i.e., contain the same commission rates). The analyst should also consider comparing the health entity's loss and loss adjustment expense ratios on the business placed by the MGA or TPA with those of the other health entities utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the health entity may be receiving a disproportionate amount of "bad" business from the MGA or TPA.

Procedure #2 suggests additional steps the analyst may perform if there are concerns regarding the health entity's use of TPAs and IPAs to process claims. Many of the procedures are similar to those contained in Level 3 procedure #1. Again, the more authority that is delegated to a TPA or IPA, the more important it is for the health entity to provide active ongoing oversight into the TPAs or MGAs operations. The analyst should review a listing of all significant TPAs and IPAs and verify that all are properly licensed and that the health entity's contracts with these companies meet minimum standards. The analyst should also request from the health entity copies of financial statements for the significant TPAs and IPAs and documentation supporting the health entity's periodic review of those companies claims processing systems.

Additional Reference Sources

1. *Annual Statement Instructions - Health*, NAIC
2. *Troubled Insurance Company Handbook*, NAIC
3. *Managing General Agents Act*, NAIC
4. *Third-Party Administrator Statute*, NAIC
5. *Health Maintenance Organization Model Act,* NAIC

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III. Analysts Reference Guide – C.1. Audited Financial Reports

Overview of Audited Financial Reports

The Annual Financial Statement filed by a health entity 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 health entity. However, most state insurance departments perform financial condition examinations of their domestic health entities to verify the accuracy of the financial information reported in the Annual Financial Statement only once every three to five years. The Audited Financial Reports can provide comfort to the analyst regarding the accuracy of the financial information in the Annual Financial Statement.

Per the NAIC *Annual Financial Statement Instructions*, health entities are required to file an Audited Financial Report by June 1 each year, which includes an opinion by an independent certified public accountant or accounting firm (hereinafter referred to as CPA) regarding the financial statements audited. The independent CPA's opinion may be unqualified, unqualified with explanatory language added, qualified or adverse, or there may be a disclaimer of opinion. If the financial statements included in the Audited Financial Report include amounts different from the filed Annual Financial Statement, a reconciliation of the differences and a description of the nature of the differences is required to be included 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 a health entity's financial statements might, at first glance, appear to be a standard unqualified opinion, additional explanatory language included in the opinion may flag a potential problem. For example, the CPA might issue an unqualified opinion on the financial statements while also including additional language in the auditor's report emphasizing uncertainties, such as contingencies concerning future events which could impact the health entity's financial position or expressing substantial doubt by the CPA regarding the health entity's ability to continue as a going concern. In addition, the notes to the Audited Financial Report should be thoroughly reviewed, especially for information concerning investments, reserves, reinsurance, transactions with affiliates, 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 health entity. The notes should also be reviewed to deterime if the information included in section B of the Annual Financial Statement Instructions for Notes to Financial Statements are addressed in the Audited Financial Report.

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 health entity. The letter further states that the CPA will agree to make all workpapers prepared during the audit available for review by the domiciliary state insurance department examiners.

If the insurer is and SEC registrant or significant deficiencies in a health entity's internal control structure are noted during the audit, the independent CPA is required to prepare a report which describes the deficiencies. This report, along with a description of the improvements made or proposed by the health entity to correct the deficiencies noted, must be filed with the domiciliary state insurance department.

The independent CPA is required to notify the board of directors of a health entity within five business days of any determination that the health entity has materially misstated its financial condition as reported to the domiciliary state insurance department or that the health entity does not meet the minimum capital and surplus requirement of the domiciliary state. Once notified, the health entity 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 health entity 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.

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The health entity is required to notify the domiciliary state insurance department within five business days when the health entity's independent CPA is dismissed or resigns. The health entity is also required to furnish a separate letter within ten 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 health entity is further required to furnish a letter from the former independent CPA stating whether the independent CPA agrees with the statements contained in the health entity's letter and, if not, stating the reasons for which there is disagreement.

The Audited Financial Report Procedures are designed to assist the analyst in reviewing the Audited Financial Report and identifying significant information and explanatory language regarding the health entity which has been emphasized by the independent CPA. In addition, the procedures of the Audited Financial Reports includes review of the independent CPA's letter of qualifications and, if applicable, the report of significant deficiencies in the health entity's internal control structure.

Procedures Related to Level 1 Annual Procedures

Generally an Audited Financial Report will not be available at the time of the Annual Financial Statement review. There is one question within the Level 1 Annual Procedures that is used to identify if any unusual items were noted in the Audited Financial Report, if indeed it was received. However, an analyst should consider performing a review of information related to the potential filing of an Audited Financial Report that is available within the Annual Financial Statement itself. Any unusual responses at this preliminary stage should be noted within the Level 1 Annual Procedures at this point. The Annual Financial Statement Supplemental Exhibits and Schedules of Interrogatories ask whether the health entity will file an audited financial report by June 1 and requires an explanation if an Audited Financial Report will not be filed. Every health entity required to file an Annual Financial Statement is also required to file an Audited Financial Report by an independent CPA as a supplement to the Annual Financial Statement on or before June 1. However, there are two exemptions from this requirement, which are as follows:

1. Health entities having direct premiums written less than $1 million nationwide in any calendar year <u>and</u> fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of the calendar year shall be exempt from this requirement for that year (unless the domiciliary Commissioner makes a specific finding that compliance is necessary for the domiciliary Commissioner to carry out statutory responsibilities) except that health entities having assumed premiums pursuant to contracts and/or treaties of reinsurance of $1 million or more will not be so exempt.
2. The domiciliary Commissioner may grant an exemption from compliance with this requirement, upon written application from a health entity, if the domiciliary Commissioner finds that compliance with this requirement would constitute a financial or organizational hardship upon the health entity.

Discussion of Supplemental Procedures

The analysis of the Audited Financial Report is documented on the separate Audited Financial Report Supplemental Procedures rather than the Annual Financial Statement Supplemental Procedures due to its significance and due to the timing of the receipt of the Audited Financial Reports on June 1 rather than on March 1 with the Annual Financial Statement. The Audited Financial Reports Supplemental Procedures are broken down into three parts 1) review of the Audited Financial Reports; 2) review of the CPA's letter of qualifications; and 3) other, including review of the report of significant deficiencies in internal control, if applicable, and the letter regarding any disagreements with the former CPA in the event of a change in CPA.

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III. Analysts Reference Guide – C.1. Audited Financial Reports

Audited Financial Report

Procedure #1 assists the analyst in determining that the financial statements included in the Audited Financial Report have been prepared in conformity with statutory accounting practices prescribed, or otherwise permitted, by the domiciliary state insurance department. The health entity may not file audited financial statements prepared in conformity with generally accepted accounting principles (GAAP).

Procedure #2 assists the analyst in determining whether the financial statements included in the Audited Financial Report are those of the health entity on a separate company stand-alone basis. While most health entities are required to file Audited Financial Reports on a separate company stand-alone basis, a health entity may make written application to the domiciliary Commissioner to file audited consolidated or combined financial statements if the health entity is a part of a group of insurance companies which utilizes a pooling or 100 percent reinsurance agreement that affects the solvency and integrity of the health entity's reserves and the health entity cedes all of its direct and assumed business to the pool.

Procedure #3 should be completed in those instances where audited consolidated or combined financial statements are filed. This procedure assists the analyst in determining that the domiciliary Commissioner approved the health entity's application to file on a consolidated or combined basis due to a pooling or 100 percent reinsurance agreement and that a consolidating or combining worksheet has been included with the financial statements. This worksheet shows amounts for each health entity separately, includes explanations for consolidating and eliminating entries, and includes a reconciliation for any differences between the amounts shown for an individual health entity and the amounts per the health entity's Annual Financial Statement. This allows the analyst to reconcile from the audited consolidated or combined financial statements to the Annual Financial Statement filed by the individual health entity being analyzed.

Procedure #4 assists the analyst in determining the type of audit opinion which was issued by the independent CPA. The opinion may be unqualified, unqualified with explanatory language added to the independent CPA's standard report, qualified, adverse or there may be a disclaimer of opinion. The following is a discussion of each of these types of audit opinions:

1. Unqualified Opinion

   An unqualified opinion states that the financial statements present fairly, in all material respects, the financial position, results of operations, changes in capital and surplus and cash flows of the health entity in conformity with the accounting practices prescribed or permitted by the domestic state insurance department. (This is the standard "clean" opinion.)

2. Unqualified Opinion With Explanatory Language Added

   Certain circumstances, while not affecting the independent CPA's unqualified opinion, may require that the independent CPA add an explanatory paragraph or other explanatory wording to the report. This explanatory paragraph may either precede or follow the opinion paragraph in the independent CPA's report. Examples of circumstances which may require the independent CPA to add explanatory language to the report include the following: the financial statements are affected by uncertainties concerning future events, the outcome of which cannot be reasonably estimated as of the date of the independent CPA's report; there is substantial doubt about the health entity's ability to continue as a going concern; there has been a material change in accounting practices or in the method of their application between periods being reported on; or that the independent CPA's opinion is based in part on the report of another auditor.

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3. Qualified Opinion

   A qualified opinion states that, except for the effects of the matter or matters to which the qualification relates, the financial statements present fairly, in all material respects, the financial position, results of operations, changes in capital and surplus and cash flows of the health entity in conformity with the accounting practices prescribed or permitted by the domestic state insurance department. When the independent CPA issues a qualified opinion, the reasons for the qualification are disclosed in one or more separate explanatory paragraphs preceding the opinion paragraph of the report and these paragraphs are referenced in the opinion paragraph. Qualified opinions are issued when 1) there is a lack of sufficient competent evidential matter or there are restrictions on the scope of the audit that have led the independent CPA to conclude that an unqualified opinion cannot be expressed and a conclusion has been made not to disclaim an opinion, or 2) the independent CPA believes, as a result of the audit, that the financial statements contain a departure from accounting practices prescribed or permitted by the domestic state insurance department, the effect of which is material, and the independent CPA has concluded not to express an adverse opinion.

4. Adverse Opinion

   An adverse opinion states that the financial statements do not present fairly the financial position, results of operations, changes in capital and surplus and cash flows of the health entity in conformity with accounting practices prescribed or permitted by the domestic state insurance department. When the independent CPA issues an adverse opinion, the reasons for the adverse opinion and the principal effects of the subject matter of the adverse opinion on the financial position, results of operations, changes in capital and surplus and cash flows, if practicable, are disclosed in one or more separate explanatory paragraphs preceding the opinion paragraph in the CPA's report and these paragraphs are referenced in the opinion paragraph. If the effects are not reasonably determinable, this should be indicated in the independent CPA's report. Adverse opinions are issued when, in the independent CPA's judgment, the financial statements are not presented in conformity with accounting practices prescribed or permitted by the domestic state insurance department.

5. Disclaimer of Opinion

   A disclaimer of opinion states that the independent CPA does not express an opinion on the financial statements and is issued when the independent CPA has not performed an audit sufficient in scope to allow the CPA to form an opinion on the financial statements. When the independent CPA issues a disclaimer of opinion because of a scope limitation, the reasons why the audit did not comply with generally accepted auditing standards should be disclosed in one or more separate paragraphs and the report should state that the scope of the audit was not sufficient to warrant the expression of an opinion on the financial statements.

Procedure #5 should be completed in those instances where the independent CPA's audit opinion is other than the standard unqualified "clean" opinion. The analyst will document the reason(s) for the deviation. The analyst's comments should be as detailed as possible to provide the reason for the deviation based on information in the audit opinion and in the Notes to Financial Statements and should include how the deviation will affect the health entity's financial position

Procedure #6 assists the analyst in determining that total assets, net income and capital and surplus per the Audited Financial Report agree with the amounts per the health entity's Annual Financial Statement which has previously been analyzed. The analyst should compare these amounts between the Audited Financial Reports and the Annual Financial Statement which was filed with the state insurance department. If differences exist, the independent CPA is required to include, in the Notes to Financial Statements, a

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reconciliation of the differences between the audited financial statements and the Annual Financial Statement along with a written description of the nature of these differences.

Procedure #7 should be completed in those instances where differences exist between the Audited Financial Reports and the Annual Financial Statement. This procedure requires the analyst to document these differences and the reasons for the differences, based on a review of the independent CPA's reconciliation in the Notes to Financial Statements. The analyst should also consider the impact of the audit adjustments made by the independent CPA on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (e.g., complete additional supplemental checklists for items impacted by the audit adjustments) on the Annual Financial Statement information.

Procedure #8 assists the analyst in reviewing the Notes to Financial Statements included in the Audited Financial Report and commenting on any items of significance, including, but not limited to: investments (e.g., fair value and duration/maturity of bonds, realized and unrealized gains and losses), reserves (e.g., variability of reserves, the impact of any estimated salvage and subrogation and/or discounting), reinsurance (e.g., reserve credits taken, recoverables, transfer of risk, collectibility), transactions with affiliates (e.g., pooling, administrative agreements and fees, dividends, transfers), and contingent liabilities (e.g., litigation, assessments). The information included in the Notes to Financial Statements is an integral part of the information included in the Audited Financial Report and should be closely scrutinized by the analyst. The comments included by the analyst in *Procedure #8* should focus on all significant items noted and not just those with a negative impact on the health entity's current financial position.

Procedure #9 should be completed in those instances where transactions with affiliates are significant. This procedure suggests that the analyst consider comparing information regarding affiliated relationships and transactions per the Audited Financial Report to information reported by the health entity in the Annual Financial Statement and in the various holding company filings (Form B - Annual Registration Statement, Form C - Summary of Registration Statement, Form D - Prior Notice of a Transaction, Form E (or Other Required Information) – Pre-Acquisition Notification regarding Potential Competitive Impact of a Proposed Merger or Acquisition, and Extraordinary Dividend/Distribution) to verify the information in these other filings and to determine that all appropriate filings were made by the health entity.

Internal Controls

In addition to the Audited Financial Report, insurers are required to furnish the domiciliary state insurance department with a written report by the independent CPA describing significant deficiencies in the insurer's internal control structure as noted by the independent CPA during the audit, if applicable. Such report is not required if the CPA does not identify significant deficiencies. In those instances where significant deficiencies are noted, the insurer is also required to provide a description of remedial actions taken or proposed to correct the significant deficiencies, if such actions are not described in the Audited Report.

Procedure #10 assists the analyst in documenting the review of the report of significant deficiencies, if applicable (the report is only prepared if the insurer is an SEC registrant or significant deficiencies are noted by the CPA during the audit), and the improvements made or proposed by the insurer. In addition to commenting on any deficiencies noted, the analyst should also comment on the adequacy of the improvements made or proposed by the insurer to correct the deficiencies.

CPA's Letter of Qualifications

This section of the Audited Financial Reports Procedures should be completed whenever there has been a change in the independent CPA from the prior year and may be completed annually whether or not there has been a change in independent CPA.

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Procedure #11 should be completed in order to determine if the independent CPA must also furnish to the health entity, in connection with and for inclusion in the filing of the Audited Financial Report, a letter of qualifications which includes all of the statements listed in the procedure. The analyst should verify that the independent CPA included all of the statements in the letter of qualifications (especially those included in *Procedures #1b, #1c, and #1f*).

Procedure #12 assists the analyst in documenting any deviations or omissions from the required statements in the independent CPA's letter of qualifications. In addition, if the analyst has concerns regarding the independent CPA's qualifications, these concerns should also be documented as a part of this procedure.

Change in CPA

Procedure #13 assists the analyst in determining whether the independent CPA who issued the opinion on the health entity's financial statements is the same CPA who issued the opinion in the prior year. The health entity is required to notify the domiciliary state insurance department within five business days when the health entity's independent CPA is dismissed or resigns. The health entity is also required to furnish a separate letter within ten 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 health entity is further required to furnish a letter from the former independent CPA stating whether the independent CPA agrees with the statements contained in the health entity's letter and, if not, stating the reasons for which he or she does not agree.

Procedure #14 is to be completed in those instances where the CPA who issued the opinion on the health entity's financial statements in the current year is different from the CPA in the prior year. This procedure assists the analyst in determining whether the domiciliary state insurance department was notified of the change and whether the letters from the health entity and the former CPA regarding any disagreements were filed.

Procedure #15 should be completed in those instances where disagreements were noted in the letter from either the health entity or the former CPA. This procedure directs the analyst to comment on the disagreements noted. In commenting on the disagreements noted, the analyst should consider the impact of the disagreements on any other analysis of the health entity performed by the analyst.

Audit Committee

Procedure #16 is intended to verify that the insurer has established an audit committee as required at January 1, 2010. As of this date, every insurer required to file an audited financial report shall also be required to have designated an audit committee. The procedures also ask the analyst to verify that audit committee membership meets state requirements.

Revisions to the Annual Financial Reporting Model Regulation (Model Audit Rule) – Effective January 1, 2010

Amendments to the Annual Financial Reporting Model Regulation, commonly known as the Model Audit Rule, become effective on January 1, 2010. The purpose of this regulation is to improve a state's surveillance of the financial condition of insurers by requiring an independent annual audit of the financial statements by certified public accountants. The revisions deal with primarily three areas: auditor independence, corporate governance and internal control over financial reporting.

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Auditor Independence

Significant revisions to the model related to auditor independence are as follows:

- The lead audit partner may not serve in that capacity for more than five consecutive years and may not rejoin in that capacity for a period for more than five consecutive years. Previously, the requirement was seven and two years, respectively.
- Includes various non-audit services that, if performed by the auditor, 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 engagement may not serve as a member of the Board of Directors, President, Chief Executive Officer, Controller, Chief Financial Officer or other similar position of the insurer if employed by the independent public accounting firm that audited the insurer during the one-year period which preceded the most current statutory opinion.

Corporate Responsibility/Governance

Significant revisions to the model related to corporate responsibility/governance are as follows:

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

Internal Control over Financial Reporting

Significant revisions to the model related to internal control over financial reporting are as follows:

- Management of insurance companies with more than $500 million in direct and assumed premium shall file a report with the state insurance department regarding its assessment of internal control over financial reporting. This report will include a statement by management whether these controls are effective to provide reasonable assurance regarding the reliability of the statutory financial statements and disclosure of any unremediated material weaknesses in internal control over financial reporting. At this premium threshold, nearly 90% of all premiums are captured with only 40% of companies needing to comply with the requirements, a vast majority of which are already SEC registrants. In fact, at this premium threshold, only 6% of non-public companies would have to comply with the proposed internal control reporting requirements. That is only 190 companies out of a population of 3,061.
- No CPA attestation (or opinion) will be required of management's assessment. This CPA attestation can be costly, and the elimination of such emphasizes the regulator's understanding of the need to balance the costs and benefits.

With the exception of Audit Committee requirements as discussed in procedure #16 above, these amendments do not impact 2009 Annual *Financial Analysis Handbook* procedures. However analysts should be aware that changes to the Annual 2010 *Financial Analysis Handbook* guidance and procedures are anticipated.

2010 annual statement instructions will refer to state statutes or regulations that require an annual audit of their insurance companies by an independent certified public accountant based on the NAIC's Annual

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Financial Reporting Model Regulation. For guidance regarding this model, see the Implementation Guide for the Annual Financial Reporting Model Regulation in Appendix G of the *Accounting Practices and Procedures Manual.*

Additional Reference Sources

1. *Annual Statement Instructions for Health Insurance Companies*, NAIC
2. Annual Financial Reporting Model Regulation, *Model Laws, Regulations and Guidelines*, NAIC
3. *Accounting Practices and Procedures Manual,* NAIC

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III. Analysts Reference Guide – C.2. Statement of Actuarial Opinion

Overview of Statement of Actuarial Opinion

The Statement of Actuarial Opinion (Opinion) contained in the Health Annual Statement instructions has been significantly modified beginning with the 2009 Annual Statement. The most significant change is the adoption of prescribed language and a Table of Key Indicators. The Table of Key Indicators will note where prescribed language has not been used, as well as if the Statement is other than unqualified. Generally the analyst can focus on the following four steps to compose much of the Level 1 Procedures.

1. Review Table of Key Indicators for use of other than prescribed language.
2. Review Table of Key Indicators for use of an unqualified opinion.
3. Determine if the Company has provided a notification letter to the domiciliary state describing the appointment of the actuary.
4. Determine if a certification letter is attached if the actuary has relied upon someone for data.

As noted in the discussion of Level 1 Procedures below, in most instances proper review and analysis of the Opinion beyond Level 1 Procedures will use in-depth knowledge of actuarial science where most Opinions will be reviewed in detail by actuarial staff members. However, it is up to each state to determine how best to address this review with available resources.

The following provides an in depth description of elements of the Opinion.

The Health Annual Statement instructions contain 10 sections which provide instructions for the Opinion which include instructions relevant to the Actuarial Memorandum that supports the Opinion. These 10 sections are summarized below.

Section 1 requires a Qualified Health Actuary (actuary) to render the Opinion. For this Opinion an actuary means a member of the American Academy of Actuaries, or a person recognized by the American Academy of Actuaries as qualified for such actuarial valuation. The actuary must be appointed (Appointed Actuary) by the Board of Directors (or a committee of the board) to render the Opinion. Section 1 includes specific responsibilities of the insurer regarding the appointment of the Appointed Actuary and addresses documentation, and replacement requirements. Requirements include notification of any replacement of the Appointed Actuary to the commissioner with disclosure of any disagreements with the prior actuary relevant to the Opinion. Requirements are also provided regarding a responsive letter from the prior actuary addressing agreement or disagreement to reasons for replacement provided by the company. When reviewing compliance with Section 1, note that the publication of the changes to the Health Actuarial Opinion Annual Statement Instructions in September 2009 may impact the timeliness of notification and compliance. Section 1 also provides for reporting and documentation requirements between the Appointed Actuary and the Board of Directors or the Audit Committee. Section 1A provides definitions and Section 1B provides requirements for the Actuarial Memorandum which supports the Opinion.

Section 2 requires that the Opinion contain four clearly designated sections: Identification, Scope, Reliance, and Opinion. A fifth section, Relevant Comments, may be provided at the option of the actuary. A Table of Key Indicators must be provided which indicate whether these five sections use prescribed wording only, prescribed wording with additional wording, or revised wording. The Table of Key Indicators also provides whether the Opinion is unqualified, qualified, adverse, or inconclusive.

Section 3 provides a Table of Key Indicators, which indicates whether the sections of Identification, Scope, Reliance, or Opinion use prescribed wording only, prescribed wording with additional wording, or revised wording. The Relevant Comments section provides boxes to be checked that indicate if there is revised wording or if any of the actuary's work, as detailed in the Actuarial Memorandum deviates from Actuarial Standards of

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Practice. The Table of Key Indicators also provides whether the Opinion is unqualified, qualified, adverse, or inconclusive.

Section 4 (Identification section) is self-explanatory.

Section 5 (Scope section) is also self-explanatory where all actuarial items listed in the instructions should be provided even if amounts are zero.

Section 6 (Reliance section) requires the actuary to identify any person upon whom the actuary relied for data used in the reserve analysis. A statement from the person relied on also required by this section. The actuary may choose to accept responsibility for the data without reliance on another. The actuary would state this by using prescribed language in this section.

Section 7 (Opinion section) provides the prescribed statements the actuary is to make that opine on the items identified in Section 5. This is a key section to review for deviations from prescribed language that form the basis for whether the Opinion is unqualified, qualified, adverse, or inconclusive as indicated in Section 3.

Section 8 (Relevant Comments section) is optional. The actuary may use this section to state a qualification of his or her opinion or provide greater explanation of that qualification. The actuary may also address topics of regulatory importance or explain some aspect of the annual statement. Examples may include explanations of any material changes in assumptions or methods that were made during the year.

Section 9 of the Opinion instructions provides additional guidance to the actuary regarding adverse, qualified, or inconclusive opinions. The determination of adverse, qualified, or inconclusive must be explicitly stated in the Table of Key Indicators provided in the Opinion. It is expected that adequate explanation of this determination be provided in the Opinion.

Section 10 of the Opinion provides for signatures which is self explanatory.

Considerations

Requirements for the Opinion provide for conformance with specific Standards of Practice adopted by the Actuarial Standards Board (ASB) of the American Academy of Actuaries including standards relating to follow-up studies and standards of what should be included in an Opinion. For managed-care health plans, ASB standards for Opinions (ASOP 5, "Incurred Health and Disability Claims" or ASOP 42,"Determining Health and Disability Liabilities Other than Liabilities for Incurred Claims") require consideration by the actuary of any capitated risk contracts that exist. Such consideration should also include or indicate whether the actuary has evaluated the financial position of the provider entities.

There is a significant difference between the Opinion requirements as found in the Life & Health or Property & Casualty Annual Financial Statements and the Health Annual Financial Statement. Effective for 2003 Statutory Statements, companies with over 95 percent of specific types of health insurance would file the Health Annual Financial Statement regardless of their state license. Such companies must comply with not only the Opinion requirements of the Health Annual Financial Statement but also with the Opinion requirements based on their state license. For example, life insurance companies who file the Health Annual Financial Statement are still subject to any asset adequacy opinion requirements as required by the Actuarial Opinion and Memorandum Regulation pursuant to the Standard Valuation Law.

The NAIC *Health Insurance Reserves Model Regulation* if implemented by a state with respect to health entities defines the minimum reserve requirements. The NAIC *Accounting Practice and Procedures Manual* (*AP&P Manual*) Appendix A-010 defines minimum health reserve requirements when there are no other state specific

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requirements[1]. Although Appendix A-010 describes the separate minimum standard for each type of reserve separately, SSAP 54 requires a health entity's health insurance reserves to also be tested in total using the gross premium valuation method. The Opinion for the Health Annual Financial Statement is required to address certain other liabilities as well as these specific reserves. The *Annual Financial Statement Instructions* specifically include:

A. Claims unpaid (Page 3, Line 1)

B. Accrued medical incentive pool and bonus payments (Page 3, Line 2)

C. Unpaid claims adjustment expenses (Page 3, Line 3)

D. Aggregate health policy reserves (Page 3, Line 4) including unearned premium reserves and additional policy reserves from the Underwriting and Investment Exhibit – Part 2D

E. Aggregate life policy reserves (Page 3, Line 5)

F. Property/casualty unearned premium reserves (Page 3, Line 6)

G. Aggregate health claim reserves (Page 3, Line 7)

H. Any actuarial reserves or liabilities not included in the items above.

Although the instructions specifically identify the above actuarial items for review, certain other actuarial items also require review as provided in the general item H above. Some actuarial items are often incorporated into the required items while others have not been incorporated in the required list.

Actuarial reserves and liabilities that are incorporated into the required items above are as follows (note items 1a & 1b are specifically referenced in item D in the list above):

1. Aggregate Health Policy Reserves (Page 3, Line 4) includes:

    a. Unearned Premium Reserve (Underwriting and Investment Exhibit, Part 2D, Line 1)

    b. Additional Policy Reserves (Underwriting and Investment Exhibit, Part 2D, Line 2)

    c. Reserve For Future Contingent Benefits (Underwriting and Investment Exhibit, Part 2D, Line 3)

    d. Reserve For Rate Credits or Experience Rated Refunds (Underwriting and Investment Exhibit, Part 2D, Line 4)

    e. Aggregate Write-ins For Other Policy Reserves (Underwriting and Investment Exhibit, Part 2D, Line 5)

2. Aggregate Health Claim Reserves (Page 3, Line 7) includes

    a. Present Values of Amounts Not Yet Due On Claims (Underwriting and Investment Exhibit, Part 2D, Line 9)

    b. Reserve For Future Contingent Benefits (Underwriting and Investment Exhibit, Part 2D, Line 10)

[1] The NAIC *Accounting Practices and Procedures Manual Appendix A-010* incorporates minimum reserve requirements from the *Health Insurance Reserves Model Regulation.*

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c. Aggregate Write-ins For Other Claim Reserves; Actuarial Reserves Should Be Included in the Opinion (Underwriting and Investment Exhibit, Part 2D, Line 11)

Note that additional policy reserves include premium deficiency reserves. Premium deficiency reserves are identified in Underwriting and Investment Exhibit Part 2D, Footnote a.

Scope section, discussed above for Section 5 of the Annual Statement Opinion Instructions, should specifically identify those items and amounts to which the actuary is expressing an opinion, including but not limited to the above specifically identified lines from the Annual Financial Statement. Where the actuary determines that no liability exists, the value $0.00 should be entered. Lines should not be deleted.

If there has been a material change in the actuarial assumptions from those previously employed, that change should be described in the Annual Financial Statement and in the Relevant Comments section of the Opinion (see Section 8 of the Annual Statement Opinion Instructions & summarized above).

If the actuary has not examined the underlying records, but has relied upon product definitions, computer listings and summaries of enrollment and claims payments prepared by the health entity, a prescribed statement to this effect is required by the Reliance section of the Opinion. A signed statement by the person relied on is also required by this Reliance section for items provided, confirming the accuracy, completeness, and/or reasonableness of the items. Instructions for the Reliance section of the Opinion are provided in Section 6 of the annual statement Opinion instructions.

Most health coverages do not require extensive cash flow testing, due to the short duration of the claim liabilities. The Actuarial Standards Board has issued Actuarial Standards of Practice to guide actuaries in determining when an asset adequacy analysis should be performed and methods of asset adequacy analysis to consider. One of these is a prospective gross premium valuation. There is also guidance in the *AP&P Manual*, Appendix A-822. If required by either regulation or professional standards, the actuary should have included an opinion of the asset adequacy.[2] Unlike life insurance Opinions, there is currently no specific guidance for health asset adequacy Opinions.

As provided in the instructions and mentioned above the Opinion can take four forms:

- Unqualified opinion
- Qualified opinion
- Adverse opinion
- Inconclusive opinion

In cases where the Opinion is other than unqualified, the analyst should determine what the weakness is that prevents an unqualified Opinion. A qualified opinion would state that the reserves may be adequate, but there are somewhat likely circumstances under which they would not be adequate. An adverse Opinion is one in which the amounts reviewed do not satisfy opining statement "D" in the Opinion section of the Opinion. This opining statement "D" reads as, "Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements." An adverse Opinion implies that amounts reviewed are not adequate under state regulations and/or actuarial standards. If the actuary's Opinion is adverse or qualified, the actuary should specifically stated the reason(s) for such an Opinion in the Opinion section and/or

2 *Accounting Practices and Procedures Manual, Appendix A-822* provides guidance for Asset Adequacy Analysis Requirements. The only companies filing the Health Annual Financial Statement that are subject to the requirements of Appendix A-822 are those licensed as life insurance companies.

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Relevant Comments section of the Opinion. If the actuary is unable to form an opinion, the actuary should issue an inconclusive Opinion and specifically state the reason(s) for this.

Discussion of Level 1 Annual Procedures

In most instances proper review and analysis of the Opinion and Actuarial Memorandum will require in-depth knowledge of actuarial science. In order to achieve this as a part of the financial review process, most Opinions will be reviewed in detail by actuarial staff members. Their review should encompass procedures discussed in the next section covering the Supplemental Procedures for the Opinion.

Soon after the Annual Financial Statement is received, a cursory review of the Opinion should be performed to identify if any extraordinary item is detailed in the Opinion. The primary goal of the Level 1 Procedures is to determine if an Opinion was received and available for later review. And if so, was it an Opinion which was unqualified, qualified, adverse, or inconclusive.

Discussion of Supplemental Procedures

The analysis of the Opinion, although filed with the Annual Financial Statement, is documented on the separate Opinion Supplemental Procedures because of its significance. These supplemental procedures are found in Section V of this Health Financial Analysis Handbook and are discussed as follows:

Procedure #1 assists the analyst in determining that the Table of Key Indicators has been completed. The analyst should note that within each section of the Table, only one box should be checked. The Table assists the analyst in identifying those sections of the Opinion for which it may be appropriate to perform additional analysis, specifically when "Prescribed Wording with Additional Writing" or "Revised Wording" has been checked.

Procedures #2, #3,#4 and #5 assist the analyst in determining that the Opinion was prepared by a qualified actuary and that the reserve amounts agree with the Annual Financial Statement.

Procedure #6 assists the analyst in determining if the health entity's actuary, the health entity's accounting firm, or an officer of the health entity has verified the accuracy and completeness of source data.

Procedure #7 assists the analyst in determining if the health entity's actuary has covered the required reserves.

Procedure #8 assists the analyst in determining that the health entity's actuary's opinion statement on reserves is in accordance with the criteria found in the *Health Annual Financial Statement Instructions* paragraph #7 and in particular that the opinion states that the reserves meet the requirements of the state of domicile. The *Annual Financial Statement Instructions* list certain items to include in the Opinion paragraph, A through H. Certain other items have been included as separate lines in the past. For 2009, these items should be included within item #H.. The analyst should also determine the actuary's conclusion concerning reserve adequacy in total. It is important for the actuary to document the reasons for his or her conclusion, which should be available upon request by the analyst.

Procedure #9 and #10 is intended to assist the analyst in determining that the health entity's actuarial methods, considerations and analyses used in forming the actuary's opinion conform to the relevant Standards of Practice as promulgated by the Actuarial Standards Board.

Procedures #11, #12, and #13 are performed only in the situation where an asset adequacy test has been performed by the actuary. These procedures assist the analyst in reviewing the actuary's asset adequacy testing and actuarial memorandum that supports the Opinion. The *Annual Financial Statement Instructions* and *Health Insurance Reserves Model Regulation* do not specifically require asset adequacy testing for health entities, but

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may be required by actuarial standards of practices in some specific situations. A small number of health entities hold life insurance licenses and may, therefore, be subject to the asset adequacy and memorandum regulations. The analyst should become familiar with his or her state requirements and special situations that may exist.

For the small number of health entities that are subject to actuarial memorandum requirements, the actuarial memorandum is a comprehensive document that provides an understanding of the health entity's reserves, the assets available to support the reserves, and the projected impact on the health entity's financial condition of varying economic and interest rate projection scenarios. It is not automatically filed with the Annual Financial Statement, but is provided to the regulator only upon request. The decision as to whether to request the actuarial memorandum is an important one. The actuarial memorandum should be requested for health entities with known financial problems, significant changes in product mix or investment strategy, or significant growth in a particular product line. The Regulatory Asset Adequacy Issues Summary, which is filed with the Annual Financial Statement, assists the regulatory actuary in determining whether to request the actuarial memorandum. The Regulatory Asset Adequacy Issues Summary would include the following eight data requests, many of which may not apply to health asset adequacy analysis (Refer to the NAIC *Actuarial Opinion and Memorandum Regulation*, Section 7):

1) For interest sensitive products, the amount of any negative ending surplus values on a market value basis under each of the Required Interest Scenarios.

2) The extent to which the Appointed Actuary uses assumptions in the asset adequacy analysis which are materially different than the assumptions used in the previous asset adequacy analysis.

3) The amount of reserves and the identity of the product lines which have been subject to asset adequacy analysis in the prior opinion but were not subject to such analysis for the current Opinion.

4) The number of additional interest rate scenarios that were tested identifying separately the number of deterministic scenarios and stochastic scenarios. Also, identify the number of such scenarios which produced ending negative surplus values on market value basis.

5) If sensitivity testing was performed, identify the assumptions tested and describe the variation in ending surplus values on a market value basis from the base case values.

6) Comments should be provided on any interim results that may be of significant concern to the Appointed Actuary.

7) The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested.

8) Whether the actuary has verified that all options embedded in fixed income securities and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

Additional Reference Sources

1. *Annual Statement Instructions Health Insurance Companies*, NAIC

2. *Standard Valuation Law*, NAIC

3. *Health Insurance Reserves Model Regulation*, NAIC

4. *Actuarial Standards of Practice*, Actuarial Standards Board

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5. *Accounting Practices and Procedures Manual Appendix C (specifically Actuarial Guideline XIV, as applicable)*, NAIC

6. *Accounting Practices and Procedures Manual Appendix A-822*, NAIC

7. *Actuarial Opinion and Memorandum Regulation*, NAIC.

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III. Analysts Reference Guide – C.3. Management's Discussion and Analysis

Overview of Management's Discussion and Analysis

The Management's Discussion and Analysis (MD&A) requirements are intended to provide, in one section, material historical and prospective textual disclosure enabling regulators to assess the financial condition and results of operations of the reporting entity. There is a need for a narrative explanation of the financial statements, because a numerical presentation and brief accompanying footnotes alone may be insufficient for regulators to judge the quality of earnings and the likelihood that past performance is indicative of future performance. The MD&A is intended to give the regulator 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 MD&A shall be of the Annual Financial Statements and of other statistical data that the reporting entity believes will enhance the analyst's understanding of its financial condition, changes in financial condition and results of operations. Generally, the discussion shall cover the two year period covered by the Annual Financial Statements and shall use year-to-year comparisons or any other formats that, in the reporting entity's judgment, will enhance the analyst's understanding. However, where trend information is relevant, reference to the Five-Year Historical Data pages in the Annual Financial Statement may be necessary.

The purpose of the MD&A shall be to provide analysts with information relevant to an assessment of the financial condition and results of operations of the reporting entity as determined by evaluating the amounts and certainty of cash flows from operations and from outside sources. The information provided pursuant to this MD&A need only include that which is available to the reporting entity without undue effort or expense and which does not clearly appear in the reporting entity's Annual Financial Statements.

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 condition. This would include descriptions and amounts of 1) matters that would have an impact on future operations and have not had an impact in the past, and 2) matters that have had an impact on reported operations and are not expected to have an impact upon future operations.

Discussion of Supplemental Procedures

The analysis of the MD&A is documented on the separate MD&A Supplemental Procedures due to its significance and due to the timing of the filing of the MD&A on April 1 rather than on March 1 with the Annual Financial Statement.

Procedure #1 assists the analyst in evaluating the overall completeness of the MD&A. Specifically, it should address the two-year period covered by the health entity's Annual Financial Statement and should discuss material changes in the health entity's financial statement.

Procedure #2 assists the analyst in determining if the reporting entity was required to prepare the MD&A on a non-consolidated basis, unless the following conditions were met: 1) The entity is part of a consolidated group of health entities that utilizes a pooling arrangement or one hundred percent reinsurance agreement that affects the solvency and integrity of the entity's reserves and such entity ceded substantially all of its direct and assumed business to the pool. An entity is deemed to have ceded substantially all of its direct and assumed business to a pool if the entity has less than $1,000,000 total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5 percent of the health entity's capital and surplus. 2) The entity's state of domicile permits audited consolidated financial statements.

Procedure #3 assists the analyst in determining if results of operations have been disclosed. Reporting entities should describe any unusual or infrequent events or transactions or any significant economic changes that

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materially affected the amount of reported net income or other gains/losses in surplus and, in each case, indicate the extent to which net income or surplus was so affected. In addition, describe any other significant components of income that, in the reporting entity's judgment, should be described in order to understand the reporting entity's results of operations.

Reporting entities should describe any known trends or uncertainties that have had or are reasonably probable to have a material favorable or unfavorable impact on premiums, net income or other gains/losses in surplus. If the reporting entity knows of events that will cause a material change in the relationship between expenses and premium, the change in the relationship shall be disclosed.

To the extent that the Annual Financial Statements disclose material increases in premium, reporting entities should provide a narrative discussion of the extent to which such increases are attributable to increases in prices or to increases in the volume or amount of existing products being sold or to the introduction of new products.

Procedure #4 assists the analyst in determining if results of prospective information have been disclosed. Health entities are encouraged to supply forward-looking information. The MD&A may include discussions of "known trends or any known demands, commitments, events or uncertainties that will result in or that are reasonably likely to result in the reporting entity's liquidity increasing or decreasing in any material way." Further, descriptions of known material trends in the reporting entity's capital resources and expected changes in the mix and cost of such resources should be included. Disclosure of known trends or uncertainties that the reporting entity reasonably expects will have a material impact on premium, net income or other gains/losses in surplus is also encouraged.

Procedure #5 assists the analyst in determining if material changes have been disclosed. Reporting entities are required to provide adequate disclosure of the reasons for material year-to-year changes in line items, or discussion and quantification of the contribution of two or more factors to such material changes. An analysis of changes in line items is required where material and where the changes diverge from changes in related line items of the Annual Financial Statements, where identification and quantification of the extent of contribution of each of two or more factors is necessary to an understanding of a material change, or where there are material increases or decreases in net premium.

Procedure #6 assists the analyst in determining if liquidity, asset/liability matching and capital resources have been disclosed. The discussion of liquidity shall include a discussion of the nature and extent of restrictions on the ability of subsidiaries to transfer funds to the reporting entity in the form of cash dividends, loans or advances and the impact such restrictions may, if any, have on the ability of the reporting entity to meet its cash obligations. Generally, short-term liquidity and short-term capital resources cover cash needs up to 12 months into the future. These cash needs and the sources of funds to meet such needs relate to the day-to-day operating expenses of the reporting entity and material commitments coming due during that 12-month period.

The discussion of long-term liquidity and long-term capital resources must address material expenditures, significant balloon payments or other payments due on long-term obligations, and other demands or commitments, including any off-balance sheet items, to be incurred beyond the next 12 months, as well as the proposed sources of funding required to satisfy such obligations. Reporting entities should identify any known trends or any known demands, commitments, events or uncertainties that will result in or that are reasonably likely to result in the reporting entity's liquidity increasing or decreasing in any material way. If a material decline in liquidity is identified, indicate the course of action that the reporting entity has taken or proposes to take to remedy the decline. Also, identify and separately describe internal and external sources of liquidity, and briefly discuss any material unused sources of liquid assets. Reporting entities should describe any known material trends, favorable or unfavorable, in the reporting entity's capital resources. Indicate any expected material changes in the mix and relative cost of such resources. The discussion shall consider changes between equity, debt and any

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off-balance sheet financing arrangements. Reporting entities should present a balanced discussion dealing with cash flows from operations, investing, and financing activities.

Procedure #7 assists the analyst in determining if loss reserves have been disclosed. The MD&A should include a discussion of those items that affect the reporting entity's volatility of loss reserves, including a description of those risks that contribute to the volatility.

Procedure #8 assists the analyst in determining if off-balance sheet arrangements have been disclosed. Reporting entities should consider the need to provide disclosures concerning transactions, arrangements and other relationships with entities or other persons that are reasonably likely to affect materially liquidity or the availability of, or requirements for, capital resources. Material sources of liquidity and financing, including off-balance sheet arrangements and transactions with limited purpose entities, should be discussed.

Procedure #9 assists the analyst in determining if participation in high yield financings, highly leveraged transactions or non-investment grade loans and investments have been disclosed. In view of these potentially greater returns and potentially greater risks, disclosure of the nature and extent of a reporting entity's involvement with high yield or highly leveraged transactions and non-investment grade loans and investments may be required, if such participation or involvement has had or is reasonably likely to have a material effect on financial condition or results of operations. For each such participation or involvement or grouping thereof, there shall be identification, consistent with the Annual Financial Statement schedules or detail; description of the risks added to the reporting entity; associated fees recognized or deferred; amount, if any, of loss recognized; the reporting entity's judgment whether there has been material negative effect on the entity's financial condition; and the reporting entity's judgment whether there will be material negative effect on the entity's financial condition in subsequent reporting periods.

Procedure #10 assists the analyst in determining if preliminary merger/acquisition negotiations have been disclosed.

Additional Reference Sources

1. *Annual Statement Instructions for Health Insurance Companies*, NAIC

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III. Analysts Reference Guide – C.4. Holding Company Analysis

Overview

The following information is intended to provide guidance for state insurance regulators to analyze holding companies. For additional information, regulators may download the NAIC *Framework for Insurance Holding Company Analysis* from I-SITE Utilities or the NAIC StateNet Web site.

State insurance regulators examine and analyze the financial condition of individual insurers domiciled or licensed in their respective states based on individual state's statutes, regulations, policies and procedures, and in accordance with the handbooks and other tools developed and adopted by the NAIC. Consistent with state law and the related regulatory structure, exam and analysis procedures are more focused on the legal entity level rather than on the overall holding company system. Notwithstanding the structural need to focus on the legal entity level, state regulators have for years recognized that individual company analysis may require a more broad understanding of the overall insurance group. Also, as more companies merge and consolidate, and insurance reporting becomes more complex, the need to further understand the group organizational structure becomes greater.

The purpose of this section is to provide state insurance regulators with a common set of tools and the related guidance necessary to gain an understanding of the holding company structure and the impact its management, business practices, and financial condition have on the insurance subsidiaries. The information provided will assist in analyzing holding companies and their insurance subsidiaries and supplement the efforts among state regulators to more fully coordinate regulatory activities.

Holding Company Structure

A holding company 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. In the case of a stock company, the holding company may own any percentage of another company's stock as long as it is sufficient to provide the holding company control over the operations of the company. The controlling entity often delegates operational functions to subsidiaries so it can focus on the management of the overall group. Some holding company structures are established to hold only insurance operations and others may be more complex while engage in multiple types of businesses.

In order to identify a holding company with insurance subsidiaries, refer to statutory filings submitted to state insurance regulators and/or the NAIC. Some examples of the filings include initial applications for licensure, holding company registration statements (Form B), or organizational charts (Schedule Y). It is important to identify all insurance subsidiaries within a holding company structure and to identify all the states responsible for regulating those subsidiaries.

There can be variations as to how a holding company is classified. The most common types of holding company structures are described below.

<u>Public Holding Company</u>
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. Holding company stock can be purchased via a public securities exchange market. Transactions that result from the public holding company are approved by a board of directors. Public holding companies may be obligated to pay dividends in order to maintain expectations of the shareholders. Additionally, these companies are subject to reputational risk should they suffer a decline in financial performance.

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Private Holding Company
A private holding company is a separate legal entity designed to hold either investment 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.

Mutual Insurers
Mutual insurance companies are formed and bound by their policyholders. Mutual insurers do not issue stock, and therefore do 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 a holding company system. It may also create a subsidiary to act as a holding company for other downstream affiliates.

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, including through the issuance of stock. Such a conversion is subject to the approval of the policyholders and the domiciliary state's commissioner.

Understanding the Holding Company Structure

It is important for the analyst to gain a thorough understanding of the organizational structure in order to properly analyze how each subsidiary in the holding company operates. Organizational structures can vary significantly between 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. Smaller holding company systems may be closely held and maintain only a few subsidiaries. Others may be partially held by different individuals and companies or have indirect ownership relationships.

The most readily available source for gaining an understanding of holding company structure is through review of the statutory filings submitted by insurers. Insurers are required to submit an organizational chart and details of affiliated transactions in Schedule Y—Information Concerning Activities of Insurer Members of a Holding Company. Schedule Y - Part 1, includes the organizational chart that illustrates the relationships within the holding company group to the ultimate controlling person(s) or entity. Additionally, all insurers are required to report their state of domicile. This schedule provides valuable insight into the ownership structure, insurance holdings, locale, and affiliated relationships within the holding company.

Under guidance from SSAP No. 25, *Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties*, insurers are also required to provide detailed information on related party transactions and relationships in Note 10—Information Concerning Parent, Subsidiaries, and Affiliates. Refer to the Guidance for Notes to Financials section.

The statutory Management's Discussion and Analysis (MD&A) and Audited Statutory Financial Report also contain information on the holding company structure. These annual 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, products lines, marketing systems and actions such as corporate restructuring, acquisitions and dispositions.

The Audited Statutory Financial Statement provides background, operational information, affiliated transactions, mergers and subsidiary holdings. Several of the footnotes (e.g., 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

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affiliated interactions. These footnotes provide disclosures on such issues as affiliated transactions, agreements, guarantees, reinsurance transactions, capital contributions, and organizational structure that allow the analyst to gain an understanding of how the different entities within the holding company operate together.

Disclosures on non-insurance entities found within the holding company may be limited. For publicly traded companies, the analyst can also reference reports filed with the Securities and Exchange Commission (SEC) to gain insight on the 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 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 the analyst to assess the organization as a whole by its major operating business segments.

Directors and Executive Officers: This section helps the analyst 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: The analyst can find discussion on affiliated transactions and business relationships in this section.

Form 10-Q is used to report quarterly financial data. Form 10-Q is much more limited in scope than Form 10-K, but 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.

Understanding the Lead State Role

It is important for the analyst to understand the concept of a lead state in order to determine how states coordinate regulatory activities in their reviews of insurance groups. Typically, the lead state is the state where the parent company is domiciled or, if there is no insurance parent, the state where the largest (by direct written premium volume as reported in the most recently filed Annual Financial Statement) insurance subsidiary is domiciled. The passage of the Gramm-Leach-Bliley Act (GLBA), stresses the importance of a lead state. Also, it may be necessary for other financial regulators, including the Federal Reserve and other federal and state banking agencies and securities regulators, to identify a central point of contact. State regulators should communicate with federal regulators if the insurance company is affiliated with a bank, thrift or security firm that reports to a federal agency. Communication between state and federal regulators will allow for more effective and efficient regulation on key issues impacting the insurer or financial institution.

The concept of a lead state is not intended to relinquish the authority of any state, nor increase any state's statutory authority, or to put any state at any disadvantage. It is intended to facilitate efficiencies when one or more state(s) coordinate the regulatory processes of all states involved.

Factors that may be considered when determining the lead state:

- State with the largest number of domestic insurance companies in the group.
- State with large or largest premium volume or exposure.
- Domiciliary state of top-tiered insurance company in an insurance holding company system.

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- Physical location of the main corporate offices or largest operational offices of the group.
- Expertise in the area of concern and expertise of staff in like situations.
- State whose regulatory requirements have driven the design of the organization's infrastructure.

The NAIC *Lead State Summary Report* is a valuable resource available on I-SITE, within Summary Reports. The Report provides each state a listing of the insurance groups and their respective lead state(s). The Report also provides up-to-date information on the direct premium, gross premium, admitted assets, and last examination date for each company. The Report can be run on a particular NAIC group code to determine the lead state.

The role of the lead state encompasses many responsibilities, which may vary depending upon the situation creating the need for regulatory coordination of activities of the regulators involved. However, of utmost importance is maintaining confidentiality of all information, which includes implementing confidentiality arrangements with other states and regulators. The lead state and other interested states also perform a review of the consolidated group, which includes an analysis of the group's financial results and overall business strategy.

The operations of an insurance company often are not limited to one state. In some cases, when multiple states are involved in monitoring the activities or approving the transactions of a company or group of companies, multiple states may coordinate regulatory efforts. These coordinated efforts have increased over the last few years as the insurance industry has consolidated and as insurance holding companies with insurers domiciled in more than one state have increased.

These coordinated activities may include:

- The establishment of procedures to communicate information regarding troubled insurers with other state insurance departments.
- The participation on joint examinations of insurers.
- Consensus assignment of specific regulatory tasks to different state insurance departments in order to achieve efficiency and effectiveness in regulatory efforts and to share personnel resources and expertise.
- The establishment of a task force consisting of personnel from various state insurance departments to carry out coordinated activities.

These types of coordinated efforts may be effective for both regulators and the insurance companies involved.

Once the lead state or states are determined, there are a number of responsibilities the state must assume in order for the oversight process to function effectively and efficiently. These responsibilities may include designating a lead person involved in the specific transaction or monitoring. If necessary, the lead state should contact other identified states to establish points of contact and to determine the amount of interest in participating in the multi-state coordination. The lead state should then establish lines of communication and serve as regulatory contact with top management of the organization.

Procedures should be established as to how information will be shared with other states and regulators. This step is critical in establishing the lead state as a coordinator by supplying states and other regulators with pertinent information. When necessary, verbal or written briefings arranged by the lead state in conjunction with company management have been the most effective.

Early in the oversight process, the lead state should collect information on the status of company filings, analysis, examinations and other activity from each of the other states. The lead state should also obtain information on the group as a whole. In order to gain this understanding, the lead state should focus on the holding company and

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subsequently on the underlying affiliated relationships. This information will be helpful in preparing for discussions with insurance company and holding company management.

Data Collection

There are a number of sources of information available to assist the analyst in analyzing holding companies. The most useful sources include the insurance company statutory financial statements, GAAP financial statements filed with the SEC, MD&A, the Audited Statutory Financial Report and the holding company's annual shareholder's report. However, other external sources of information exist, including rating reports and analysis from Nationally Recognized Statistical Rating Organizations (NRSRO), press releases from the holding company, and news and other analytical profiles from various financial and news organizations.

Sources of Information

The *Statutory Financial Statements* contain information on the financial condition of the insurance company. Schedule Y, the General Interrogatories and Notes to Financial Statements provide holding company information, such as the holding company structure, the ultimate controlling person(s), affiliated relationships, investments and other transactions.

Form 10-K, 10-Q, 8-K and other SEC filings can be accessed via the SEC Web site. Refer to Chapter 1, External Information of this Handbook for more discussion on the information available in these SEC filings. The report of the independent public accountant should include not only a report on the audited financial statements but also a report on the assessment of internal controls and management's assessment of internal controls. Also, included should be a statement of management's responsibility for establishing and maintaining adequate internal control over financial reporting for the company, a statement identifying the framework used by management to evaluate the effectiveness of this internal control, management's assessment of the effectiveness of this internal control as of the end of the insurer's most recent fiscal year, and a statement that its auditor has issued an attestation report on management's assessment.

Shareholder's Reports are generally available on a holding company's website. The scope of the shareholder's report may vary between companies but generally it is reported on a consolidated GAAP basis and may contain segment information. A holding company'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 statutory financial statement. 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.

The *Internet* offers a variety of websites that contain information on the financial background for 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 include MD&A, Audited Statutory Financial Reports, NRSROs, NAIC Database, I-SITE, prior analysis performed on the group, 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.

International Data Sources

When a holding company is domiciled in a foreign country, it is necessary to determine the supervisory authority in that country and the filing requirements for the holding company. Some countries have an agency that

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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 Canadian 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.

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.

Holding Company Analysis

The following process can be followed in analyzing a holding company system or insurance group.

Scope

Review the holding company structure and flowchart to determine how much detail is relevant in the group analysis. Obtain a thorough understanding of the insurance company and its relationships and interdependencies with its affiliates. Utilize statutory filings, specifically Schedule Y. Determine the scope of the review by selecting the companies and/or entities based on the material segments within the group.

A thorough review of a holding company's 10-K or other filings assists the analyst in understanding the factors and/or segments driving adverse results in the organization. The analyst should concentrate on identifying the legal entities within the holding company structure that have contributed significantly to the adverse results of the organization.

Rating Agencies

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 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.

Consolidated GAAP Financial Information

Review the holding company's 10-K filing for consolidated GAAP financial information, including total assets, liabilities, debt, stockholder's equity, revenues, expenses, net income, and net cash provided by operations, if applicable. If a 10-K filing is unavailable, research Internet sources or directly contact the group's management. Compare current-year results with prior-year results, noting any positive or negative trends.

Stock Price Evaluation

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. The analyst should strive to determine the factors impacting 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.

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III. Analysts Reference Guide – C.4. Holding Company Analysis

History of the Holding Company and Insurer

Utilize the financial filings and the Internet to determine the group's organizational history and corporate structure. Include relevant information regarding mergers and/or acquisitions, and consider potential effects on the stability of the group. The analyst should become familiar with geographic diversification, dates of organization and relevant changes made to the holding company structure.

Plan of Operation

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 if 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 that 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.
- *Management's Philosophy* – Gain an understanding of the group's culture, management's expertise, and management's future vision of the group.

Reinsurance

Determine whether the reinsurance programs in place appear to 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 collectibility. Identify whether reinsurance between affiliates within the group involves 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.

Recent News

Research recent news events relevant to the group. Press releases and publications may provide valuable information 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 lay-offs, losses of key personnel, and issues with customers or providers.

For the following analysis sections, consider both the financial review of insurance and non-insurance entities within the group. In certain cases, the review of non-insurance entities may be mitigated by the lack of interdependence of the entities.

Assets

Review 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.

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III. Analysts Reference Guide – C.4. Holding Company Analysis

Analyze 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 recoverables and receivables and miscellaneous balances. Also, assess the risk related to any miscellaneous assets such as goodwill or other intangible assets.

Liabilities

Review the liabilities of the group, noting any significant increases or decreases from the prior reporting period. Assess reserves and reserve development to determine the trending and historical accuracy. Determine if debt exists at the holding company level, which may be 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.

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 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. The analyst should take note of the trend over past reporting periods and the factors that have significantly influenced an increase or decline.

Profitability

The profitability of a holding company is measured by its ability to generate earnings, and is reported on a consolidated basis as net earnings (loss). The earnings statement includes revenues and expenses and their contributing factors to net earnings (loss). 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 earnings drain on the holding company. These operations should be investigated thoroughly to identify the types of operations involved, expected durations and their impact on holding company earnings.

Operations

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/loss, total revenue, and total assets. This information is helpful because it provides the analyst 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) - Identifies business produced by MGAs or TPAs. For additional information regarding MGAs and TPAs, the analyst should refer to the Analyst Reference Guide section of this Handbook.

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The analyst should focus on the overall profitability of the segments as well as the stability of earnings over a period of time. To the extent the segment has reported inconsistent earnings, or has reported any losses, the analyst may wish to obtain a greater understanding of the causes.

Cash Flow and Liquidity

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 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 continued negative trend could present a drain on assets.

The analyst should assess the level of liquid assets to current liabilities to determine the proper matching of assets to claims obligations. The analyst should also assess the material risk associated with low-quality assets and understated reserves.

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 of these holding companies, financial information is not readily available through a government sponsored source similar to the SEC. The analyst may find that the investor's page on 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 their countries of origin. For most European Economic Community organizations, accounting treatment and reporting is somewhat consistent and is improving due to the efforts of many groups working with the International Accounting Standards Board. However, for many organizations domiciled in offshore countries like Ireland, those located in the Caribbean and others, no regulation regarding public financial reporting exists.

The analyst 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. The analyst 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 than similar transactions between two domestic entities.

Foreign holding companies invest in their U.S. subsidiaries to nurture profitable operations, to compliment existing operations, or to add to existing capacity. As opposed to their U.S. counterparts, foreign holding companies may not be under the same obligation to ensure the continued viability of their U.S. enterprises. 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.

The analyst should be aware of a holding company's stated commitment to ensure the continued stability of U.S. operations. This commitment may include written or verbal parental guarantee.

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 holding company structure

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- The holding company's historical involvement in supporting its subsidiaries
- Parental guarantees or commitments of financial support or failures to act on these commitments

Discussion of Supplemental Procedures - Holding Company Analysis

The analysis of the Holding Company is documented in the separate Holding Company Supplemental Procedures due to its significance and due to the difference in the timing of holding company financial data.

The procedures may be completed in part or in total at the discretion of the analyst, depending on the level of concern, the area in which the risk was identified, and the degree of interdependence within the holding company entities.

Procedures #1-15 assist the analyst in identifying and understanding the type of holding company system in which the group operates. Various documents are available as a resource to help to understand the historical formation of the group and its business purpose.

Procedures #16-19 assist the analyst in determining the lead state and establishing lines of communication between states. Refer to the NAIC *Framework for Insurance Holding Company Analysis* in I-SITE Utilities.

Procedures #20-43 guide the analyst through procedures for reviewing the primary sections of a holding company's financial statements. The primary sections include assets, liabilities, equity, profitability, writings and cash flow.

Procedures #44-46 offers procedures to identify the foreign supervisory authority, establish communication and convert foreign currency.

Procedure #47 and the Supplemental Procedures assist the analyst in reviewing Forms A, B, D, E (or Other Required Information) and Extraordinary Dividend/Distribution.

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.

<u>Form A – Statement of Acquisition of Control of or Merger with a Domestic Insurer</u>
The NAIC *Insurance Holding Company System Regulatory Act* (the Holding Company Act) outlines specific filing requirements for persons 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 of 1999 (GBLA) is limited to 60-days prior to the effective date of the transaction. Under Section 104(c)(2) of the GLBA, 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.

<u>Form B – Insurance Holding Company System Annual Registration Statement</u>
The Holding Company Act is the model that defines insurance holding companies and the related registration, disclosure, and approval requirements. Form B is the insurance holding company system annual registration

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statement. The Holding Company Act requires every insurer, that 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, is a member of a holding company system, and 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 persons, one or more of which is an insurer. An affiliate is an entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, another entity. Control is presumed to exist when an entity or person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies, representing 10 percent or more of the voting securities.

Form D – Prior Notice of a Transaction

The Holding Company Act 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 percent of the insurer's admitted assets or 25 percent of policyholder's surplus and for life insurers, 3 percent of the insurer's admitted assets, each as of the most recent prior December 31. Some states have stricter definitions of materiality in their holding company regulations.

Holding company regulations require that affiliated transactions be fair and reasonable to the interests of the insurer. Generally, affiliated management or service agreements should be based on actual cost in order to meet the fair and reasonable standard.

The appropriate Statement of Statutory Accounting Principle should be reviewed within the NAIC *Accounting Practices and Procedures Manual* to ensure proper accounting.

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

The Holding Company Act mandates that any domestic insurer, together with any person controlling a domestic insurer or, proposing a merger or acquisition to file a Form E (or Other Required Information), pre-acquisition notification form. Any differences between the Holding Company Act and the applicable state regulations should be considered.

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 Section 104(c)(2) of the GLBA, 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

The Holding Company Act mandates 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 with the 30 day period.

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Each state has its own definition of "extraordinary"; however, the Holding Company Act 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:

(i) Ten percent of the insurer's surplus as it regards to policyholders as of December 31st of the prior year; or

(ii) For life insurers, net gain from operations and for non-life insurers, net income, excluding realized capital gains for the 12 months ending December 31st of the prior year. This should not include pro-rata distributions of any class of the insurer's own securities.

Discussion of Supplemental Procedures - Forms A, B, D, E (or Other Required Information) and Extraordinary Dividend/Distribution

The analysis of Forms A, B, D, E (or Other Required Information) and Extraordinary Dividend/Distribution are documented in the separate Holding Company Supplemental Procedures due to the significance of the filings and the timing of these filings.

Form A

Procedures #1-19 assist the analyst in reviewing the Form A filing for completeness. It guides the analyst through each of the major items of information required by Form A.

Procedures #20-32 assist the analyst in assessing the impact of the acquisition or merger on the domestic insurer and policyholders.

Form B

Procedure #1 assists the analyst in reviewing Form B for completeness. It guides the analyst through each of the major items of information required by Form B.

Procedure #2 assists the analyst in determining whether dividends to shareholders were proper and in accordance with regulatory guidelines. The analyst should be particularly alert to extraordinary dividends, which require prior regulatory notification.

Procedure # 3-5 assists the analyst in reviewing other types of transactions involving the insurer and other entities in its holding company system. They guide the analyst through each type of transaction that requires prior regulatory notification. The analyst should identify disclosures about the holding company that may potentially affect the insurer. The analyst should focus specifically on shareholders that may also have a relationship with the insurer and on litigation or administrative proceedings involving the holding company that may affect the insurer, such as bankruptcy, receivership, or other corporate reorganizations. The analyst 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. The analyst 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.

Form D

Procedures #1-15 assist the analyst in reviewing the Form D filing for completeness and helps guide the analyst through major items of information required by Form D.

Form E (or Other Required Information)

Procedures #1 and #2 provide the analyst with names and addresses of all of the parties involved with the proposed merger or acquisition.

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Procedures #3-#6 assist the analyst in gaining a clear understanding of the rationale and goals of the proposed merger or acquisition.

Extraordinary Dividend/Distribution

Procedures #1-#5 assist the analyst in ensuring that any extraordinary dividend or distribution was approved by all of the appropriate channels and was fair and reasonable.

Additional Reference Sources

1. *Insurance Holding Company System Regulatory Act*, NAIC
2. *Framework for Insurance Holding Company Analysis*, NAIC
3. *Accounting Practices and Procedures Manual,* NAIC

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IV.A. Level 1 Annual Procedures

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IV. A. Level 1 Annual Procedures

Background Analysis

1. Review the analysis performed on the health entity for the prior year and prior quarters.

   a. Indicate the state's priority designation or any prioritization tool result as of the last review and start of the current review:

   State's Priority Designation _____
   Scoring System Total _____
   Analyst Team System Validated Level _____
   RBC Ratio and RBC Trend Test_____

   b. Were there any issues or concerns noted in previous annual or quarterly analysis completed in the prior year? If "yes," discuss the issues or concerns, the follow-up conducted, and include any correspondence with the insurer, along with any conclusions.

   c. As the domestic regulator, review the Insurer Profile Summary, including the Supervisory Plan, if applicable, and document any areas of concern that impact the current analysis.

2. Review any inter-departmental communication, as well as communication with other state insurance departments and the health entity. Note any unusual items or areas that indicate further review or follow-up is necessary.

3. Review General Interrogatory #5.1 and #5.2. Has the health entity been a party to a merger or consolidation? If yes, review the list of companies involved in the merger/consolidation, noting any observations. Also, ensure Form A or additional filings have been approved.

4. Review General Interrogatory #6.1 and #6.2. Has the health entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? If yes, review the reason(s) stated for the revocation or suspension, noting any observations.

5. Are there any changes in the state's statutes and/or regulations that could impact the insurer's financial position or reporting? If yes, to the extent information is available, has the insurer failed to comply with the new state's statutes and regulations enacted during the period?

6. Review the most recent report from a nationally recognized rating agency. Note the current financial strength and credit rating and briefly discuss the explanation of the rating or any change in the rating.

7. Review any industry reports, news releases and emerging issues that have the potential to negatively impact the insurer.

8. Review the most recent business plan and financial projections, if available from recent surveillance activity and if considered necessary based on the insurer's priority designation and financial condition.

   a. If significant changes in business plan or philosophy have occurred, assess the insurer's ability to attain the expectations of the business plan.

   b. Are actual results consistent with management's expectations?

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IV. A. Level 1 Annual Procedures

Management Assessment

9. Review the Annual Financial Statement Jurat Page (page 1).

   a. Did the health entity fail to properly execute and notarize the Jurat Page?

   b. Has there been any change(s) in officers, directors or trustees since the previous Annual Financial Statement filing (indicated by a "#" after the name)? If yes, indicate the position(s) in which the change(s) have occurred. Review the Biographical Affidavit(s) for any new officers, directors or trustees indicated above and note any areas of concern that would indicate further review is necessary.

      - ☐ President
      - ☐ Secretary
      - ☐ Treasurer
      - ☐ Vice Presidents (number: ____)
      - ☐ Directors or Trustees (number: ____)
      - ☐ Other

   c. Assess any significant corporate governance changes and determine whether these changes appear to indicate a shift in management philosophy, or whether management has made any changes in business culture or business plan..

Balance Sheet Assessment

10. Review the Annual Financial Statement Assets (page 2) and Liabilities, Capital and Surplus and Other Funds (page 3).

    a. Is capital and surplus below the statutory minimum capital and surplus required?

    b. Has capital and surplus decreased by more than 10 percent or increased by more than 40 percent from the prior year?

    c. Is the RBC ratio (total adjusted capital divided by authorized control level risk-based capital shown in the Annual Financial Statement Five-Year Historical Data) less than or equal to 250 percent?

    d. Did the insurer fail the RBC Trend Test?

    e. Has there been any change in surplus notes compared to the prior year-end? If yes, indicate the current and prior year-end balances and the amount of the change. Also, comment on any notes issued, principal or interest paid, or any other changes that have been made and whether any necessary approvals were obtained.

    f. Is the amount of any individual non-invested asset category greater than 10 percent of total admitted assets? If yes, indicate the asset category and amount.

    g. Has any individual asset category, which exceeds 5 percent of total assets, changed by greater than +/-20 percent from the prior year? If yes, indicate the asset category, current year-end balance and the percentage change from the prior year. The analyst should also consider shifts within individual asset categories, such as between investment grade and non-investment grade bonds, and between publicly traded and privately placed securities.

    h. Is the amount of any individual liability category, other than claims unpaid, aggregate policy reserves and aggregate claim reserves, greater than 10 percent of total liabilities? If yes, indicate the liability category and amount.

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i. Has any individual liability category, which exceeds 5 percent of total liabilities, changed by greater than +/-20 percent from the prior year? If yes, indicate the liability category, current year-end balance and the percentage change from the prior year.

Operations Assessment

11. Review the Annual Financial Statement, Statement of Revenue and Expenses (pages 4 and 5).

    a. If the absolute value of net income exceeds 5 percent of capital and surplus, has net income decreased by more than 20 percent or increased by more than 40 percent from the prior year?

    b. Has any individual income or expense category, for which the current or prior year balance exceeded 5 percent of capital and surplus, changed by more than +/-20 percent from the prior year? If yes, indicate the income or expense category, current year-end balance and the percentage change from the prior year.

    c. Has any individual capital and surplus account category changed by greater than +/-10 percent from prior year-end? If yes, indicate the capital and surplus category, current year-end balance change and the percent change from the prior year.

    d. Are net unrealized capital gains/(losses) more than 5 percent of prior year-end capital and surplus?

12. During the review of the Medicare Supplement Insurance Experience Exhibit (filed March 1st), the Long-Term Care Experience Exhibit Reporting Form (filed April 1st) and the Accident and Health Policy Experience Exhibit (filed April 1st), did the analyst note any unusual items or areas that indicate further review is warranted?

13. Review the Annual Financial Statement of Cash Flow (page 6). Is net cash from operations negative?

14. Evaluate any material ceded reinsurance as reported in Schedule S, Part 3 – Reinsurance Ceded and review all General Interrogatories and Notes to Financials pertaining to reinsurance and note any areas of concern.

Investment Practices

15. Evaluate the health entity's investment management practices.

    a. Review General Interrogatory #14. Has the purchase or sale of any investments not been approved by the board of directors or a subordinate committee thereof?

    b. Review General Interrogatory #22.1 and #22.2. Were any securities owned, over which the health entity has exclusive control, not in the actual possession of the health entity, except as shown by the Schedule E - Part 3, Special Deposits?

    c. Review General Interrogatory #23.1 and #23.2. Were any assets owned by the health entity not exclusively under the control of the health entity? If yes, indicate the amount at December 31st of the current year.

    d. Review General Interrogatory #19.1 and #19.2. Were any assets subject to a contractual obligation to transfer to another party without the liability for such obligation being reported? If yes, indicate the amount at December 31st of the current year.

16. Review the Annual Financial Statement Summary Investment Schedule (page S101). Note any unusual items or areas that indicate further review is warranted.

17. Review the Supplemental Investment Risks Interrogatories. Note any unusual items that would indicate a nondiversified portfolio or inappropriate liquidity.

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18. Review Annual Financial Statement Schedule E, Part 3 – Special Deposits. Is the book/adjusted carrying value of total special deposits greater than 10 percent of assets?

Review of Disclosures

19. Review the Annual Financial Statement Notes to Financial Statements (page 25).
    a. Have any notes required per the NAIC's *Annual Statement Instructions for Health Insurance Companies* been omitted?
    b. Provide an explanation for any unusual or significant items.
20. Review the Annual Financial Statement, General Interrogatories (page 27) and note any unusual responses.

Assessment of Latest Examination Report and Results

21. Review General Interrogatory #3.1 through #3.3 and determine if a financial examination report was released by the domiciliary state since the last review.
    a. As of what balance sheet date is/was the latest financial examination of the health entity?
    b. As of what balance sheet date is the latest financial examination report available from either the state of domicile or the health entity?
    c. As of what release date is the latest financial examination report available from either the state of domicile or the health entity?
    d. Per Gen. Int. #3, have any financial statement adjustments within the latest financial examination report not been accounted for in a subsequent financial statement filed with the Department?
    e. Per Gen. Int. #3, have any of the recommendations within the latest financial examination report not been complied with?

If yes, or if follow up was required from the review of the examination report in a previous analysis period, complete the following procedures.

    f. If the answers to 21.d. or 21.e. are yes, follow up with the insurer regarding the implementation of recommendations in the Financial Examination Report.
    g. Assess the current and future impact of any financial statement adjustments on the insurer's financial condition.
22. During the review of the latest state examination report, the results from that examination and communication with the examiner-in-charge (for domestic insurers), did the analyst note any items or areas that indicate further review is warranted?
23. Follow-up and document on any management letter comments that should be addressed in the current period, if applicable.

Assessment of Results From Prioritization & Analytical Tools

24. Review the health entity's NAIC Annual Scoring System results.
    a. Indicate the health entity's total annual score.
    b. Provide an explanation on each individual ratio result, which received a score of 50 points or more.
25. Review and understand the assigned Analyst Team System Validated Level.

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IV. A. Level 1 Annual Procedures

26. Review the NAIC Annual Financial Profile Report for the health entity and provide an explanation for any unusual or significant fluctuations or trends.

27. Review any market conduct information, including information available from the state's market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee) and the NAIC market analysis tools and databases (MAP, ETS, MARS, RIRS, SAD, MITS, and Complaints). The analyst should note any unusual items that translate into financial risks or that indicate further review and/or additional communication is needed with the Department's market analysis staff.

Assessment of Current Year Supplemental Filings

28. During the review of the Actuarial Opinion, did the analyst note any unusual items or areas that indicate further review is warranted?

29. During the review of the Management's Discussion and Analysis, did the analyst note any unusual items or areas that indicate further review is warranted (April 1st Filing)?

30. During the review of the Audited Financial Report, did the analyst note any unusual items or areas that indicate further review is warranted (June 1st Filing)?

31. Review the most recent Annual Financial Statement of the health entity's holding company and its subsidiaries and holding company filings (such as Form A, B, D, E (or Other Required Information) and Extraordinary Dividend/Distribution and forms 10K and 8-K), if available.

    a. During the review, did the analyst note any new or unusual items or areas of concern that may potentially impact the health entity?

    b. If other insurers within the group exist, note any communication with the domestic state insurance departments for those affiliated insurers.

Recommendation for Further Analysis

Based on the Level 1 procedures performed, do you recommend that the Level 2, 3 or Supplemental Annual Procedures or other procedures listed below be completed? If yes, indicate the sections that you recommend be completed:

A. Perform Level 2 and/or Level 3 Procedures:

All Sections	☐
Investments	☐
Other Assets	☐
Health Reserves and Liabilities	☐
Other Provider Liabilities	☐
Income Statement and Surplus	☐
Risk-Based Capital	☐
Cash Flow and Liquidity	☐
Risk Transfer Other than Reinsurance	☐
Reinsurance Only	☐
Affiliated Transactions	☐
TPAs, IPAs and MGAs	☐

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IV. A. Level 1 Annual Procedures

B. Perform Supplemental Procedures:

Audited Financial Reports	☐
Actuarial Opinion	☐
Management's Discussion and Analysis	☐
Holding Company Analysis	☐
Form A	☐
Form B	☐
Form D	☐
Form E (or Other Required Information)	☐
Extraordinary Dividend/Distribution	☐

C. Request and review the current business plan and financial projections.

i. If significant changes in the business plan or philosophy have occurred, assess the insurer's ability to attain these expectations.

ii. Determine if actual results are tracking with projection and note any significant variances and the reason(s).

Summary and Conclusion

After completion of any Level 2 or subordinate procedures, develop and document an overall summary and conclusion based on the findings. In developing a conclusion, the analyst should consider the above procedures, as well as any other factors that, in the analyst's judgment, are relevant to evaluating the health entity's overall financial condition. The summary and conclusion should include details regarding the health entity's strengths and weaknesses. In addition, update the Insurer Profile Summary, including the Supervisory Plan, if applicable, for the results of the analysis performed.

Do you recommend that the health entity be designated a priority as a result of the procedures performed? If yes, indicate the recommended priority designation and rationale.

Describe the rationale for these recommendations.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

Correspondence

The analyst should document any follow-up regarding the Levels 1, 2, 3, and Supplemental Procedures.

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IV.B. Level 2 Annual Procedures

1. Investments
2. Other Assets
3. Health Reserves and Liabilities
4. Other Provider Liabilities
5. Income Statement and Surplus
6. Risk-Based Capital
7. Cash Flow and Liquidity
8. Risk Transfer Other Than Reinsurance
9. Reinsurance
10. Affiliated Transactions
11. TPAs, IPAs, and MGAs

IV. Level 2 Annual Procedures – B.1. Investments

1. Determine whether the health entity's investment portfolio appears to be adequately diversified to avoid concentration of investments by type or issue.
   a. Are the total of industrial and miscellaneous bonds and credit tenant loans owned greater than 25 percent of total admitted assets?
   b. Are multi-class securities owned greater than 20 percent of total admitted assets?
   c. Are foreign bonds owned greater than 5 percent of total admitted assets?
   d. Are preferred stocks owned greater than 3 percent of total admitted assets?
   e. Are common stocks owned greater than 20 percent of total admitted assets?
   f. Are mortgage loans and real estate, including home office real estate, owned greater than 5 percent of total admitted assets?
   g. Are other invested assets (Schedule BA) greater than 5 percent of total admitted assets?
   h. Are aggregate write-ins for invested assets greater than 5 percent of total admitted assets?
   i. Are investments in affiliates greater than 5 percent of total admitted assets?
   j. Is any one single investment greater than 3 percent of total admitted assets (excluding federal issues and affiliated investments)?
   k. Has the health entity failed to comply with state-specific investment laws, regulations or guidelines for diversity and limitations?

2. Determine whether there are concerns due to the level of investment in certain types of securities, which tend to be riskier and/or less liquid than publicly traded investment grade bonds and cash and short-term investments.
   a. Determine whether there are concerns due to the level of investment in non-investment grade securities.
      i. Is the ratio of non-investment grade securities to capital and surplus greater than 15 percent?
      ii. If investments in non-investment grade bonds exceed 3.5 percent of capital and surplus, have such investments increased by greater than 15 percent over the prior year?
   b. Review Schedule D, Part 1A, Section 2 to determine whether there are concerns due to the level of investment in multi-class securities.
      i. Is the ratio of all multi-class securities (residential, commercial and other) owned to capital and surplus greater than 25 percent?
      ii. If investments in all multi-class securities currently exceed 15 percent of capital and surplus, have these investments increased by greater than 20 percent over the prior year?
      iii. Is the ratio of multi-class residential mortgage backed securities to capital and surplus greater than 5 percent?
   c. Determine whether there are concerns due to the level of investment in private placement bonds.
      i. Is the ratio of private placement bonds owned to capital and surplus greater than 15 percent?
      ii. If private placement bonds owned exceed 5 percent of capital and surplus, have such investments increased by greater than 15 percent over the prior year?

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d. Determine whether there are concerns due to the level of investment in total real estate and mortgage loans.

   i. Is the ratio of total real estate and mortgage loans to capital and surplus greater than 15 percent?

   ii. If total real estate and mortgage loans exceed 10 percent of capital and surplus, have such investments increased by greater than 15 percent over the prior year?

e. Determine whether there are concerns due to the level of investment in Schedule BA assets.

   i. Is the ratio of Schedule BA assets to capital and surplus greater than 10 percent?

   ii. If total Schedule BA assets exceed 5 percent of capital and surplus, have such investments increased by greater than 10 percent over the prior year?

3. Determine whether the board of directors approves all purchases and sales of investments and whether all securities owned are under the control of the health entity and in the health entity's possession.

   a. Review General Interrogatory, Part 1, #14. Has the purchase or sale of any investments not been approved by the board of directors or a subordinate committee thereof?

   b. Review General Interrogatory, Part 1, #22.1. Were any stocks, bonds and other securities owned, over which the health entity has exclusive control, not in the actual possession of the health entity, except as shown on Schedule E Part 2 - Special Deposits?

   c. Review General Interrogatory, Part 1, #23.1. Were any stocks, bonds or other assets owned by the health entity not exclusively under the control of the health entity?

   d. Review General Interrogatory, Part 1, #19.1. Were there any assets reported subject to a contractual obligation to transfer to another party without the liability for such obligation being reported?

4. Determine whether securities owned have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office.

   a. Review General Interrogatory for Investments Part 1, #29.

      i. Has the health entity failed to follow the filing requirements of the *Purposes and Procedures Manual of the NAIC Securities Valuation Office*?

      ii. If the answer to 4.a.i is yes, document the exceptions listed in General Interrogatory Part 1, #29.2.

   b. Review Schedule D - Part 1 (Bonds) and Schedule D - Part 2 (Preferred Stocks and Common Stocks). Does it appear that the health entity is not complying with the requirement to submit securities that are not filing exempt to the SVO for a valuation (i.e., there are securities which were acquired prior to the current year with a "Z" suffix after the NAIC designation and there is a significant number of securities which were acquired during the current year with a "Z" suffix after the NAIC designation)?

5. Determine whether the statement value of bonds and sinking fund preferred stocks is significantly greater than their fair value.

   a. Review General Interrogatory Part 1, #28 (which shows the aggregate statement value and the aggregate fair value of bonds and preferred stocks owned). Is the aggregate excess of the statement value over the fair value of bonds and preferred stocks owned greater than 5 percent of the statement value of bonds and preferred stocks owned?

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b. Is the aggregate excess of the statement value over the fair value of bonds and preferred stocks owned greater than 5 percent of capital and surplus?

6. Determine whether the fair value of common stock is significantly greater than or less than the cost.

a. Review Schedule D - Part 2 - Section 2 (Common Stocks). Is the aggregate fair value of common stock below the actual cost?

i. If 6.a. is yes, is the difference greater than 5 percent of capital and surplus?

b. Review Schedule D - Part 2 - Section 2, (Common Stocks). Is the aggregate actual cost of common stock below the fair value?

i. If 6.b. is yes, is the difference greater than 5 percent of capital and surplus?

c. If an investment in one issue of common stock exceeds 5 percent of invested assets, does the fair value of the common stock exceed the actual cost by greater than 30 percent or is the fair value less than the actual cost by greater than -20 percent?

7. Determine whether concerns exist due to significant purchases or sales of securities near the beginning and/or end of the year.

a. Scan Schedule D - Part 3 (Long-Term Bonds and Stocks Acquired During Current Year). Were significant amounts of bonds or stocks purchased near the beginning or the end of the year?

b. Review the Annual Financial Statement Liabilities (page 3). Is payable for securities greater than 3 percent of invested assets?

c. Scan Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or otherwise Disposed of During Current Year). Were significant amounts of bonds or stocks disposed of near the beginning and/or the end of the year?

d. Review the Annual Financial Statement Assets (page 2). Is receivable for securities greater than 3 percent of invested assets?

e. Scan Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed Of During Current Year). Were significant amounts of bonds or stocks acquired near the beginning of the year and disposed of near the end of the year?

8. Determine whether concerns exist due to significant turnover of long-term bonds, preferred stocks, or common stocks during the year.

a. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired During Current Year and Disposed of During Current Year). Is the long-term bond turnover ratio greater than 50 percent?

b. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired During Current Year and Disposed of During Current Year). Is the stock turnover ratio greater than 50 percent?

c. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired During Current Year and Disposed of During Current Year). Is the total long-term bond and stock turnover ratio greater than 50 percent?

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IV. Level 2 Annual Procedures – B.1. Investments

9. Determine whether there are concerns due to investments in derivative instruments. Review the Notes to Financial Statements #1 and #8; General Interrogatory, Part 1, #23.27; the write-ins for assets and liabilities; Exhibit of Net Investment Income, Line 7; Exhibit of Capital Gains and Losses Line 7; Schedule DB - all parts; the MD&A; and the Audited Financial Report. Is the health entity engaging in derivative activity?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the health entity's investments under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for Investments be completed or does the state recommend any actions? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comment as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B.2. Other Assets

1. Review Uncollected Premiums.
   a. Is the ratio of uncollected premiums and agent's balances to capital and surplus greater than 20 percent?
   b. Have uncollected premiums and agent's balances changed by greater than +/- 25 percent from the prior year?
   c. Is the ratio of uncollected premiums to net premium income greater than 5 percent?
   d. Does the amount due from any one group or subscriber equal or exceed 10 percent of the uncollected premiums?
   e. Does the health entity report any nonadmitted uncollected premiums?
   f. If the answer to 1.e. above is yes, do nonadmitted uncollected premiums exceed 10 percent of the balance of uncollected premiums?

2. Review Health Care Receivables.
   a. Is the ratio of health care receivables to capital and surplus greater than 5 percent?
   b. Does the amount due from any one debtor equal or exceed 10 percent of gross health care receivables?
   c. Have health care receivables increased or decreased by greater than 20 percent from the prior year?
   d. Did the health entity report any nonadmitted health care receivable balances?
   e. If the answer to 2.d. above is yes, do nonadmitted health care receivables exceed 10 percent of admitted health care receivables?

3. Review Amounts Receivable Relating to Uninsured Accident and Health Plans.
   a. Is the asset for receivables relating to uninsured plans greater than 5 percent of capital and surplus?
   b. Review Notes to Financial Statements #18, Uninsured Plans. Do concerns exist regarding the profitability of uninsured accident and health plans and the uninsured portion of partially insured plans for which the health entity serves as an Administrative Services Only (ASO) or an Administrative Services Contract (ASC) plan administrator?

4. Review Furniture, Equipment and Supplies.
   a. Is the ratio of admitted furniture, equipment and supplies greater than 5 percent of capital and surplus?
   b. Has the admitted balance of furniture, equipment and supplies changed by greater than +/-10 percent from the prior year?

5. Review EDP Equipment.
   a. Is admitted EDP equipment and software greater than 3 percent of capital and surplus? (Refer to the Analysts Reference Guide.)
   b. Has the admitted balance of EDP equipment and software changed by greater than +/- 25 percent from the prior year?

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IV. Level 2 Annual Procedures – B.2. Other Assets

6. Are aggregate write-ins for other than invested assets greater than 10 percent of capital and surplus?

7. Has the health entity failed to comply with state-specific laws, regulations or guidelines for limitations related to other assets?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding other assets. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the health entity's other assets under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for Other Assets be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B.3 Health Reserves and Liabilities

1. Determine whether an understatement of health reserves would be significant.
   a. Is the ratio of gross claims unpaid and gross aggregate health reserves to capital and surplus greater than 300 percent?
   b. Is the ratio of net claims unpaid and net aggregate health reserves to capital and surplus greater than 200 percent?
   c. Would a 10 percent understatement of net claims unpaid and aggregate claim reserves drop the health entity's Risk-Based Capital ratio below 200 percent?
2. Determine whether health policies appear to have been adequately reserved.
   a. Review the results of the Actuarial Opinion Supplemental Procedures. Were any concerns noted regarding the valuation of the health entity's total health reserves in accordance with minimum statutory valuation standards?
   b. Does any line of business report an underwriting loss?
   c. Compare the one-year reserve development to capital and surplus.
      i. Did the health entity report a reserve deficiency?
      ii. If yes, is the reserve deficiency greater than 5 percent of capital and surplus?
   d. Review the Underwriting and Investment Exhibit Part 2C incurred claims development. Has there been an adverse trend or unusual fluctuation over the last five years?
   e. Review the Underwriting and Investment Exhibit Part 2B – Analysis of Claims Unpaid and Part C Incurred Claims Development. Has the reserve been adequate to pay actual claims?
   f. Review the Underwriting and Investment Exhibit Part 2B - Analysis of Claims Unpaid - Prior Year – Net of Reinsurance. Has there been an increase or decrease in the claim reserve and claim liability as a percent of incurred claims of more than +/-10 percentage points since prior year-end?
   g. Has there been a significant point change in the loss ratio for any product line from the prior year (+/- 10 points)?
   h. Compare the direction of any changes in the loss ratio to the direction of changes in membership. Is there an indication that increased loss ratios may be resulting from falling membership?
   i. Has the annual per member per month medical claims expense increased since last year-end compared to similarly situated health entities?
   j. Compare the amount of claims in process of adjudication to the average incurred non-capitated claims per day. Is the number of days represented by the reserve greater than 30 days?
   k. Is the ratio of unpaid claims adjustment expenses to claims unpaid greater than 10 percent?
   l. Is the ratio of unpaid claims adjustment expenses to incurred claims adjustment expenses greater than 20 percent?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding health reserves. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating health reserves under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for Health Reserves be completed? Describe rationale for this recommendation.

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IV. Level 2 Annual Procedures – B.3 Health Reserves and Liabilities

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B.4. Other Provider Liabilities

1. Determine whether the health entity's liability for bonus and withhold arrangements are significant.
   a. Is the liability for accrued medical incentive pool and bonus payments greater than 5 percent of the total hospital and medical expense?
   b. Is the liability for amounts withheld from paid claims and capitations greater than 5 percent of the total hospital and medical expense?
   c. Is the ratio of incentive pool and withhold adjustment expense to total hospital and medical expense greater than 5 percent?
   d. Is the change in bonus/withhold accrual from prior year to current year greater than +/- 25 percent?
2. Verify that amounts reported for bonuses and withholds in the entity's Risk-Based Capital (RBC) filing are consistent with what is reported in the Annual Financial Statement filing.
   a. Is there an amount entered in accrued medical incentive pool and bonus Payments on Page 3, Column 3, Line 2, even though the RBC filing on worksheet XR016, Column 2, Lines 3 and 4, indicates that no business is subject to withholds or bonuses?
   b. Is there no amount entered in accrued medical incentive pool and bonus payments on Page 3, Column 3, Line 2, even though the RBC filing on worksheet XR016 Column 2, Lines 3 and 4, indicates that some business is subject to withholds or bonuses?
   c. Did the prior year withholds and bonuses paid differ by more than 40 percent from prior year withholds and bonuses available from RBC worksheet XR017 in the RBC filing? (XR017: ABS (Line 18 - Line 19) / (Line 18))

Summary and Conclusion

Develop and document an overall summary and conclusion regarding other provider liability. In developing a conclusion, the analyst should consider the entity's use of these types of arrangements and the relative consistency of reporting between the Annual Financial Statement and RBC filing.

Do you recommend that one or more of the procedures in Level 3 Procedures for Other Provider Liabilities be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comment as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B.5. Income Statement and Surplus

1. Determine whether concerns exist based on the primary operating ratios.
   a. Is the profit margin ratio less than 0 percent or greater than 10 percent?
   b. Is the combined ratio greater than 100 percent?
   c. Is the medical loss ratio greater than 85 percent?
   d. Is the administrative expense ratio greater than 15 percent?
   e. Based upon the health entity's primary lines of business, do the combined, medical loss, and administrative expense ratios appear reasonable?
   f. Review Note 18 regarding ASO/ASC plans. Were any losses incurred from these plans?

2. Determine whether concerns exist based on the change in primary operating ratios when compared to the prior year.
   a. Has the profit margin ratio (see procedure 1a above) increased more than 5 points or decreased more than 10 points?
   b. Has the combined ratio (see procedure 1b above) increased more than 5 points or decreased more than 10 points?
   c. Has the medical loss ratio (see procedure 1c above) increased more than 5 points or decreased more than 10 points?
   d. Has the administrative expense ratio (see procedure 1d above) increased more than 3 points or decreased more than 5 points?

3. Determine whether concerns exist based on other profitability indicators.
   a. Is the investment yield less than 2 percent or greater than 6 percent? (See Financial Profile Report.)
   b. Is the ratio of return on capital & surplus less than 3 percent or greater than 50 percent?
   c. Are net realized capital gains or losses more than (i) +/- 3 percent of capital & surplus or (ii) +/- 25 percent of net income?

4. Determine whether concerns exist regarding changes in the volume of premium, enrollment levels or changes in the health entity's mix of business (lines of business written and/or geographic location of premiums written).
   a. Has there been a significant change (+/- 10 percent) in net premium income from the prior year?
   b. Has there been a significant change (+/- 10 percent) in enrollment from the prior year-end?
   c. Review the Annual Financial Profile Report. Has there been a shift in the mix of premium income?
   d. Have direct premiums written for any line of business changed by greater than +/-33 percent?
   e. If premiums are being written in any new lines, do they account for more than 10 percent of the total net premium income?
   f. Review Schedule T, and determine if any direct business is being written in a state in which there were no prior writings.

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IV. Level 2 Annual Procedures – B.5. Income Statement and Surplus

5. Determine whether the health entity is excessively leveraged due to the volume of premiums written.
   a. Are premiums and risk revenue to capital and surplus greater than,
      i. 10 to 1 for HMOs?

      Or

      ii. 8 to 1 for non-HMOs?
   b. Has the ratio of premiums and risk revenue (see procedure 5a) to capital and surplus increased more than 1.5 points or decreased more than 2 points?
   c. Does the health entity write long-term care and disability income (long-tailed lines) premium? If yes, list the percent of total direct premium.

6. Determine whether concerns exist regarding the pricing of the health entity's products.
   a. Is current year premium per member per month less than 105 percent of prior year's premium per member per month?
   b. Is the change in claims per member per month less the change in premium and risk revenue per member per month greater than zero? (See Financial Profile Report.)
   c. Review Health General Interrogatories – Part 2, #9.1 and #9.2, does the health entity have a significant amount of multi-year contracts with premium rate guarantees?

7. Review the Annual Statement Medicare Part D Coverage Supplement.
   a. Did the health entity report an underwriting loss of either group or individual coverage?
   b. Did the health entity report a medical loss ratio greater than 85 percent on either group or individual coverage?
   c. Did the health entity report an expense loss ratio greater than 15 percent on either group or individual coverage?
   d. Did the health entity report a combined ratio greater than 100 percent on either group or individual coverage?

8. Determine whether concerns exist regarding the amount of the health entity's capital and surplus.
   a. Has capital and surplus decreased more than 10 percent or increased more than 40 percent from the prior year-end?
   b. Review the five-year historical data in the Annual Financial Statement. Has the health entity's capital and surplus decreased by more than 10 percent from the ending balance for any of the prior four years?
   c. Did the health entity declare dividends to stockholders during the year?
      i. If the answer to 8.c. above is yes, was the amount of the stockholder dividend at a level that required prior regulatory approval or notification?
      ii. If the answer to 8.c.i. above is yes, did the health entity fail to obtain proper prior regulatory approvals?
   d. Review surplus notes. Is the ratio of surplus notes to capital and surplus greater than 10 percent?
   e. Are write-ins for other than surplus funds greater than 10 percent of capital & surplus?

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IV. Level 2 Annual Procedures – B.5. Income Statement and Surplus

f. Does the absolute value of the current year change exceed 3 percent of current year capital and surplus for any of the following items: 1) reserve valuation basis, 2) net unrealized capital gains/losses, 3) foreign exchange capital gains/losses, 4) net deferred income tax, 5) nonadmitted assets, 6) the liability for unauthorized reinsurance, 7) surplus notes, 8) change in accounting principles?

g. Did the health entity report interest expense on capital or surplus notes during the year?

h. Are unassigned funds negative?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the health entity's income statement and capital and surplus. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating the health entity's income statement and capital and surplus under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for Income Statement and Capital & Surplus be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B.6. Risk-Based Capital

1. Determine whether concerns exist regarding the health entity's Risk-Based Capital (RBC) position.
   a. Review the Annual Financial Statement, Five-Year Historical Data Schedule, RBC Analysis and/or the RBC filing, and consider the following:
      i. Is the ratio of Total Adjusted Capital divided by Authorized Control (RBC Ratio) less than or equal to 250 percent?
      ii. If the current RBC ratio is less than or equal to 300 percent, has there been a significant change of +/-30 points in the RBC Ratio from the prior year?
      iii. Has the RBC Ratio declined each of the past two years? If yes, show the percentage point decline over the two years and the current year's RBC Ratio.
      iv. Has the Total Adjusted Capital declined by 15 percent or greater from the prior year?
      v. Has the Authorized Control Level increased by 15 percent or greater from the prior year? If yes, review the five RBC risk factors for material changes from the prior year and document the leading underlying causes for the changes.

2. Did the insurer fail the RBC Trend Test? If yes, discuss the plans to address the RBC Trend Test failure.

3. If the insurer has triggered an action level RBC event and if authorized by statute:
   a. Obtain and review a copy of the health entity's RBC Plan.
   b. Monitor the health entity's RBC plan and overall progress in implementing plan initiatives and improving the RBC level.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding RBC. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating RBC.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B.7. Cash Flow and Liquidity

1. Determine whether concerns exist regarding the health entity's overall level of liquidity.
   a. Is the ratio of total liabilities to liquid assets greater than 100 percent?
   b. Review changes in the total liabilities to liquid assets ratio in past years for unusual fluctuations or negative trends between years.
   c. Is the change in liquid assets greater than 75 percent or less than -15 percent?
   d. Is the liquid assets & receivables to current liabilities ratio (excluding non-investment grade bonds) less than 200 percent?
   e. Review changes in the liquid assets & receivables to current liabilities ratio in past years for unusual fluctuations or negative trends between years.
   f. Are affiliated investments and receivables greater than 20 percent of capital and surplus?
   g. Is the average number of days of unpaid claims greater than 30 days?
   h. Review changes in the average number of days of unpaid claims in past years for unusual fluctuations or negative trends between years.

   Consider the following procedures to provide further depth to the analysis:

   i. Compare the health entity's liability to liquid assets ratio or liquid assets & receivables to current liabilities ratio with industry and peer group averages in order to identify significant deviations.

2. Determine whether concerns exist regarding the health entity's cash flow. Review the Statement of Cash Flow.
   a. Is net cash from operations negative? If yes:
      i. Calculate the ratio of net cash from operations to capital and surplus.
      ii. Calculate the ratio of net cash from operations to premiums collected net of reinsurance.
      iii. Was the prior year net cash from operations negative?
   b. Review the trend in cash flow in past years for unusual fluctuations or negative trends between years.
   c. Is other cash provided greater than 10 percent of capital and surplus?
   d. Is other cash provided greater than 20 percent of net cash from operations?
   e. Review the trend in other cash provided in past years for unusual fluctuations such as significant reliance on other cash provided.
   f. Is the ratio of benefits and loss related payments to premiums collected net of reinsurance greater than 85 percent?

   Consider the following procedures to provide further depth to the analysis:

   g. Compare liability to liquid assets ratio or liquid assets & receivables to current liabilities ratio and cash flow from operations with industry and peer group averages in order to identify significant deviations.

3. Review the Z-Score Analysis included in the Financial Profile Report.
   a. Is the total Z-Score less than 2.6?

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b. If the total Z-Score is 6.0 or less in the current year, has the Z-Score decreased 1.5 or more points from the prior year?

c. Review the trend of the Z-Score. If the Z-Score is 6.0 or less in the current year, has the Z-Score decreased 2.0 or more points over the past three years?

d. Is the ratio of working capital to total assets less than 30 percent?

e. Review the working capital to total assets ratio for past years and review any unusual fluctuations or negative trends between years.

4. Review other sources, including the Management's Discussion & Analysis and the Asset Adequacy Analysis from the Statement of Actuarial Opinion (if required). Do concerns exist relating to cash flow & liquidity or asset adequacy?

5. Review Schedule E Part 3 and determine whether concerns exist regarding the insurer's special deposits.

a. Is the book adjusted carrying value of all other special deposits, (not for the benefit of all policyholders), greater than 50 percent of total special deposits?

b. Is the difference between the book adjusted carrying value of total special deposits to the fair value of total deposits greater than 5 percent?

Consider the following procedures to provide further depth to the analysis.

c. Review the listing of special deposits held by the health entity not for the benefit of all policyholders and consider:

i. The number of states in which the health entity has these types of deposits. The greater the number, the more difficult it may be for the domiciliary state to call on these deposits in rehabilitation.

ii. The amount of concentration in any one particular state.

d. Contact the domiciliary state or perform research to determine if any of the states have restrictions on the ability of those deposits to be called by the domiciliary state during rehabilitation.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding cash flow and liquidity. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating cash flow and liquidity under the specific circumstances involved.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B.8. Risk Transfer Other Than Reinsurance

1. Determine if uninsured volume or receivables is material.
   a. Review Note #18 parts A&B and compare the ratio of ASO/ASC claim payments to total hospital and medical expenses plus ASO/ASC claim payments. Is the ratio greater than 10 percent?
   b. Review Underwriting and Investment Exhibit Part 3 and compare the ratio of reimbursements from uninsured plans to total expenses plus reimbursements from uninsured plans. Is the ratio greater than 25 percent?
   c. Are uninsured receivables relating to uninsured accident and health plans greater than 5 percent of capital and surplus?
   d. Has the uninsured receivable relating to uninsured accident and health plans increased or decreased by greater than 20 percent since last year-end?
   e. Does the health entity report any non-admitted uninsured receivables relating to uninsured accident and health plans?

2. Determine if experience rating arrangements are significant.
   a. Compare reserve for rate credits or experience rating refunds in Underwriting and Investment Exhibit Part 2D, Line 4 to total hospital and medical expenses. Does the health entity report reserve for rate credits or experience rating refunds?
   b. Compare amounts due from experience rating arrangements from the write-in for other than invested assets to total hospital and medical expenses. Does the health entity report amounts due from experience rating arrangements?

3. Determine if capitation payments are material or their distribution is a problem.
   a. Compare total capitation payments to intermediaries from Exhibit 7, Part 1 to total hospital and medical expenses. Is the ratio greater than 10 percent?
   b. Is the ratio of net health care receivables to capital and surplus greater than 8 percent?
   c. Based on capitation payments to total payments, is the percentage of members covered by capitated arrangements greater than 50 percent?

4. Determine if special payment arrangement with providers are material.
   a. Compare total bonus/withhold arrangement payments to total hospital and medical benefits. Is the ratio greater than 20 percent?
   b. Compare pool/withhold arrangement payments to total bonus/withhold accrual. Is the ratio greater than 100 percent?
   c. Did the health entity report bonus/withhold payments and prior year underwriting losses?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding risk transfer other than reinsurance. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the health entity's risk transfer other than reinsurance under the specific circumstances involved.

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IV. Level 2 Annual Procedures – B.8. Risk Transfer Other Than Reinsurance

Do you recommend that one or more of the procedures in the Level 3 Procedures for Risk Transfer Other Than Reinsurance be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B.9. Reinsurance

1. Determine whether the health entity has a reinsurance program in place that adequately supports its risk profile. Review General Interrogatory, Part 2, #5.1. Did the health entity report they do not have stop-loss reinsurance?

   If yes, review the health entity's explanation and the maximum retained risk in General Interrogatory Part 2, #5.2 and #5.3. Do any concerns exist regarding the health entities lack of stop-loss coverage or the level of maximum retained risk?

2. Determine whether the health entity's accounting treatment for reinsurance ceded is proper and in accordance with the Annual Financial Statement Instructions.

   a. Briefly scan the individual reinsurers listed in Schedule S - Part 3 – Section 2. Do any of the reinsurers listed as authorized appear to be improperly classified as such?

   b. Briefly scan the Annual Financial Statement pages related to Assets, Liabilities, and Statement of Revenues and Expenses. Are any unusual items noted relating to write-ins or significant changes or inconsistencies from prior years regarding reinsurance activities?

3. Determine whether amounts recoverable from reinsurers are significant and collectible.

   a. Are amounts recoverable from reinsurers greater than 10 percent of capital and surplus?

   b. Are ceded premiums written greater than 10 percent of gross premiums written?

   c. Are ceded reserve credits greater than 10 percent of capital and surplus?

   d. Review Schedule S – Part 3 – Section 2. Are any unusual items noted regarding the types of reinsurance and their relative significance, or the specific reinsurers involved?

   e. Review Notes to the Financials #22. Did the health entity report any items that cause concern regarding reinsurance balances?

   f. Review the results of the Actuarial Opinion Supplemental Procedures. Were any concerns noted regarding the collectibility of reinsurance recoverables?

4. Determine whether reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another.

   a. Are affiliated ceded premiums written greater than 10 percent of total gross premiums written?

   b. Review Schedule S – Part 2 (amounts recoverable on paid and unpaid losses for claims) and Schedule S – Part 3 – Section 2 (ceded reinsurance). Are reinsurance recoverables from affiliates greater than 10 percent of capital and surplus?

   c. Is there a significant point change in the above two ratios from the prior year of 15 points or over the past five years of 25 points?

   d. Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10 percent or controlled, either directly or indirectly, by the health entity or any representative, officer, trustee, or director of the health entity? (Notes to Financials - Note #22; Ceded Reinsurance Report - Section 1 - General Interrogatory Part 1)

      i. If yes, review 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?

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IV. Level 2 Annual Procedures – B.9. Reinsurance

e. Have any policies issued by the health entity 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 Financials – Note #22; Ceded Reinsurance Report - Section 1 - General Interrogatory Part 2)

5. Does the health entity have any agreements with reinsurance intermediaries or did the health entity enter into any transactions or agreements with reinsurance intermediaries during the year?

6. Review Schedule S, Note to Financial Statements #22, the results of the Actuarial Opinion Supplemental Procedures and any other information available to the analyst regarding the health entities reinsurance agreements. Were any of the following types of reinsurance transactions or agreements completed during the year: 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?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding reinsurance. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating reinsurance under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for Reinsurance be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B.10. Affiliated Transactions

1. Determine whether the health entity is a member of a holding company group and, if so, whether the corporate structure, or any changes in the corporate structure, elevate concerns about affiliated transactions.[1]

   a. Review General Interrogatory Part 1, #1.1

      i. Is the health entity a member of an insurance holding company system consisting of two or more affiliates, one or more of which is a health entity or insurer? If yes, what is the name of the ultimate controlling person or entity as reported on the holding company system registration statement?

      ii. Is the answer for 1.a.i. above different from the prior year?

      iii. Review Schedule Y, Part 1 and Part 2, along with the General Interrogatories and Notes to Financial Statements. Is there any information noted that contradicts the response in 1.a.i. above?

      iv. Is the company required to file a holding company registration statement with the Department statement?

If 1.a.i.-1.a.iv. are all "no," do not proceed with the remaining Affiliated Transactions procedures and skip to the next financial analysis procedure.

   b. Review General Interrogatory Part 1, #1.2. Did the health entity fail to file a registration statement in accordance with the Model Insurance Holding Company System Regulatory Act?

   c. Review Schedule Y - Information Concerning Activities of Health Entity Members of the Holding Company Group, Part 1 - Organizational Chart for the current and the prior year.

      i. Were there any significant changes to the corporate structure during the year (i.e., acquisitions, divestitures, mergers)?

      ii. If the answer to 1.c.i. above is yes, and the change involved ownership of the health entity or a transaction with an affiliate, did the health entity fail to receive proper regulatory approvals?

      iii. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company?

      iv. Does the health entity have an agency or brokerage subsidiary?

      v. Are there any indications the corporate structure may include a hospital or that the reporting entity may be affiliated with any other type of medical provider(s) or provider intermediaries?

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

   a. Review Schedule Y - Information Concerning Activities of Health Entity Members of the Holding Company Group, Part 2 - Summary of Insurer's Transactions with Any Affiliates.

      i. Were any unusual items noted, such as significant new affiliated transactions from the prior year, or significant increases in transaction amounts?

      ii. On a selected basis, review Schedule Y, Part 2 for other affiliates. Does it appear that a different schedule is included for the other affiliates?

[1] Health entities have not been incorporated into the *Insurance Holding Company System Regulatory Act* in all states.

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iii. Has the health entity forwarded funds greater than 15 percent of the health entity's surplus to any one affiliate?

iv. Were management fees paid to affiliates, as identified in footnotes to the Underwriting and Investment Exhibit-Part 3, greater than 15 percent of the total incurred general expenses reported in this exhibit?

b. Review Note to Financial Statements #10, Information Concerning Parent, Subsidiaries and Affiliates.

i. Are any unusual items noted, such as significant new affiliated transactions from the prior year, or significant increases in transaction amounts?

ii. Do any transactions described appear to conflict with the transactions disclosed in Schedule Y, Part 2?

iii. Are any transactions disclosed with an affiliate that is not listed on Schedule Y, Part 1?

iv. Do affiliated business ventures resulting in a contingent liability to the health entity involve financial exposure greater than 25 percent of surplus?

v. Review the description of management and administrative services agreements. Is an allocation basis involved other than one designed to estimate actual cost?

vi. If the answer to 2.b.v. above is yes, are the allocation or cost bases used for service charges periodically reviewed and adjusted?

vii. Were management and service agreements between affiliates either submitted and/or approved in conformity with regulatory requirements?

viii. Was the amount of the shareholder dividend at a level that required prior regulatory approval or notification?

ix. If the response to 2.b.viii. above is yes, did the health entity fail to obtain proper prior regulatory approvals?

x. Does the amount of the dividend disclosed in the Notes to Financial Statements differ from the amount reflected on the Statement of Cash Flow?

xi. Did the capital contributions from the health entity to another affiliate substantially impact the financial condition of the health entity?

xii. Were non-cash capital contributions into the health entity not recorded at fair value?

xiii. Were purchases, sales, or exchanges of loans, securities, real estate, mortgage loans, or other investments, not at arms length or not recorded at fair value?

xiv. Did any transfer of assets between insurance affiliates impact the risk-based capital calculation?

xv. Does the health entity have a parental guaranty to maintain capital and surplus at a pre-determined level?

c. Review Note to Financial Statements #13, Capital and Surplus and Shareholder's Dividend Restrictions and Quasi-Reorganizations. Are any unusual items noted?

d. Has the health entity historically required capital contributions from its parent to offset operating losses or other decreases in capital and surplus?

3. Determine whether investments in affiliates are significant.

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a. Is the total of all investments in affiliates greater than 20 percent of capital and surplus?

b. Has the total of all investments in affiliates changed by greater than +/- 20 percent from the prior year-end?

c. Has there been any change in any category of affiliated investments greater than +/- 10 percent from the prior year-end?

d. Does the company have an interest in the capital stock of another insurance company or other health entity?

i. If the response to 3.d. above is yes, and if the health entity was a member of a holding company group at the end of the reporting period, did the health entity fail to properly disclose the investment on Schedule Y, Part 1?

e. Are affiliated investments in violation of state statutes?

4. Determine whether investments in affiliates are properly valued in accordance with statutory accounting practices.

a. If investments in common stocks of parents, subsidiaries and affiliates involve publicly traded securities, is the investment valued on a basis other than market valuation?

b. If investments in common stocks of parents, subsidiaries and affiliates do not involve publicly traded securities, is the investment valued on a basis other than the Statutory Equity of GAAP Equity methods?

5. Determine whether other affiliated transactions are legitimate and properly accounted for.

a. Review the balance sheet asset receivable from parent, subsidiaries and, as well as the liability payable to parent, subsidiaries and affiliates. Are either of these items greater than 10 percent of capital and surplus?

b. Review Exhibit 5, Amounts Due from Parent, Subsidiaries and Affiliates.

i. Are there any balances over 90 days, which are admitted?

ii. Does the exhibit otherwise suggest that the health entity may have collectibility issues with its affiliates?

iii. Are any of the receivable balances from an affiliate which the health entity also reports a payable balance on Exhibit 6, and could therefore net the balances on the face of the balance sheet if the requirements of SSAP 64 were met?

iv. Is the analyst aware of any receivable balances from an affiliate, which has experienced some financial problems?

v. Are there any affiliated receivable balances from medical providers or intermediaries included on Exhibit 5?

c. Review Exhibit 6, Amounts Due to Parent, Subsidiaries and Affiliates.

i. Are any of the balances non-current?

ii. Are any of the balances unusually large for the description or are any of the descriptions unusual?

d. Review Exhibit 7, Summary of Transactions with Providers.

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i. Is the ratio of payments made to affiliated providers to total payments greater than 50 percent?

ii. Has there been any indication that the amount charged by the affiliated provider is non-economic or non-arms-length?

e. Review Schedule E.

i. Were any open depositories a parent, subsidiary or affiliate?

ii. Based upon a review of the holding company financial statements, are there any holding company lenders that appear as open depositories of the health entity?

f. Review Note to Financial Statements #9, Income Taxes.

i. Is the health entity included in a consolidated federal income tax return?

ii. If the answer to 5.f.i. is yes, are there any concerns about the manner in which federal income taxes are allocated to the health entity?

iii. Are federal income tax recoverables greater than 5 percent of capital and surplus?

a) If the answer to 5.f.iii. above is yes, are federal income tax recoverables due from an affiliate?

g. Review General Interrogatory Part 1, #7. Does any foreign entity control 10 percent or more of the health entity, either directly or indirectly, through a holding company?

i. If the response to 5.g. above is yes, did the health entity fail to properly disclose the investment on Schedule Y, Part 1?

h. Review General Interrogatory Part 1, #18.1 & 18.2.

i. Did the health entity report amounts loaned during the year to directors, other officers and stockholders? If yes, what is the percent of statutory net income and capital and surplus?

ii. Did the health entity report amount of loans outstanding at the end of the year to directors, officers and stockholders? If yes, what are the percent of statutory net income and capital and surplus?

i. Review General Interrogatory Part 1, #16. Has the health entity failed to establish a conflict of interest disclosure policy?

j. Is there any evidence that activities of directors, officers or shareholders were in violation of state statutes?

k. Review Schedule SIS, Stockholder Information Supplement. Are any unusual items noted regarding transactions with, or compensation to, directors and officers?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding affiliated transactions. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating affiliated transactions under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for Affiliated Transactions be completed?

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IV. Level 2 Annual Procedures – B.10. Affiliated Transactions

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B.11. TPAs, IPAs, and MGAs

1. Determine whether concerns exist due to a significant amount of the health entity's direct premiums being written through Managing General Agents (MGAs) and Third Party Administrators (TPAs).

   a. Review General Interrogatories #4.1 & 4.2. Did any agent, general agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the insurer) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of either the sale of new business or renewals?

   b. Review Notes to Financial Statements #19 - Direct Premiums Written produced by Managing General Agents/Third Party Administrators. Was the aggregate amount of direct premiums written through MGAs and TPAs greater than (i) 10 percent of total direct premiums written or (ii) 5 percent of capital and surplus?

2. Determine whether concerns exist due to a significant amount of the claims that are preauthorized or processed by TPAs or Independent Practice Associations (IPAs).

   a. Is the ratio of direct medical expense payments made to intermediaries to total medical expense payments greater than 5 percent?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding whether concerns exist due to a significant reliance on TPAs, IPAs or MGAs. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the health entity's use of TPAs, IPAs and MGAs under the specific circumstances involved.

Do you recommend that one or more of the Level 3 Procedures for TPAs, IPAs and MGAs be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV.C. Level 3 Procedures

1. Investments
2. Other Assets
3. Health Reserves and Liabilities
4. Other Provider Liabilities
5. Income Statement and Surplus
6. Risk Transfer Other Than Reinsurance
7. Reinsurance
8. Affiliated Transactions
9. TPAs, IPAs, and MGAs

IV. Level 3 Procedures– C.1. Investments

1. If there are concerns regarding whether the health entity's investment portfolio is adequately diversified to avoid an undue concentration of investments by type or issue (Level 2 Annual Procedure #1), consider performing one or more of the following procedures:

   a. Determine whether the health entity's investment portfolio is in compliance with the investment limitations and diversification requirements per the state's insurance laws.

   b. Review the Percentage Distribution of Total Assets for significant shifts in the mix of investments owned during the past five years.

   c. Compare the health entity's distribution of invested assets per the Percentage Distribution of Total Assets with the industry and peer groups in order to identify significant deviations.

   d. Request a copy of the health entity's investment plan which 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 which are appropriate for the health entity based on the types of business written and its liquidity and cash flow needs.

      ii. Determine whether the health entity appears to be adhering to the investment plan.

   e. Review the maturity distribution of bonds in Schedule D - Part 1A - Section 1 (Quality and Maturity Distribution of all Bonds Owned) and consider the liquidity of the health entity's investments to determine whether the health entity's investment portfolio appears reasonable based on the types of business written.

   f. If the health entity's investments include a significant amount of foreign bonds, consider the health entity's potential foreign currency exposure from holding bonds denominated in a foreign currency.

   g. If there are concerns regarding liquidity or cash flows, consider having a cash flow analysis performed by an actuary.

2. If there are concerns regarding the level of investment in non-investment grade bonds (Level 2 Annual Procedure #2a), consider performing one or more of the following procedures:

   a. Review Schedule D - Part 1A - Section 1 (Quality and Maturity Distribution of all Bonds Owned) and compare the health entity's holdings of non-investment grade bonds to the limitations included in the NAIC's Investments in Medium Grade and Lower Grade Obligations Model Regulation:

      i. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 3, 4, 5, or 6 is less than 20 percent of total admitted assets.

      ii. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 4, 5, or 6 is less than 10 percent of total admitted assets.

      iii. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 5 or 6 is less than 3 percent of total admitted assets.

      iv. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 6 is less than 1 percent of total admitted assets.

   b. Request a copy of the health entity's plan for investing in non-investment grade bonds and review the guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity and geographic location.

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c. Determine whether the health entity appears to be adhering to its plan for investing in non-investment grade bonds.

d. For the more significant non-investment grade bonds, request the following current information regarding the issuer from the health entity to determine the issuer's financial position and ability to repay its debt:

i. Audited financial statements.

ii. Report from a recognized rating agency (Moody's Investors Service, Standard and Poor's, or Fitch).

3. If there are concerns regarding the level of investment in multi-class securities (Level 2 Annual Procedure #2b), consider performing one or more of the following procedures:

a. Review the multi-class securities categories in Schedule D - Part 1 (Bonds) for bonds with a book-adjusted carrying value significantly in excess of par value, which could result in a loss being realized if bond prepayments occur faster than anticipated.

b. Review the multi-class securities categories in Schedule D - Part 1 for bonds with an unusually high effective yield.

c. Request information from the health entity regarding the percentage distribution of the amounts of each type of multi-class residential mortgage-backed security held; Planned Amortization Class (PACs), support bonds, interest only (IO) tranches, principle only (PO) tranches to evaluate the level of prepayment risk in the portfolio.

d. Request and examine information from the health entity regarding the estimated prepayment speeds on its MRMBSs.

A document is available in the File Repository on I-SITE that discusses mortgage backed securities and their pricing/valuation, prepayment models, measures of prepayments, extension risk and contraction risk, average life, option-adjusted spread (OAS), effective duration, and convexity.

e. Request information from the health entity regarding the background and expertise in structured securities of its investment advisors (in-house and/or contractual) and its analytical systems capabilities. Determine whether the advisors and systems are adequate to allow the health entity to continuously monitor its structured securities investments.

f. Consider having the CMOs modeled by an actuary as part of a cash flow analysis.

4. If there are concerns regarding the level of investment in private placement bonds (Level 2 Annual Procedure #2c), consider performing one or more of the following procedures:

a. Review Schedule D - Part 1A - Section 1 & 2 (Quality and Maturity Distribution of all Bonds Owned) and Schedule D - Part 1A - Section 2 (Maturity Distribution of All Bonds Owned December 31 by Major Type and Subtype) and determine the following:

i. The total amount of privately placed bonds owned.

ii. The types of issues with privately placed bonds.

iii. The NAIC designations of the privately placed bonds.

iv. The maturity distribution of the privately placed bonds.

v. The amount of total privately placed bonds which are freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.

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b. For the more significant privately placed bonds, request current audited financial information regarding the issuer from the health entity and evaluate the issuer's financial position and ability to repay its debt.

5. If there are concerns regarding the level of investment in real estate and mortgage loans (Level 2 Annual Procedure #2d), consider performing one or more of the following procedures:

   a. Review Schedule A - Part 1 (Real Estate Owned) to determine whether updated appraisals should be obtained for any of the properties owned based on the location of the property, the book-adjusted carrying value and reported fair value of the property and the year of last appraisal.

   b. Review Schedule A - Part 1 (Real Estate Owned) and:

      i. Investigate any instances where a property has a book-adjusted carrying value in excess of its cost.

      ii. Request information from the health entity regarding any increases by adjustment in book-adjusted carrying value during the year.

   c. Review Schedule A - Part 1 (Real Estate Owned) for any properties owned which have a book-adjusted carrying value in excess of fair value and determine whether the asset should be written down.

   d. Review Schedule B - Part 1 (Mortgage Loans Owned) and:

      i. Compare the book value of each loan to the value of the land and buildings mortgaged to determine whether the mortgage loans are adequately collateralized.

      ii. Request information from the health entity regarding any increases by adjustment in book value during the year.

      iii. Determine whether any of the mortgage loans are to an officer, director, parent, subsidiary, or affiliate.

6. If there are concerns regarding the level of investment in other invested assets (Level 2 Annual Procedure #2e), consider performing one or more of the following procedures:

   a. Review Schedule BA - Part 1 (Other Long-Term Invested Assets Owned) to determine the amount and types of other invested assets owned and to determine whether they are properly categorized as other invested assets.

   b. Request information from the health entity to support significant increases by adjustment in book-adjusted carrying value during the year.

   c. Request current audited financial statements and other documents (partnership agreements, etc.) necessary to support the book-adjusted carrying value of the health entity's investment in partnerships, joint ventures and limited liability companies.

   d. Request information necessary to support the book-adjusted carrying value of significant other invested assets other than partnerships, joint ventures and limited liability companies.

   e. Request information necessary to determine the fair value of collateral to the amount loaned to ensure the loan is adequately collateralized.

7. If there are concerns regarding investment approval or control and possession (Level 2 Annual Procedure #3), consider performing one or more of the following procedures:

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

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b. If the health entity has securities under its exclusive control which are not in its actual possession, review General Interrogatory, Part 1, #22 to determine the reason the securities are not in the health entity's possession, who holds the securities, and whether they qualify as admitted assets of the health entity.

c. If the health entity owns assets which are not under its exclusive control, review General Interrogatory, Part 1, #23.1, 23.2 and 23.3 to determine the reason the assets are not under the health entity's exclusive control, who holds the assets, and whether they qualify as admitted assets of the health entity.

8. If there are concerns regarding whether securities have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office (Level 2 Annual Procedure #4), consider performing one or more of the following procedures:

a. Review Schedule D - Part 1 (Long-Term Bonds Owned) to determine whether all bonds with an NAIC designation of 3, 4, 5, or 6 (non-investment grade bonds) have been valued at the lesser of book-adjusted carrying value or fair value and all other bonds have been valued at their book-adjusted carrying value.

b. Review Schedule D - Part 2 (Preferred Stocks and Common Stocks Owned) to determine whether sinking fund preferred stocks have been valued at their cost and all other stocks have been valued at their fair value.

c. If securities are listed in Schedule D - Part 1 (Long-Term Bonds Owned) or Schedule D - Part 2 (Preferred Stocks and Common Stocks Owned) with a "Z" suffix after the NAIC designation:

i. Request verification from the health entity that the securities, if not filing exempt, have been submitted to, and subsequently valued by, the SVO.

ii. If the securities do not qualify as filing exempt, compare the price or designation actually received from the SVO to that included in the Annual Finanical Statement for significant securities.

9. If there are concerns regarding the significance of any excess of the book-adjusted carrying value over the fair value of bonds and sinking fund preferred stocks owned (Level 2 Annual Procedure #5), consider performing one or more of the following procedures:

a. Review Schedule D - Part 1 (Long-Term Bonds Owned) and Schedule D - Part 2 (Preferred Stocks and Common Stocks Owned) or request additional information from the health entity to determine which individual securities have a book-adjusted carrying value significantly in excess of their fair value. For those securities:

i. Verify the NAIC designation assigned and, if not filing exempt, determine whether it has been updated recently by the SVO.

ii. If filing exempt, determine the current rating by a recognized rating agency (Moody's Investors Service, Standard and Poor's, or Fitch).

iii. Determine whether there has been an other than temporary impairment in fair value.

b. Request information from the health entity regarding investment strategies and short-term cash flow needs to determine whether investments with a book-adjusted carrying value significantly in excess of their fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

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IV. Level 3 Procedures– C.1. Investments

10. If there are concerns regarding the significance of any excess of the cost over the fair value of common stocks owned (Level 2 Annual Procedure #6), consider performing one or more of the following procedures:

    a. Review Schedule D - Part 2 - Section 2, (Common Stocks Owned) or request additional information from the health entity to determine which individual common stocks have a cost significantly in excess of their fair value. For those securities:

        i. If the stock is listed on a market or exchange, (designated by the symbol L or U), such as the New York Stock Exchange, the American Stock Exchange, the NASDAQ National Market system, or a foreign exchange, verify the price and total fair value.

        ii. If the stock is designated "A" (Unit Price of the share has been analytically determined by the SVO) determine whether the rating has been updated recently by the SVO.

        iii. Determine whether there has been an other than temporary impairment in the fair value of the common stock.

    b. Request information from the health entity regarding investment strategies and short-term cash flow needs to determine whether common stock with a cost significantly in excess of its fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

11. If there are concerns regarding significant purchases or sales of securities near the beginning and/or the end of the year (Level 2 Annual Procedure #7), consider performing one or more of the following procedures:

    a. Review Schedule D - Part 3 (Long-Term Bonds and Stocks Acquired During Current Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year) to determine the types of securities purchased at or near the beginning and the end of the year and the vendors used for those purchases.

    b. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year) to determine the types of securities sold at or near the beginning and the end of the year and the purchasers of those securities.

    c. Based on the results of a. and b. above, determine whether the health entity might have engaged in "window dressing" of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring lower quality investments after year-end).

12. If there are concerns regarding the level of turnover of long-term bonds, and both preferred and common stock (Level 2 Annual Procedure #8), consider performing one or more of the following procedures:

    a. Determine that all brokers used by the company for investment transactions are licensed and in good standing with the Securities Exchange Commission.

    b. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During the Current Year) to determine the amount of bonds and stocks disposed of during the current year.

        i. Review Schedule D - Part 3 (Long-Term Bonds and Stocks Acquired During Current Year) to determine the quality of bonds acquired, noting any "Z" rated (not filing exempt or not rated by the SVO) securities. Also, note any NAIC designations of 3, 4, 5, or 6 (non-investment grade bonds).

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ii. Review Schedule D - Part 3 (Long-Term Bonds and Stocks Acquired During Current Year) to determine the quality of preferred and common stocks acquired. Evaluate any "U" (unlisted) or "A" (analytically determined) rated stocks.

c. High turnover of investments can result in realized capital gains. Review the Exhibit of Capital Gains (Losses) to determine the degree of reliance on capital gains to increase surplus or to offset underwriting losses.

13. If there are concerns regarding the level of investment in derivative instruments (Level 2 Annual Procedure #9), consider performing one or more of the following procedures:

a. Request and review a comprehensive description of the health entity's hedge program in order to obtain an understanding of the health entity's use of derivative instruments 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 which the health entity has acquired or incurred, or anticipates acquiring or incurring and:

i. Evaluate whether the hedge program appears to result in hedges, which are appropriate for the health entity based on its assets, liabilities, and cash flow risks.

ii. Determine whether the health entity appears to be adhering to the description of the hedge program.

b. Review Schedule DB (Derivative Instruments). For significant derivative instruments, which are open at year-end, request the following information from the health entity:

i. A description of the methodology used to verify the continued effectiveness of the hedge provided.

ii. A description of the methodology to determine the fair value.

iii. A description of the determination of the book-adjusted carrying value.

c. Consider having the health entity's derivative instruments and hedge program reviewed by an investment expert to determine whether the derivative instruments are providing an effective hedge.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments based on the additional procedures performed in the Level 3 Procedures.

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

- ☐ Contact the health entity seeking explanations or additional information
- ☐ Obtain the health entity's business plan
- ☐ Require additional interim reporting from the health entity
- ☐ Refer concerns to examination section for targeted examination
- ☐ Engage an independent appraiser to value particular investments
- ☐ Engage an independent actuary to perform cash flow analysis
- ☐ Meet with the health entity's management
- ☐ Obtain a corrective plan from the health entity
- ☐ Other (explain)

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IV. Level 3 Procedures– C.1. Investments

Analyst _____ Date _____

Comments as a result of supervisory review.

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IV. Level 3 Procedures – C.2. Other Assets

1. If there are concerns regarding uncollected premiums and agents' balances (Level 2 Annual Procedure #1), consider performing one or more of the following procedures:
   a. Review Uncollected Premiums and perform the following:
      i. Contact the health entity and request adequate detail to allow for further analysis.
      ii. Obtain an explanation for the significant balance.
      iii. Request a listing of balances of subscribers, which individually account for 10 percent or more of the premiums uncollected and compare to a similar list from prior years.
      iv. Review amounts nonadmitted and compare to prior years.
      v. With respect to agents' balances verify the creditworthiness of the agent.
      vi. Obtain and review the amounts of any uncollectible balances that have been written off in the current period. Compare the write-offs to those of the prior reporting period, if any.
      vii. Obtain and review the health entity's written procedures for monitoring and collecting uncollected premiums, including amounts already written off.
      viii. Inquire whether the health entity has factored or sold its uncollected premium balances to a third party. Note whether the receivables were discounted in the transaction.

2. If there are concerns regarding Health Care Receivables (Level 2 Annual Procedure #2), consider performing one or more of the following procedures:
   a. Review Health Care Receivables and perform the following:
      i. Contact the health entity and request adequate detail to allow for further analysis.
      ii. Obtain an explanation for the significant balance.
      iii. Request a listing of balances of debtors which individually account for 10 percent or more of the balance of health care receivables and compare to a similar list from prior years.
      iv. Review amounts nonadmitted and compare to prior years.
      v. Obtain and review the amounts of any uncollectible balances that have been written off in the current period. Compare the write-offs to those of the prior reporting period, if any.
      vi. Obtain and review the health entity's written procedures for monitoring and collecting uncollected premiums, including amounts already written off.
      vii. Inquire whether the health entity has factored or sold its health care receivables to a third party. Note whether the receivables were discounted in the transaction.
   b. Review capitation and other agreements with providers and hospitals and the level of receivables from these parties.

3. If there are concerns regarding the other asset amounts receivable relating to uninsured plans (Level 2 Annual Procedure #3), consider performing one or more of the following procedures:
   a. Request a listing of plans adminstered by the health entity.
   b. Request an aging schedule of receivables related to uninsured plans.
   c. Evaluate the financial condition of the uninsured plans.

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d. Obtain and review the amounts of any uncollectible receivables under uninsured plans that have been written off in the current period. Compare the write-offs to those of the prior reporting period, if any.

4. If there are concerns regarding the asset furniture and equipment (Level 2 Annual Procedure #4), consider performing one or more of the following procedures:

   a. Review Exhibit 8 - Furniture, Equipment and Supplies Owned and review the reporting distribution of furniture, equipment and supplies.

   b. Review disclosures made in the Notes to the Audited Financial Report regarding furniture and equipment and consider performing one or more of the following procedures:

      i. Contact the health entity or request access to its independent auditor for clarification of any unusual responses.

      ii. If the amount of admitted furniture and equipment is material, request information regarding depreciation and review for reasonableness. Determine if the depreciation period exceeds three years.

5. If there are concerns regarding the other asset electronic data processing (EDP) Equipment and Software (Level 2 Annual Procedure #6), consider performing one or more of the following procedures:

   a. Review disclosures in the Notes to the Audited Financial Report for reasonableness.

   b. Perform a review to determine that the minimum capitalization amount, depreciable life and admissibility are in compliance with statutory limitations.

   c. Request a description of the methodology used to compute depreciation.

      i. Determine if the period of depreciation exceeds three years.

      ii. Determine if the health entity nonadmitted nonoperating software.

   d. Review the management or service agreements, if any, which provide for EDP services and evaluate whether the charges appear reasonable for the services provided.

   e. If the health entity did not report an asset for EDP equipment and operating system software, does a management or service agreement exist that provides for electronic data processing services?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding other assets based on the additional procedures performed in the Level 3 Procedures.

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

- ☐ Contact the health entity seeking explanations or additional information
- ☐ Obtain the health entity's business plan
- ☐ Require additional interim reporting from the health entity
- ☐ Refer concerns to examination section for targeted examination
- ☐ Meet with the health entity's management
- ☐ Obtain a corrective plan from the health entity
- ☐ Other (explain)

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IV. Level 3 Annual Procedures – C.2. Other Assets

Analyst _____ Date_____

Comments as a result of supervisory review.

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IV. Level 3 Procedures – C.3. Health Reserves and Liabilities

1. If there are concerns regarding whether an understatement of health reserves (Level 2 Annual Procedures #1 and #2) would be significant or if health policies have not been adequately reserved, consider performing one or more of the following procedures:

   a. Determine which health lines of business are being written by the health entity.

   b. Review the health entity's most recent business plan to determine how it intends to reduce its risk exposure.

   c. Review Underwriting and Investment Exhibit to determine which lines of business may have been under reserved at the prior year-end.

   d. Review the health entity's health insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific features and benefits.

   e. Review the health entity's risk-based capital filing to better understand the types of risk and risk management techniques being used, such as the types of managed care arrangements being used.

   f. Contact the policy forms section of the insurance department and inquire as to whether the health entity has filed any new and unusual health policy forms during the past year.

   g. Review the health entity's description of the valuation standards used in calculating the additional contract reserves (which is required to be attached to and filed with the Annual Financial Statement) and consider whether the reserve bases, interest rates, and/or methods appear reasonable.

   h. Contact the qualified actuary who signed the health entity's actuarial opinion to discuss the nature and scope of the health reserve valuation procedures performed.

   i. Request a copy of the qualified actuary's actuarial memorandum and review the actuary's comments regarding the analysis performed and conclusions reached regarding health reserves.

   j. Review the ratio of claims unpaid plus aggregate health reserve to incurred claims by line of business for past years to determine unusual fluctuations or trends between years.

   k. Compare the ratio of claims unpaid plus aggregate health reserve to incurred claims to similar companies in the industry to determine any significant deviations from the industry average.

   l. Obtain information from the health entity regarding health claims paid after year-end which were incurred prior to year-end and test the reasonableness of the year-end claim liabilities established by the health entity.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding health reserves based on the additional procedures performed in the Level 3 Procedures.

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

- ☐ Contact the health entity seeking explanations or additional information
- ☐ Require additional interim reporting from the health entity
- ☐ Refer concerns to examination section for targeted examination
- ☐ Engage independent actuary to review health entity's reserves and liabilities
- ☐ Meet with the health entity's management
- ☐ Obtain a corrective plan from the health entity

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IV. Level 3 Procedures – C.3. Health Reserves and Liabilities

☐ Other (explain)

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IV. Level 3 Procedures– C.4. Other Provider Liabilities

1. If withhold and bonuses arrangements are significant consider (Level 2 Annual Procedure #1):
   a. Requesting information concerning the specific contract provisions of the primary bonuses and withhold arrangements that the health entity is using.
   b. Requesting withheld and bonus liability amounts (included in "Accrued medical incentive pool and bonus payments" from Page 3, Column 3, Line 2) for the top five provider groups.
   c. Reviewing the actuarial opinion to determine if potential provider insolvencies were considered when determining the reserves and liabilities.
   d. Reviewing the actuarial opinion to determine if the provider's financial strength was or was not reviewed or excluded by the opining actuary.
   e. Contacting the qualified actuary who signed the insurer's actuarial opinion to discuss the nature and scope of the review of the provider contracts.

2. If amounts reported for bonuses and withholds in the entity's Risk-Based Capital filing appear to be potentially inconsistent with what is reported in the annual statement filing, request that the health entity provide an explanation (Level 2 Annual Procedure #2). If further analysis indicates that there is a disconnect between the two filings, request that the entity amend whichever filing is incorrect.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding health reserves based on the additional procedures performed in the Level 3 Procedures.

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

- ☐ Contact the health entity seeking explanations or additional contract information
- ☐ Require additional interim reporting from the health entity
- ☐ Speak to the opining actuary concerning any concerns he or she may have had
- ☐ Refer concerns to examination section for targeted examination
- ☐ Meet with the health entity's management
- ☐ Obtain a filing from the health entity
- ☐ Other (explain)

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IV. Level 3 Procedures – C.5. Income Statement and Surplus

1. If there are concerns regarding the health entity's primary operating ratios, (Level 2 Annual Procedures #1 & #2), consider performing one or more of the following procedures:
   a. Review the Analysis of Operations by Line of Business to determine which lines of business were profitable for the health entity and which lines of business generated a loss.
   b. Compare the combined ratios on each of the lines of business with approximate industry averages by line of business. Determine which lines of business the health entity is most successful in, and which lines of business the health entity could improve upon the most to become more profitable.
   c. Compare each of the primary operating ratios for the current period with the prior periods to determine any unusual fluctuations or trends between years.
   d. Compare all of the income and expense items from the revenues and expenses section of the Company Profile Reports to determine any unusual fluctuations or trends between years.
   e. Compare the current year combined ratios on each line of business with the prior year combined ratios by line of business to determine where the health entity experienced the most significant changes.
   f. Compare the health entity's actual results against projections. Determine any variances and request additional information for those areas where unfavorable variances exist. If material differences exist, request updated projections based upon revised assumptions.

2. If there are concerns regarding the health entity's operating performance based upon other indicators (Level 2 Annual Procedure #3), consider performing one or more of the following procedures:
   a. Review the health entity's investment yield ratio for unusual fluctuations and trends between years.
   b. Compare the investment yield ratio to the industry average investment yield to determine any significant deviation from the industry average.
   c. Review the detail of investment income in the Exhibit of Investment Income and the detail of realized gains or (losses) in the Exhibit of Realized Gains (Losses) for reasonableness.
   d. Compare the ratio of return on capital and surplus to the industry average return on capital and surplus to determine any significant deviation from industry average.
   e. Review the components of the Statement of Revenues and Expenses line item aggregate write-ins for other health care related revenues for reasonableness.
   f. Review the components of the Statement of Revenues and Expenses line item aggregate write-ins for other income or expenses for reasonableness.

3. If there are concerns regarding changes in the volume of premiums or changes in the health entity's product mix (Level 2 Annual Procedure #4), consider performing one or more of the following procedures:
   a. Determine any lines of business which have experienced a significant increase or decrease in premium writings.
      i. Determine if the changes are consistent with the health entity's most recent projections and business plan. Request additional information for variances not discussed in the most recent plan.
      ii. For an overall increase in premium, obtain specific information on when additional funds are expected to be deposited into the health entity to support the growth.

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iii. For an overall decrease, determine the health entity's plans for addressing its expense structure under its new premium base.

b. In new, or increasing lines of business, determine whether the health entity has the expertise (systems, underwriting, claims and reserving) needed. (Consider reviewing the health entity's Management's Discussion and Analysis and or seeking additional information from the health entity to determine the health entity's expertise in the lines of business written.)

c. If the health entity has entered a new region or has significantly increased the business written in an existing region, request information on how the health entity establishes product prices in those regions, the provider contracts used by the health entity in that region and a discussion of the health entity's future expected changes in the region. Compare this information with information available from the health entity's competitors.

4. If there are concerns regarding whether the health entity may be excessively leveraged (Level 2 Annual Procedure #5), consider performing one or more of the following procedures:

a. Request information from the health entity on how it shares risk with other entities in order to minimize the overall underwriting risk to the health entity.

b. If long-tail business is being written by the health entity, consider the impact that a reserve shortfall could have on the health entity's overall leverage risk.

c. Consider requesting information from the health entity on how it intends to address its operating leverage issue.

5. If there are concerns regarding whether the health entity may be underpriced on one or more of its products (Level 2 Annual Procedure #6), consider performing one or more of the following procedures:

a. Determine if there any lines of business with a combined ratio greater than 105 percent.

b. Consider if the health entity is dependent upon investment income.

c. Determine whether a premium deficiency reserve has been established by the health entity on any products in question.

d. For lines of business for which a premium deficiency reserve has been established, request information monthly from the health entity that details estimates of how actual claims compare with expected claims, and details the estimated impact on the reserve established.

6. If there are concerns regarding the amount of the health entity's Medicare Part D business (Level 2 Annual Procedure #7), consider performing one or more of the following procedures:

a. Obtain and review information regarding the contracted benefits, premium and cost sharing with the Centers for Medicare and Medicaid Services.

b. Review the types of products being written, including any enhanced benefit products.

c. Request information on and review the assumptions for reserves, utilization and benefit costs projected in the development of the contract.

7. Review the procedures in the Risk-Based Capital Level 2 Annual Procedure. If there are concerns regarding the amount of the health entity's capital and surplus (Level 2 Annual Procedure #8), consider performing one or more of the following procedures:

a. Review the procedures in the Risk-Based Capital Level 2 Annual Procedure.

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b. If the health entity has outstanding surplus notes issued, review Note to Financial Statements #13 - Capital and Surplus, Shareholders Dividend Restrictions and Quasi-Reorganizations and consider the following:

   i. Date issued

   ii. Interest rate

   iii. Amount of note and current value

   iv. Interest paid-current year and in total

   v. Accrued interest

   vi. Date of maturity

   vii. Name of holder (and indication of whether holder is an affiliated entity)

   viii. Description of assets received

   ix. Repayment conditions or restrictions

c. If the health entity has outstanding debt issued, review Note to Financial Statements #11 - Debt and consider the following:

   i. Date issued

   ii. Interest rate

   iii. Amount of note and current value

   iv. Interest paid-current year and in total

   v. Accrued interest

   vi. Date of maturity

   vii. Name of holder (and indication of whether holder is an affiliated entity)

   viii. Description of assets received

   ix. Repayment conditions or restrictions

d. If capital or surplus notes were issued during the year, determine whether they were approved by the domiciliary state insurance department

e. If principal was repaid and/or interest was paid on surplus notes during the year, determine that the principal repayments and/or the interest payments were approved by the domiciliary state insurance department

f. If surplus notes represent a significant portion of capital and surplus, recalculate important ratios excluding the amount of surplus notes to determine the effect of surplus notes on the ratio results

g. Review the write-ins for special surplus funds and for other than special surplus funds for reasonableness

h. Review the Capital and Surplus Analysis (roll forward) in the Financial Profile Reports for unusual fluctuations or trends in the changes in the individual components of capital and surplus between years

i. Review the detail of unrealized gains or (losses) in Exhibit of Capital Gains (Losses) for reasonableness

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IV. Level 3 Procedures – C.5. Income Statement and Surplus

Summary and Conclusion

Develop and document an overall summary and conclusion regarding income statement and surplus based on the additional procedures performed in the Level 3 Procedures.

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

- ☐ Contact the health entity seeking explanations or additional information
- ☐ Obtain the health entity's business plan
- ☐ Require additional interim reporting from the health entity
- ☐ Refer concerns to examination section for targeted examination
- ☐ Meet with the health entity's management
- ☐ Obtain a corrective plan from the health entity
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

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IV. Level 3 Procedures – C.6. Risk Transfer Other Than Reinsurance

1. If there are concerns regarding the reporting entities' ASO and ASC arrangements, (Level 2 Annual Procedure #1), consider performing one or more of the following procedures:
   a. Request a listing of plans adminstered by the health entity.
   b. Request an aging schedule of receivables related to uninsured plans.
   c. Evaluate the adequacy of funds held for plans' claims and expenses.
   d. Evaluate the financial condition of the uninsured plans.
   e. Request a copy of the I.D. card used by members covered under ASO and ASC arrangments to determine potential exposure to financial risk and compliance penalties.

2. Determine whether the health entity has reported appropriate reserves (Level 2 Annual Procedure #2). Has a premium stabilization reserve been included in the reserve for rate credits or experience rating refunds on Part 2D of the Underwriting and Investment Exhibit line 4 in the annual statement?

3. Determine whether the health entity has properly reported amounts receivable relating to uninsured accident and health plans (ASO or ASC arrangements).
   a. Has the health entity reported ASO and/or ASC amounts in its Risk–Based Capital (RBC) filing (worksheet XR018) and not reported receivables or assets related to uninsured accident and health plans on its Annual Financial Statement?
   b. Has the health entity reported receivables or assets related to uninsured accident and health plans on its Annual Financial Statement and not reported ASO and/or ASC amounts in its RBC filing?
   c. Does the analyst believe that the asset receivables relating to uninsured accident and health plans on page 2 of the Annual or Quarterly Financial Statement have been netted against the liability on page 3 for amounts held under uninsured accident and health plans? One indication that these amounts have been netted would be if there was an uninsured receivable relating to uninsured accident and health plans" (Page 2, Column 3, Line 15) without a Liability for amounts held under uninsured accident and health plans (Page 3, Column 3, Line 20) or visa versa.
   d. If ASO and/or ASC contracts are indicated, have the Notes to Financial Statements failed to be completed with regard to the profitability to the health entity of uninsured accident and health plans and the uninsured portion of partially insured plans for which the health entity serves as an Administrative Services Only (ASO) or an Administrative Services Contract (ASC) plan administrator?
   e. Have disclosures been made in the Notes to Financial Statements regarding the possible uncollectibility of amounts receivable under uninsured plans?

4. If there are concerns about the reporting entities' capitation arrangements (Level 2 Annual Procedure #3), determine whether the health entity is recording transactions with providers.
   a. Has the health entity failed to complete Exhibit 7, Part 1 – Summary of Transactions with Providers?
   b. Does the health entity have capitation arrangements with providers?
      i. Has the health entity failed to file copies of provider agreements, if required, with the domiciliary commissioner?
      ii. If the health entity has capitation arrangements with providers did it fail to enter the appropriate information in the RBC filing (worksheet XR015)?

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c. Determine if capitation to groups or intermediaries reported in Exhibit 7 is actually disbursed or withheld by the health entity for future payment of claims as they are submitted.

d. Determine if the health entity pays or processes claims for the particpating providers of a capitated intermediary.

e. Request the most recent independent audited report of the intermediary (TPA or IPA). If not available, request the most recent annual report.

f. Obtain the opinion of an actuary attesting to the adequacy of claim reserves and claim adjustment expenses established for claims incurred and outstanding on business produced by the intermediaries, if available.

g. Review analyst notes or exam reports for the other companies using the same intermediaries if there is reason to believe problems exist with those entities.

h. Did the health entity fail to complete General Interrogatory Part 2 – Health Interrogatories in the Annual Financial Statement?

   i. Does the health entity have bonus/withhold arrangements with providers?

   ii. If the health entity has bonus/withhold arrangements with providers did it fail to enter the appropriate information in the RBC filing?

5. Determine if risk transfer arrangements with providers has had a negative impact on utilization. Review the Exhibit of Premiums, Enrollment, and Utilization in the annual statement and compare to prior years. Has utilization compared to membership increased?

6. Has the health entity failed to comply with state-specific laws, regulations, or guidelines regarding arrangements for risk transfer other than reinsurance?

7. If there are concerns regarding the reporting entities' contracts with providers (Level 2 Annual Procedure #4):

   a. Request a listing of provider groups contracting with the health entity.

   b. Review the Statement of Actuarial Opinion to determine if capitation arrangements were reviewed.

   c. Review the Statement of Actuarial Opinion to determine if the financial strength of contracting provider groups was reviewed.

   d. Evaluate the financial condition of the largest contracting provider groups.

8. If there is a concern about bonus/withhold arrangements with providers:

   a. Review bonus/withhold provisions of the provider contracts.

   b. Obtain detailed calculation of direct bonus and withhold payments, and accruals and those covering capitated arrangements.

   c. Evaluate the appropriateness of withhold distributions or bonus payments made to providers relative to contract provisions and the entity's underwriting results.

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IV. Level 3 Procedures – C.6. Risk Transfer Other Than Reinsurance

Summary and Conclusion

Develop and document an overall summary and conclusion regarding risk transfer other than reinsurance based on the additional procedures performed in the Level 3 Procedures.

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

- ☐ Contact the health entity seeking explanations or additional information
- ☐ Require additional interim reporting from the health entity
- ☐ Speak to the opining actuary to determine if there were any concerns with provider contracts or financial strength
- ☐ Meet with the health entity's management
- ☐ Obtain a corrective plan from the health entity
- ☐ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

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IV. Level 3 Procedures – C.7. Reinsurance

1. If there are concerns that the health entity's risk profile is not adequately supported by its reinsurance program (Level 2 Annual Procedure #1), consider completing one or more of the following procedures:

   a. Review, for each line of business included in the Analysis of Operations by Lines of Business, the trends in loss ratios for indications of deteriorating underwriting results.

   b. Obtain a copy of the health entity's A.M. Best Supplemental Ratings Questionnaire, if available, and review the reinsurance section.

   Briefly scan the individual reinsurers listed on Schedule S - Part 3 - Section 2.

   c. Determine if there are any significant new reinsurers known to engage in financial reinsurance transactions that may trigger concerns as to transfer of risk with respect to the health entity.

   d. 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.

2. If there are concerns regarding the health entity's accounting treatment for reinsurance ceded (Level 2 Annual Procedure #2), consider further investigating whether specific reinsurers classified as authorized on Schedule S - Part 3 – Section 2 are, in fact, authorized.

   a. Select the 5 largest individual reinsurers based on the total reinsurance recoverables amount and determine that they are authorized.

   b. On a test basis, as considered necessary, select a sample from among the remaining reinsurers and determine that they are authorized.

3. If there are concerns regarding the collectibility of reinsurance recoverables from significant individual reinsurers (Level 2 Annual Procedure #3), consider completing one or more of the following procedures:

   a. Review the analysis and supporting documentation that is already available within the department (i.e., examination reports, recent analysis, current financial statements, etc.).

   b. Determine the current ratings of the reinsurer from the major rating agencies and investigate significant changes during the past twelve months.

   c. Review information about the reinsurer available from industry analysts and benchmark capital adequacy with top performers and peer groups.

   d. Request a copy of the health entity's A.M. Best Supplemental Ratings Questionnaire, if available, and review the reinsurance section for unusual items.

   e. Obtain and review the Annual Audited Financial Report and the Annual Financial Statement of the reinsurer for additional insight regarding collectibility.

   f. Review SEC filings of the reinsurer if applicable, for insight regarding collectibility.

   g. Obtain and review the actuarial opinion of the reinsurer for additional insight regarding collectibility.

   h. Determine whether adequate levels of collateral (letters of credit, etc.) are being maintained to secure outstanding losses.

   i. Contact the domiciliary state to determine whether any regulatory actions are pending against the reinsurer.

   j. Review the reinsurer's historical payment patterns of recoverables and comment on any findings.

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k. Review the NAIC I-SITE Regulatory Information Retrieval System (RIRS) Reports and review the status of any relevant multistate insurance company departmental supervisions, conservatorships, rehabilitations, and liquidations.

l. Determine whether the reinsurance transactions involved going "in and out" of treaties in such a manner that, in substance, the transactions are for financial reinsurance purposes.

m. Using the Global Receivership Information Database (GRID) within I-SITE, review the status of any relevant multistate, single state or alien reinsurance company departmental or jurisdictional supervised receivership (i.e., conservatorship, rehabilitation, or liquidation proceedings).

4. If there are concerns that reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another (Level 2 Annual Procedure #4), consider completing one or more of the following procedures:

   a. Obtain and review the underlying agreements that support the transaction(s) in question.

   b. Critically assess the substance of the transaction in terms of the following criteria:

      i. The transaction must be economic-based and at arm's length.

      ii. The transaction must result in the transfer of risk and represent a consummated or permanent act.

      iii. Any assets transferred to an affiliate must be transferred at fair value if an economic-based transaction.

      iv. In the case of a portfolio transfer involving an affiliate, the transaction may not be allowable under state law or may require prior regulatory approvals.

5. Determine whether pyramiding may be occurring that could cause significant collectibility risk to the health entity.

   a. Review the individual authorized reinsurers listed in Schedule S - Part 3 – Section 2. Are any of the reinsurers generally known to enter into significant retrocession agreements?

   b. If there are concerns that pyramiding exists, consider completing one or more of the following procedures, paying attention to declines in the overall quality level of reinsurers:

      i. Obtain the annual financial statement of selected, large reinsurers and determine the extent to which the reinsurer cedes business to other reinsurers.

      ii. If significant collectibility concerns surface as a result of these procedures, perform the procedures to evaluate collectibility (see Level 3 Procedure #3).

6. If there are concerns that transactions or agreements with reinsurance intermediaries exist (Level 2 Annual Procedure #5), obtain and review underlying documents relating to the use of the reinsurance intermediaries.

7. If there are concerns as to significant or unusual reinsurance transactions (Level 2 Annual Procedure #6), consider completing one or more of the following procedures:

   a. Obtain and review significant commutation agreements, portfolio transfer agreements, bulk or assumption reinsurance agreements, surplus relief or financial reinsurance agreements.

   b. Obtain and review supporting documentation for material transactions regarding non-renewal, cancellations or revisions of ceded reinsurance agreements.

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IV. Level 3 Procedures – C.7. Reinsurance

Summary and Conclusion

Develop and document an overall summary and conclusion regarding reinsurance based on the additional procedures performed in the Level 3 Procedures.

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

- ☐ Contact the health entity seeking explanations or additional information
- ☐ Obtain the health entity's business plan
- ☐ Require additional interim reporting from the health entity
- ☐ Refer concerns to examination section for targeted examination
- ☐ Engage an independent actuary or other reinsurance expert to review specific reinsurance contracts
- ☐ Meet with the health entity's management
- ☐ Obtain a corrective plan from the health entity
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 3 Procedure – C.8. Affiliated Transactions

1. If the health entity's corporate structure elevates concerns about affiliated transactions (Level 2 Annual Procedure #1), consider completing one or more of the following procedures:
   a. Obtain and review the financial statements and Audited Financial Report of the parent holding company (if available with Form B filing) in order to understand its debt and equity structure.
   b. Determine the level of debt service required by the holding company and gain an understanding of its primary sources of revenue.
   c. If the holding company's primary sources of revenue are dividends and fees from the health entity, evaluate these sources to determine their validity and reasonableness.
   d. Obtain and review SEC filings, if available.
   e. Request a parental guarantee from the health entity to maintain capital and surplus at a pre-determined level.

2. If there are concerns that major transactions with affiliates are <u>not</u> economic based or that they are not in compliance with regulatory guidelines (Level 2 Annual Procedure #2), consider completing one or more of the following procedures:
   a. Verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.
   b. If the concern relates to the economic substance of the transaction, obtain and review supporting documents.
   c. If the concern relates to the fair value used to record the transaction:
      i. Obtain and review an appraisal of the asset transferred.
      ii. Consider consulting an independent appraiser.
   d. If the concern involves a Management Agreement or Service Contract:
      i. Determine that appropriate regulatory approvals were received and that the health entity is complying with the terms as approved.
      ii. Obtain and review the supporting contract.
      iii. Determine that the amounts involved are reasonable approximations of actual costs.
      iv. Determine that actual amounts paid are in agreement with the supporting contract.
      v. Determine if allocation bases and results are periodically reviewed and adjusted.
      vi. For any agreement based on a cost plus formula or percent of premiums formula, request justification from the health entity for amounts in excess of the actual cost of providing the service.
      vii. For those services being performed by/for an affiliate, and which are also provided by unrelated third-party vendors (i.e., data processing, actuarial, investment management), contact such vendors or review vendor pricing schedules in order to determine the reasonableness of the intercompany transfer pricing level.
      viii. Evaluate whether any portion of such fees is in substance dividends that should be evaluated in the context of dividend regulations.

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IV. Level 3 Procedure – C.8. Affiliated Transactions

3. If investments in affiliates are significant or if there are concerns whether investments in affiliates are properly valued in accordance with statutory accounting practices (Level 2 Annual Procedures #3 and #4), consider completing one or more of the following procedures (some procedures may not apply if the subsidiary is a non-insurance company):
   a. Review details of affiliated investments as reported in Schedules A, B, and D, and compare with prior years.
   b. Obtain an understanding of the primary business activity of the affiliate and determine that such an investment complies with regulatory requirements.
   c. Review the components of investment income reflected on the Exhibit of Net Investment Income and the Exhibit of Capital Gains (Losses).
      i. Calculate the return on investment for current and prior years.
      ii. Review the components of investment income and determine whether the source is cash or merely an increase in accrued interest income.
      iii. If a substantial portion of investment income relates to an increase in the accrual, determine whether such revenue recognition is legitimate and reasonable.
      iv. Determine whether accrued interest on investments in affiliates have grown to a significant level.
   d. Obtain and review the Audited Financial Report and Annual Financial Statement of the affiliate, if available.
   e. Determine the current ratings of the affiliate from the major rating agencies, if available.
   f. Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.
   g. Obtain and review the Statement of Actuarial Opinion of the affiliate, if available.
   h. Contact the affiliate's primary regulator (if applicable) to determine whether any regulatory actions are pending against the affiliate.
   i. Using the Global Receivership Information Database (GRID) within I-Site, review the status of any relevant multi-state, single state or alien affiliated company departmental or jurisdictional supervised receivership (i.e., conservatorship, rehabilitation, or liquidation proceedings).

4. If there are concerns whether other affiliated transactions are legitimate and are properly accounted for (Level 2 Annual Procedure #4), consider completing one or more of the following procedures:
   a. If the concern relates to federal tax recoverables from a parent or affiliate:
      i. Obtain and review the financial statements of the parent or affiliate and evaluate any collectibility risk to the health entity.
      ii. Review tax-sharing agreement and verify that terms of the tax sharing agreement are being followed.
      iii. Verify that the amount recoverable from the prior year-end has been paid.
   b. Assemble a list of all affiliates and other related parties.
      i. Summarize the financial impact of each transaction.

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IV. Level 3 Procedure – C.8. Affiliated Transactions

ii. Identify any other unusual transactions and investigate for reasonableness.

iii. Determine that any required regulatory approvals were obtained.

5. If concern exists regarding downstream risk with affiliated provider intermediaries:

   a. Obtain and review the Audited Financial Report and Annual Financial Statement of the affiliate, if available.

   b. Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups, if available.

   c. Obtain and review the actuarial opinion of the affiliate, if available.

   d. Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding affiliated transactions based on the additional procedures performed in the Level 3 Procedures.

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

- ☐ Contact health entity seeking explanations or additional information
- ☐ Obtain the health entity's business plan
- ☐ Request consolidating holding company schedules
- ☐ Require additional interim reporting from the health entity
- ☐ Refer concerns to examination section for targeted examination
- ☐ Consult an independent appraiser to evaluate specific transactions involving significant transfers of assets
- ☐ Meet with the health entity's management
- ☐ Recommend that a cease and desist order and/or fines be issued for holding company violations that were detected during the review
- ☐ Obtain a corrective plan from the health entity
- ☐ Recommend that action be taken to reverse or modify contracts that are harmful to health entity
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 3 Procedures – C. 9. TPAs, IPAs and MGAs

1. If there are concerns due to a significant amount of the health entity's direct premiums being written through MGAs and TPAs (Level 2 Annual Procedure #1), consider performing one or more of the following procedures:

   a. Review Notes to Financial Statements #19 - Direct Premiums Written by Managing General Agents/Third Party Administrators (which lists individual MGAs and TPAs through which direct writings are greater than 5 percent of capital and surplus) to determine 1) which MGAs and TPAs are being utilized (and whether any of the MGAs or TPAs are affiliated with the health entity), 2) the types and amount of direct business written by the MGAs and TPAs, and 3) the types of authority granted to the MGAs and TPAs by the health entity.

   b. For the more significant MGAs and TPAs, request information from the health entity regarding commission rates and any other amounts paid to the MGAs and TPAs, review the information for reasonableness and compare the commission rates to those paid by the health entity to other agents.

   c. For more significant MGAs and TPAs, request information from the health entity to determine whether the business produced by the MGA or TPA is ceded to a particular reinsurer and, if so, whether the reinsurance was arranged by the MGA or TPA. If the MGA or TPA arranged for the reinsurance, determine whether the MGA or TPA is affiliated with the reinsurer and consider reviewing the reinsurance agreements to determine if the terms are reasonable.

   d. Determine whether the MGAs utilized by the health entity are properly licensed and whether the TPAs utilized by the health entity hold valid certificates of authority. (In some states, a health entity may utilize an MGA who is not licensed if biographical questionnaires have been submitted for each individual owning more than 10 percent of the MGA. If this provision is applicable and the MGA is not licensed, verify that the required biographical questionnaires have been submitted.)

   e. Request copies of the contracts between the health entity and its more significant MGAs and review to determine that the contracts include the minimum required provisions per Section 4 of the NAIC Model Managing General Agents Act and/or the applicable sections of the Insurance Code.

   f. Request copies of the contracts between the health entity and its more significant TPAs and review to determine that the contracts include the minimum required provisions per Sections 2, 4, 6, 7 and 8 of the NAIC Model Third Party Administrator Statute and/or the applicable sections of the Insurance Code.

   g. For the more significant MGAs utilized by the health entity, request and review the following:

      i. The most recent independent CPA audit of the MGA. If not available, request the most recent annual report.

      ii. If, with respect to business produced by the MGA, the MGA provides the health entity with claim reserve and/or claim adjustment expense reserve estimates that are incorporated into the health entity's financial statement, an opinion from an actuary employed or retained by the MGA attesting to the adequacy of such reserves.

      iii. Documentation supporting the health entity's periodic (at least semi-annual) on-site review of the MGAs underwriting and claims processing operations, as well as it's disaster recovery plan.

   h. If there are concerns regarding the business placed with the health entity by an MGA or TPA, consider determining if other health entities are utilizing the same MGA or TPA and perform the following:

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i. Compare the contract between the health entity and the MGA or TPA with the contracts between the other health entities and the MGA or TPA to determine whether they are similar (i.e., contain the same commission rates).

ii. Compare the health entity's claim and claim adjustment expense ratios on the business placed by the MGA or TPA with those of the other health entities utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the health entity may be receiving a disproportionate amount of "bad" business from the MGA or TPA.

iii. Review analyst notes or exam reports for the other companies for potential problems or adverse findings.

2. If there are concerns due to the proportion of claims pre-authorized or processed by a TPA or IPA consider performing one or more of the following procedures:

a. Request a listing of significant TPAs and IPAs that pre-authorize or process claims for the health entity, by line of health business (e.g., Pharmacy, Vision, Mental Health) and/or provider types (Hospitals, Physicians).

b. Determine whether the TPAs and IPAs utilized by the health entity are properly licensed to process, preauthorize or otherwise administrator claims.

c. For the more significant TPAs or IPAs utilized by the health entity, request and review the following:

i. Contracts between the health entity and the TPA or IPA to determine that the contracts include minimum provisions.

ii. The most recent independent CPA audit of the TPA or IPA. If not available, request the most recent annual report.

iii. If, with respect to business produced by the TPA or IPA, the TPA or IPA provides the health entity with claim reserve and/or claim adjustment expense reserve estimates that are incorporated into the health entity's financial statement, an opinion from an actuary employed or retained by the TPA or IPA attesting to the adequacy of such reserves.

iv. If the TPA or IPA provides paid claims data that is used by the health entity in establishing claim reserves, determine whether the health entity or the actuary providing the health entity's claim reserve certification tested data provided by the TPA or IPA.

v. Documentation supporting the health entity's periodic (at least semi-annual) on-site review of the TPAs or IPAs underwriting and claims processing operations, as well as its disaster recovery plan.

vi. Review analyst notes or exam reports for the other companies using the same TPA or IPA if there is reason to believe problems exist with those entities.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the health entity's use of TPAs, IPAs and MGAs based on the additional procedures performed in the Level 3 Procedures.

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

- ☐ Contact the health entity seeking explanations or additional information
- ☐ Obtain the health entity's business plan

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IV. Level 3 Procedures – C. 9. TPAs, IPAs and MGAs

- ☐ Require additional interim reporting from the health entity
- ☐ Refer concerns to the examination section for targeted examination
- ☐ Refer concerns regarding a particular TPA, IPA or MGA to the examination section for examination of the TPA, IPA or MGA
- ☐ Meet with the health entity's management
- ☐ Obtain a corrective plan from the health entity
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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V. Supplemental Procedures

A. Audited Financial Reports

B. Statement of Actuarial Opinion

C. Management's Discussion and Analysis

D. Holding Company Analysis

E. Form A

F. Form B

G. Form D

H. Form E or Other Required Information

I. Extraordinary Dividend/Distribution

V. Supplemental Procedures – A. Audited Financial Report

Audited Financial Report

1. Were the financial statements included in the Audited Financial Report prepared based on statutory accounting practices?

2. Were the financial statements included in the Audited Financial Report specific to the health entity rather than on a consolidated or combined basis?

3. If the financial statements included in the Audited Financial Report were prepared on a consolidated or combined basis, answer the following questions:

   a. Was this basis approved by the domiciliary commissioner upon application by the health entity due to a pooling or 100 percent reinsurance agreement with affiliates?

   b. Was a consolidating or combining worksheet included with the financial statements which:

      i. Shows amounts separately for each health entity (non-insurance operations may be shown on a combined or individual basis)?

      ii. Provides explanations for consolidating and eliminating entries?

      iii. Includes a reconciliation of any differences between the amounts shown for an individual health entity and the amounts per the health entities's Annual Financial Statement?

4. What type of opinion was issued by the CPA?

   ☐ Unqualified

   ☐ Unqualified with explanatory language added

   ☐ Qualified

   ☐ Adverse

   ☐ Disclaimer of opinion

5. If the opinion was other than unqualified, comment on the reasons for the deviation.

6. Do total assets, net income and surplus per the Audited Financial Report, agree with the amounts per the health entity's Annual Financial Statement?

7. If total assets, net income and/or surplus, do not agree with the amounts per the Annual Financial Statement, review the reconciliation of differences and comment on the differences and the reasons, based on the Notes to Financial Statements. Also, consider the impact of the audit adjustments made by the independent CPA on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (e.g., complete additional Level 3 Procedures for items impacted by the audit adjustments, etc.) on the Annual Financial Statement information.

8. Review the Notes to Financial Statements and comment on items of significance, including, but not limited to investments, other assets, reserves, reinsurance, transactions with affiliates, contingent liabilities and the summary of ownership and relationships with affiliated companies. Determine if the information included in Section A and Section B of the Annual Financial Statement Instructions for the Notes to Financial Statements have been addressed in the Audited Financial Report. Also, consider the impact, if any, of the information in the Notes to Financial Statements on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional

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analysis (e.g., complete portions of the Level 3 Procedures, etc.) on the Annual Financial Statement information.

9. If affiliated transactions are significant, consider comparing information regarding affiliated relationships and affiliated transactions per the Audited Financial Report to information reported by the health entity in the Annual Financial Statement and in the various holding company filings and comment on any discrepancies noted.

Internal Controls

10. Review the report of significant deficiencies in the health entity's internal control structure prepared by the CPA, if applicable (the report is only prepared if the health entity is a SEC registrant or significant deficiencies are reported in the Audited Financial Report) and comment on the deficiencies noted and the improvements made or proposed by the health entity to correct those deficiencies.

CPA's Letter of Qualifications

This section of the Audited Financial Report Procedures should be completed whenever there has been a change in the independent CPA from the prior year and may be completed annually whether or not there has been a change in independent CPA.

11. Does the CPA's letter of qualifications include the following?

    a. A statement that the CPA is independent with respect to the health entity and conforms to the standards of the profession?

    b. Information regarding the background and experience, including the experience in audits of health entities, of the staff assigned to the audit and whether each is a certified public accountant?

    c. A statement that the CPA understands that the domiciliary commissioner will be relying on the Audited Financial Report, and the CPA's opinion thereon, in the monitoring and regulation of the financial position of the health entity?

    d. A statement that the CPA is properly licensed by an appropriate state licensing authority?

    e. A statement that the CPA is in compliance with the following qualifications, which are specified in the NAIC *Annual Financial Statement Instructions* for Audited Financial Report:

        i. The CPA is in good standing with the American Institute of Certified Public Accountants and with all states in which the CPA is licensed to practice, or, for a Canadian or British health entity, is a chartered accountant?

        ii. The CPA conforms to the standards of the profession?

        iii. The partner or other person responsible for rendering the Annual Audited Financial Report has not acted in that capacity for more than seven consecutive years, and that following any such period of service, that person shall be disqualified from serving in that or a similar position for the same health entity for a period of two years?

        iv. The domiciliary commissioner has not ruled that the CPA is unqualified for purposes of expressing an opinion on the financial statements in the Annual Audited Financial Report?

    f. A statement that the CPA agrees to:

        i. Make available for review by the domiciliary state insurance department examiners, at any reasonable place designated by the domiciliary commissioner, all workpapers prepared in the conduct of the audit and any communications between the CPA and the

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health entity related to the audit at any reasonable place designated by the domiciliary commissioner?

ii. Retain the audit workpapers and communications until the domiciliary state insurance department has filed an examination report covering the period of the audit, but no longer than seven years from the date of the audit report?

iii. Allow copies of pertinent audit workpapers to be made and retained by the domiciliary state insurance department examiners?

12. Comment on any deviations between the statements in the CPA's letter of qualifications and the required statements per the NAIC *Annual Financial Statement Instructions* for health entities as summarized in step 1 above.

Change in CPA

13. Was the CPA who issued the opinion on the health entity's financial statements the same CPA who issued the opinion on the health entity's financial statements in the prior year?

14. If the CPA who issued the opinion on the health entity's financial statements this year is different from the CPA in the prior year:

    a. Was the domiciliary state insurance department notified of the change?

    b. Has a letter from the new CPA been filed with the domiciliary state insurance department which states that the CPA is aware of the provisions of the Insurance Code and the rules and regulations of the domiciliary state insurance department that relate to accounting and financial matters and which affirms that the CPA will express an opinion on the financial statements of the health entity in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that department, specifying such exceptions as the CPA may believe appropriate?

    c. Did the health entity file a letter with the domiciliary state insurance department stating whether, in the 24 months preceding the change in CPAs, there were any disagreements with the former CPA regarding accounting principles or practices, financial statement disclosure, or auditing scope or procedure which, if not resolved to the satisfaction of the former CPA, would have caused the CPA to make reference to the subject matter of the disagreement in connection with the CPA's opinion?

    d. With regard to the letter referred to in item 14.c., did the health entity also file a letter from the former CPA stating whether the CPA agrees with the statements regarding disagreements in the health entity's letter?

15. Comment on any disagreements noted in the letters from either the health entity or the former CPA.

16. Effective January 1, 2010, every insurer is required to have designated an Audit Committee, a percentage of whose members should be independent from the insurer depending upon premium volumes.

    a. Has the insurer established an Audit Committee?

    b. Does the Audit Committee membership meet independence requirements of the domicilary state insurance laws?

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V. Supplemental Procedures – A. Audited Financial Report

Summary and Conclusion

Develop and document an overall summary and conclusion regarding Audited Financial Report. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the Audited Financial Report under the specific circumstances involved. In documenting the conclusion, the analyst should comment specifically on the reasons for anything but a standard unqualified opinion.

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

- ☐ Contact health entity seeking explanations or additional information from the health entity or the independent CPA
- ☐ Obtain the health entity's business plan
- ☐ Require additional interim reporting from the health entity
- ☐ Refer concerns to examination section for targeted examination
- ☐ Meet with health entity's management
- ☐ Obtain a corrective plan from the health entity
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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V. Supplemental Procedures – B. Statement of Actuarial Opinion

The instructions to the Health Annual Financial Statement require a Statement of Actuarial Opinion (Opinion) to be attached to the Annual Financial Statement.

The Opinion must be issued by the Appointed Actuary who is a qualified health actuary appointed by the board of directors. For purposes of the health Actuarial Opinion, the Health Annual Statement Instructions provide a qualified health actuary means a member of the American Academy of Actuaries or a person recognized by the American Academy of Actuaries as qualified for such health actuarial valuation.

1. Does the Opinion include a completed Table of Key Indicators?

2. Does the Opinion state the actuary's qualifications and affiliation?

3. Was the actuary appointed by the board of directors (or its equivalent) or by a committee of the board by December 31 of the calendar year for which the Opinion was rendered.

4. Is this the same actuary who was appointed for the previous Opinion?

   a. If no, did the insurer notify the domiciliary state insurance regulator within 5 business days of the replacement? (When reviewing compliance with Section 1, note that the publication of the changes to the Health Actuarial Opinion Annual Statement Instructions in September 2009 may impact the timeliness of notification and compliance.)
   b. Within 10 business days of the above notification, did the insurer also provide an additional letter stating whether or not there were any disagreements with the former actuary during the preceding 24 months and also in writing request the former actuary a responsive letter as to whether the former actuary agrees or disagrees with the statements provided in the company's letter?

   c. Did the company provide the responsive letter from the replaced actuary?

5. Do the reserve amounts included in the Opinion agree with the amounts per the Annual Financial Statement?

6. If the Appointed Actuary has not examined the underlying records and has relied upon the data prepared by the health entity or a third party, is there a certification letter attached to the Opinion signed by the individual or firm who prepared such underlying data?

7. The Health Annual Statement Instructions list A through H as prescribed items. If the following items are included in the Annual Financial Statement and required by the Annual Statement Instructions, does the Opinion cover the following in the scope and opinion of amounts?

   <u>Per Annual Statement Instructions:</u>

   a. Claims unpaid (Page 3, Line 1).

   b. Accrued medical incentive pool and bonus payments (Page 3, Line 2).

   c. Unpaid claims adjustment expenses (Page 3, Line 3).

   d. Aggregate health policy reserves (Page 3, Line 4 including unearned premium reserves and additional policy reserves from the Underwriting and Investment Exhibit – Part 2D.

   e. Aggregate life policy reserves (Page 3, Line 5).

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f. Property/casualty unearned premium reserves (Page 3, Line 6).

g. Aggregate health claim reserves (Page 3, Line 7).

h. Any actuarial reserves or liabilities not included in the items above.

Any examples of an item included in H above include the retrospective premium asset (Page 2, line 13.3):

If any of the above are no, what item(s) are missing?

8. Does the actuarial opinion state? ”In my opinion, the amounts carried in the balance sheet on account of the items identified above”:

   a. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles?

   b. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared?

   c. Meet the requirements of the laws of the state of domicile, and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed?

   d. Make good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements?

   e. Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the Annual Statement of the preceding year-end?

   f. Include appropriate provisions for all actuarial items that ought to be established?

   g. Was the Underwriting and Investment Exhibit – Part 2B reviewed for reasonableness and consistency with applicable Actuarial Standards of Practice?

      (In particular, item (g) should be prepared consistent with Actuarial Standard of Practice No. 5, “Incurred Health and Disability Claims”, section 3.6, “Follow-Up Studies.”)

9. Does the Opinion state, ”The Underwriting and Investment Exhibit – Part 2B was reviewed for reasonableness and consistency with the applicable Actuarial Standards of Practice”? (In particular, was it consistent with Actuarial Standard of Practice No. 5, “Incurred Health and Disability Claims”, Section 3.6, “Follow-Up Studies.”)

10. Does the Opinion state, “Actuarial methods, considerations, and analyses used in forming my opinion conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this statement of opinion”?

If an asset adequacy analysis was not required, do not proceed with the procedures for asset adequacy analysis (# 11, 12, & 13) and skip to the Summary and Conclusion.

11. If the Opinion was based on an asset adequacy analysis, did the actuary determine that the reserves were sufficient in light of the assets held to meet future policy obligations?

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V. Supplemental Procedures – B. Statement of Actuarial Opinion

12. If the Opinion was based on an asset adequacy analysis, based upon the judgment of the analyst and after reviewing the Opinion and Regulatory Asset Adequacy Issues Summary, if available, should the actuarial memorandum or other supporting documentation be requested from the health entity? If no, skip to the summary and conclusion.

13. Based on an asset adequacy analysis, does the actuarial memorandum or other supporting documentation include the following:

    a. For reserves:

        i. Product descriptions.
        ii. Source of liability in-force.
        iii. Reserve method and basis.
        iv. Investment reserves.
        v. Reinsurance arrangements.
        vi. Persistency of in-force business.

    b. For assets (if the actuarial opinion is based on an asset adequacy analysis that involved the direct analysis of investments):

        i. Portfolio descriptions.
        ii. Investment and disinvestment assumptions.
        iii. Source of asset data.
        iv. Asset valuation bases.

    c. For analysis basis:

        i. Methodology.
        ii. Rationale for inclusion/exclusion of different blocks of business and how pertinent risks were analyzed.
        iii. Rationale for degree of rigor in analyzing different blocks of business.
        iv. Criteria for determining asset adequacy.
        v. Effect of federal income taxes, reinsurance and other relevant factors such as dividends, commissions, etc.

    d. Summary of results.

    e. Conclusions.

    f. A statement that the actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Actuarial Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for the memorandum.

    g. Method for aggregating reserves and assets.

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V. Supplemental Procedures – B. Statement of Actuarial Opinion

Summary and Conclusion

Note any section where the Table of Key Indicators reflects that the actuary has not used the prescribed wording and summarize analysis performed. Summarize any pertinent comments by the qualified actuary. Develop and document an overall summary and conclusion regarding the Opinion, and if applicable, the actuarial memorandum. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst's judgment, are relevant to evaluating the Opinion and actuarial memorandum under the specific circumstances involved. If there are serious inadequacies they should be reviewed with the actuary involved. If the inadequacies are not adequately explained, the analyst should consider consulting the Actuarial Board of Counseling and Discipline, which provides guidance to the actuarial profession to improve the quality of actuarial activities.

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

- ☐ Contact the health entity seeking explanations or additional information from the health entity or the qualified actuary
- ☐ Obtain the health entity's business plan
- ☐ Require additional interim reporting from the health entity
- ☐ Refer concerns to examination section for targeted examination
- ☐ Consult with the in-house actuary
- ☐ Engage an independent actuary to review health entity's reserves
- ☐ Meet with the health entity's management
- ☐ Obtain a corrective plan from the health entity.
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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V. Supplemental Procedures – C. Management's Discussion and Analysis

1. Did the Management's Discussion and Analysis (MD&A) filed in accordance with the Annual Financial Statement Instructions include the following overall content?
   a. Discussion of short and long-term analysis of the business of the health entity.
   b. Discussion of the two-year period covered by the Annual Financial Statement including year-to-year comparisons.
   c. Reference to the Five-Year Historical Data Exhibit and other exhibits or schedules where trend information is relevant.
   d. Explanation of accounting policies applied, judgments made in their application and changes in assumptions or conditions that result in materially different reported results.
   e. Discussion of material events known to management that would cause reported financial information not to be necessarily indicative of future operating results or of future financial position.
2. Was the MD&A prepared on a non-consolidated basis? If no, does the domiciliary state permit audited consolidated financial statements, or does the health entity cede substantially all of its direct and assumed business to a pool?
3. Did the MD&A include a discussion regarding the health entity's results of operations?
   a. Describe any unusual or infrequent events, transactions, significant economic changes that materially impact income or other gains/losses in surplus, or any significant components of income.
   b. Describe any known trends or uncertainties that could have a material impact on premiums, income or surplus.
   c. Describe known changes in the relationship of expenses and premiums.
   d. Discuss the extent to which material increases in premiums are due to increases in prices or volume of existing products or new products being sold.
4. Did the MD&A include a discussion regarding prospective information?
   a. Discuss known trends or uncertainties that are reasonably likely to impact liquidity, capital resources and the mix and cost of such resources.
   b. Discuss known trends or uncertainties that are reasonably likely to impact premiums, net income and surplus.
5. Did the MD&A include disclosure of reasons for material changes to line items or discussion and quantification of the contribution of two or more factors to such material changes?
6. Did the MD&A include a discussion on liquidity, asset/liability matching and capital resources?
   a. Indicate those balance sheet, income statement, or cash flow items which the health entity believes may be indicators of its liquidity condition.
   b. Discuss the nature and extent of restrictions on the ability of subsidiaries to transfer funds to the health entity and the impact such restrictions may have on the ability of the health entity to meet cash obligations.
   c. Identify any known trends, demands, commitments, events, or uncertainties that are reasonably likely to result in material changes in the health entity's liquidity. If any are identified, describe the course of action taken by the health entity to remedy a decline in liquidity.

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d. Describe internal and external sources of capital available to improve liquidity and any material unused sources of liquid assets.

e. Describe any material trends in the health entity's capital resources including any material changes in the mix or relative cost of such resources.

f. Discuss cash flows from investing and financing.

g. Discuss off-balance sheet financing if liquidity is dependent on such arrangements.

h. Disclose circumstances that materially effect liquidity, such as market price changes, economic declines, defaults on guarantees, etc.

7. Did the MD&A include a discussion on those items that affect the volatility of loss reserves (property/casualty only)?

8. Did the MD&A include a discussion on off-balance sheet arrangements?

a. Discuss off-balance sheet arrangements and transactions with limited purpose entities.

b. Describe the extent of the health entity's reliance on off-balance sheet arrangements.

c. Disclose uncertainties where contingencies inherent in the arrangements are reasonably likely to affect the continued availability of a material historical source of liquidity and finance.

9. Did the MD&A include a discussion on participation in high yield financings, highly leveraged transactions or non-investment grade loans and investments?

a. Identify transactions or investments and the nature and extent of the health entity's involvement in such transactions or investments, if participation or involvement is reasonably likely to have a material effect on financial condition or results of operations.

b. Describe additional risks to the health entity as well as associated fees and recognized losses.

c. Describe the health entity's judgment as to the material effect, if any, on the financial condition of the health entity.

10. Did the MD&A include a discussion on preliminary merger/acquisition negotiations, where disclosure is otherwise required or has been made by or on behalf of the health entity?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding MD&A. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating MD&A under the specific circumstances involved.

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

- ☐ If the health entity's MD&A is not sufficient, request the health entity re-submit the MD&A with more disclosure
- ☐ Obtain the health entity's business plan
- ☐ Require additional interim reporting from the health entity
- ☐ Refer concerns to examination section for targeted examination
- ☐ Consult with the in-house actuary
- ☐ Meet with the health entity's management

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V. Supplemental Procedures – C. Management's Discussion and Analysis

☐ Obtain a corrective plan from the health entity

☐ Other (explain)

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Comments as a result of supervisory review.

Reviewer _____ Date _____

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V. Supplemental Procedures – D. Holding Company Analysis

Special Note: The following procedures may be completed in part or in total at the discretion of the analyst depending on the level of concern, the area in which the risk was identified, and the degree of interdependence within the holding company entities.

Identify and Understand the Holding Company Structure

1. Identify the organization structure (e.g., public, non-public, mutual, etc.).

2. Evaluate the health entity's statutory Schedule Y, Notes to Financial Statements, and the GAAP financial filings of the holding company. Identify and understand the following:
   - Ultimate controlling entity or person(s)
   - Intermediate holding companies
   - Insurance vs. non-insurance entities
   - Ownership structure

3. Review the health entity's General Interrogatories Part 1, #8.1 through #8.4 and identify other regulatory bodies that have authority over the group: Federal Reserve, Office of the Comptroller of the Currency, Office of Thrift Supervision, etc.).

   Identify the following:
   - Controlling federal regulatory services agency
   - Any federally regulated action taken
   - Any communication between state and federal regulators that has been planned or initiated

4. Utilize the following financial filings to summarize the group's background:
   - SEC filings (if applicable)
   - Management's Discussion and Analysis
   - Statutory and GAAP Auditor's Report(s)
   - Statutory filings including combined filings and forms
   - Annual Report to Shareholders

5. Is the ultimate holding company a shell dedicated only to the insurance subsidiary's benefit? If so, identify the intermediate holding company to be analyzed.

6. Review the health entity's Jurat Page in the Annual Statutory Financial Statement of the domestic health entity and identify changes or trends of changes in officers and directors.

7. Review the health entity's Notes to Financial Statements, Interrogatories, and Holding Company Form B as well as recent examination reports. Identify and understand the following types of agreements the health entity has in place with the holding company and/or affiliates.
   - Management agreements
   - Third-Party agreements
   - Managing general agent agreements

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- Investment management pools
- Reinsurance agreements and pools
- Income tax pool

8. Describe the nature of the insurance subsidiaries interdependence on the holding company or affiliated entities for business operations or financial stability (e.g., employees, services provided, reinsurance and/or capital support in the near term).

9. Determine and describe the level of reputational risk that the holding company poses to the insurance subsidiaries.

10. Determine if income of the insurance subsidiaries is being used to finance holding company debt or other corporate initiatives.

11. Determine the level of holding company debt (e.g. corporate debt, borrowed money, and other types of debt) and its relative value to equity. If significant, summarize the following:
    - Type of debt
    - Terms of the debt covenants
    - Maturity schedules
    - Interest payment schedules
    - Ability to meet payments
    - Business purpose
    - Collateral

12. Determine the level of reliance on cash flows from subsidiaries to fund the holding company's interest and principal payments on the debt.

13. Have any subsidiaries of the 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 policyholders' surplus as well as the materiality of the insurance company dividends.

    b. Did the domiciliary Department of Insurance approve extraordinary dividends in order to support the holding company?

14. Understand and evaluate the method in which the group markets its products through the review of the legal entity's marketing plan.

15. Review the holding company and legal entity reports of the independent public accountant. Comment on the following:
    - Auditor's Opinion
    - Notes to Financial Statements
    - Management's Assessment on Internal Controls

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- Auditor's Assessment on Management's Assessment on Internal Controls
- Material differences between statutory and GAAP opinions where relevant

I-SITE Lead State Report and Interstate Coordination

16. Using the I-SITE Lead State Report, identify the lead state(s).

17. Identify a lead person or team of experts to create a contact list of key individuals within other interested states.

18. Establish a plan for communicating and coordinating with the lead state(s) if significant events or material concerns or prospective risk are identified.

19. Has your Department considered implementing the following methods of communication with other states, if significant events or material concerns are identified:
    - Establish a multi-state team of regulators
    - Establish a structure for obtaining updated information
    - Conference calls
    - Status e-mails
    - Disseminating relevant health entity documents and reports
    - Holding meetings with the health entity and relevant regulators

Evaluate the Financial Condition of the Holding Company Group

For the following financial assessment procedures, utilize the shareholders' report, combined financial statements, SEC filings, audited financial statements, media releases, confidential information from other regulatory bodies, and any other available sources.

Assets

20. Review the distribution of the invested assets in order to assess the overall asset quality and note any shift in the mix.

21. 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.

22. Review the distribution of the non-invested assets and assess the overall collectibility risk.

23. Review the level of goodwill and intangible assets. Determine the level of goodwill and intangible assets relative to the value of equity. If significant, summarize the following:
    - Nature of intangible assets
    - Change or trend in goodwill
    - Source of goodwill
    - Impairment of goodwill

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V. Supplemental Procedures – D. Holding Company Analysis

Liabilities (also see questions 12 & 13 regarding holding company debt)

24. Assess overall reserves and loss reserve development and note any unusual trends.

25. Have loss reserves shown an increasing pattern while writings have remained flat? If yes, explain any unusual changes.

26. Review the holding company's commitments and contingent liabilities.
    a. Has the holding company been subject to substantial complaints, class action lawsuits or other litigation or investigations? If so, document the nature and outcome of those matters.
    b. Are any contingencies expected to have a material impact on the financial condition of the holding company? If so, document whether the holding company estimated the potential costs and established a reserve liability.

27. Review all other liabilities (including off-balance sheet risks) and assess any material risks.

Shareholders' Equity (also see question 14 regarding dividends)

28. Review the holding company's statement of shareholders' equity. Has equity decreased from the prior year or deteriorated over the past three years? If yes, describe the reason(s) for the decline.

29. 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.

30. If publicly traded, review the changes in the 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.

31. Assess the holding company's sources of capital and access to capital markets.

Operations

32. Review the revenue of the group.
    a. Identify and understand the lines of business and the types of non-insurance business.
    b. Has the holding company entered into any new lines of business or types of non-insurance business or discontinued any business?
    c. Has the volume of business increased or decreased significantly over the prior year? If so, explain the reason for the change.

33. Review the holding company's gross and net writings to surplus leverage. Are the ratios within an acceptable range?

34. If the holding company group places a significant amount of gross business with reinsurers, assess the following regarding reinsurance agreements:
    - Risk Transfer
    - Collateralization to Unauthorized Reinsurance
    - Recent Reinsurance Transactions

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- Credit Quality of the Reinsurer
- Collectibility of Recoverables
- Level of Surplus Aid

Profitability

35. Review the holding company's Statement of Income.
    a. Did the holding company report material operating or net losses?
    b. Review the trend in net earnings. Have net earnings declined over the prior year or over the past five years?

36. Evaluate the earnings trend for insurance operations vs. non-insurance operations and document and determine the causes for weak and/or deteriorating performance by business segment.

37. Review investment income and realized capital gains and losses.
    a. Has net investment income increased or decreased significantly over the prior year? If so, explain the reason for the change.
    b. Document the amount of investment income that is attributed to dividends received from insurance subsidiaries.
    c. Document the annual investment yield. Has the yield decreased materially over the prior year? If so, explain the reason for the change.
    d. Review the components of investment income. Has investment income from any asset category changed significantly over the prior year? If so, explain the reason for the change.
    e. Did the holding company report material realized capital gains/losses? If so, identify the cause of the loss.

38. Review all other sources of revenue and note any material changes or weaknesses.

39. Review benefits and expenses.
    a. Have insurance policy losses increased or decreased substantially over the prior year? If so, explain the reason for the change.
    b. Have administrative and other expenses increased significantly over the prior year? If so, explain the reason for the change.
    c. Summarize the loss and expense ratios by line of business and review the trend.

40. Has the holding company reported any non-recurring revenues or expenses that materially inflate or reduce earnings? If so, describe the reason for the revenue or expense.

41. Did the holding company report income or losses from discontinued operations? If so, summarize the nature of those operations and evaluate the earnings from those operations.

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V. Supplemental Procedures – D. Holding Company Analysis

Cash Flow

42. Examine Cash Flow.
    a. Has there been a negative trend in operating activities over the past five years?
    b. Has there been a negative trend in investing activities over the past five years?
    c. Has there been a negative trend in financing activities over the past five years?

43. Evaluate any downstream payments.

International

44. If applicable, develop an overall understanding of the relevant regulatory requirements of the domiciliary country as well as the appropriate supervisory authority.

45. If necessary, identify the appropriate channels of communication with the supervisory authority.

46. Ensure proper monetary conversion of financial data to U.S. currency.

Supplemental Forms

47. If any of the following forms have been filed and the analyst has concerns, consider completing the applicable checklist.

	Analyst Recommendation
Form A (Acquisition of Control or Merger)	☐
Form B (Insurance Holding Company System)	☐
Form D (Prior Notice of a Transaction)	☐
Form E (Pre-Acquisition Notification or Other Required Information)	☐
Extraordinary Dividend/Distribution	☐

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company analysis. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures which, in the analyst's judgment, are relevant to evaluating holding company under the specific circumstances involved.

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

☐ Contact the health entity seeking explanations or additional information
☐ Obtain the health entity's business plan
☐ Require additional interim reporting from the health entity
☐ Refer concerns to examination section for targeted examination
☐ Meet with the health entity's management
☐ Obtain a corrective plan from the health entity

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V. Supplemental Procedures – D. Holding Company Analysis

☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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V. Supplemental Procedures – E. Form A

Special Note: The following procedures do not supercede state regulation, but are merely additional guidance an analyst may consider useful.

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. The review of these transactions may vary as some states may have regulations that differ for Form A.

1. Review the NAIC's Form A database to determine whether or not the Form A is pending or has been approved, denied, or withdrawn in another state.

2. Perform a query of the Form A database on the name of the applicant, directors, executive officers or owners of 10 percent or more of the voting securities of the applicant to identify the nature of other filings made in other states by similar individuals.

3. Establish contacts with other states to discuss the status and/or disposition of the current and prior filings made with those states.

4. Does Form A provide a brief description of how control is to be acquired?

5. Does Form A contain the following information:
   - Name and address (legal residence for an individual or street address if not an individual) of the applicant
   - State the nature of the applicant's business operations for the past five years, if the applicant is not an individual
   - Describe the business to be performed by the applicant and its subsidiaries
   - Determine if the organization chart identifies and states the relationship of every member of the insurance holding company system, except for affiliates with total assets less than 0.5 percent of the total assets of the ultimate controlling person within the holding company system

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

7. Does 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?

8. If amounts will be borrowed, does 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? Although not specifically required, if amounts will be borrowed, are the sources of funds to be used to service the debt stated?

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V. Supplemental Procedures – E. Form A

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

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

11. Does Form A state the number of each class of shares of the health entity's voting securities that the applicant, its affiliates and any person plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was determined?

12. Does Form A state the amount of each class of any voting security of the health entity that is beneficially owned or concerning that there is a right to acquire beneficial ownership by the applicant, its affiliates or any person?

13. Does Form A give a full description of any contracts, arrangements or understandings with respect to any voting security of the health entity 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.

14. Does Form A describe any purchases of any voting securities of the health entity by the applicant, its affiliates or any person during the 12 calendar months preceding the filing of Form A?

15. Does Form A describe any recommendations to purchase any voting securities of the health entity made by the applicant, its affiliates or any person, or by anyone based upon interviews or the suggestion of the applicant, its affiliates or any person during the 12 calendar months preceding the filing of the Form A?

16. Does Form A describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the health entity for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers?

17. Does Form A summarize the financial statements and exhibits attached to the filing?

    - Audited Financial Statements of persons identified in Form A
    - 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
    - Management's assessment of internal controls accompanied by an independent public accountant's report to the effect that the applicant maintained effective internal control

18. Does Form A 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 health entity and of additional soliciting material relating thereto, any proposed employment,

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consultation, advisory or management contracts concerning the health entity, annual reports to the stockholders of the health entity and the applicant for the last two fiscal years, and any additional documents or papers required by Form A?

19. Does Form A contain the required signature and certification?

Assessment of the Change in Control

20. After the change of control, will the health entity be able to satisfy the requirements for the issuance of a license to write the classes of insurance for which it is presently licensed?

21. 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 Form E been filed?

22. Is the financial condition of any acquiring person such that it might jeopardize the financial stability of the health entity, or prejudice the interest of the health entity's policyholders?

23. Will dividends from the health entity be required to support debt payments of the applicant or the applicant's subsidiaries?

24. Are the competence, experience, and integrity of those persons who would control the operation of the health entity such that it would not be in the interest of the health entity's policyholders and of the public to permit the acquisition of control?

25. After the change in control, will the health entity's policyholders' surplus be reasonable in relation to its outstanding liabilities and adequate for its financial needs?

26. Review financial projections for both the applicant and the health entity to ensure that they are consistent with the description of the intended business plan of the health entity and other assertions and representations made in the Form A filing and are based on reasonable expectations.

27. 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 cash flows appear adequate to cover such obligations without relying heavily on cash flows from the health entity.

28. 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 health entity. Review these contracts to ensure that the terms are arms-length, fair and reasonable to the health entity.

29. 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.)?

30. Has the application been publicized to all interested persons both inside and outside of the insurance department in accordance with the department's policy or applicable laws?

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

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V. Supplemental Procedures – E. Form A

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

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form A. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating holding company Form A under the specific circumstances involved.

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

- ☐ Contact the health entity seeking explanations or additional information
- ☐ Obtain the health entity's business plan
- ☐ Require additional interim reporting from the health entity
- ☐ Refer concerns to examination section for targeted examination
- ☐ Meet with the health entity's management
- ☐ Obtain a corrective plan from the health entity
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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V. Supplemental Procedures – F. Form B

Special Note: The following procedures do not supercede state regulation, but are merely additional guidance an analyst may consider useful.

Form B – Insurance Holding Company System Annual Registration Statement

1. Did the registration statement, filed in accordance with the NAIC Model Holding Company System Regulatory Act, include the following current information?
   a. The capital structure, general financial condition, including the most recent Annual Financial Statement, ownership, and management of the health entity, and any person controlling the health entity.
   b. The identity and relationship of every member of the insurance holding company system, except affiliates with total assets equal to or less than 0.5 percent of the total assets of the ultimate controlling person within the holding company system.
   c. The following agreements in force and transactions currently outstanding or which have occurred during the last calendar year between the health entity and its affiliates:
      i. Loans, other investments, purchases, sales, or exchanges of securities of the affiliates by the health entity or vice versa, involving 0.5 percent or more of the registrant's admitted assets as of December 31, of the most recent prior year ended.
      ii. Purchases, sales, or exchange of assets involving 0.5 percent or more of registrant's admitted assets as of December 31, of the most recent prior year ended.
      iii. Transactions not in the ordinary course of business.
      iv. Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the health entity's assets to liability, involving 0.5 percent or more of registrant's admitted assets as of December 31 of the most recent prior year ended, other than insurance contracts entered into in the ordinary course of the health entity's business.
      v. All reinsurance or management agreements, service contracts, consolidated tax allocation agreements, and cost-sharing arrangements.
      vi. Dividends and other distributions to shareholders.
   d. Any pledge of the health entity's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.
   e. Other matters concerning transactions between registered health entity and any affiliates as may be included from time to time in any registration forms adopted or approved by the Commissioner.
   f. A summary outlining all items in the current registration statement representing changes from the prior registration statement (Form C).

2. If the response is yes to any of the questions in 1.c. - 1.e. above, did the health entity provide a description of the transaction or agreement, which would permit a proper evaluation by the Commissioner, 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.

3. Did each registered health entity properly report dividends and other distributions to shareholders in accordance with the following Model Holding Company System Regulatory Act requirements?

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a. Were all dividends and other distributions to shareholders reported within fifteen business days following the declaration thereof?

b. Were any dividends and other distributions to shareholders considered extraordinary?

c. If the answer to 3.b. above is yes, did the transaction receive proper regulatory approval?

4. Did any transaction, which occurred during the last calendar year involving the health entity and others in its holding company system, require prior regulatory approval?

a. Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments where the transactions equal or exceed:

i. With respect to non-life insurers, the lesser of 3 percent of the health entity's admitted assets or 25 percent of policyholders' surplus as of December 31 of the most recent prior year ended.

ii. With respect to life insurers, 3 percent of the insurer's admitted assets as of December 31 of the most recent prior year ended.

b. Loans or extensions of credit to any person who is not an affiliate, where the health entity 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 health entity making the loans or extensions of credit provided the transactions are equal to or exceed:

i. With respect to non-life insurers, the lesser of 3 percent of the health entity's admitted assets or 25 percent of policyholders' surplus as of December 31 of the most recent prior year ended.

ii. With respect to life insurers, 3 percent of the health entity's admitted assets as of December 31 of the most recent prior year ended.

c. Reinsurance agreements or modifications thereto, in which the reinsurance premium or a change in the health entity's liabilities equals or exceeds 5 percent of the health entity's policyholders' surplus as of December 31 of the most recent prior year ended, including those agreements which may require, as consideration, the transfer of assets from a health entity to a non-affiliate, if an agreement or understanding exists between the health entity and non-affiliate that any portion of such assets will be transferred to one or more affiliates of the health entity.

d. All management agreements, service contracts, and cost-sharing arrangements.

e. Any material transactions, specified by regulation, which the Commissioner determines may adversely affect the interest of the health entity's policyholders.

f. If the answer to any of the questions in 4.a. - 4.e. above is yes, did the health entity receive proper prior regulatory approval?

5. Based upon a review of the registration statement, were any significant and/or unusual items noted, such as the following:

a. Persons holding 10 percent or more of any class of voting security who also have a history of transacting business of any kind directly or indirectly with the health entity.

b. Biographical information about directors or officers, which may elevate concerns such as convictions of crimes.

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

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effect upon the solvency or capital structure of the ultimate holding company, such as bankruptcy, receivership, or other corporate reorganization.

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.

e. Unusual information included in the holding company financial statements, such as:

i. Heavy reliance on dividends from the health entity to fund any holding company debt service requirements.

ii. Lenders of the holding company that are open depositories of the health entity.

iii. Evidence of any financial problems that may potentially impact the health entity.

6. Were there any inconsistencies between responses indicated in the Affiliated Transactions Annual Level 2 Procedures and the response in the Form B analysis?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form B. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating holding company Form B under the specific circumstances involved.

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

- ☐ Contact the health entity seeking explanations or additional information
- ☐ Obtain the health entity's business plan
- ☐ Require additional interim reporting from the health entity
- ☐ Refer concerns to examination section for targeted examination
- ☐ Meet with the health entity's management
- ☐ Obtain a corrective plan from the health entity
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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V. Supplemental Procedures – G. Form D

Special Note: The following procedures do not supercede state regulation, but are merely additional guidance an analyst may consider useful.

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.

1. If a material transaction has occurred, did the health entity file a Form D with their domestic state? (Section 5 of the NAIC Insurance Holding Company System Regulatory Act requires each health entity to give prior notice of certain proposed transactions.)

2. Did Form D include the following information for each party to the transaction:
   - 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 health entity filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the health entity seeking approval, or by the health entity 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
   - 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 health entity filing notice, by any party to the transaction, or by any affiliate of the health entity 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

5. If the transaction involves consideration other than cash, does the 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 which the health entity 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?

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V. Supplemental Procedures – G. Form D

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 the Form D provide a brief statement as to the effect of the transaction upon the health entity'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 health entity 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 health entity's surplus

9. If the transaction is a reinsurance agreement or modification thereto, 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 health entity 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 health entity's surplus

10. Determine whether 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)

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

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- ☐ A brief description of the accounting basis to be used in calculating each party's costs under the agreement
- ☐ A description of when amounts are settled and a provision for interest in the event that settlements are not made timely

14. Review Form D for any significant and/or unusual items or inconsistencies. Determine if the transaction appears fair and reasonable in relation to the following:
    a. For reinsurance agreements, are the general terms, settlement provision and pricing consistent with those of non-affiliated agreements?
    b. For management, service or cost-sharing agreement are the fees to be paid by/to the health entity 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: Health entities 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 health entity have adequate surplus upon completion of the transaction?
    e. Does the transaction comply with the NAIC *AP&P Manual*?
    f. Do unusual circumstances or concerns exist?

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

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form D. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures, which in the analyst's judgment are relevant to evaluating holding company Form D under the specific circumstances involved.

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

- ☐ Contact the health entity seeking explanations or additional information
- ☐ Obtain the health entity's business plan
- ☐ Require additional interim reporting from the health entity
- ☐ Refer concerns to examination section for targeted examination
- ☐ Meet with the health entity's management
- ☐ Obtain a corrective plan from the health entity
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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V. Supplemental Procedures – H. Form E or Other Required Information

Special Note: The following procedures do not supersede state regulation, but are merely additional guidance an analyst 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 persons 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 persons affiliated with the persons 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 persons 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 persons identified in questions 1 and 2 currently benefit from in this state
   - Historical market and market share data for each person identified in questions 1 and 2 for the past five years
   - The sources of the above 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?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form E or other required information. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating holding company Form E, or other required information, under the specific circumstances involved.

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

- Contact the health entity seeking explanations or additional information
- Obtain the health entity's business plan

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V. Supplemental Procedures – H. Form E or Other Required Information

- ❑ Require additional interim reporting from the health entity
- ❑ Meet with the health entity's management
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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V. Supplemental Procedures – I. Extraordinary Dividend/Distribution

Special Note: The following procedures do not supersede state regulation, but are merely additional guidance an analyst 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/Distribution 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.

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 health entity's surplus, the reasonableness of surplus in relation to the health entity's outstanding liabilities, and the adequacy of surplus relative to the health entity'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 health entity have adequate surplus?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Extraordinary Dividend/Distribution form. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the holding company Extraordinary Dividend/Distribution form under the specific circumstances involved.

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

- ❑ Contact the health entity seeking explanations or additional information
- ❑ Obtain the health entity's business plan
- ❑ Require additional interim reporting from the health entity
- ❑ Meet with the health entity's management

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V. Supplemental Procedures – I. Extraordinary Dividend/Distribution

❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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VI.A. Level 1 Quarterly Procedures

VI. A. Level 1 Quarterly Procedures

Background Analysis

1. Review the analysis performed on the health entity in the prior year and prior quarters.

   a. Indicate the state's priority designation or any prioritization tool result as of the last review and start of the current review:

      State's priority designation _____
      Scoring System Total _____
      Analyst Team System Validated Level _____
      RBC Ratio and RBC Trend Test _____

   b. Were there any issues or concerns noted in previous annual or quarterly analysis completed in the prior year? If yes, discuss the issues or concerns, the follow-up conducted, and include any correspondence with the insurer, along with any conclusions.

   c. Have any of the following been received or reviewed since the last analysis? If yes, complete or review any Level 2 or Supplemental Procedures that relate to these items and comment on them here:

      - ☐ Financial Examination Report
      - ☐ Audited Financial Report
      - ☐ Statement of Actuarial Opinion
      - ☐ MD&A
      - ☐ Holding Company Filing(s)

   d. As the domestic regulator, review the Insurer Profile Summary, including the Supervisory Plan, if applicable, and document any areas of concern that impact the current analysis.

2. Review any inter-department communication, as well as communication with other state insurance departments and the health entity. Note any unusual items or areas that indicate further review or follow-up is necessary.

3. Review General Interrogatories, Part 1, #4.1. Has the health entity been a party to a merger or consolidation? If yes, review the list of the companies involved in the merger/consolidation, noting any observations. Also, ensure Form A or additional filings have been approved.

4. Review General Interrogatories, Part 1, #7.1. Has the health entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? If yes, review the reason(s) stated for the revocation or suspension, noting any observations.

5. Are there any changes in the state's statutes and/or regulations that could impact the health entity's financial position or reporting? If yes, to the extent information is available, has the health entity failed to comply with the new state's statutes and regulations enacted during the period?

6. Review the most recent report from an Acceptable Rating Organization. Also note the current financial strength and credit rating and briefly discuss the explanation of the rating or any change in the rating.

7. Review any industry reports, news releases and emerging issues that have the potential to negatively impact the health entity.

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8. Review the most recent business plan and financial projections, if available from recent surveillance activity and if considered necessary based on the insurer's priority designation and financial condition.

   a. If significant changes in business plan or philosophy have occurred, assess the health entity's ability to attain the expectations of the business plan.

   b. Are actual results consistent with management's expectations?

Management Assessment

9. Review the Quarterly Financial Statement Jurat Page (page 1).

   a. Did the health entity fail to properly execute and notarize the Jurat Page?

   b. Has there been any change(s) in officers, directors or trustees since the previous Financial Statement (indicated by a "#" after the name)? If yes, indicate the positions in which the changes have occurred. Review the Biographical Affidavit(s) for any new officers, directors or trustees indicated above and note any areas of concern that would indicate further review is necessary.

      - ☐ President
      - ☐ Secretary
      - ☐ Treasurer
      - ☐ Vice Presidents (number: ____)
      - ☐ Directors or Trustees (number: ____)
      - ☐ Other

   c. Assess any significant corporate governance changes and determine whether these changes appear to indicate a shift in management philosophy, or whether management has made any changes in business culture or business plan.

Balance Sheet Assessment

10. Review the Quarterly Financial Statement Assets (page 2) and Liabilities, Capital and Surplus (page 3) and the Quarterly Financial Profile Report.

    a. Is capital and surplus below the statutory required minimum?

    b. Has capital and surplus increased by more than 40 percent or declined by more than 10 percent from the prior year-end? If yes, indicate the current quarter balance and the percentage change from the prior year-end.

    c. Has there been any change in surplus notes compared to the prior year-end? If yes, indicate the current and prior year-end balances and the amount of the change. Also, comment on any notes issued, principal or interest paid, or any other changes that have been made and whether any necessary approvals were obtained.

    d. Is the amount of any individual asset category, other than cash and invested assets, greater than 10 percent of total admitted assets? If yes, indicate the asset category and amount.

    e. Has any individual asset category, which exceeds 5 percent of total assets for either the current or prior year, changed by greater than +/-20 percent from the prior year-end? If yes, indicate the asset category, current balance, and the percentage change from the prior year-end.

    f. Is the amount of any individual liability category, other than claims unpaid, aggregate policy reserves and aggregate claim reserves, greater than 10 percent of total liabilities? If yes, indicate the liability category and amount.

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g. Has any individual liability category, which exceeds 5 percent of total liabilities for either the current or prior year, changed by greater than +/-20 percent from the prior year-end? If yes, indicate the liability category, current balance, and the percentage change from the prior year-end.

h. Have any of the asset and liquidity ratios in the Quarterly Financial Profile Report changed by greater than +/-10 percentage points from the prior year-end? If yes, indicate the ratio, current results, and the percentage point change from the prior year-end.

Operations Assessment

11. Review the Quarterly Financial Statement Statement of Revenue and Expenses (pages 4 and 5) and the Quarterly Financial Profile Report.

a. If the absolute value of net income (loss) exceeds 5 percent of capital and surplus, has net income (loss) decreased by more than 20 percent or increased by more than 40 percent from the prior year-to-date? If yes, indicate the current quarter balance and the percentage change from the prior year-to-date.

b. Has any individual income and expense category, for which the current or prior year balance exceeded 5 percent of capital and surplus, changed by more than +/-20 percent from the prior year-to-date? If yes, indicate the income or expense category, current balance, and the percentage change from the prior year-to-date.

c. Have earned premiums for any individual premium category changed by greater than +/-20 percent from the prior year-to-date? If yes, indicate the premium category, current year-to-date balance, and the percentage change from the prior year-to-date.

d. Are net unrealized capital gains(losses) greater than 5 percent of prior year-end capital and surplus?

e. Have any of the profitability ratios (medical loss, administrative expense, combined, profit margin) in the Financial Profile Report changed by greater than +/-10 percentage points from the prior year-end? If yes, indicate the ratio, current results, and the percentage point change from the prior year-end.

f. Have any of the leverage ratios in the Financial Profile Report changed by greater than +/-10 percentage points from the prior year-end? If yes, indicate the ratio, current results, and the percentage point change from the prior year-end.

g. Have any of the enrollment ratios in the Financial Profile Report changed by greater than +/-10 percentage points from the prior year-end? If yes, indicate the ratio, current results, and the percentage point change from the prior year-end.

Investment Practices

12. Review Schedule D – Part 1B, showing the acquisitions, dispositions and non-trading activity during the current period for bonds and preferred stocks by rating class.

a. Has the percentage of (i) investment or (ii) non-investment grade bonds to total bonds at the end of the quarter changed by +/- 10 percentage points or greater from the percentage owned at the beginning of the quarter?

b. Has the percentage of (i) investment or (ii) non-investment grade preferred stock to total preferred stock at the end of the quarter changed by +/- 10 percentage points or greater from the percentage owned at the beginning of the quarter?

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VI. A. Level 1 Quarterly Procedures

Review of Disclosures

13. Review the Quarterly Statement Notes to Financials, General Interrogatories and Supplemental Exhibits and Schedules noting any unusual responses.

Assessment of Results From Prioritization & Analytical Tools

14. Review the health entity's Quarterly Scoring System results.
    a. Indicate the health entity's total quarterly score.
    b. Provide an explanation on each individual ratio result that received a score of 50 points or more.

15. Review the Quarterly Financial Profile Report and provide an explanation for any unusual or significant fluctuations or trends.

16. Review any market conduct information including information available from the state's market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee), and the NAIC market analysis tools and databases (MAP, ETS, MARS, RIRS, SAD, MITS, and Complaints). The analyst should note any unusual items that translate into financial risks or indicate further review and/or additional communication is needed with the Department's market analysis staff.

Assessment of Latest Examination Report and Results

17. Review General Interrogatory #6 and determine if a financial examintation report was released by the domiciliary state since the last review.
    a. As of what balance sheet date is/was the latest financial examination of the health entity?
    b. As of what balance sheet date is the latest financial examination report available from either the state of domicile or the health entity?
    c. As of what release date is the latest financial examination report available from either the state of domicile or the health entity?
    d. Have any financial statement adjustments within the latest financial examination report not been accounted for in a subsequent financial statement filed with the Department?
    e. Have any of the recommendations within the latest financial examination report not been complied with?

If yes, or if follow-up was required from the review of the examination report in a previous analysis period, complete the following procedures.

    f. If the answers to 17.d. or 17.e. are yes, follow up with the health entity regarding the implementation of recommendations in the Financial Examination Report.
    g. During the review of the latest state examination report, the results from that examination and communication with the examiner-in-charge (for domestic insurers), did the analyst note any items or areas that indicate further review is warranted?
    h. Follow up and document on any management letter comments that should be addressed in the current period, if applicable.

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VI. A. Level 1 Quarterly Procedures

Recommendation for Further Analysis

Based on the Level 1 Procedures performed, do you recommend that any Level 2, 3 or Supplemental Procedures be completed? If yes, indicate the sections that the analyst recommends to be completed:

A. Perform Level 2 or Level 3 Procedures:

- All Sections ☐
- Investments ☐
- Other Assets ☐
- Health Reserves and Liabilities ☐
- Other Provider Liabilities ☐
- Income Statement and Surplus ☐
- Cash Flow and Liquidity ☐
- Risk Transfer Other Than Reinsurance ☐
- Reinsurance Only ☐
- Affiliated Transactions ☐
- TPAs, IPAs and MGAs ☐

B. Perform Supplemental Procedures:

- Audited Annual Financial Statement ☐
- Statement of Actuarial Opinion ☐
- Management's Discussion and Analysis ☐
- Holding Company Analysis ☐
  - Form A ☐
  - Form B ☐
  - Form D ☐
  - Form E (or Other Required Information) ☐
  - Extraordinary Dividends/Distributions ☐

C. Request and review the current business plan and financial projections.

i. If significant changes in the business plan or philosophy have occurred, assess the health entity's ability to attain these expectations.

ii. Determine if actual results are tracking with projection and note any significant variances and the reason(s).

Summary and Conclusion

After completion of any Level 2 or subordinate procedures, develop and document an overall summary and conclusion based on the findings. In developing a conclusion, the analyst should consider the above procedures, as well as any other factors that, in the analyst's judgment, are relevant to evaluating the health entity's overall financial condition. The summary and conclusion should include details regarding strengths and weaknesses. In addition, update the Insurer Profile Summary, including the Supervisory Plan, if applicable, for the results of the analysis performed.

Do you recommend that the health entity be designated a priority as a result of the procedures performed? If yes, indicate the recommended priority designation and rationale.

Describe the rationale for these recommendations.

Analyst _____ Date _____

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VI. A. Level 1 Quarterly Procedures

Comments as a result of supervisory review.

Reviewer _____ Date _____

Correspondence

The analyst should document any follow-up regarding the Level 1, 2, 3 and Supplemental Procedures.

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VI.B. Level 2 Quarterly Procedures

1. Investments
2. Other Assets
3. Health Reserves and Liabilities
4. Other Provider Liabilities
5. Income Statement and Surplus
6. Cash Flow and Liquidity
7. Risk Transfer Other Than Reinsurance
8. Reinsurance
9. Affiliated Transactions
10. TPAs, IPAs, and MGAs

VI. Level 2 Quarterly Procedures – B.1. Investments

1. Determine whether the health entity's investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type or issue.
   a. Are preferred stocks owned greater than 3 percent of total admitted assets?
   b. Are common stocks owned greater than 10 percent of total admitted assets?
   c. Are non-investment grade bonds owned greater than 3.5 percent of total admitted assets?
   d. Are mortgage loans and real estate, including home office real estate, owned greater than 5 percent of total admitted assets?
   e. Are other invested assets (Schedule BA) greater than 3 percent of total admitted assets?
   f. Are aggregate write-ins for invested assets greater than 3 percent of total admitted assets?
   g. Are investments in affiliates greater than 5 percent of total admitted assets?

2. Determine whether the health entity has significantly increased its holdings since the prior year-end in certain types of investments, which tend to be riskier and/or less liquid than publicly traded investment grade bonds and stocks and cash and short-term investments.
   a. If non-investment grade bonds exceed 3.5 percent of capital and surplus, have such investments increased by greater than 15 percent over the prior year-end?
   b. If total real estate and mortgage loans exceed 5 percent of capital and surplus, have such investments increased by greater than 15 percent over the prior year-end?
   c. If other invested assets (Schedule BA) exceed 5 percent of capital and surplus, have such investments increased by greater than 10 percent over the prior year-end?
   d. If aggregate write-ins for invested assets exceed 2 percent of capital and surplus, have such investments increased by greater than 20 percent over the prior year-end?
   e. If affiliated investments exceed 10 percent of capital and surplus, have such investments increased by greater than 20 percent over the prior year-end?

3. Determine whether the health entity invests in derivatives, which tend to be riskier and/or less liquid than publicly traded investment grade bonds, stocks, cash, and short-term investments. Review Schedule DB, all Parts, the write-ins for assets and liabilities, General Interrogatory #15.1 and #15.2, Notes to the Financial Statements #1 and #8 (if reported). Does the health entity engage in derivative activity?

4. Determine whether all securities owned are under the control of the health entity and in the health entity's possession. Review General Interrogatory, Part 1, #11.1. Were any of the assets of the health entity loaned, placed under option agreement or otherwise made available for use by another person (excluding securities under securities lending agreements)?

5. Determine whether securities owned have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office.
   a. Review General Interrogatory for Investments Part 1, #17.1. Has the Company failed to follow the filing requirements of the *Purposes and Procedures Manual of the NAIC Securities Valuation Office*?
   b. If the answer to 5.a above is yes, document the exceptions listed in General Interrogatory Part 1, #17.2.

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VI. Level 2 Quarterly Procedures – B.1. Investments

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating the health entity's investments under the specific circumstances involved.

Do you recommend that one or more of the Level 3 Procedures for Investments be completed?

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comment as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B.2. Other Assets

1. Review Uncollected Premiums.
   a. Is the ratio of uncollected premiums and agent's balances to capital and surplus greater than 20 percent?
   b. Has the receivable for uncollected premiums and agent's balances changed by greater than +/- 25 percent from the prior year-end?
   c. Has the level of non-admitted balances, if any, changed by greater than +/-25 percent from the prior year-end?

2. Review Health Care and Other Receivables.
   a. Is the ratio of health care and other receivables to capital and surplus greater than 5 percent?
   b. Have health care and other receivables changed by greater than +/- 20 percent since the prior year-end?
   c. Have non-admitted balances for health care and other receivables, if any, changed by greater than +/- 25 percent since the prior year-end?

3. Review the balance for amounts receivable relating to uninsured plans. Have receivables relating to uninsured plans changed by greater than +/- 10 percent since the prior year-end? If yes, indicate the amount.

4. Review Furniture and Equipment.
   a. Is the ratio of admitted furniture, equipment and supplies greater than 5 percent of capital and surplus?
   b. Has the admitted balance of furniture, equipment and supplies changed by greater than +/- 10 percent since the prior year-end?

5. Review EDP Equipment and Software.
   a. Is admitted EDP equipment and software greater than 3 percent of capital and surplus? (Refer to the Analyst Reference Guide).
   b. Has the admitted balance of EDP equipment and software changed by greater than +/- 25 percent since the prior year-end?

6. Are aggregate write-ins for other than invested assets greater than 10 percent of capital and surplus? If yes, document any concerns.

7. Has the health entity failed to comply with state-specific laws, regulations or guidelines for limitations related to Other Assets? If so, document any concerns.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding other assets. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the health entity's other assets under the specific circumstances involved.

Do you recommend that one or more of the Level 3 Procedures for Other Assets be completed?
Describe the rationale for this recommendation.

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VI. Level 2 Quarterly Procedures– B.2 Other Assets

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B.3. Health Reserves and Liabilities

1. Determine whether an understatement of health reserves would be significant.
   a. Is the ratio of net claims unpaid and net aggregate health reserves to capital and surplus greater than 300 percent?
   b. Would the current estimate of the health entity's claim unpaid and aggregate claim reserves drop the health entity's prior year Risk-Based Capital ratio below 200 percent?

2. Determine whether health policies appear to have been adequately reserved.
   a. Have claims unpaid, the aggregate policy reserves, or aggregate claim reserves changed by greater than +/- 10 percent from the prior year-end?
   b. Review the Underwriting and Investment Exhibit Analysis of Claims Unpaid - Prior Year – Net of Reinsurance. Has there been an increase or decrease in the claim reserve and claim liability as a percent of incurred claims of greater than +/- 10 percent since prior year-end?
   c. Review, by line of business, the year-to-date member months for the current and prior year in Exhibit of Premiums, Enrollment, and Utilization. Have member months for any line of business changed by greater than +/-20 percent from the prior year, same period?
   d. Has there been a significant point change in the medical loss ratio for any product line from the same period in the prior year (+/- 10 points)?
   e. Compare the direction of any changes in loss ratio to the direction of changes in membership. Is there an indication that increased loss ratios may be resulting from falling membership? (See Quarterly Financial Profile).
   f. Has the annual per member per month hospital and medical claims expense increased since last year-end and/or since last quarter more than similary situated health entities?

Summary and Conclusion

Develop and document overall summary and conclusion regarding health reserves. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating health reserves under the specific circumstances involved.

Do you recommend that one or more of the Level 3 Procedures for Health Reserves be completed?

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B.4. Other Provider Liabilities

1. Determine whether the health entity's use of bonus and withhold arrangements are significant.
   a. Is the liability for accrued medical incentive pool and bonus payments greater than 5 percent of the annualized total hospital and medical expenses?
   b. Is the ratio of incentive pool and withhold adjustments to total hospital and medical expense greater than 5 percent?

Summary and Conclusion

Develop and document overall summary and conclusion regarding the provider liability. In developing a conclusion, the analyst should consider the health entity's use of these types of arrangements.

Do you recommend that one or more of the Level 3 Procedures for Other Provider Liabilities be completed?

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comment as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B.5. Income Statement and Surplus

1. Determine whether concerns exist based on the primary operating ratios.
   a. Is the profit margin ratio less than 0 percent or greater than 10 percent?
   b. Is the combined ratio greater than 100 percent?
   c. Is the medical loss ratio greater than 85 percent?
   d. Is the administrative expense ratio greater than 15 percent?
   e. Based upon the health entity's primary lines of business, do the combined, medical loss, and administrative expense ratios appear reasonable?

2. Determine whether concerns exist based on the change in primary operating ratios when compared to the prior year-end.
   a. Has the profit margin ratio (See procedure 1a above) increased more than 5 points or decreased more than 10 points?
   b. Has the combined ratio (See procedure 1b above) increased more than 5 points or decreased more than 10 points?
   c. Has the medical loss ratio (See procedure 1c above) increased more than 5 points or decreased more than 10 points?
   d. Has the administrative expense ratio (See procedure 1d above) increased more than 3 points or decreased more than 5 points?

3. Determine whether concerns exist based on the change in primary operating ratios when compared to the prior year quarter.
   a. Has the profit margin ratio (See procedure 1a above) increased more than 5 points or decreased more than 10 points?
   b. Has the combined ratio (See procedure 1b above) increased more than 5 points or decreased more than 10 points?
   c. Has the medical loss ratio (See procedure 1c above) increased more than 5 points or decreased more than 10 points?
   d. Has the administrative expense ratio (See procedure 1d above) increased more than 3 points or decreased more than 5 points?

4. Determine whether concerns exist based on other profitability indicators.
   a. Is the investment yield less than 2 percent or greater than 6 percent? (See Quarterly Financial Profile Report.)
   b. Is the ratio of return on capital & surplus less than 5 percent or greater than 20 percent?
   c. Are net realized capital gains or losses more than (i) +/-3 percent of prior year capital & surplus or (ii) +/- 25 percent of year-to-date net income?

5. Determine whether concerns exist regarding changes in the volume of premium, enrollment levels or changes in the health entity's mix of business (lines of business written and/or geographic location of premiums written).
   a. Has there been a significant change (+/- 10 percent) in net premium income from the prior year-to-date?

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b. Has there been a significant change (+/- 10 percent) in enrollment from the prior year-end?

c. Have direct premiums written for any line of business changed by greater than +/-33 percent?

d. If premiums are being written in any new lines, do they account for more than 5 percent of the total earned premiums?

e. Review Schedule T, and determine if any direct business is being written in a state in which there were no prior writings.

6. Determine whether the health entity is excessively leveraged due to the volume of premiums written.

a. Are premiums and risk revenue to capital and surplus greater than:

i. 10 to 1 for HMOs?

Or

ii. 8 to 1 for non-HMOs?

b. Has the ratio of premiums and risk revenue (see procedure 6a) to capital and surplus increased more than 1.5 points or decreased more than 2 points?

7. Determine whether concerns exist regarding the pricing of the health entity's products.

a. Has premium per member per month increased by less than 10 percent from the prior year-end?

b. Is the change in claims per member per month less the change in premium and risk revenue per member per month greater than zero from the prior year-end?

8. Determine whether concerns exist regarding the amount of the health entity's capital and surplus.

a. Has capital and surplus decreased more than 10 percent or increased more than 40 percent from the prior year-end?

b. Did the health entity declare dividends to stockholders during the quarter?

i. If the answer to 8.b. above is yes, was the amount of the stockholder dividend at a level that required prior regulatory approval or notification?

ii. If the answer to 8.b.i. above is yes, did the health entity fail to obtain proper prior regulatory approvals?

c. Review surplus notes. Is the ratio of surplus notes to capital and surplus greater than 10 percent?

d. Are write-ins for other than surplus funds greater than 10 percent of capital & surplus?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the health entity's income statement and capital and surplus. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating the health entity's income statement and capital and surplus under the specific circumstances involved.

Do you recommend that one or more of the Level 3 Procedures for Income Statement and Capital & Surplus be completed?

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VI. Level 2 Quarterly Procedures – B.5. Income Statement and Surplus

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B.6. Cash Flow and Liquidity

1. Determine whether concerns exist regarding the health entity's overall level of liquidity.
   a. Is the change in liquid assets greater than 75 percent or less than -15 percent from the prior year-end?
   b. Is the liquid assets and receivables to current liabilities ratio less than 200 percent?
   c. Is the ratio of working capital to total assets less than 30 percent?
   d. Are affiliated investments and receivables greater than 20 percent of capital and surplus?

2. Determine whether concerns exist regarding the health entity's cash flow. Review the Statements of Cash Flow for the current quarter and prior year quarter.
   a. Is net cash from operations negative?
   b. Does the decline in net cash from operations from the prior year to date exceed 5 percent of capital and surplus?
   c. Is the ratio of benefits and loss related to payments to premiums collected net of reinsurance greater than 85 percent?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding cash flow and liquidity. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating cash flow and liquidity under the specific circumstances involved.

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B.7. Risk Transfer Other Than Reinsurance

1. Determine if uninsured volume or receivables is material.
   a. Are uninsured plan receivables +/-10 percent of capital and surplus?
   b. Has the uninsured receivables relating to uninsured accident and health plans increased or decreased by greater than 20 percent since last year-end?
   c. Does the health entity report any nonadmitted uninsured receivables relating to uninsured accident and health plans?
   d. If the health entity reported liabilities on page 3 of the quarterly statement for uninsured accident and health plans has the amount changed by greater than +/-25 percent from the prior year-end?
   e. If the health entity reported any nonadmitted balances in uninsured plan receivables, has the amount changed by greater than +/-25 percent from the prior year-end?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding risk transfer other than reinsurance. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the health entity's risk transfer other than reinsurance under the specific circumstances involved.

Do you recommend that one or more of the Level 3 Procedures for Risk Transfer Other Than Reinsurance be completed?

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B.8. Reinsurance

1. Determine whether amounts recoverable from reinsurers are significant.
   a. Are amounts recoverable from reinsurers greater than 10 percent of capital and surplus?
   b. If 1.a is yes, have amounts recoverable from reinsurers changed by (i) greater than +/-10 percent from the prior quarter or (ii) +/-35 percent from the prior year-end?

2. Determine whether any unusual reinsurance transactions were completed during the quarter.
   a. Review Schedule S – Ceded Reinsurance. Were any new reinsurers added since the prior quarter?
   b. Review General Interrogatory, Part 1, #1.1. Did the health entity experience any material transactions requiring the filing of Disclosure of Material Transactions with the state of domicile, as required by the Model Act?
   c. If the answer to 2.b is yes, did the health entity fail to make the appropriate filing of a Disclosure of Material Transactions with the State of Domicile (General Interrogatory #1.2)?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding reinsurance. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating reinsurance under the specific circumstances involved.

Do you recommend that one or more of the Level 3 Procedures for Reinsurance be completed?

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B.9. Affiliated Transactions

1. Determine whether the health entity is a member of a holding company group and, if so, whether the corporate structure, or any changes in the corporate structure, elevate concerns about affiliated transactions.
   a. Was the health entity a member of an Insurance Holding Company System as of the prior year-end?
   b. Has the Department directed the health entity to file a Holding Company registration statement?
   c. Did the health entity fail to file a registration statement in accordance with the Model Holding Company System Regulatory Act?
   d. Review Schedule Y, along with the General Interrogatories. Is there any information noted that contradicts the response to 1.a above?

If the answers to 1 a. – 1 d. are no, do not proceed with the Affiliated Transactions Procedures and skip to the next financial analysis topic.

   e. Review Notes to Financials. Did the health entity report a change in the health entity's capital structure?
   f. Review General Interrogatory #3. Have there been substantial changes in the organization chart?
   g. If the answer to 1.f. above is yes, and the change involved ownership of the health entity or a transaction with an affiliate, did the health entity fail to receive proper regulatory approvals?
   h. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company?
   i. Does the health entity have an agency or brokerage subsidiary?
   j. Are there any indications the corporate structure may include a hospital or that the reporting entity may be affiliated with any other type of medical provider(s) or provider intermediaries?
   k. Review General Interrogatory #5. Have there been changes to any management agreement in terms of the agreement or principals involved?

2. Determine whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines.
   a. Review the Summary of Operations, capital and surplus account line item dividends to stockholders.
      i. Is the amount of the stockholder dividend at a level that required prior regulatory approval or notification?
      ii. If the answer to 2.a.i. above is yes, did the health entity fail to obtain proper prior regulatory approvals?
   b. Review Schedule A - Part 2, Real Estate Acquired and Additions Made During the Current Quarter, and Schedule BA - Part 1, Long-Term Invested Assets Acquired and Additions Made During the Current Quarter?
      i. Did any such acquisitions involve an affiliate, or other related party?
      ii. If the answer to 2.b.i. above is yes, is the amount of the acquisition greater than 5 percent of capital and surplus?

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iii. If either answer to 2.b.i. and ii. above is yes, is there any reason to believe the sale was recorded on a basis other than fair value?

c. Review Schedule A - Part 3, Real Estate Disposed During the Current Quarter, and Schedule BA - Part 3, Long-Term Invested Assets Disposed , Transferred or Repaid During the Current Quarter.

i. Did any such dispositions involve an affiliate or other related party?

ii. If the answer to 2.c.i. above is yes, is the amount of the disposition greater than 5 percent of capital and surplus?

iii. If either answer to 2.c.i. or 2.c.ii. above is yes, is there any reason to believe the sale was recorded on a basis other than fair market value?

3. Review General Interrogatory #14. Determine whether investments in affiliates are significant.

a. Is the total of all investments in affiliates greater than 20 percent of capital and surplus?

b. Has the total of all investments in affiliates changed by greater than +/- 20 percent from the prior year-end?

c. Has there been any change in any category of affiliated investments greater than +/- 10 percent from the prior year-end?

4. Determine whether other affiliated transactions are legitimate and properly accounted for.

a. If federal and foreign income tax recoverables exceed 3 percent of total assets, have such recoverables changed by greater than (i) +/- 10% from the prior quarter or (ii) +/- 20 percent from the prior year-end?

b. Is the receivable from parent, subsidiaries and affiliates greater than 10 percent of capital and surplus?

c. Has the receivable from parent, subsidiaries and affiliates changed by greater than +/- 25 percent from the prior year-end?

d. Is the payable to parent, subsidiaries and affiliates greater than 10 percent of capital and surplus?

e. Has the payable to parent, subsidiaries and affiliates changed by greater than +/- 25 percent from the prior year-end?

f. Review Schedule E.

i. Were any open depositories a parent, subsidiary or affiliate?

ii. Based upon a review of the holding company financial statements, are there any holding company lenders that appear as open depositories of the health entity?

5. Are there any indications that significant transactions or unusual transactions involve an affiliate or other related party?

Summary and Conclusion

Develop and document overall summary and conclusion regarding affiliated transactions. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating affiliated transactions under the specific circumstances involved.

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VI. Level 2 Quarterly Procedures – B.9. Affiliated Transactions

Do you recommend that one or more of the Level 3 Procedures for Affiliated Transactions be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B.10. TPAs, IPAs and MGAs

1. Review General Interrogatories, Part 1, #5. Have there been any significant changes regarding the terms of any agreements with MGAs or TPAs?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding whether concerns exist due to a significant reliance on TPAs, IPAs and MGAs. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the health entity's use of TPAs, IPAs and MGAs under the specific circumstances involved.

Do you recommend that one or more of the Level 3 Procedures for TPAs, IPAs and MGAs be completed?

Describe rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VII. Guidance for Notes to Financial Statements

VII. Guidance for Notes to Financial Statements

Note 1- Summary of Significant Accounting Policies

This Note is split into three primary sections. The first section (A) focuses on the health entity's accounting policies compared to the *Accounting Practices and Procedures Manual (AP&P Manual)* and represents a disclosure that is required as a result of SSAP 1, *Disclosure of Accounting Policies, Risks, & Uncertainties, and Other Disclosures* (SSAP 1). The second section (B) is also required by SSAP 1 and is focused on the health entity's compliance with the NAIC *Annual Statement Instructions* and the *AP&P Manual* and the health entity's use of estimates. The third section (C) is also required by SSAP 1 and is focused on disclosure of all accounting policies that materially affect the assets, liabilities, capital and surplus or results of operations. These sections each provide information that an analyst should use in evaluating the accounting procedures of the health entity.

The first section (A) of this Note is broken into two different parts. The first part of the first section addresses accounting policies that differ from the *AP&P Manual*. The second part of the first section addresses accounting policies not discussed in the *AP&P Manual*.

The analyst should use the information provided in the first part of the first section (A) of this Note to determine if a health entity's financial position would be different if all the accounting rules of the NAIC were followed. Not only does the disclosure require the health entity to indicate permitted practices that have been provided by the state of domicile (a disclosure that was previously required by the model audit rule), but it also requires that prescribed differences be disclosed. Prescribed differences represent differences in the accounting methods that the state requires for all of its companies and the accounting methods of the NAIC *AP&P Manual*. This disclosure primarily assists regulators in reviewing the financial statements of foreign (non-domestic) companies. The analyst should consider the dollar amount of differences that exist in this disclosure in determining the priority given to a health entity. The analyst should obtain an understanding of the differences if the health entity's capital and surplus is reduced by 5 percent or greater as a result of applying the NAIC methods. A difference of this magnitude indicates that the health entity's financial position may vary significantly from what is reported using the accounting rules that have been established by the state of domicile.

The analyst should use the information provided in the second part of the first section (A) of this Note to determine if the health entity has any unusual transaction(s) for which the NAIC has not developed any standard accounting rules. Generally speaking, the *AP&P Manual* contains accounting guidance for most transactions common to the health entities. However, transactions that are unusual within the industry are not documented within the manual. The analyst should review the health entity's disclosure to obtain an understanding of the transaction(s). 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 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 health entity and its state of domicile.

The second section (B) of this Note requires the health entity to disclose its compliance with the NAIC *Annual Statement Instructions*. The NAIC *Annual Statement Instructions* are required to be followed by most insurance departments; 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 health entity has disclosed in this section in order to more clearly understand the accounting principles used by the health entity.

The analyst should use the information provided in the third section (C) of this Note to determine if the health entity has used any unusual accounting methods for its invested assets. Health entities are generally required to follow the *AP&P Manual* for invested assets. Any differences in accounting principles used must be disclosed by a health entity on an annual basis in the Summary Investment Schedule that is required under SSAP 1 and Appendix A-001, *Investments of Reporting Entities*. This section of this Note highlights the importance of the

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accounting methods used by a health entity for each of its invested assets. Although any material differences between the health entity'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.

Note 2 - Accounting Changes and Corrrection of Errors

Section (A) focuses on general changes in accounting principles and/or corrections of errors and is required as a result of SSAP 3, *Accounting Changes and Correction of Errors* (SSAP 3). Section (A) includes three parts that require additional details regarding the accounting changes and correction of errors. The information provided in section (A) of this Note can be helpful in assessing the continuing operations of the health entity.

The analyst should use the information provided in section (A) of this Note to determine the initial impact that any change in accounting principle or correction of an error had on the health entity's financial position and determine if further changes are expected based on the knowledge of the health entity and its business. In cases where the health entity's total capital and surplus decreased by 5 percent or greater, special attention should be given. The NAIC prescribes specific accounting rules to maintain consistency among health entities, 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 principle may highlight the exposure that a health entity has to a particular issue.

The analyst should also use the information provided in section (A) of this Note to understand any errors the health entity has corrected and determine the financial impact of the correction. In cases where the health entity's total capital and surplus decreased by 5 percent or greater, special attention should be given. SSAP 3 allows correction of errors to be reported as direct charges to surplus. SSAP 3 and SSAP 24, *Discontinued Operations and Extraordinary Operations* 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 health entity's ability to pay dividends. Even though the focus within the industry is on the capital and surplus of a health entity 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.

The analyst should also use the information provided in section (A) of this Note to understand any change in accounting estimates, which are also required by SSAP 3. The most important concept in reviewing this part of the Note is to determine the effect that the change will have on the health entity in the future. The Note does not require that the health entity 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.

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.

Note 3 - Business Combinations and Goodwill

This Note has four primary sections. Part A focuses on statutory purchases and Part B focusing on statutory mergers. Part C focuses on assumption reinsurance. The last section, Part D, focuses on impairment losses.

For the first part of business combinations, the statutory purchase method is addressed in Part A, and is probably the most common. The accounting guidance for the statutory purchase method is discussed in SSAP 68, *Business Combinations and Goodwill* (SSAP 68). One of the most significant aspects of SSAP 68 provides that under the statutory purchase method, the health entity records goodwill when the purchase price paid for the investment exceeds the statutory book value of that investment. Part A of this Note focuses on the goodwill and requires the health entity to disclose all pertintent information on the business combination, as long as the health entity reports

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unamortized goodwill as a component of the investment. This section of the Note does not require any information to be reported if the health entity 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 68 provides specific guidance on determining if an impairment in the asset has occurred. Because the disclosure for assumption reinsurance (Part C) is substantially the same as this section, it is not discussed further.

The second type of business combination, the statutory merger, is addressed in Part B of the Note. The accounting guidance for this type of business combination is also discussed in SSAP 68. The SSAP references SSAP 3, *Accounting Changes and Corrections of Errors*, 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 occured. Part B of this Note focuses on the transaction that occurred and requires the health entity to disclose all pertintent information related to the merger. This includes financial information on each of the companies before they 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 health entity.

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 the health entity has entered into. The analyst should use that information in those parts to determine if the value of any unamortized goodwill appears reasonable, but should also use the information in Part D of this Note to obtain a greater understanding of any impairments that have actually been recorded by the health entity. The analyst should use this information together to continue to determine if the value of the unamortized goodwill appears to be reasonable.

Note 4 - Discontinued Operations

This Note is split into five different sections which each require the health entity to report certain information on discontinued operations. The analyst should use the information provided in the Note to obtain a greater understanding of the operations that have been discontinued and determine the effect that the decision to discontinue could have on the current and future periods. It should be noted that SSAP 24, *Discontinued Operations and Extraordinary Operations* requires that a health entity report its results from discontinued operations consistent with its reporting of continuing operations (i.e., no separate line item presentation).

The first section requires a health entity to identify the segment of business that has been or will be discontinued. The second section requires a health entity to identify the date of disposal and the third section requires the health entity to disclose the manner of disposal. All of this information should be used to obtain a greater understanding of the transaction. Sometimes, the health entity's decision to dispose of a segment of business is voluntary, and may either allow the health entity to generate a significant amount of cash or may allow the health entity to focus on other segments of business. Other times, the health entity's decision to dispose of a segment of business may be involuntary and may be needed to generate cash to support the other lines of business or may be needed in order to reduce the amount of future losses the company is exposed to. 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 health entity, but may not always be in the best interests of all policyholders. The analyst should use the information provided to gain a greater understanding of why the segment was discontinued. The analyst should consider if the disposal was approved by the domiciliary state and if a plan of run-off was also approved.

As noted above, although the run-off of certain lines of business can alleviate certain problems of a health entity, it may not always be in the best interests of all policyholders. The analyst should consider the type of business being discontinued and the geographic locations of the business to better understand the potential problems that could develop from the run-off. Generally, run-off of business with longer tails represents a greater risk to health

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entities and should be reviewed more closely. However, run-off of shorter tail business still represents a risk to health entities because, in some cases, the run-off can lead to greater utilization. In all cases, the analyst should understand the assumptions used and the work that was performed to assure that the assets will be sufficient to run-off outstanding losses, such as that performed by a consulting actuary. However, in some cases, where an independent review of the payout pattern was not performed, the health entity may have obtained an irrevocable guarantee from its parent. The health entity may have also arranged for a portfolio transfer of the business through a reinsurance arrangement.

The fourth section requires a health entity to describe the remaining assets and liabilities of the segment at the balance sheet date. The fifth section requires a health entity to quantify the effect on the financial statements including the balance sheet and the income statement. The analyst should use the information provided in these sections to better understand the potential impact on the health entity. By using this information, the analyst will be able to determine if the business being discontinued is significant in terms of premium volume and reserve levels. Using this information, the analyst may be able to determine if the results of the discontinued operations will be positive or negative. The analyst should not only consider the positive impact that the discontinued operations may have on the profitability of the health entity, but also the impact that the decision will have on cash flow and liquidity. In making this determination, the analyst should also understand how the health entity has accounted for the transaction. As noted above, SSAP 24 requires that discontinued operations be reported with a health entity's continuing operations. Additionally, the risk the health entity is exposed to under the discontinuance is of utmost importance. In determining the financial impact that the transaction will have on continuing operations, the analyst must still consider the risks the health entity is still exposed to after discontinuance.

Note 5 - Investments

This Note is split into seven primary sections. The first section (A) focuses on the accounting for mortgage loans including mezzanine real estate loans and the allowance for credit losses as required as a result of SSAP 37, *Mortgage Loans* (SSAP 37). The second section (B) focuses on the recording of the investment in loans that have been recognized as impaired as required by SSAP 36, *Troubled Debt Restructuring* (SSAP 36). The third section (C) focuses on 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 39, *Reverse Mortgages* (SSAP 39). The fourth section (D) focuses on determining prepayment assumptions for yield calculations and the risk exposure in Loan-backed securities as required by SSAP 43R, *Revised Loan-backed and Structured Securities* (SSAP 43R). The fifth section (E) focuses on the health entity'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 91R, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities* (SSAP 91R). The sixth section (F) focuses on the 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. 40, *Real Estate Investments* (SSAP 40). The seventh section (G) focuses on 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 93, *Accounting for Low Income Housing Tax Credit Property Investments (SSAP93).* All seven sections of this Note include significant parts but each part of each section simply requires additional details. 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.

The information provided in the first section (A) of this Note can be helpful in quantifying the health entity's investment in mortgage loans, including mezzanine real estate loans, and assessing the impact of impaired loans. The analyst should use the information provided in this section to determine whether the health entity followed the guidelines as prescribed by SSAP 37 to record the carrying value of the loan and what allowances for credit losses on impaired loans has been made by the health entity.

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VII. Guidance for Notes to Financial Statements

The analyst should pay particular attention to the amount of mortgage loans deemed to be impaired. Under SSAP 37, a mortgage loan is considered to be impaired when, based on current information and events, it is probable that a health entity will be unable to collect all amounts due as stated in the contractual terms of the mortgage agreement. The analyst should note information the health entity provided for impaired loans including the total investment in impaired loans at the end of each period and the allowance for credit losses. The health entity should have also disclosed the amount of investment in impaired mortgage loans for which there is no related allowance for credit losses.

The health entity should have also 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.

The analyst should also 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.

The information provided in the second section (B) of this Note can be helpful in quantifying the health entity's investment in loans determined to be impaired. The analyst should use the information provided in this section to determine whether the health entity has recorded the investment in loans recognized as impaired as prescribed by SSAP 36.

The analyst should consider the information disclosed in this section to evaluate the health entity's investment in loans impaired and the terms agreed upon for debt restructuring. The analyst should note the amount of commitments, if any, to lend additional funds to debtors owing receivables whose terms have been modified in troubled debt restructuring. The health entity may accept cash, other assets, or an equity interest in the debtor in satisfaction of the debt though the value received is less than the amount of the debt, if the health entity concludes that it can maximize recovery of the loan.

The analyst should review the information provided in the third section (C) to determine whether the health entity followed the guidelines as prescribed by SSAP 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 note the methods and assumptions the health entity 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 set up by the health entity 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.

The analyst should consider the information provided in the fourth section (D) to gain an understanding of the health entity's assumptions in determining prepayment of loan-backed securities. The information should help the analyst determine how closely the health entity followed the principles of valuation and prepayment assumptions

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as prescribed by SSAP 43R. As described in SSAP 43R paragraphs 48f, 48g and 48h, insurers are also required to disclose certain aggregate information about securities with recognized other-than-temporary impairments and impaired securities (fair value is less than cost or amortized cost) for with 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 health entity 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 health entity should periodically review prepayment assumptions and cash flows and makes changes when necessary. In doing so, the health entity 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 health entity's assumptions, and develop more specific questions regarding the impact of the rate changes on the portfolio.

The analyst should use the information provided in the fifth section (E) to gain an understanding of the health entity'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 91R, 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 health entity but rather as short-term investments. The analyst should note 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 health entity 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. Per SSAP 91R, if the insurer has accepted collateral that is permitted by contract or custom to sell or repledge, regardless of whether the transaction is "on-balance sheet" or "off-balance sheet", the insurer should disclose certain information 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 aggregate fair value of all reinvested collateral. 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.

The information provided in the sixth section (F) of this Note can be helpful in quantifying the health entity's investment in real estate determined to be impaired. The analyst should use the information provided in this section to determine whether the health entity has recorded the investment in real estate recognized as impaired as prescribed by SSAP 40. Additionally, if the health entity 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 40. Real estate for some health entities can be significant and the information should be used by the analyst to gain a better understanding of what has lead to the impairment and the health entity's method for determining the value of the impairment. Section F also provides disclosure for the rare instances in which the health entity has engaged in the sale of an operation that focuses on improving and selling real estate.

The analyst should use the information provided in the seventh section (G) of this Note to gain an understanding a health entity's investment in LIHTC properties. The health entity is required by SSAP 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

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review. The health entity 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 percent of total admitted assets. In addition, the health entity is required to disclose any recognized impairments and the nature of any write-downs or reclassifications made during the year. The information can be helpful in the rare instances where health entities hold this type of investment to help to identify the extent of the health entity's exposure and any issues regarding impairments, write-downs or reclassifications.

The analyst should consider the information disclosed in this section to evaluate the health entity's investment in real estate impaired. 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 and the planned expenditures and recorded obligations for improvements.

Note 6 - Joint Ventures, Partnerships and Limited Liability Companies

This Note focuses on investments in joint ventures, partnerships and limited liability companies and is split into two primary sections. The first section (A) requires the health entity to disclose various information about investments in joint ventures, partnerships and limited liability companies that exceed 10 percent of the admitted assets of the health entity. The second section (B) requires the health entity to disclose specific information on the above types of investments that have become impaired.

The accounting guidance for the above types of investments is addressed in SSAP 48, *Joint Ventures, Partnerships and Limited Liability Companies* (SSAP 48). SSAP 48 defines a corporate joint venture as a corporation owned and operated by a small group (the joint venturers) as a separate and specific business or project for the mutual benefit of the members of the group. SSAP 48 defines a general partnership as an association in which each partner has unlimited liability and a limited liability company is a hybrid organization which falls between a corporation and a partnership whereby the owners have limited their individual 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 of these types of investments that are held by the health entity, 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 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 health entity's overall risk in these types of investments compared to its equity position.

Note 7- Investment Income

This Note is split into two primary sections. The first section (A) focuses on the health entity's basis for nonadmitting due and accrued investment income as required as a result of SSAP 34, *Investment Income Due and Accrued* (SSAP 34) and SSAP 99, *Accounting for Certain Securities Subsequent to an Other-Than-Temporary Impairment* (SSAP 99). The second section (B) discloses the amount the health entity nonadmits upon determining collectibility of due and accrued investment income. The information provided in both sections is helpful to the analyst in reviewing the financial statements and related exhibits and schedules for real estate, mortgage loans and long term bonds.

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VII. Guidance for Notes to Financial Statements

The analyst should use the information provided in section (A) to understand the health entity'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 defines investment income due as investment income earned and legally due to be paid to the health entity as a 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 health entity until subsequent to the reporting date. Investment income should be recorded as an asset on the balance sheet. However, the analyst should review SSAP 4, *Assets and Nonadmitted* Assets (SSAP 4) to obtain an understanding of the distinction between an asset that has a probable future economic benefit versus an asset that is unavailable to meet policyholder obligations due to encumbrances or third party interests. The nonadmitted asset should not be included on the balance sheet as well as the balance for investment income due and accrued.

To the extent the nonadmitted investment income is material, the analyst should question the collectibility of the remaining investment income due. The analyst should review SSAP 99 and SSAP 5, *Liabilities, Contingencies and Impairments of Assets* (SSAP 5) to obtain an understanding of the principle of asset impairment and the collection of investment income. The analyst should also review SSAP 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 uncollectible and should be written off and charged against investment income. Interest can be accrued on mortgage loans in default if interest is deemed collectible. But if interest is deemed uncollectible, 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 which has been determined to be collectible, all accrued interest should be reported as a nonadmitted asset.

Note 8 - Derivative Instruments

This Note contains separate information and accounting requirements based on the date of the derivative instrument transaction. For those derivative transactions entered into, or modified on or after January 1, 2003, SSAP 86, *Accounting for Derivative Instruments and Hedging Activities* (SSAP 86), will provide guidance for this Note. For derivative transactions prior to January 1, 2003, SSAP 31, *Derivative Instruments* (SSAP 31), will apply. Alternatively, an insurer may choose to apply SSAP 86 to all derivatives to which the insurer is a party as of January 1, 2003. In either case, the insurer is to disclose the transition approach that is being used.

<u>Disclosure Guidance for Derivative Transactions Occurring Prior to January 1, 2003</u>
This Note contains four sections. The first section (A) focuses on 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 31. The discussion provided in the first section (A) of this Note can be helpful in determining the insurer's risk exposure associated with its derivative investments. The second section (B) focuses on the insurer's objectives for holding or issuing derivative financial instruments and is also required under SSAP 31. The information provided in the second section (B) of this Note is useful in understanding the insurer's investment stategy in regards to its use of deriviative instuments. The third section (C) focuses on how each category of derivative instrument is reported in the financial statements and is also required by SSAP 31. The information provided in the third section (C) is helpful to the analyst in reviewing the financial statements and more specifically, the related schedules for derivatives and exhibits for investment income from derivatives and gains & losses on derivatives. The fourth section (D) focuses on the unrealized gains and losses resulting from derivatives that no longer qualify for hedge accounting. The information provided in the fourth section (D) assists the analyst in evaluating the portion of the unrealized gain or loss on derivatives that represents derivatives that no longer qualifying for hedge accounting.

Derivative instruments are often complex and involve substantial risk of loss. The analyst should use the discussion provided in the first section (A) of this Note to evaluate the impact of the derivative instruments on the

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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.

The analyst should use the information provided in the second 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 31 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 or liabilities or future cash flows for which the derivative transactions were entered into or issued to hedge against. See section III. Analyst Reference Guide B.1. Investments – Primer on Derivatives for further discussion of derivative instruments.

The analyst should consider the information disclosed in the third section (C) in conjunction with information provided 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 & losses. Accounting procedures for derivatives vary widely depending on the nature of the derivative. SSAP 31 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 percent of net investment income or if the insurer is experiencing capital losses on derivative instruments of more than 10 percent of capital and surplus. In cases where the insurer's total derivative instruments represent more than 10 percent of capital and surplus, special attention should also be given to this Note. See section IV Annual Procedures B.1. – Investments procedure # 9 for specific guidance in evaluating the materiality of an insurer's risk to derivatives.

<u>Disclosure Guidance for Derivative Transactions Occurring After January 1, 2003</u>
This Note contains six sections. The first section (A) focuses on 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 86. The discussion provided in the first section (A) of this Note can be helpful in determining the insurer's risk exposure associated with its derivative investments. The second section (B) focuses on the insurer's objectives for holding or issuing derivative financial instruments and is also required under SSAP 86. The information provided in the second section (B) of this Note is useful in understanding the insurer's investment stategy in regards to its use of deriviative instuments. The third section (C) focuses on how each category of derivative is reported in the financial statements and is also required by SSAP 86. The information provided in the third section (C) is helpful to the analyst in reviewing the financial statements and more specifically, the related schedules for derivatives and exhibits for investment income from derivatives and gains & losses on derivatives. The information provided in the fourth (D) and fifth (E) sections assist the analyst in evaluating the portion of the unrealized gain or loss on derivatives that represents derivatives excluded from the assessment of hedge effectiveness or no longer qualifying for hedge accounting. The information in the sixth section (F) provides details about derivatives accounted for as cash flow hedges of a forcasted transaction.

Derivative instruments are often complex and involve substantial risk of loss. The analyst should use the discussion provided in the first 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.

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The analyst should use the information provided in the second 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 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 or liabilities or future cash flows for which the derivative transactions were entered into or issued to hedge against. See section III. Analyst Reference Guide B.1. Investments – Primer on Derivatives for further discussion of derivative instruments.

The analyst should consider the information disclosed in the third section (C) in conjunction with information provided 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 & losses. Accounting procedures for derivatives vary widely depending on the nature of the derivative. SSAP 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 percent of net investment income or if the insurer is experiencing capital losses on derivative instruments of more than 10 percent of capital and surplus. In cases where the insurer's total derivative instruments represent more than 10 percent of capital and surplus, special attention should also be given to this Note. See section IV. Annual Procedures B.1. – Investments procedure # 9 for specific guidance in evaluating the materiality of an insurer's risk to derivatives.

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 and liabilities 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 10R, *Income Taxes-Revised*, *A Temporary Replacement of SSAP 10* (SSAP 10R) simply requires the recognition of the tax consequences of that transaction or event in the financial statements. Note that SSAP 10R is only effective for annual periods ending December 31, 2009 and interim and annual periods of 2010.

Deferred tax liabilities (DTLs) represent temporary differences that will result in future taxable amounts. Deferred tax assets (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 may not understand what is meant by the term temporary differences. The easiest way to understand the concept of a temporary difference is to review an example of one.

One of the most common types of temporary differences for life insurers is deferred acquisition expense. SSAP 71, *Policy Acquisition Costs and Commissions* (SSAP 71), 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 IRS requires an insurer to set up what is know as a Proxy DAC asset.

The Proxy DAC asset that is set up by insurers for tax purposes is based upon a percentage of net premiums from specified insurance contracts (i.e., life, annuity and accident and health), 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 a 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

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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.

Example:
Insurer XYZ incurred $10.0 million of policy acquisition expenses to establish ordinary life policies in year 2002, which brought in $100.0 million of premium income in that same year. For statutory purposes, all of these costs are expensed in 2001 since the expenses have been incurred. As a result, the insurer's book income is reduced by the entire amount in 2002. For tax purposes, the insurer establishes a Proxy DAC asset of approximately $7.1 million ($100.0 million premium income multiplied by 7.07 percent-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 2002, the insurer will only be allowed to amortize $355,000, since 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. The $0 recorded for statutory purposes 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. The $6.7 million recorded for tax purposes 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 percent), since 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 10R 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 Differences

Health Insurance Companies

Discounting of Unpaid Loss Reserves-This difference is very 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 health entity, this temporary difference will result in a DTA.

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

All Insurance Companies

Accrued Market Discount-For statutory purposes, SSAP 26, *Bonds excluding Loan-Backed and Structured Securities* (SSAP 26) requires health entities to accrue any market discount into income over the life of the bond. For example, if a bond is purchased for $900,000 with a par value of $1.0 million, the $100,000 discount is accrued into income (increases investment income) over the life of the bond. This has the effect of adjusting the

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investment income on a bond to reflect the true yield on the initial investment, $900,000 in this case. However, for tax purposes, companies generally do not amortize this market discount into income, and instead, are taxed on the gain ($100,000 ($1.0 million for consideration received when the bond matures - $900,000 cost paid)) when the bond matures. A similar type of effect would result if the health entity 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 health entity 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 since they hold large amounts of bonds.

Unrealized Gains/Losses-This temporary difference is similar to that which exists for accrued market discount and will result in a DTL if a health entity has recorded a significant amount of unrealized gains or a DTA if a health entity has recorded a significant amount of unrealized losses. 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 a health entity's change in surplus section as unrealized gains/losses. The only thing different about this item is that paragraph 14 of SSAP 10R 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 health entity'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 10R uses what is known as a balance sheet approach to measure a health entity's temporary differences. This is consistent with *Statement of Financial Accounting Standards* (FASB) *No. 109*, but differs from the approach used in *Statement of Financial Accounting Standards No. 96*, which used an income statement approach. The balance sheet approach is simpler than the income statement approach, because it doesn't require the health entity to schedule out the temporary differences that exist. In other words, the health entity does not need to know what the health entity's book to tax differences will be in 2010 to perform this calculation. However, SSAP 10R does use some conservatism that requires the health entity to determine what will reverse in the next year.

Limitations

The SSAP limits the amount of net DTAs that a health entity can carry to 10 percent and if the insurer meets certain criteria in paragraph 10 of SSAP 10R, it limits the DTA to 10 percent of capital and surplus. Additionally, the SSAP further limits the amount of DTAs that a health entity can hold to the amount of DTAs that will reverse within a year, three years, or during a timeframe corresponding with IRS tax loss carryback provisions. This limitation is consistent with the overall definition of an admitted asset. See SSAP 10 for 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 & surplus through a line within the capital and surplus section of the health entity's financial statements. Deferred tax assets or deferred tax liabilities should be reported on the balance sheet as indicated in the NAIC *Annual Statement Instructions*. 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.

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Disclosure

The disclosure requirements of SSAP 10R are rather extensive, and are broken down into six parts. The first section (A) of this Note requires that the health entity disclose the financial components (assets, liabilities and surplus impact) of the deferred taxes. The second section (B) of this Note requires that the health entity disclose any DTLs that are not required to be reported as a liability in connection with paragraph 31 of FASB 109. The third section (C) of this Note requires the health entity to disclose the significant components of its current income taxes incurred. The fourth section (D) of this Note requires a health entity to disclose the types and amount of temporary differences that affect the health entity's effective tax rate. The fifth section (E) of this Note requires the health entity to disclose certain information on operating loss and tax credit carry forwards. The sixth section (F) of this Note requires the health entity to disclose certain information on consolidated tax returns if applicable.

The analyst should use the information required in the first section (A) of this Note to determine the overall impact that SSAP 10R has had on the financial position of the health entity. The first section requires the health entity to report its gross, adjusted gross, admitted and nonadmitted DTAs by tax character, total DTLs by tax character, total nonadmitted DTAs and overall surplus impact. SSAP 10R also requires the disclosure of certain information resulting from the application of SSAP 10R 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 total adjusted capital in the RBC calculation; and the increased amount of DTAs, admitted assets and surplus. 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 a health entity can admit. Despite these limitations, the number of health entities that may report an increase in capital and surplus as a result of this statement may outnumber the number of health entities that report a decrease. Because a DTA will result in an increase in capital and surplus, the analyst should obtain an understanding of what is included in the health entity'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 health entity's DTL.

The analyst should use the information required in the second section (B) of this Note to better understand the financial position of the health entity. 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" (See the Internal Revenue Code for further discussion) account.

The analyst should use the information required in the third section (C) of this Note to better understand the components of a health entity's total income taxes incurred. This section provides the analysts 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 health entity has used the correct statutory tax rates in the calculation of its DTAs and DTLs. SSAP 10R prohibits the use of anticipated tax rates in its application.

The analyst should use the information required in the fourth section (D) of this Note to understand the significant temporary differences of a health entity. This disclosure could be the most helpful part of this Note. The disclosure requires the health entity to compare the expected tax expense (based upon the corporate tax rate) with the actual incurred tax expense. This disclosure also requires the health entity to disclose all of the significant reconciling items between the two amounts. Again, this disclosure can be helpful in analyzing the significant temporary differences that a health entity maintains.

The analyst should use the information required in the fifth section (E) of this Note to understand if the health entity's DTA includes a provision for a net operating loss. As noted above, the calculation limits a health entity to those DTAs that can be utilized within one year. However, if a significant portion of the DTA includes an

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operating loss carryforward, the analyst should consider if the health entity will be able to utilize the amount within one year.

The analyst should use the information required in the sixth section (F) of this Note to determine if the health entity has appropriately applied the principles of SSAP 10R to its financial statements regardless of a consolidated tax return being prepared. SSAP 10R allows the allocation of taxes between affiliated entities that file a consolidated tax return but the basic requirements of SSAP 10R still must be met. The analyst should review the disclosure to ascertain that the health entity has not avoided the recording of any DTLs through its income tax allocation agreement.

Using information from the balance sheet and the Note, the analyst should also determine if the health entity 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 a health entity has not reported these items on a net basis as required by SSAP 10R.

The analyst should also determine if the health entity has appropriately limited the DTA to 10 percent of capital and surplus. Under SSAP 10R, if the insurer is subject to RBC requirements and meets the requirements outlined in SSAP 10R paragraph 10, the insurer may elect to admit a higher amount of adjusted gross DTAs up to a limit of 15 percent of capital and surplus.

Potential Reporting Problems

As illustrated above, the reporting requirements of this Note, and the complications in calculating a health entity's deferred taxes, are quite significant. Most health entities do not have any internal tax department that can perform a deferred tax calculation. Because of this, many health entities will have to rely on a CPA firm to perform this calculation. The health entity's reliance on a CPA firm to perform this work on an annual basis may not present a problem, but it is anticipated that some health entities 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 upon changes in the health entity's reserves and invested assets.

Note 10 – Information Concerning Parent, Subsidiaries and Affiliates

As discussed in SSAP No. 25 *Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties* (SSAP 25), related party transactions are subject to abuse because reporting entities may be induced to enter transactions that may not reflect economic realities or may not be fair and reasonable to the health entity or its policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny. Because of this, the purpose of this Note is to provide detailed information regarding all types of affiliates and affiliated transactions. It is broken up into eleven different sections, which provide specific information on a health entity's affiliated relationships or transactions. The accounting guidance for affiliates is addressed in SSAP 25. SSAP 25 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.

The analyst should use the information in this Note to gain an understanding of the effects of the related party transactions on the financial statement and determine whether concerns exist regarding affiliated transactions. The analyst should evaluate amounts owed by a related party to determine if there may be a significant collectabality 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 health entity from a related party may pose a liquidity risk should the health entity require immediate repayment, and may also indicate an inability to repay the amount due to the health entity. Large or increasing amounts owed by the health entity to a related party may also pose a liquidity risk to the health entity because the payable may have resulted from an effort to move available cash to an affiliated

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entity that is experiencing cash flow problems. The terms and manner of settlement should be reviewed to determine if there are any unusual disclosures, which 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's important to evaluate the effect of any guarantees or affiliated undertakings that may have a substantial impact on the health entity in the future. For example, if the health entity 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 health entity.

The amounts disclosed in the Notes to Financial Statements should be consistent with other schedules and filings. If the health entity is part of a holding company system, the health entity'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., 10K filing), to understand the amount of debt, 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 health entity's future financial condition and generally require prior regulatory approval.

It's 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.

In cases where the health entity 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 health entity may pose. The risks may be significantly different than those that would have existed if the enterprises were autonomous. Unusual agreements or affiliated transactions may not make good business sense in terms of the consequences to the health entity. 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 health entity and whether any regulatory action is appropriate.

Note 11 – Debt

This note contains two sections. The first section (A) requires disclosure of information related to all other debt, including capital notes. The accounting guidance is provided by SSAP 15, *Debt and Holding Company Obligations* (SSAP 15). SSAP 15 requires a full description of the type of borrowing; amounts; interest rates; collateral; interest paid; and debt terms, covenants, and any violations. The section (B) requires disclosure of information related to agreements with the Federal Home Loan Bank (FHLB).

For the first section (A), the analyst should use the information in this Note to review the health entity's total debt. In cases where the health entity's total debt exceeds 10 percent of capital and surplus, special attention should be given. For all debt, the analyst will want to verify the health entity 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 of the health entity for additional funding. Another

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important area to review is repayment conditions, restrictions or covenants. In particular, the analyst needs to be aware if there are any violations of the covenants or restrictions and possible ramification (i.e. collateral pledged) to the health entity 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.

For the second section (B) the analyst should review for 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 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 contains five sections. The first section (A) requires the health entity to disclose details of employer sponsored defined benefit plans and is required by SSAP 89, *Accounting for Pensions*, *A Replacement of SSAP No. 8*, SSAP 11 - *Postemployment Benefits and Compensated Absences* (SSAP 11) and SSAP 14 - *Postretirement Benefits Other Than Pensions* (SSAP 14). The second section (B) focuses on the details of defined contribution plans and other postretirement benefit plans and is required by SSAP 89 and SSAP 14. The third section (C) focuses on multi-employer plans and is required by SSAP 89 and SSAP 14. The fourth section (D) discusses parent or holding company sponsored plans and is required by SSAP 8, SSAP 11 & SSAP 14. The fifth section (E) discusses postemployment benefits and compensated absences that do not meet the conditions for accrual as a liability and is required by SSAP 11.

The first section (A) of this Note provides significant disclosure regarding the health entity's employer sponsored defined benefit plans. As discussed in SSAP 89, 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 health entity's defined benefit plan and to determine if the costs and changes in liabilities associated with the plan have a material impact on the health entity.

As defined in SSAP 89, a defined contribution plan defines the amount of the employer's contributions to the plan and its allocation to plan participants. Less disclosure is required for this type of pension plan. In section two (B), the health entity is required to disclose the cost recognized for the defined contribution plan separately from the amount of cost recognized for defined benefit plans. Also, they must disclose a description of significant changes to the plan. The analyst should evaluate the plan disclosures to determine the impact to the financial statements.

The third section (C) of this Note focuses on multi-employer plans. It is very similar to section two (B) in regards to the type of disclosure required. 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 health entity.

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 provided in the fourth section (D) of this Note to evaluate the net expense for the holding company's qualified pension and other postretirement benefits for which the health entity is allocated and determine the impact of this expense on the entity's operations.

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As defined in SSAP 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 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 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 in section five (E) to determine if there is concern regarding a potential impact to the financial statements.

Note 13 – Capital & Surplus, Shareholders' Dividend Restrictions & Quasi Reorganization

This Note is split into twelve separate sections and covers several key areas of a health entity's overall capitalization. The first area is capital and surplus and includes items 1-9. This area has questions regarding the capital structure of the health entity. The analyst should be familiar with the overall holding company structure of the health entity before reviewing and analyzing the information included in this Note. However, the analyst should use the information in this area of this Note to obtain a greater understanding of the capital structure of the health entity. The first section of this Note provides the number of shares of capital stock authorized, issued and outstanding as of the statement date. Sections two through nine of this Note disclose restrictions on dividends and surplus, along with other information on the company's capital and surplus. These sections should be reviewed by the analyst to determine the amount of the health entity's surplus that is available to meet policyholders' liabilities. When considering the overall capital structure of the health entity, the analyst should take into account any recent Form A filings made by the health entity. If there is any change in the capital stock of the health entity, the analyst should consider if a Form A was necessary and if it was filed, reviewed and approved by the Department.

The second area of this Note requires the health entity to disclose certain information on surplus notes. The analyst should use the information required in this second area of the Note to obtain a greater understanding of the health entity's surplus note obligations. Using the information required, the analyst should be able to determine if the health entity has issued any surplus notes recently. Health entities must have prior 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. Other areas the analyst should review and consider when there are any new surplus notes include: verifying the proper accounting for the notes and any associated interest, the payment schedule for repayment and if the health entity will be able to meet this schedule, the type and quality of assets received in the transaction, and if the notes were issued to a parent or affiliates. If the notes were issued to an affiliate the analyst should consider reviewing the affiliate's financial statements to verify the notes are appropriately reported by the other entity.

The third and final area covered in this Note is quasi-reorganization. The analyst should use the information required in this third area of the Note to obtain an understanding of any quasi-reorganizations that may have occurred during the most recent period. Health entities 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 health entity has received prior approval, the analyst should verify proper disclosures and accounting for this transaction (see SSAP 72, *Surplus and Quasi-reorganizations* for further discussion).

Note 14 – Contingencies

This Note is split into four sections: contingent commitments, assessments, gain contingencies, and all other contingencies. The accounting guidance for contingencies is addressed in SSAP 5 and for specific items in SSAP

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35, *Guaranty Fund and Other Assessments* (SSAP 35), SSAP 97, *Investments in Subsidiary, Controlled and Affiliated Entities, A Replacement of SSAP No. 88,* and SSAP 48.

Contingencies are defined in SSAP 5 as an existing condition, situation or set of circumstances involving uncertainty as to a possible loss or gain to an enterprise that will ultimately be resolved when one or more future event(s) occur or fail to occur.

As discussed in SSAP 5, 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 health entity's future operations.

It's important for the analyst to ensure the company has reported all contingent commitments to an SCA, joint venture, partnership or limited liability company (SSAPs 97 & 48). The note requires detailed disclosure of guarantees on indebtedness of others, for example a guarantee on the indebtedness of a subsidiary.

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 35 for specific statutory reporting guidance and required disclosure in this Note.

Per SSAP 5, gain contingencies are not to be recognized in a reporting 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 un-issued 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.

Note 15- Leases

This Note is split into two primary sections. The first section (Section A) focuses on the disclosure of items related to lessee arrangements. The second section (Section B) focuses on the disclosure of items related to lessor business activities. Both sections of this Note include 2 or 3 parts, but each part of each section simply requires additional details regarding the breakdown and disclosure of the lessee or lessor's arrangements.

The accounting guidance for leases is in SSAP 22*, Leases* (SSAP 22). A lease is defined by SSAP 22 as an agreement conveying the right to use property, plant, or equipment usually for a stated period of time. Under SSAP 22, 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 NAIC *Annual Statement Instructions* to determine the impact of current and future rental expense on the health entity'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 health entity's operations or conflict with statutory regulations.

Per SSAP 22, 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

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22, 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, increase the seller-lessees deposit account.

Leaseback transactions occur for several reasons. Under a normal leaseback transaction, the health entity's appropriate asset and associated debt is 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 health entity has chosen and gain a better understanding of how the transaction impacts the financial statements.

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 22, 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 in the balance sheet and income statement. Lessor's that complete this section may rely on leasing for revenue, net income, and assets. The analyst should note property-type asset concentrations and examine the lessor's current and future profitability reliance on its rental income.

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. Additionally, the analyst should examine the components of net investment in leveraged assets to judge the accuracy of the amount.

Note 16 – Information About Financial Instruments With Off-Balance Sheet Risk And Financial Instruments With Concentrations of Credit Risk

This Note contains four parts, each of which is required by SSAP 27 - *Disclosure of Information about Financial Instruments with Off-Balance-Sheet Risk, Financial Instruments with Concentrations of Credit Risk and Disclosures about Fair Value of Financial Instruments* (SSAP 27). The first part (1) summarizes the face amount of financial instruments with off-balance sheet risk by class of financial instrument. The second part (2) discusses the credit risk, market risk, cash requirements of the instrument and the accounting policies related to the instrument. The third part (3) discloses the amount of accounting loss the entity would incur in a situation where there was non-performance of the contract terms of the financial instrument and the related collateral or other security supporting the financial instrument. The fourth part (4) focuses on the health entity's policies for requiring collateral or other security to support financial instruments subject to credit risk and requires the health entity to disclose the nature and description of the collateral or other security.

SSAP 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 in the balance sheet because they fail to meet some of the criterion for recognition as an asset or liability as defined in SSAP 4 and SSAP 5; however, due to the nature of the instrument, they pose a financial risk to the health entity. Concentration of credit risk exists where

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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 health entity 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 to Financial Statements.

In the first part of this Note, the health entity 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 a health entity's investment in financial instruments with off-balance sheet risk. The analyst should use the second part of this Note 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 health entity's total risk exposure.

The analyst should use the third part of this Note to evaluate the risk to the health entity for a default on the terms of the contract or the risk to the health entity should the collateral or other security for the amount due have no value for the health entity. 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 health entity's total risk exposure. The fourth part of this Note 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 their evaluation of the risks associated with their collateral.

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

This Note is split into three primary sections. The first section (A) focuses on the transfer of receivables reported as sales and represents a new disclosure that is required as a result of SSAP 42, *Sale of Premium Receivables*. The second section (B) focuses on the transfer and servicing of other financial assets and represents a new disclosure that is required as a result of SSAP 91R, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities* (SSAP 91R). The third section (C) is also required by SSAP 91R, but pertains only to wash sales. The third section, unlike most of the notes, is actually required to be included in the Quarterly Financial Statement if applicable.

The first section (A) of this Note requires a health entity to disclose the proceeds received, and the amount of gain or loss recorded on the sale of any premium receivables. The analyst should use the information required in the first section (A) to determine the overall impact that the sale of the health entity's premium receivables may have on its financial position. The analyst should also consider if the health entity 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 health entity, 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 health entity's annual audit report on fair value of financial instruments as required by SSAP 27.

The second section (B) of this Note is broken up into six different areas. The first part of the second section (B) of this Note requires a health entity to disclose certain information regarding the valuation of certain assets transferred. The analyst should use the information required in this part of the Note to evaluate the reasonableness of the information recorded by the health entity. The second part of the second section (B) of this Note requires a health entity to disclose 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 the information required in this part of the Note to help understand the types of investing and financing contracts the health entity uses to maximize profits and liquidity. The third part of the second section (B) of this Note requires a health entity to disclose

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certain information regarding servicing assets and liabilities recorded in the financial statements. The analyst should use the information required in this part of the Note to help understand the materiality of the servicing process in relation to the insurance operations. The analyst should also use the information required in this part of the Note, as well as other economic events to evaluate if certain circumstances have occurred within the health entity, or the marketplace, that indicate that a liability should be recorded. The fourth part of the second section (B) of this Note requires a health entity to disclose certain information regarding securitized financial assets in which the transfer is accounted for as a sale. The analyst should use the information required in this part of the Notes to understand the health entity's accounting policies for initially measuring the interests that continue to be held by the transferor, if any, and the methodology used in determining the fair value of the underlying assets and of the interest in the securitization. The fifth part of the second section (B) of this Note requires an insurer to disclose certain information regarding the subsequent measurement of interests and fair market valuation. In addition, the health entity 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 the information required in this part of the Note to evaluate the possible impact of adverse outcomes highlighted in the sensitivity analysis or stress test. The sixth part of the second section (B) of this Note requires a health entity to disclose any transfers of receivables with recourse. The analyst should use the information required in this part of the Note to gauge the materiality of possible effects of recources associated with transfers of receivables.

The third section (C) of this Note requires a health entity to disclose certain information regarding its use of "wash sales" as defined in SSAP 91R. The analyst should use the information required in this part of the Note to help understand the purpose and types of various financial contracts the health entity uses.

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

This Note is split into three primary sections. The first section focuses on the profitability of uninsured and partially insured A&H plans under Administrative Services Only (ASO) contracts. The second section focuses on the profitability of uninsured and partially insured A&H plans for the reporting entities of Administrative Service Contract (ASC) plans. The third section focuses on the profitability of Medicare or similarly structured cost based reimbursement contracts. All three sections of this Note of the NAIC *Annual Statement Instructions* include 4 or 5 parts, but each part of each section simply requires additional details regarding the break down of the uninsured or partially insured plan's expenses, fee income, and gain or loss. (See Section III. B.7. Cash Flow and Liquidity for more discussion.)

The accounting guidance for health entities that operate uninsured plans and partially insured plans is in SSAP 47, *Uninsured Plans* (SSAP 47). An uninsured A&H plan may be either an ASO plan or an ASC plan. 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 may not be reimbursable and revenues may be adjusted based on subsequent challenges of costs included in filed cost reports,

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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 health entity is profitable in its servicing of uninsured plans. It also provides information necessary to establish the extent to which the health entity depends on uninsured business. If a health entity'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.

This Note should also be used by the analyst to perform a more comparable analysis of general insurance expenses from one year to the next since the reimbursement on these types of plans are netted against a health entity's general expenses.

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

This Note requires the health entity to disclose the amount of direct premiums written through each Managing General Agent (MGA), Third Party Administrator (TPA) or Individual Practice Association (IPA), that exceeds 5 percent of surplus. This Note is required by SSAP 53, *Property Casualty Contracts-Premiums* (SSAP 53) and SSAP 54, *Individual and Group Accident and Health Contracts* (SSAP 54). Managing general agents (MGAs) and third party administrators (TPAs) produce or solicit business for a health entity and also provide one or more of the following services: underwriting, premium collection, claims adjustment, claims payment and reinsurance negotiation. In addition, Individual Practice Associations (IPAs) or other provider-based organizations are utilized to perform similar services but also add the element of risk transfer. IPAs are required to be licensed as TPAs in some states. MGAs, TPAs and IPAs are used by health entities to increase the volume of business written or to facilitate entry into new lines of business or geographical locations [See Section III.B.11. for a detailed explanation of MGAs, TPAs and IPAs].

The analyst should use the information in this Note to determine 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's 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 may indicate that the health entity has contracted new MGAs and TPAs or is increasing overall production to improve cash flow.

For each MGA and TPA that meets the disclosure requirement of this Note, the health entity 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 (i.e., 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 health entity 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's 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.

Note 20 - Other Items

This Note is split into seven primary sections. Each of the sections are individually unique and is required by various SSAPs, INTs and other sources. Some of the items are included in this Note on a temporary basis. Because of these reasons, the guidance on this Note is limited to an identification of the items and does not include a discussion of how to use the data.

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VII. Guidance for Notes to Financial Statements

The first section (A) focuses on extraordinary items and is required by SSAP No. 24, *Discontinued Operations and Extraordinary Items* (SSAP 24). The second section (B) focuses on troubled debt restructuring for debtors and is required by SSAP 36. The third section (C) focuses on disclosures of other miscellaneous amounts not recorded in the financial statements that represent assets pledged to others as collateral in accordance with SSAP 1, *Disclosure of Accounting Policies, Risks and Uncertainties, and Other Disclosures* (SSAP 1). The fourth section (D) focuses on the disclosure requirements of reasonable possibly uncollectibile assets and is required by SSAP 6, *Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers* (SSAP 6), SSAP 47, Uninsured Plans (SSAP 47), or SSAP 66, *Retrospectively Rated Contracts* (SSAP 66). The fifth section (E) focuses on disclosures for business interruption insurance recoveries including information related to the nature and aggregate amount of losses and recoveries recognized due to business interruption. The sixth section (F) focuses on disclosure of state transferable tax credits. The seventh section (G) focuses on the disclosure requirements of subprime mortgage related risk exposure and related risk management practices. The analyst may need to reference the *AP&P* Manual for further guidance on each particular section.

The first section (A) requires a health entity to disclose the nature of any extraordinary items. Under SSAP 24, a health entity is required to account for an extraordinary item using the same lines that are used to report continuing operations. The disclosure in section (A) of this Note allows the analyst to understand the impact that the extraordinary item has 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 health entity's overall financial position and allows the analyst to more easily compare the financials of the current period with prior periods.

The second section (B) requires a health entity to disclose specifics regarding any troubled debt restructuring occuring within the past year, including a description of the terms and the gain or loss recorded on the restructure. The analyst should use the information in this Note to obtain a greater understanding of the impact that such a transaction may have had on the health entity's current year financial statements. If the current year gain or loss was material, or if the health entity holds significant investments in other loans, the analyst should consider asking the health entity for detailed information on other mortage loans to determine if similar events are likely to occur on other loans.

The third section (C) requires a health entity to disclose various items that do not meet the definition of an asset, a liability, revenue or expense as defined within the Accounting Practices and Procedures Manual (AP&P Manual), but are relevant to the overall financial position of a health entity. Such items include segregated funds held for others, assets pledged to others as collateral, forward commitments, or events that are unusual or infrequent, but not both. 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 health entity.

The fourth section (D) requires a health entity to disclosure the nature of any portion of an asset that is reasonably possible to be uncollectible. This disclosure is required by specific statements within the AP&P Manual but applies generally to all assets that have become impaired but do not meet the requirements of a loss contingency or impairment of an asset according to SSAP 5. Under SSAP 5, a loss contingency or impairment of an asset is only required to be recorded if the event is probable and the amount of the loss can be reasonably estimated. The SSAP defines probable, as well as reasonably possible, and remote. The loss contingency or impairment of an asset is not required to be recorded when the event is reasonably possible or when it is remote, however disclosure is required if the event is reasonably possible. 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 health entity.

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The fifth section (E) requires the health entity to disclose information related to business interruption insurance recoveries received during the period. This information includes the nature of the event resulting in losses, the aggregate amount of the recoveries and the line items on the statement of operations in which those recoveries are classified and includes amounts defined as extraordinary items. The analyst review this information to determine if these recoveries have had a material impact of the operations of the health entity.

The sixth section (F) requires the health entity 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: the carrying value of transferable state tax credits gross of any related state tax liabilities and total unused transferable state tax credits by state and in total, the method of estimating utilization of remaining transferable state tax credits or other projected recovery of the current carrying value, and the impairment amount recognized by the reporting period, if any. To the degree the amount of the transferable tax credits is material to the health entity, the analyst should perform a more indepth review.

The seventh section (G) requires the health entity to disclose informtion 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 health entity 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 health entity additional analysis should be performed.

Note 21 - Events Subsequent

Subsequent events are required to be disclosed in the financial statements and/or notes as a result of SSAP 9, *Subsequent Events* (SSAP 9). 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, that have a material effect on the financial statements and therefore, require adjustment and/or disclosure in the statements. This Note is split into two primary parts. The first section (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 subsequent events 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. The second section (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 subsequent events provide relevant information needed to evaluate the information in the financial statements. Type II events are only disclosed in the Notes to Financial Statements.

The analyst should use the information disclosed in Type I of this Note to determine what impact subsequent events had to the financial statements for the current period. SSAP 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 health entity's financial position since 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 subsequent events disclosed in this Note in conjunction with the financial statements to get a clear picture of the changes in the health entity's financials and the reasons behind them.

The analyst should use the information disclosed in Type II of this Note to assess and quantify the impact that subsequent events, having conditions that did not exist at the balance sheet date but arose subsequent to that date,

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would have on the current and future financials of the health entity. 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 health entity structure should be carefully examined. Pro-forma supplements, if provided, should also be incorporated into the analysis.

Note 22 - Reinsurance

This Note is split into three primary sections. The first section (A) requires the health entity to report a variety of ceded reinsurance information. The second section (B) requires the health entity to report certain information on uncollectible reinsurance that was written off during the year. The third section (C) requires the health entity to report certain information on commutation of ceded reinsurance. The analyst should use the information provided in this Note to gain a better understanding of the health entity's reinsurance program and any risk the health entity is exposed to under the program.

Reinsurance is a vital part of a health entity's risk management and financial stability. The most common type of reinsurance arrangement used by most health entities is "excess of loss" coverage; however, some HMDI company's may have coinsurance arrangements. Certain transactions or conditions of a health entity's reinsurance could have a significant and disparaging impact on its financial health. Dependence on reinsurance or its potential effect on the health entity'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 of the standards. Therefore, an assessment of the financial stability of the reinsurer is extremely important task of the analyst. To assist in accomplishing this, the analyst may consult the following: the financial statements of the reinsurer, Analyst Team designations, regulatory and governmental filings (SEC and insurance department's Form B), rating agency reports (A.M. Best, etc.), financial reports on the insurance industry, and other financial sources.

Under the AP&P Manual, SSAP 61*, Life, Deposit-Type and Accident and Health Reinsurance* (SSAP 61), Uncollectible Reinsurance, "The ceding and assuming companies must determine if reinsurance recoverables are collectible. If it is probable that reinsurance recoverables on paid or unpaid claims or benefit payments will be uncollectible, consistent with SSAP 5, *Liabilities, Contingencies, and Impairments of Assets*, these amounts shall be written off through a charge to the Statement of Operations utilizing the same accounts which established the reinsurance recoverables."

In addition to using all of the information in this Note to obtain a greater understanding of the health entity's reinsurance program, the analyst should also consider using specific sections of the Note as follows:

The analyst should use the information provided in the second section (B) of this Note to determine if any uncollectible 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 health entity.

The analyst should use the information provided in the third section (C) of this Note to determine if the health entity 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.

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Note 23 - Retrospectively Rated Contracts & Contracts Subject to Redetermination

This Note requires the health entity to disclose general information regarding its premium volume under retrospectively written contracts. The accounting guidance for retrospectively rated contracts is addressed in SSAP 66, *Retrospectively Rated Contracts* (SSAP 66). SSAP 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 may 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 some time 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.

Although these types of contracts generally subject the health entity 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 health entity to disclose how it determined the estimated premium adjustment. The analyst should review the Note to determine that the reported amount is recorded in compliance with necessary statutory guidance.

Note 24 - Change in Incurred Claims and Claim Adjustment Expenses

This Note requires a health entity to report any reasons for changes in the provision for incurred claims and claim adjustment expenses 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 claims and claim adjustment expenses, 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. Since 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 claims and claim adjustment expenses, or adverse development, is a larger issue as it indicates that the surplus of the prior period was overstated.

The provision for incurred claims and claim adjustment expenses 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 5-10 percent of surplus or higher, the analyst should reasonably expect some additional information regarding the reason for the change in the provision for incurred claims and claim adjustment expenses. 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 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 may be reviewed or the analyst may need to question the company's reserves and address Level 3 procedures for Unpaid Claims and Claim Adjustment Expense.

Note 25 - Intercompany Pooling Arrangements

This Note requires a health entity to report certain information on reinsurance pooling arrangements with affiliated health entities. The analyst should use the information required in this Note to obtain a greater understanding of the health entity's pooling agreements. The analyst should review the health entity's percentage of direct written business in comparison to the health entity's participation percentage in the pool. If the

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participation percentage assumed from the pool exceeds the percentage of direct written business the analyst needs to consider the impact to the health entity 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 health entities, interinsurer reinsurance may serve to obscure one health entity'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 where 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 health entity can support the change in the interinsurer pooling agreement and determine if it appears that other affiliates are supporting any adverse results of the health entity or if the company is supporting adverse operating results of others.

Note 26 - Structured Settlements

This Note is not applicable to health entities.

Note 27 - Health Care Receivables

This Note is divided into two primary sections. The first section (A) requires disclosure on pharmaceutical rebate receivables. The second section (B) requires the health entity to disclose 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 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP 84). Exhibit C – Implementation Guide, of SSAP 84 provides additional accounting guidance for the practical application of SSAP 84.

Section (A) - Pharmaceutical Rebate Receivables:
As stated in SSAP 84, pharmaceutical rebates are arrangements between pharmaceutical companies and health entities in which the health entity receives rebates based upon the drug utilization of its subscribers. These rebates are recorded as receivables by the health entity and include both billed amounts and estimated amounts. Estimates are calculated using a variety of methods. The first section (A) of the Note should address the method used by the reporting entity to estimate pharmaceutical rebate receivables. As stated in Exhibit C of SSAP 84, the health entity 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 a health entity has not taken into consideration all of the factors that can impact the amount of the receivable, material differences may exist between the estimated receivable and the actual receivable.

The first section (A) of the Note also contains a table, 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 following example.

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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
12/31/2004	$150 (A)				
9/30/2004	130 (B)	$133 (C)	$62 (D)		
6/30/2004	142	143	138	$5	
3/31/2004	157	152	150	1	$1
12/31/2003	125	132	129	3	0
9/30/2003	123	129	125	1	0
6/30/2003	112	120	110	4	6
3/31/2003	110	118	118	0	0
12/31/2002	68	75	69	5	3
9/30/2002	60	59	58	1	0
6/30/2002	57	60	49	8	1
3/31/2002	45	50	48	1	1

This example assumes a financial statement date of 12/31/2004 and further assumes full implementation of SSAP 84 retroactive to 1/1/2002, with no transition. Exhibit C of SSAP 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 2004.
B. The $130 represents the company's best estimate of rebates to be received on drugs filled in the third quarter of 2004.
C. $133 is the actual amount of rebates determined for the third quarter of 2004, i.e. the amount billed to the pharmaceutical company or confirmed to the Pharmacy Benefit Manager. This amount was billed by 11/30/2004. 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 11/30/2004, the $62 represents the actual rebates received by the company during December 2004. In subsequent disclosures, the company would "update" this to include amounts received in January and February of 2005.

The admitted asset balance for pharmacy rebates at 12/31/2004 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 3/31/2004 (1st quarter of 2003) line, actual rebates would have to be billed by May 31, so the column entitled "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).

The disclosure for pharmaceutical rebates was developed to compare a health entity'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

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actual amount), the analyst can gain an understanding of the health entity's ability to reasonably estimate their pharmacy receivables. If a health entity reported significant discrepancies between their estimated and actual receivable balances, the analyst may consider doing further analysis into causes for the discrepancy and the methods used by the health entity to calculate their estimated receivable.

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 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 are not explained in the Note.

The Note was also designed to provide information on collectability. If, in accordance with SSAP 5, it is probable the balance of a receivable is uncollectible, any uncollectible 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 may indicate to the analyst that the health entity has not appropriately evaluated the collectability of pharmaceutical rebate receivables and certain receivables should be written off if they are deemed to be uncollectible.

Section (B) - Risk Sharing Receivables:
SSAP 84 defines risk sharing agreements as contracts between health entities and providers with a risk sharing element based upon utilization. These agreements can result in receivables due from providers if the actual utilization differs from the estimates. The second 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 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, a health entity 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 a health entity has not taken into consideration all of the factors that can impact the amount of the receivable, material differences may 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 84 provides an illustration of the disclosure and an explanation of the amounts in the table. Exhibit C, Question #17 of SSAP 84 provides an 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 entitled "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

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Current Year," unless the company has invoiced amounts in a certain year and collected on that invoice in the current year.

The purpose of this disclosure is to show how a health entity'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 a health entity reported significant discrepancies between their estimated and actual receivable balances, the analyst may consider doing further analysis to determine the causes for the discrepancy and to evaluate the methods used by the health entity 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 health entity has not appropriately evaluated the collectability of risk sharing receivables and certain receivables should be written off if they are deemed to be uncollectible. Risk sharing receivables from affiliated entities are included in this footnote and are reported as Health Care Receivables.

Note 28 - Participating Policies

This Note requires the health entity to disclose information on participating contracts. The Note for participating policies is required by SSAP 51, *Life Contracts* (SSAP 51) and SSAP 54, *Individual and Group Accident and Health Contracts* (SSAP 54).

Participating policies are policies where the contract holder is entitled to share in the health entity'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 policyholder dividends, the amount 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 health entity's financial position, therefore, the analyst should review the disclosure to determine the extent of any impact policyholder dividends have on the health entity's financials.

Note 29 - Premium Deficiency Reserves

This Note requires the health entity to disclose information on premium deficiency reserves. The Note for premium deficiency reserves is required by SSAP 53 and SSAP 54.

Premium deficiency reserves are established when anticipated losses, LAEs, 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 disclosure requires the health entity to provide the amount of that reserve and disclose if the reporting entity utilized anticipated investment income as a factor in the premium deficiency calculation. Premium deficiency reserves could impact the health entity's financial position, therefore, the analyst should review the disclosure to determine the extent of any impact on the health entity's financials.

Note 30 - 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, *Unpaid Claims, Losses and Loss Adjustment Expenses* (SSAP 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

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party. SSAP 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.

SSAP 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 55 and to determine the impact on the balance sheet of any large recoverable amounts.

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VIII. Health Insurance Industry

A. Medical Insurance Market

B. Health Lines of Business

C. Product Types

D. Company Financial Structures

E. Types of Ownership Structures

F. Solvency and Liquidity

VIII. Health Insurance Industry – A. 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 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 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 (HMDI). Health Maintenance Organizations (HMO) 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. Many HMDIs tend to provide service benefits via HMO lines of business, but otherwise offer indemnity policies similar to those offered by life and A&H insurers and P&C insurers.

Companies licensed as Life, Accident & Health file the Life/A&H blank and use the Life RBC formula. Some Blue Cross Blue Shield Plans are licensed as Life/A&H carrier, 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 AVR and 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 over 95 percent 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 the laws and regulations specific to Life/A&H insurers such as the Standard Valuation Law. Life insurers will also be required to perform asset adequacy analysis pursuant to the requirements of the state's Standard Valuation Law. 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 and long-term care insurance do not count toward the 95 percent requirement. The 95 percent rule must be passed based on both earned premiums and reserves.

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Property and Casualty companies (P&C) 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/Accident & Health insurers and P&C insurers generally issue indemnity policies, which reimburse policyholders for claims they pay, or make direct payments to providers who have been assigned payments (under the policy), by the policyholder.

Preferred Provider Organizations (PPOs) sometimes resemble HMOs. Generally PPOs contract with providers for discounts. The contracting providers make up the PPO network. The PPO then executes a contract with a health entity and the PPO network providers render health services to policyholders of the health entity. PPOs can also perform medical management such as utilization review and inpatient pre-authorization. PPOs are normally not allowed to actually assume insurance risk for the services provided by its contracted providers. In some states PPOs are required to be licensed by the Insurance Department.

A term that is being used more frequently 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 NAIC HMO Model Act 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. Some states require special licenses for RBEs. Provider groups such as Independent Provider Associations (IPAs), contract with member providers to provide health care services. When IPAs are paid a capitation for services and then pay the contracted providers on a reduced fee-for-service basis, they are assuming insurance risk. If the IPA becomes insolvent because the costs of health care being provided are more than the capitation payments, the health entity is responsible for finding other providers for its members. The individuals who are insured by the health entity may lose access to the physicians that have been treating them and the health entity may have to pay more for health services than contemplated when it establishes its premium rates. This can result in angry policyholders and financial losses for the health entity.

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

2. Health Care Cost Increases - General

Pressures come from many directions such as from new ways to provide health care and from mandated requirements to cover additional services. Health entities in the voluntary market face the financial pressures to keep premiums down while still covering all those that they must or agree to insure. Overall, the cost of health care is increasing much more than general inflation. The cost of any one service increases by the normal inflation associated with the service, plus any additional costs. In recent history, the cost of malpractice insurance has been pointed to as a primary reason that physician, lab, and hospital costs are increasing faster than inflation. Increasing medical malpractice awards have added to the cost of the actual services being provided. Some also suggest that excess health care (e.g. when providers request more tests than necessary or agree to care requested by the patient even if not justified) may result from defensive medicine to avoid malpractice claims.

The overall cost of health care also increases as the services are utilized more. As individuals and populations age they consume more health care services. Now that the "baby boomers" are passing through middle age, the average age of Americans is rising. Consequently, the average number of services used by Americans is also increasing. As with any industry, use of services increases with advertisement.

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In the late 1990s, prescription drug advertising began to stimulate increased use of many prescription drugs. Low co-payments for prescriptions that kept the cost to the consumer very low also contributed to higher demand.

New technology adds cost to the health care market in two important ways. First, it provides new and often expensive services to the range of treatments available. Second, the use of long-term treatments as well as new procedures as noted above 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 all of the factors that contribute to overall health care costs, but it is also affected 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, the individual will have more of a tendency to utilize them.

Individuals with high health care costs are more likely to purchase insurance, especially more comprehensive benefit plans, and are less likely to drop their coverage. In a totally voluntary health insurance market, segments of the market would become too expensive as this 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 much 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. Health entities have to be careful that their benefit designs are not appreciably richer than the competition or includes 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 been urged to force health entities to cover health care services that might otherwise not be covered by their policies. 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 $100 deductible. If a person's medical expenses are $150, the health entity will pay $50. If the expenses increase by 10 percent in the next year, to $165, and the deductible has not been changed, then the health entity will pay $65, an increase of 30 percent over the health entity's prior-year payment of $50. Since the health entity's expense has increased 30 percent, that increase, and not merely the underlying 10 percent increase, will have to be reflected in premium rates. In general, if the corridor is very small relative to the overall cost per person, deductible leveraging will have a very small impact; but if the corridor is large relative to overall cost, the leveraging likewise will be very high. 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.

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The combination of the general and insurance issue 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 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 though various risk sharing methods including the following:

a. Premium risk sharing – the most obvious is experience rating of large employers.

b. 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.

c. Provider risk sharing – the use of capitation, withholds, provider discounts and plans to encourage quality care through bonuses share the risks and rewards of effective health coverage with the providers.

d. 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).

   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 fee schedules 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.

The analyst 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. 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.

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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.

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.

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 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 of the care/benefits that the program requires but is paid a fixed fee by the program (e.g. Medicaid HMOs and Medicare Advantage). These sub-markets involving health entities have different risks than the primary markets (non-government) since the primary markets do not have fiscal constraints. Section VIII. B. - Health Lines of Business 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. The analyst 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. 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. The analyst 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

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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 terminate all similar policies, which would entail leaving a market completely for some time. As noted elsewhere, some of the markets have specific additional requirements for guaranteed issue or mandated benefits and premium subsidization. These are described in Section VIII. B. - Health Lines of Business.

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VIII. Health Insurance Industry – B. Health Lines of Business

This section describes differences in lines of health insurance that can be written by a health entity. The Product Types section will describe in more detail additional distinctions within the primary line of health coverage – comprehensive major medical including medical services provided through an HMO.

Differences 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 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, Long-term Care, Specified Disease and Medicare supplement). The contract may cover the insured as well as family members. The renewal provisions of individual contracts are important in that if the insurance is cancelled, many of the insureds may not be able to replace it because of their poor health.
- 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. 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 complete retention of risk through ASO/ASC to high deductible minimum premium policies with stop-loss coverage.
  - 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 similar coverage and pooling to the employers 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.
  - 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

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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., AARP) or interest group (Sierra Club). Besides primary health coverage, this can include the sale of limited pay/supplemental coverage ("work-place" sales of accident, specified disease, hospital indemnity, etc.), Medicare supplement, disability income, and long-term care 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), Medicaid, Medicare Advantage) as well as the federal Long-Term Care (LTC) insurance 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., Small Employer regulations, Medicare supplement standardized plans, LTC level premium and inflationary protection are key examples).

- Individual - Coverage is frequently underwritten and therefore subject to rate variations based on the applicant's health, to offset self-selection. States vary allowable underwriting practices and must address the availability of individual coverage for people who meet 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). There are high administrative costs relative to other relationship arrangements, both annually and for acquisition of new business. From a regulatory point-of-view, this market will typically be a smaller portion of the health entity's total business and may be treated simply as an addition.

  One aspect of the risk is to review the health entity's participation in a state's provision for offering coverage to the uninsured and HIPAA eligibles. States may use approaches, which do not affect the health entity (e.g., high risk pools, 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.
- Small Employer – Variations by state are key in determining the unique risks for this market. What benefit packages must be offered and pricing allowances for demographic differences (e.g., age, sex, location) or health (claims experience and health status) are limited by the states. 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 percent share than a company with a 25 percent 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. In addition, administrative costs are higher for small employers than for large employers

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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 also allow purchasing groups or alliances for small groups.

- 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 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 bases for presenting these offerings on an annual basis to employees. Current health status will affect the employee's 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.

- 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 regulatory oversight may add to administrative costs or limit the areas where the plan 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 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.

- Medicare Advantage – This market is primarily to seniors and allows the entity to define benefit packages, subject to meeting minimum benefits provided by Medicare. It has increasingly moved toward managed care arrangements. Income comes from the Center for Medicare and Medicaid Services (CMS)

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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.

- Supplemental Coverage – This coverage is generally sold by another company than the carrier for primary health coverage. It may coordinate (e.g., Medicare supplement), be in addition to (e.g., hospital indemnity) or may be unrelated (e.g., 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/work place. 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 – 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 disability income (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 indemnity). The products are either guaranteed renewable or in the case of much 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 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).

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VIII. Health Insurance Industry – C. 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

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. Cosmetic treatments are excluded because they are not medically necessary. There is much debate concerning specific services and whether or not they are experimental 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 are payments, made by the insured person at the time of service, for physician visits and prescription drugs. Co-payments are generally applicable when services are rendered by providers under contract with the health entity. These may or may not be included in maximum out-of-pocket amounts and are not credited to deductibles. Prescription drug co-payments vary depending upon whether or not the drug is generic and may vary by drug classification. 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.

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 services not covered by co-payments and may vary by in-network services and out-of-net work services, but are more common for out-of-network service. Individuals may choose not to submit claims to a health entity for reimbursement until meeting their deductible amount, resulting in 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 they 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 claim amounts until the maximum out-of-pocket expense is met. This is often referred to as co-insurance. Normally, the health entity will not make payments based upon the full value of the claim after deductible and coinsurance, but rather uses a schedule of "customary" fees to determine the benefit due. A maximum deductible usually applies for family coverage that is a multiple of the individual maximum. Some policies have an in-network maximum out-of-pocket and an out-of-network maximum out-of-pocket. Before health entities instituted the policy of two maximums, once an individual met their maximum out-of-pocket they had no further incentive to use contracted providers since the health entity paid 100 percent of the cost.

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VIII. Health Insurance Industry – C. Product Types

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 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 heath entities moving to more indemnity type products. Now, 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 indemnity or PPO products with high deductibles. 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 may offer preventative care or other services for a co-payment amount without being subject to deductibles. The result is that some physician and prescription drug services may be available on a co-payment basis, while policies primarily pay for expensive services such as hospital stays and surgeries. In addition to uninsured ASO/ASC plans, other alternatives to insured products have gained popularity as employers try to control benefit costs.

High-deductible plans may be offered in conjunction with Medical Spending (or "Medical Savings") Accounts (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 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 plans grew out of employer concern over double digit premium increases for indemnity plans in the early 1970s and are still very common depending on the state. Employers pressuring insurers to reduce costs, and federal legislators' beliefs that having HMOs available may solve some of the health care cost problem, and has resulted in a growth in managed care plans. A provider based HMO could manage the health care more efficiently and possibly eliminate some of the administrative cost that exists with insurance. Other health entities and self-insured employers then looked at how they could use some of the techniques used by the HMOs to control health care cost increases.

Managed care techniques include the use of a primary care physician as a "gatekeeper" and other 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, and
- Limiting access to specialists.

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VIII. Health Insurance Industry – C. Product Types

As indemnity plans added more managed care mechanisms and HMOs started to use contracted providers rather than their own 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. Providers are resisting capitations that have led to losses and in some cases provider insolvency. More capitations are limiting the services under the capitation, leaving the health entity with the risk for non-capitated services. Recent capitation agreements are moving 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. Arrangements can 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). The PCP must authorize all or most specialty care and hospitalizations.

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.

Preferred provider organizations (PPOs) are utilized by HMDIs and insurers to bring elements of managed care to their products by contracting for discounted fees from participating providers. They may also perform other managed care functions such as pre-authorization and utilization review.

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VIII. Health Insurance Industry – D. 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 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 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[2], 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 have recently received significant backlash and are not as effective as they once were, and 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 technology advances, such as electronic claim filing or other techniques that reduce administrative costs.

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 principle payments, the lender can demand payment and the health entity could be forced into

[2] RBC requirements will generally increase for the same number of covered lives because of medical trend increases.

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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.

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VIII. Health Insurance Industry - E. Types of Ownership Structures

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. The analyst 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, should be subject to regulatory approval.

Reinsurance by one affiliate of the others can be used to manage capital and change Risk-Based Capital requirements. This can result in more centralized Risk-Based Capital than would exist without the reinsurance. Also, captive reinsurers can be used to move profits and capital requirements to another entity in another state.

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 decided 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 heath 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 isn't enough of an advantage to offer "one stop shopping".

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VIII. Health Insurance Industry – F. 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); and
4. The adequacy of existing capital - the Risk-Based Capital (RBC) formula compares actual capital (in the form of Total Adjusted Capital or 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.

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):
        - 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);
        - 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

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population. When the actual is materially different from what was expected (e.g. more older insured, fewer males), the premiums may be inadequate;

- 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;
- 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; and

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.

Managed care techniques often make claims costs less variable and therefore easier to predict. The more of the 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 predicable. The effectiveness of these arrangements has been reduced recently with the influence of and the push back from providers and patients.

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2. Reserves, including 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 under-pricing. 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 etc. 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:

   - 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.

     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.

   - 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 Administrative Services Only (ASO) or Administrative Services Contract (ASC). In both of these 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

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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.

- 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.

  Risk is transferred to hospitals by the use of DRG payments[3]. 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 complicating circumstances or extreme cases as "outliers". Additional payments will then be approved for outlier cases.

- 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, 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;

[3] 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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- 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), 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., LTC, 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 (are not likely to occur simultaneously) through a "co-variance" calculation.

3. Some states have guaranty funds that are used to take insolvent health entities into receivership and pay claims. The guaranty funds are funded by assessments levied against all health entities that are required by law to participate, which might not include HMOs.

4. For HMOs, most states have adopted some version of the HMO Model Act, 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.

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NAIC Financial Analysis Solvency Tools

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Life/A&H Edition
2009 Annual/2010 Quarterly

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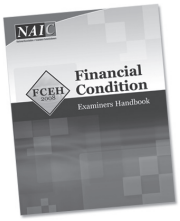
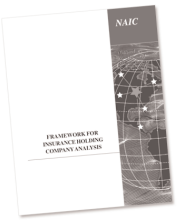


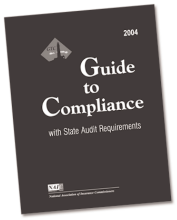
Financial Condition Examiners Handbook

This handbook provides a guide to assist state insurance departments in establishing an effective examination system. It provides an overview of the entire examination process and then offers specific instructions and suggestions for carrying out each individual phase of examination. Updated annually.



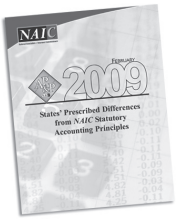
Framework for Insurance Holding Company Analysis

The Framework for Insurance Holding Company Analysis was created to document the best practices of states' efforts in analyzing holding companies and their insurance subsidiaries and in sharing information and coordinating regulatory action. The overall purpose of the Framework is to provide state insurance regulators with the tools and guidance necessary to gain an overall understanding of the holding company structure and the impact its management, business practices and financial condition has on its insurance subsidiaries. Copyright 2002.



Guide to Compliance with State Audit Requirements - As of 2004

This publication is a tool to assist insurers, CPAs and other interested parties in complying with the various state filing mandates for annual audited financial reports and related correspondence. It highlights differences in the states' requirements from the NAIC Model Audit Rule Requiring Audited Financial Statements and provides documentation of each state's rules and regulations. This guide also includes a copy of the AICPA's Statement Position 95-4, "Letters to State Insurance Regulators to Comply with the NAIC Model Audit Rule," as well as examples of various required letters and forms. This guide is also available on CD-ROM, providing instantaneous search capabilities powered by NextPage. Copyright 2004.



States' Prescribed Differences from NAIC Statutory Accounting Principles

The Accounting Practices and Procedures Manual presents a comprehensive basis of accounting that should be followed if not in conflict with state statutes and/or regulations. Should the domiciliary state set forth accounting guidance that differs from the AP&P Manual, disclosures of such must be made. This publication provides information regarding each state's prescribed differences from NAIC statutory accounting principles, including a citation to the respective state statute and/or regulation. Updated annually.

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NAIC National Association of Insurance Commissioners
& The Center for Insurance Policy and Research

Date: **January 2, 2010**

To: **Users of the NAIC's Financial Analysis Handbook—Life/A&H Edition**

From: **NAIC Staff**

This edition of the NAIC *Financial Analysis Handbook* is to be used in conjunction with the 2009 Annual and 2010 Quarterly Financial Statements. The following summarizes the most significant changes since the prior edition:

Level 1 – Analyst Reference Guide and Procedures

Non-Routine Analysis

A new section was added to the Analyst Reference Guide that discusses non-routine analysis related to events or situations that fall outside the normal course of business and may have a material impact on the overall financial condition of an insurer. The discussion includes several examples of the types of non-routine analysis that may be performed.

New Procedures

A procedure was added to address RBC Trend Test failure, and a procedure was added within "Assessment of Supplemental Filings" to address communication with the domestic states of affiliated insurers within a group.

Audited Financial Report – Analyst Reference Guide and Supplemental Procedures

Audit Committee

A procedure was added to address whether an insurer has established an audit committee.

Model Audit Rule

Due to the anticipated revisions to the Model Audit Rule effective January 1, 2010, three sections were added to the Analyst Reference Guide to address auditor independence, corporate responsibility, and internal control over financial reporting.

If you have questions regarding the *Financial Analysis Handbook Property/Casualty Edition*, contact Jane Koenigsman, Life/Health Financial Analysis Manager at (816) 783-8145 or via e-mail at jkoenigs@naic.org.

EXAMINATION OVERSIGHT (E) TASK FORCE
FINANCIAL ANALYSIS HANDBOOK WORKING GROUP

SUBMIT TO
NAIC - KC
By June 1, 2010

Financial Analysis Handbook Proposed Revision Form

INSTRUCTIONS	FOR NAIC USE ONLY
1. Complete this form for EACH Handbook proposal. Under "Identification of Item(s) to be Changed", include Section & Page number, Line or Item Identifier. 2. All attachments should be presented in a format wherein new language is underscored and deletions struck through. 3. Please consider whether this revision proposal issue is also addressed elsewhere in the Handbook. 4. All submission forms and attachments must be typed originals. 5. CAUTION: before completing this form, please read additional instructions on reverse side of this form.	DISPOSITION [ ] ADOPTED [ ] REJECTED [ ] DEFERRED [ ] OTHER (SPECIFY) _____
DATE _____ NAME: _____ TITLE: _____ STATE: _____ ADDRESS: _____ TELEPHONE: _____ CONTACT PERSON: _____	NOTES

HANDBOOK SECTIONS TO WHICH PROPOSAL APPLIES

[ ] LIFE/HEALTH [ ] PROPERTY & CASUALTY [ ] HEALTH

[ ] Introductory Chapters
[ ] Financial Analysis Framework
[ ] Analysts Reference Guide
[ ] Specialized Topics
[ ] Quarterly Procedures
[ ] Level 1 Annual Procedures
[ ] Level 2 Annual Procedures
[ ] Level 3 Annual Procedures
[ ] Other (Specify)
[ ] Audited Reports Supplemental Procedures
[ ] Actuarial Opinion Supplemental Procedures
[ ] M D & A Supplemental Procedures
[ ] Holding Company Supplemental Procedures

IDENTIFICATION OF ITEM(S) TO BE CHANGED

REASON OR JUSTIFICATION FOR CHANGE **
(STATE, IN SPECIFIC TERMS, THE BENEFIT TO BE DERIVED FROM THIS PROPOSAL)

**** This section must be completed on all forms.**

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Additional Instructions and Information

The Financial Analysis Handbook Working Group meets via conference call throughout the year to consider proposed changes to the Financial Analysis Handbook (FAH). Suggestions to the FAH should be submitted by **June 1, 2010**. They will be reviewed by the Working Group and considered for adoption and implementation in the next FAH edition. Send proposals to:

National Association of Insurance Commissioners
Insurance Analysis & Information Services Department
2301 McGee Street, Suite 800
Kansas City, MO 64108-260

For questions call the Insurance Analysis & Information Services Department at (816) 842-3600.

Any member of a State Insurance Department is welcome to submit a Proposed Revision Form. The forms will be regarded as submitted on behalf of insurance departments rather than individuals.

Proposed Procedure Revisions

During the Working Group's review, changes proposed via this form will be considered along with an analysis conducted by the NAIC Insurance Analysis & Information Services Department of the effectiveness of procedures. This analysis encompasses the effectiveness of ratio limits as well as the language of procedures. Additionally, the general usefulness of procedures are considered. Specific proposals from states relative to procedures are welcome and should include detailed analysis.

Proposed Revisions for Annual Statement Changes

The Insurance Analysis & Information Services Department also studies adopted changes to the Health Annual Statements and provides revision proposals to the Working Group. The Insurance Analysis & Information Services Department automatically makes changes to the FAH for minor changes, such as for page and line numbers. Specific proposals are welcome. Additionally, please alert the Insurance Analysis & Information Services Department to any overlooked minor annual statement changes.

Proposed Software Revisions

The Life/Health, Property/Casualty and Health Handbooks are automated on I-Site. The FAH is intended to be a dynamic tool. The Working Group is interested in feedback on both analytical and software features. Please contact the NAIC Help Desk at (816) 842-3600 before submitting a form. Many enhancements have been proposed which could not be implemented. Also, some proposals may relate to existing features that the Help Desk may be able to explain.

**** This section must be completed on all forms.**

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Preface

The National Association of Insurance Commissioners (NAIC) consists of insurance regulatory officials from the 50 states, the District of Columbia, and five U. S. territories. One of the primary objectives of an insurance regulator is to identify as early as possible, insurance companies that may be financially troubled so that corrective action can be taken to protect policyholders, claimants, and creditors from financial loss.

The NAIC's *Financial Analysis Handbook* (*Handbook*) was developed and released by the Financial Analysis Handbook Working Group (FAHWG) of the Examination Oversight (E) Task Force with the assistance of outside consultants in 1997. The purpose of the *Handbook* is to provide a means for insurance departments to more accurately identify inurers experiencing financial problems or that pose the greatest potential for developing financial problems. In addition, the *Handbook* provides guidance for the insurance departments to define and evaluate particular areas of concern in troubled insurer. The overall goal of the *Handbook* is to enable regulators to identify financially troubled insurers earlier, evaluate and understand their problems better, and develop appropriate corrective action plans sooner, thus, potentially decreasing the frequency and severity of insurance company insolvencies.

The information in the *Handbook* is intended to provide concepts and approaches that will enable regulators to perform more effective and efficient analysis of insurance companies. It does not include state specific information or regulations, and does not establish guidelines that insurance companies and departments must follow. Parameters or benchmarks utilized are not regulatory requirements to be complied with by insurance companies. The accreditation standards indicate that the analyst should utilize procedures developed by their Department or Procedures within the *Handbook*.

NOTE: Please note that all references throughout this Handbook to the risk-focused surveillance approach, Insurer Profile Summary, and Supervisory Plan apply only to states that have adopted and implemented the risk-focused surveillance approach. The ownership and responsibility for updates to the Insurer Profile Summary may vary from state to state between the analysis and examination departments.

The *Handbook* contains the following:

Introductory Chapters
These chapters provide a general overview for the analyst concerning regulatory organization, communication, and prioritization.

Financial Analysis Framework
The framework discusses resources the analyst should utilize throughout the review process. In addition, the steps of the review process are presented.

Analyst Reference Guide
The Analyst Reference Guide should be utilized with the Level 1, 2, 3, and Supplemental Procedures for both annual and quarterly periods. The Analyst Reference Guide provides discussion on the Procedures that could be performed during an analysis of an insurer.

There are three levels of Procedures within the Handbook. In Level 1, the analyst performs an overall review of the insurer. If there is any area of concern, additional procedures from Level 2 should be completed. Level 2 Procedures focus on specific financial areas that assist the analyst in conducting a thorough financial analysis. If continued concerns exist after completion of any Level 2 Procedures, Level 3 Procedures should be completed. Level 3 Procedures are intended to address qualitative issues of an

insurer. The Handbook are Supplemental Procedures that assist the analyst in reviewing additional filings from the insurer such as their Audited Financial Report, Statement of Actuarial Opinion, MD&A and holding company analysis, etc. There are also quarterly Level 1 and 2 procedures.

Guidance for Notes to Financial Statements

The Guidance provides guidelines to assist the analyst in further understanding the reporting requirements of an insurer, which will aid the analyst during the review of the Notes to Financial Statements.

Health Insurance Industry

This narrative discussion section provides an overview of health insurance industry topics and terminology.

Fraternal – Level 1 Procedures

Level 1 procedures, for both annual and quarterly, assist the analyst in developing an overall review of the fraternal society

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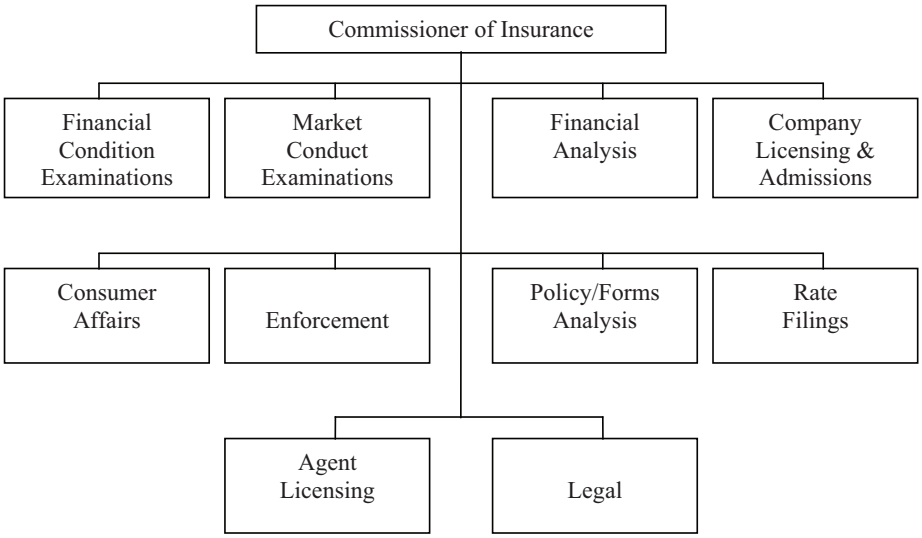
I. Introduction – A. Department Organization and Communication

Organizational Chart

There is no "typical" state insurance department. The organizational structure will vary from state to state. However, there are several basic functions, which are performed by all departments on health entities, life insurers and property/casualty insurers. It is important for the financial analyst to understand the purpose of each function and the information obtained by each function that may assist the financial analyst in the financial monitoring and solvency surveillance process. Following is a brief discussion of each of the functions of an insurance department. Because of the variance in organizational structure, the chart below depicts typical state department functions rather than trying to highlight a typical organizational structure.

Chart of State
Insurance Department Functional Units



In many states, more than one of the above functions may be performed or supervised by the same individuals. For example, the financial analysts may also perform financial examinations. Financial examiners also frequently perform market conduct examinations. Also, some state insurance departments rely on the Attorney General's office for legal assistance rather than having separate department counsel.

Financial Condition Examinations

The Insurance Code in most states allows the state insurance department to examine insurers as often as the Commissioner deems appropriate and requires that each insurer be examined at least once every three to five years (the time period varies by state). Financial condition examinations performed by the state insurance departments include full-scope periodic examinations and limited-scope or targeted examinations that focus on specific accounts and/or issues. The results of a financial condition examination are documented in an examination report, which assesses the financial condition of the insurer and sets forth findings of fact (together with citations of pertinent laws, regulations and rules) with regard to any material adverse findings disclosed by the examination. Examination reports may also include corrective actions required to be taken by the insurer and/or recommendations for improvements based on examination results. Through the risk-focused surveillance approach, the department gains knowledge about all aspects of the insurer, including its corporate governance, risk management practices, and key business activities, which can be useful to solvency analysis.

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Market Conduct Examinations

The market conduct examination focuses on such areas as sales, advertising, rating, and the handling of claims. Market conduct examinations evaluate an insurer's business practices and its compliance with statutes and regulations relating to dealings with policyholders and claimants. The results of a market conduct examination are documented in an examination report, which summarizes examination findings so the insurer's performance can be assessed. The report may also recommend corrective action to deal with significant problem areas. Because financial condition and market conduct problems are often interrelated, the examinations are frequently conducted simultaneously. Market conduct examinations are conducted by financial condition examiners in many of the states, usually an impact of the size of the department.

Financial Analysis

Financial analysis provides an in-house desk audit of the Annual Financial Statement and all other supplemental filings made by an insurer. The analyst should refer to other available information as well (including information on the NAIC Financial Data Repository), in order to monitor the insurer's statutory compliance and solvency on a continuous ongoing basis in coordination with the periodic on-site field examination process. As part of the risk-focused surveillance approach, the financial analysis unit responsibilities can include monitoring the state's domestic insurers, providing updates to the Insurer's Profile Summary, if applicable, (see Analyst Reference Guide for Level 1 Analysis), providing input for the department's priority score and supervisory plan, and providing department management with timely knowledge of significant events and performing the prospective risk analysis. Refer to the Analyst Reference Guide for Level 1 for further discussion on prospective risk. As part of the analysis process and the review of the examination report and findings, the analyst should incorporate into his/her analysis information gained about the corporate governance and risk management processes of the insurer. If desired, regulators can request the Insurer's Profile Summary, if applicable, for non-domestic insurers from the domestic or lead state.

As a result of concerns identified during the financial analysis process, the insurance department may take a variety of actions including, but not limited to, contacting the insurer for explanations or additional information; obtaining the insurer's business plan; requiring additional interim reporting from the insurer; calling for a targeted or limited scope financial condition examination; engaging an independent expert to assist in determining whether a problem exists; meeting with the insurer's management; obtaining a corrective plan from the insurer and/or restricting; suspending or revoking an insurer's certificate of authority.

Company Licensing & Admissions

An insurer that wishes to obtain a certificate of authority to write business in a state must generally complete an application form indicating the lines of business the insurer wants to write and submit the application form—along with other information, including the most recent Annual Financial Statement, Audited Financial Reports, Statement of Actuarial Opinion, etc., to support the financial condition of the insurer—to the insurance department for review and evaluation. In addition, insurance departments frequently request information supporting the insurer's experience and expertise in writing the lines of business requested, background information regarding the insurer's management and board of directors, a business plan, and a multi-year pro-forma financial projection. After reviewing this information and any other information obtained, the insurance department makes a determination whether to issue a certificate of authority to the insurer.

The Uniform Certificate of Authority Application, also known as the UCAA or Uniform Application, is a process designed to allow insurers to file copies of the same application for admission to numerous states. The National Treatment Working Group currently maintains and updates the UCAA application. Each state that accepts the UCAA is designated as a uniform state. While each uniform state still performs its own independent review of each application, the need to file different applications in different formats has been eliminated for all states that accept the Uniform Application. The Uniform Application is available to any insurer in good standing in their domiciliary state, regardless of size. Currently there are 50 uniform states and the District of Columbia.

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I. Introduction – A. Department Organization and Communication

Consumer Affairs

Consumer Affairs is responsible for developing and distributing information regarding insurance products and the insurance industry to consumers. Consumer Affairs is also generally responsible for addressing complaints filed with the insurance department by policyholders and claimants against insurers and agents. Detailed statistics regarding complaints (both in number and type of complaint) and their resolution may be maintained as a part of this function. Complaints are recorded on the NAIC's Complaints Database System, if filed with the NAIC.

Enforcement

Punitive actions taken against companies, agents, and other licensees found to be in violation of the Insurance Code are handled by the enforcement function. This function issues orders and levies fines and other penalties based on the results of investigations performed by other functions within the insurance department. Detailed records of all regulatory actions taken against companies, agents, and other licensees are maintained by the department. In addition, regulatory actions are also recorded on the NAIC Regulatory Information Retrieval System (RIRS) database, if filed with the NAIC.

Policy/Forms Analysis

Most states require an insurer to file policy forms for certain lines of business for review and/or approval by the insurance department prior to selling the policies. The primary purpose of this review is to determine statutory compliance regarding policy provisions and benefits.

Rate Filings

Information regarding premium rates, including actuarial rate development assumptions, is generally required to be filed with the insurance department for certain lines of business. Some states are "file and use" states, which allows insurers to begin selling policies at the rates filed as soon as the filing is made. However, in other states, rates must be approved by the insurance department prior to use by the insurer. Rate filings, including the actuarial assumptions, are reviewed for reasonableness and statutory compliance as a part of this function.

Agent Licensing

Agents must be licensed by the insurance department in order to write business in the state. The agent licensing function administers tests for agents, reviews new and renewal applications from agents, and performs background checks on the agents. In addition, many states have continuing-education requirements for agents, and agent licensing monitors compliance with these requirements. Detailed records of licensed agents are maintained by agent licensing, including information regarding the insurers for which the agents produce business.

Legal

Legal is generally involved in the review of proposed changes of control of insurers and other holding company transactions and frequently supports the other functions. Legal also may draft statutes and regulations to assist the insurance department in regulating insurers, agents, and other licensees; hold administrative hearings between the Commissioner and insurers, agents, and other licensees; and represent the department in judicial and other proceedings.

Communication

Communication with other divisions or areas within the department (intradepartmental communication) on a timely basis is an important element of effective solvency surveillance and in coordinating the results of the risk-focused surveillance approach. Upon identifying a problem or concern during the financial analysis process, the financial analyst should communicate this information to other divisions within the insurance department. In addition, other divisions within the insurance department should communicate certain information to the financial analyst so that the financial analyst has all of the relevant information available regarding the insurer being analyzed. (Refer to the Insurer Profile Summary in the *NAIC Financial Condition Examiners Handbook*.)

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Communication From the Financial Analyst to Other Divisions or Areas

The analyst may identify concerns as a result of the financial analysis process which, when communicated to the financial condition examinations division, may lead to a targeted or limited-scope financial condition examination. Also, since the financial analysis and risk-focused examinations are interactive processes, the analyst should be familiar with the insurer's current financial condition, including any changes in its operations since the last periodic financial condition examination. Analysts should actively communicate findings from the analysis process to examiners as this type of communication is beneficial to the financial condition examination staff during the planning of risk-focused examinations and any follow-up. An example of the type of communication may include significant financial variances found in the insurer's business plan projections. Another example may include a material turnover of high-level management positions. Statutory violations identified as a part of the financial analysis process should be communicated to the enforcement division for the issuance of appropriate penalties and/or corrective orders against the insurer. In addition, solvency-related concerns, when communicated to the legal division, may result in the restriction, suspension or revocation of an insurer's certificate of authority.

Communication From Other Divisions or Areas to the Financial Analyst

In addition to intradepartmental communication, which originates from the financial analysis division, it is equally important that the insurance department's procedures be designed to ensure that relevant information and data received by the other divisions within the insurance department be directed to the financial analysis division. Following are some examples of information or data, which may be received by other divisions within the insurance department (including an indication of the functional unit which would likely have received the information or data), that should be directed to the financial analysis division for consideration as a part of the financial analysis process:

1. Financial condition examination reports, which include significant adjustments to the financial information reported to the insurance department, corrective actions required to be taken by the insurer and/or recommendations for improvements based on examination results. Communication from financial examination staff may also include significant current events, company conditions and issues, industry conditions impacting the insurer and other financial concerns (changes in profitability trends, deterioration in asset quality, liquidity or capital adequacy or changes in investment strategies or reinsurance). Moreover, the risk-focused examination may provide information about the insurer's prospective risks and the effectiveness of the insurer's risk-management processes.
2. Market conduct examination reports containing corrective actions required to be taken by the insurer as a result of violations in sales, advertising, rating and/or claims practices, which might be an indication of financial problems or lead to the risk of financial losses through class action suits or regulatory fines (market conduct examinations).
3. Any relevant information obtained in planning the financial examination stage.
4. An increase in the number or type of complaints filed by policyholders, claimants, employees, agents or third parties, which could indicate liquidity or internal control problems (consumer affairs).
5. Corrective orders and other regulatory actions taken against an insurer, and fines and penalties levied (enforcement).
6. New policy form filings or expansion into new lines of business, including high-risk and long-tail lines of business, which might imply planned rapid growth to obtain premiums to improve liquidity or cover prior losses (policy/forms analysis).
7. Requests for significant premium rate increases, which might be an indication of insufficient rates to cover losses and expenses in the past (rate filings).

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8. An increase in the licensing of agents, including managing general agents or third-party administrators, which could indicate planned rapid expansion or relaxed underwriting standards (agent licensing).
9. The use of managing general agents or third-party administrators, which might be an indication that the insurer is not in control of its operations (agent licensing).
10. Information that management personnel of an insurer—including officers, directors or any other persons who directly or indirectly control the operations of the insurer—fail to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position (legal).
11. The unexpected resignation of an insurer's officers, directors or other management personnel, which might indicate internal turmoil or dissatisfaction with the insurer's goals or operating practices (legal).

Intradepartmental Communication System

Intradepartmental communication in most state insurance departments is primarily informal, due to the size of the insurance department and the location of insurance department personnel. The commissioner may hold periodic meetings with the division heads to discuss current developments and concerns in each division. In addition, in some states, division heads prepare monthly activity reports that highlight current developments and are circulated to the other divisions within the insurance department. Insurance departments should have a formal structured mechanism to assure appropriate ongoing intradepartmental communication. Adequate controls should be implemented to assure that recommendations, decisions, actions and results are effectively communicated and documented. Among the key objectives of a department's intradepartmental communication system are the following:

1. Key insurance department officials should possess all relevant information to permit decisions to be made on a timely basis.
2. The state insurance department should assure that all levels of staff have the appropriate knowledge, information and feedback to effectively perform their assigned functions.
3. Managers within various functional units or divisions should be responsible for the proper internal communications and documentation of decisions and actions taken under their authority.
4. The state insurance department should establish procedures to assure that orders and directives are effectively communicated to the appropriate staff and that the staff observes such orders and directives.

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I. Introduction – B. Interstate Communication and Cooperation

The operations of an insurance company often are not limited to one jurisdiction. Therefore, domestic state insurance departments need to coordinate their regulatory efforts with those of other state insurance departments in which their insurers do business. The NAIC *Troubled Insurance Company Handbook* states that opportunities to coordinate efforts should be sought throughout the entire process from the monitoring and surveillance of insurance companies through regulatory actions regarding identified troubled insurers. Coordinated activities may take various forms, including: 1) establishment and maintenance of procedures to communicate information regarding troubled insurers with other state insurance departments; 2) participation on joint examinations of insurers; 3) assignment of specific regulatory tasks to different state insurance departments in order to achieve efficiency and effectiveness in regulatory efforts and to share personnel resources and expertise; and 4) establishment of task forces consisting of personnel from various state insurance departments to carry out coordinated actions. Coordination of actions may also be useful to avoid competing individual state insurance department actions that may be counterproductive.

The NAIC Policy Statement on Financial Regulation Standards indicates that a state insurance department should generally follow and observe the procedures set forth in the NAIC *Troubled Insurance Company Handbook*. The NAIC *Troubled Insurance Company Handbook* provides guidance regarding communication with other state insurance departments about domestic insurers identified as troubled. Specifically, the standards state:

> State statute should allow for the sharing of otherwise confidential information, administrative or judicial orders, or other action with other state regulatory officials providing that those officials are required, under their law, to maintain its confidentiality. The department should have an established written policy to cooperate and share all information with respect to domestic insurers with other state regulators, including committees established by the NAIC that may be reviewing and coordinating regulatory oversight and activities. This policy should also include cooperation and sharing information with respect to domestic insurers subject to delinquency proceedings.

The insurance department should establish and implement procedures to ensure that regulatory actions are reported to the NAIC Regulatory Information Retrieval System (RIRS), that investigative information be reported to the NAIC Special Activities Database (SAD), that summary information on consumer complaints be reported to the NAIC Complaints Database System (CDS) and that the status of regulatory actions be reported to the Global Receivership Information Database (GRID). (These databases are discussed in more detail in Introduction - NAIC Information.)

Effective interdepartmental action requires timely and effective communication among the various state insurance departments. Insurance departments should develop methods to receive, as well as to communicate, pertinent information regarding troubled insurers promptly to other affected jurisdictions. Good lines of communication may provide additional information to an insurance department to assist in its surveillance, as well as provide information to other state insurance departments. Such communications should be established to foster cooperation among the various state insurance departments such that each insurance department works toward the satisfactory resolution of all troubled insurer situations, regardless of the insurer's domicile, license or operating status. Communications to other state insurance departments regarding troubled insurers should be made in an atmosphere of appropriate confidentiality. Knowledge by outsiders of actual or contemplated regulatory activities may cause undue negative consequences to the insurer (e.g., cancellation of policies or unavailability of reinsurance coverage), and those factors may diminish the insurer's ability to receive assistance or to survive.

The NAIC *Troubled Insurance Company Handbook* indicates that the effects on policyholders in all jurisdictions that may result from the actions of an insurance department should be considered. However, although the insurance department should consider any adverse consequences that possibly could result from making certain information known to other state insurance departments, those possible disadvantages may be outweighed by the advantages gained from sharing information and working with the other state insurance departments.

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I. Introduction – B. Interstate Communication and Cooperation

An insurance department may go beyond routine communications to allow other state insurance departments to participate in decision making activities related to an insurer that operates in more than one jurisdiction. Any such joint action obviously depends on the nature of the decisions to be made and the relative impact on a particular jurisdiction. However, cooperation of this nature can significantly improve communications between state insurance departments, and the resulting increased knowledge of the insurer's condition and circumstances can lead to more effective regulatory action.

The NAIC and its various committees, task forces and working groups may also provide a means for facilitating coordination and communication among the various state insurance departments. For example, the NAIC Financial Condition (E) Committee can participate in coordinating the efforts of various state insurance departments in a troubled insurer situation. An "association" examination of an insurance company may be requested through the NAIC, as described in the NAIC *Financial Examiners Handbook*. The NAIC Financial Analysis Working Group functions as a peer review by identifying insurance companies of national significance that are, or may be, financially troubled, and determining whether appropriate regulatory action is being taken. The NAIC may also assist in organizing and facilitating other cooperative regulatory efforts, such as the formation of working groups to address specific troubled insurance company situations.

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I. Introduction – C. External Information

There is a considerable amount of information available to assist the analyst in reviewing insurance companies. The NAIC maintains financial databases developed from the insurer filings and state insurance department actions, all of which are described in more detail in the next chapter. In addition to the NAIC information, there are a number of external sources of information available from the major rating agencies and industry analysts. The analyst should refer to these sources of information in order to increase his or her knowledge of the insurer's financial position, and to corroborate the financial information filed by the insurer with the NAIC and state insurance departments. These sources of information are all available through direct purchase or subscription order from the rating agencies and/or industry analysts. Following is a discussion of the major sources of external information available to the analyst.

Rating Agencies

There are five major rating agencies that analyze insurance companies. Each has its own unique methodology for assigning ratings. The rating agencies also produce other types of financial information that may be helpful to the analyst. The following paragraphs briefly describe each of the major rating agencies and the types of financial information available.

1. *A.M. Best* – The A.M. Best Company has been rating life/health insurance companies since 1900. The objective of Best's rating system is to evaluate the factors affecting the overall performance of an insurance company to provide its opinion as to the company's relative financial strength and ability to meet its contractual obligations. Best conducts an extensive quantitative and qualitative evaluation of rated insurers based on various sources of information and knowledge of the company accumulated over a long period of time. This knowledge is acquired through frequent contacts with company officials as well as by examining statutory financial statements, special questionnaires and a variety of other sources. To obtain an A.M. Best rating, a newly rated insurer should have a three to five year business plan, experienced management, $2.0 million in surplus, submit the requested financial information, and pay a fee. The ratings are available through Best's Key Rating Guide and Best's Rating Online. Best also publishes Aggregates and Averages, Company Reports, a Rating and Statistical Guide as well as many other publications, directories, reports and periodicals.

2. *Fitch* – Fitch Ratings was founded as the Fitch Publishing Company on Dec. 24, 1913. Fitch began as a publisher of financial statistics and soon became the recognized leader in providing critical financial statistics to the investment community. In 1924, Fitch introduced the "AAA" to "D" ratings scale along with in-depth analysis that was completed by a staff of investment experts. Fitch's ratings evaluations are qualitative and quantitative. Fitch provides two basic types of ratings, insurer financial strength (IFS) rating and issuer and fixed income security rating. The ratings are obtained via in-depth industry, operational, organization, management, and financial reviews. The ratings are available through Fitch's National Ratings List and Fitch Ratings Online.

3. *Moody's Investors Service* – Moody's Investors Service was founded in 1900. Today, Moody's rates approximately $30.0 trillion of debt securities in approximately 100 countries. Included in these ratings are taxable bonds, structured financings and municipal bonds in the U.S. tax-exempt market. In addition, Moody's rates U.S. Treasury debt, deposits of over 700 banking groups, trillions of dollars of credit risk exposure in derivative markets and insurance claims. In the insurance sector, Moody's has been rating the debt securities of insurance companies since the mid-1970s. Moody's began assigning insurance company financial strength ratings in 1986. Moody's financial strength ratings reflect its opinion as to an insurer's ability to discharge senior policyholder obligations and claims. It seeks to measure "credit risk" (e.g., the risk that an insurer will fail to honor its senior policyholder claims in full and on a timely basis). Moody's financial strength ratings are based on qualitative analysis. Moody's disseminates its ratings through various publications. Moody's publishes credit opinions on a semi-annual basis and in-depth analysis,

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industry outlooks and a statistical handbook on an annual basis. Moody's also publishes insurance financial strength ratings lists and insurance debt lists monthly.

4. *Standard and Poor's* - Standard and Poor's (S&P) has been rating bonds since 1923 and insurance companies' claims-paying ability since 1983. S&P's insurer rating activity draws from its expertise and procedures in rating debt issues and utilizes a similar classification framework, but is conducted by professional analysts whose background, experience and/or training is focused on the insurance industry. S&P sees its role as one of providing risk assessment of insurers to insurance buyers rather than serving as an advisor to insurers to assist them in improving their financial condition and rating. S&P's claims-paying ability rating is an assessment of an operating insurance company's financial capacity to meet its policyholder obligations in accordance with their terms. Claims-paying ability ratings are based on a comprehensive quantitative and qualitative financial analysis using various sources of information, including interviews with company management. S&P insurance ratings are available on Credit Analysis Reference Disk (CARD). The disk is updated twice a month and provides a complete database of global insurance information on CD. Each disk includes interactive and public information financial strength ratings for approximately 4,000 insurers, and debt ratings on more than 200 insurers. The disk also includes pool affiliations, NAIC codes, key statistics and full analysis on approximately 600 insurers worldwide.

5. TheStreet.com Ratings, formerly *Weiss Research*—TheStreet.com Ratings acquired the ratings business from Weiss Ratings, Inc. in August 2006. Martin D. Weiss, founder of Weiss Research, has been publishing newsletters about money markets, interest rates, bank safety, and economic forecasting since 1971. In 1989, Weiss began publishing "safety ratings" of life, health, and annuity insurers. Weiss' methodology and rating scale has generated some controversy within the industry. Weiss' safety rating indicates its opinion regarding an insurer's ability to meet its commitments to its policyholders under current economic conditions. An insurer's rating is determined based on a detailed analysis of numerous factors that are synthesized into a series of indexes such as capitalization, reserve adequacy, profitability, liquidity, and stability. The data for the analysis is obtained from statutory statements filed with the NAIC. TheStreet.com Ratings will continue to be called "Weiss Ratings" and emphasizes that it bases its analysis exclusively on objective, quantifiable information and other financial information provided by the insurers. Unlike other rating agencies, the Weiss Ratings product line does not accept compensation from the companies it rates nor does it allow the rated companies to influence the rating. Weiss supports its insurer rating activities through the sale of its rating information to the public.

Industry Analysts

In addition to the rating agencies, many of the investment houses and stock research firms do considerable research on the insurance industry. The following paragraphs briefly describe several sources.

1. *Investment Houses* - The major Wall Street firms dedicate considerable resources towards researching insurance industry issues. In general, much of this type of research is oriented towards emerging issues facing the industry. Specific insurance company research is also available, but is generally limited to companies with publicly traded debt or equity securities.

2. *Ward's Results* - Annually, Ward Financial Group publishes a financial reference series entitled *Ward's Results*, available in separate life/health and property/casualty editions. The books include financial benchmarks for U.S.-domiciled insurers, including unique peer group benchmarks. The life/health edition groups each company into peer groups that consider the insurer's product mix, asset size and ownership structure. The property/casualty edition groups each company into peer groups that considers the insurer's product mix, premium volume and geographic mix of business. In addition to peer group benchmarks, the books also include top performing, stock company and mutual company benchmarks.

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I. Introduction – C. External Information

SEC Filings

Insurers that offer debt or equity securities to the public must register with the Securities and Exchange Commission (SEC) and fulfill various reporting requirements. Where applicable, the various SEC filings provide significant background information about the insurer and can assist the analyst in corroborating the information filed by the insurer with the NAIC or state insurance departments. Most of the SEC filings are also available online at no charge. While the SEC filing requirements are quite comprehensive, the following summarizes three of the SEC filing forms that may be of particular interest to the analyst.

1. *Form 10-K* - The 10-K is the form used to fulfill the SEC's annual reporting requirements. The 10-K must be filed with the SEC within ninety days after the insurer's year-end. Types of information incorporated into the 10-K includes:

    a. Item 1 – Business

    b Item 2 – Properties

    c. Item 3 – Legal proceedings

    d. Item 4 – Submission of matters to a vote of security holders

    e. Item 5 – Market for registrant's common equity and related stockholder matters and issuer purchases of equity securities

    f. Item 6 – Selected financial data

    g. Item 7 – Management's discussion and analysis of financial condition and results of operations

    h. Item 7A. – Quantitative and qualitative disclosures about market risk

    i. Item 8 – Financial statements (which must include the audit report of an independent accountant, management's assessment of internal controls and the audit report on internal controls) and supplemental data

    j. Item 9 – Changes in and disagreements with accountants on accounting and financial disclosure

    k. Item 9A – Controls and procedures

    l. Item 9B – Other information

    m. Item 10 – Directors and executive officers of the registrant

    n. Item 11 – Executive compensation

    o. Item 12 – Security ownership of certain beneficial owners and management

    p. Item 13 – Certain relationships and related transactions

    q. Item 14 – Principal accounting fees and schedules

    r. Item 15 – Exhibits and financial statement schedules

2. *Form 10-Q* – Form 10-Q is the form used to fulfill the SEC's quarterly reporting requirements. The 10-Q must be filed with the SEC within forty-five days after the end of each of the insurer's first three quarters and must include a condensed income statement, a condensed balance sheet and an abbreviated statement of cash flow.

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3. *Form 8-K* - Form 8-K is required after any of the following events occur:
   a. Change in control
   b. Major acquisition or disposition of assets. For certain acquisitions and dispositions, historical and pro forma financial statements are required
   c. Bankruptcy or receivership
   d. Change of independent accountant
   e. Other events
   f. Resignation of registrant's directors
   g. Change in fiscal year

Other External Sources

In addition to the specific sources referenced above, other resources that provide updates about the industry and specific insurers include:

a. Business Insurance
b. BestWeek
c. Best Review
d. National Underwriter
e. The Wall Street Journal
f. Bloomberg Financial
g. Factiva (Reuters Insurance Briefing)

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I. Introduction – D. NAIC Information

In addition to the external information discussed in the previous chapter, there is a considerable amount of information available from the NAIC to assist the analyst in analyzing insurance companies. Most insurers are required to file Annual Financial Statements and Quarterly Financial Statements with the NAIC. Much of the information available from the NAIC is based on data included in these filings and is made available on the NAIC Financial Database Repository. In addition, other NAIC databases include information input by the various state insurance departments regarding regulatory actions taken against insurers, regulatory concerns about insurers or individuals and consumer complaints filed against insurers. Following is a discussion of the more significant information available to the analyst from the NAIC.

Financial Analysis Solvency Tools (FAST)

FAST is a collection of analytical tools within the Insurance Regulatory Information System (IRIS) designed to provide state insurance departments with an integrated approach to screening and analyzing the financial condition of insurance companies. In addition, FAST assists state insurance departments in allocating resources to those insurers in greatest need of regulatory attention, targeting those specific aspects of an insurer's financial position that could put the insurer at risk of future insolvency.

Scoring System

The Scoring System consists of a series of annual and quarterly ratios for which an insurer scores a given number of points based on certain parameters set for each ratio. These ratios generally focus on an insurer's financial position, results of operations, cash flow and liquidity and leverage. Certain insurers writing both life and accident and health insurance meet the requirements for "hybrid' status. For these hybrid insurers, both life and accident and health ratios are available. There are 19 annual ratios for life insurers and 18 annual ratios for accident and health insurers. On a quarterly basis, there are 14 life ratios and 18 ratios for accident and health insurers Insurers with the highest scores would generally be considered to be insurers showing a higher risk of future insolvency. The Scoring System is designed so that an analyst can screen insurers on a total score basis or analyze each ratio result separately. Annually, the NAIC Insurance Analysis & Information Services Department, under the direction of the Financial Analysis Research and Development (E) Working Group, ensures that the Scoring System ratios are current and continue to be relevant to solvency monitoring, and that the scoring parameters remain appropriate.

Financial Profile Reports

Financial Profile Reports are generated from Annual Financial Statement and Quarterly Financial Statement data. These Financial Profile Reports can be generated to provide either: 1) a quick quarterly or five-year summary of an insurer's financial position; or 2) an in-depth five-year analysis of all aspects of an insurer's operations. Financial Profile Reports can assist the analyst in identifying unusual fluctuations or trends in, or changes in the mix of, an insurer's assets, liabilities, capital and surplus, and operations.

IRIS Ratio Application

The NAIC IRIS Ratio Application is one of the tools that helps to identify those insurers that merit highest priority in the allocation of the state insurance department's resources, thus directing those resources to the best possible use.

The IRIS Ratio Application uses key financial data from the Annual Financial Statement to calculate ratio results. There are 12 IRIS ratios calculated for life/health insurers and 11 IRIS ratios for Fraternal Societies. The calculated results for each insurer are compared to the usual range of results for each ratio. Falling outside the "usual range" is not considered a "failing" result. For example, an increase in surplus or premiums that is larger than "usual" is not necessarily negative. Furthermore, in some years it may not be unusual for financially stable insurers to have several ratios with results outside the "usual range."

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I. Introduction – D. NAIC Information

IRIS ratio results are dependent on the accuracy of the Annual Financial Statement filed by insurers. The ratios cannot identify a misstatement of financial condition or the application of improper accounting practices or procedures. In fact, the NAIC warns state insurance departments not to rely on IRIS ratios as the only form of financial surveillance of insurers. IRIS ratios should be used in conjunction with the other NAIC solvency tools.

Analyst Team System

The Analyst Team reviews the Annual Financial Statements and ratio results of insurers meeting certain criteria (including four or more IRIS ratio results falling outside the "usual range" as determined by the NAIC) by experienced examiners and analysts from several of the state insurance departments representing all zones of the NAIC. The Analyst Team reviews selected insurers, validates automated level designations assigned and provides brief synopses of their validation findings or comments explaining factors that affect the insurer's overall financial condition. Insurers are selected for validation based upon scores, ratios and overall financial condition based on criteria established by the NAIC Examination Oversight (E) Task Force.

Examination Jumpstart

Examination Jumpstart, which is available through I-SITE, was developed by the NAIC to assist examiners in performing financial condition examinations. Using Examination Jumpstart, numerous reports can be generated pertaining to an insurer's reinsurance program and investment portfolio based on the information included in the NAIC database from the insurer's Annual Financial Statement. In addition, for property/casualty insurers, loss reserve analysis can be performed. Although Examination Jumpstart was developed to assist examiners in performing financial condition examinations, many of the applications may be of interest to the financial analyst as well. Following is a brief discussion of some of the Examination Jumpstart reports available that may assist the financial analyst in the analysis process.

1. Assumed/CededReinsurance Reports – Reconcile the reinsurance assumed by the selected company to the reinsurance ceded by other reinsurers, and similarly reinsurance ceded by the selected company to the reinsurance assumed by other insurers.
2. Investment CUSIP Exception/Designation Reports – Attempt to show those CUSIP numbers listed on Schedule D that are not accounted for by the NAIC's Securities Valuation Office because the CUSIP number does not exist, or it was entered improperly.
3. Investment Market Value Reports – List those investments where the listed value is significantly different than the actual value.
4. Investment Material Holdings Reports – Create reports that show material holdings and designate which holdings you want to include in the report.
5. Specific Designation Reports – Generate a list of investments having one designation.
6. Missing CUSIP – The CUSIP number is not found in the VOS datafile or the FE datafile.

Regulatory Information Retrieval System

The I-SITE application Regulatory Information Retrieval System (RIRS) is a database which contains information regarding formal administrative and regulatory actions taken against insurers and insurance agents. Information on RIRS includes: 1) the insurer or insurance agent against which formal administrative or regulatory action was taken; 2) the date of the action; 3) the state taking the action; 4) the reason for the action; 5) the disposition; and 6) the amount of monetary penalty levied. RIRS relies on input from the state insurance departments of all final actions taken and is available on-line to all state insurance departments.

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I. Introduction – D. NAIC Information

Special Activities Database

The I-SITE application, Special Activities Database (SAD), is a confidential database that tracks insurers, individuals, and entities which have been the subject of state insurance department inquiry. SAD is designed to flag entities or individuals of insurance regulatory concern and to provide regulatory contacts for obtaining more detailed information that can be considered in a more critical and subjective fashion. SAD will not provide all the particulars regarding events, dates, or related issues. These particulars should be fully investigated before any further regulatory action is contemplated.

Complaints Database System

The I-SITE application, Complaints Database System (CDS), is a database that contains information regarding consumer complaints filed against a firm or individuals in the insurance industry. CDS provides state insurance departments with the ability to evaluate an insurer's comparative performance in the marketplace. CDS generates consumer complaint activity trends by month and year and complaint counts by reason (e.g., claim payment delays).

Market Initiative Tracking System

The I-SITE application, Market Initiative Tracking System (MITS), tracks information concerning actions state regulators take in investigating the business practices of insurers. This system was designed to capture market initiatives that may impact other jurisdictions. These initiatives may include, but are not limited to, any of the options from the continuum of regulatory responses:

- Applied Regulatory Responses and Enforcement Actions
- Interviews with the Insurer, Correspondence or Information Gathering
- Desk Audits, Insurer Self Audits, or On-Site Audits
- Voluntary Compliance Programs
- Information Sharing
- Investigation
- Targeted, Comprehensive, and Multi-Jurisdictional Examinations

Global Receivership Information Database

The I-SITE application Global Receivership Information Database (GRID) allows the regulator to review the status of a receivership (i.e. conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post receivership data, creditor class/claim data, legal data, financial and reporting data.

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I. Introduction – E. SAP VS GAAP

Statutory Accounting Principles (SAP) are those accounting principles or practices which are prescribed or permitted by the insurer's domiciliary state insurance department. SAP is prescribed in the insurance statutes, regulations and administrative rules of the various states, and in the NAIC *Accounting Practices and Procedures Manual (AP&P Manual)*, the NAIC *Annual Statement Instructions*, the NAIC *Financial Condition Examiners Handbook*, the NAIC *Purposes and Procedures of the Securities Valuation Office Manual (SVO P&P Manual)*, and NAIC subcommittee and task force minutes. In addition, certain accounting practices are explicitly or implicitly permitted by the various state insurance departments on an issue by issue and/or company by company basis.

Financial statements filed with the state insurance departments are prepared on a SAP basis. Since the primary concerns of insurance regulators are the protection of the policyholders and the solvency of each insurer, SAP places emphasis on the adequacy of statutory capital and surplus. Adequate capital and surplus provides protection against adverse operating results and also permits an insurer to expand its business. In addition, SAP emphasizes the balance sheet, rather than the income statement. Statutory accounting is primarily directed toward the determination of an insurer's financial condition and its ability to satisfy its obligations to its policyholders and creditors as of a certain date.

As stated in the Preamble to the *AP&P Manual*, SAP is based on the concepts of conservatism, consistency and recognition. Each of these concepts is discussed in more detail below:

> *Conservatism* – Financial reporting by insurers requires the use of substantial judgments and estimates by management. Such estimates may vary from the actual amounts for various reasons. To the extent that factors or events result in adverse variation from management's accounting estimates, the ability to meet policyholder obligations may be lessened. In order to provide a margin of protection for policyholders, the concept of conservatism should be followed when developing estimates as well as establishing accounting principles for statutory reporting.
>
> Conservative valuation procedures provide protection to policyholders against adverse fluctuations in financial condition or operating results. Statutory accounting should be reasonably conservative over the span of economic cycles and in recognition of the primary responsibility to regulate for financial solvency. Valuation procedures should, to the extent possible, prevent sharp fluctuations in surplus.
>
> *Consistency* – The regulators' need for meaningful, comparable financial information to determine an insurer's financial condition requires consistency in the development and application of SAP. Because the marketplace, the economic and business environment, and insurance industry products and practices are constantly changing, regulatory concerns are also changing. An effective statutory accounting model must be responsive to these changes and address emerging accounting issues. Precedent or historically accepted practice alone should not be sufficient justfications for continuing to follow a particular accounting principle or practice which may not coincide with the objectives of regulators.
>
> *Recognition* – The principal focus of solvency measurement is determination of financial condition through analysis of the balance sheet. However, protection of the policyholders can only be maintained through continued monitoring of the insurance enterprise. Operating performance is another indicator of an insurer's ability to maintain itself as a going concern. Accordingly, the income statement is a secondary focus of statutory accounting and should not be diminished in importance to the extent contemplated by a liquidation basis of accounting.
>
> The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than for fulfilling policyholder obligations, or those assets which may be unavailable due to encumbrances or

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other third-party interests should not be carried on the balance sheet, but rather should be charged against surplus when acquired or when availability otherwise becomes questionable.

Liabilities require recognition as they are incurred. Certain statutorily mandated liabilities may also be required to arrive at conservative estimates of liabilities and probable loss contingencies (e.g., interest maintenance reserves, asset valuation reserves, and others).

Revenue should be recognized only as the earnings process of the underlying underwriting or investment business is completed. Accounting treatments that tend to defer expense recognition do not generally represent acceptable SAP treatment.

SAP income reflects the extent that changes have occurred in SAP assets and liabilities for current period transactions, except changes in capital resulting from receipts or distributions to owners. SAP income also excludes certain other direct charges to surplus which are not directly attributable to the earnings process (e.g., change in non-admitted assets).

Although the Annual Financial Statements, Quarterly Financial Statements and Annual Audited Financial Reports filed with the state insurance departments by insurers are prepared on the basis of SAP, financial analysts also review Holding Company filings and Securities and Exchange Commission (SEC) filings, which may include financial statements prepared based on Generally Accepted Accounting Principles (GAAP). Therefore, the financial analyst must also have a general understanding of GAAP.

There are two main conceptual differences between SAP and GAAP. First, SAP stresses measurement of ability to pay claims in the future, whereas GAAP stresses measurement of emerging earnings of a business from period to period (e.g., matching revenue to expenses).

The following is a discussion of the more significant specific differences between SAP and GAAP for a life/health insurance company:

Acquisition costs – Under Statement of Statutory Accounting Principles (SSAP) No. 71, *Policy acquisition Costs and Commissions*, all acquisition costs, such as commissions and other costs incurred in acquiring and renewing business, are expensed as they are incurred. Under GAAP, those acquisition costs that are primarily related to, and vary with, the volume of premium income are capitalized as an asset and are then amortized by periodic charges to earnings over the terms of the related policies.

Valuation of bonds and redeemable preferred stocks – Under SSAP No. 26*, Bonds, excluding Loan-Backed and Structured Securities* and SSAP No. 32*, Investments in Preferred Stock (including investments in perferred stock of subsidiary, controlled or affiliated entities)*, bonds and redeemable preferred stocks are carried at amortized cost or NAIC values in accordance with the NAIC designation of the securities. Under GAAP, bonds and redeemable preferred stocks are carried at amortized cost only if the insurer has the ability and intent to hold the securities to maturity and there are no (other-than-temporary) declines in market value, otherwise they are carried at market.

Non-admitted assets – Under SSAP No. 4*, Assets and Non-admitted Assets,* as superceded by SSAP No. 87, *Other Admitted Assets*, assets having economic value other than those which can be used to fulfill policyholder obligations, or other third party interests should not be recognized on the balance sheet and are therefore considered non-admitted. SSAP No. 4 defines non-admitted assets as an asset that is accorded limited or no value in statutory reporting, and is one that is either specifically identified as a non-admitted asset or not specifically identified as an admitted asset within the *AP&P Manual.* SSAP No. 20, *Non-admitted Assets,* specifically identifies the following as non-admitted assets: deposits in suspended depositories; bills receivable not for premium and loans unsecured or secured by assets that do

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not qualify as investments; loans on personal security, cash advances to, or in the hands of, officers or agents and travel advances; all "non-bankable" checks (e.g., non-sufficient funds); trade names and other intangible assets; automobiles, airplanes and other vehicles; furniture, fixtures and equipment; and company's stock as collateral for loan.

Deferred income taxes – Under SSAP No. 10, *Income Taxes*, deferred income tax assets are limited under admissibility test and amounts over the criterion are non-admitted. Under GAAP, a valuation allowance is used to reduce the asset to what can be realized. Also, under SSAP No. 10, changes in deferred tax assets and deferred tax liabilities are reported as a separate line in the surplus section. Under GAAP, changes in DTAs and DTLs are recognized in earnings.

Goodwill – Under SSAP No. 68, *Business Contributions and Goodwill,* as superceded by SSAP No. 97, *Investments in Subsidiary, Controlled and Affiliated Entities*, goodwill represents the difference between the cost of acquiring the entity and the book value of the acquired entity. Under GAAP, goodwill represents the difference between cost of acquiring the entity and the fair value of the assets less liabilities acquired.

Policy and contract reserves – Under SSAP No. 51, *Life Contracts* and SSAP No. 52, *Deposit-Type Contracts*, policy and contract reserves are computed using statutorily prescribed mortality and interest requirements and without consideration of withdrawals. Under GAAP, policy and contract reserves are computed based on reasonably conservative estimates of mortality, interest and withdrawals.

Asset valuation reserve – Under SSAP No. 7, *Asset Valuation Reserve and Interest Maintenance Reserve,* the asset valuation reserve (AVR) is calculated in accordance with the formula prescribed by the NAIC and reported as a liability. Under GAAP, if an asset reserve is determined to be necessary, it is reported as a valuation allowance or an appropriation of surplus.

Realized gains and losses – Under SSAP No. 7, *Asset Valuation Reserve and Interest Maintenance Reserve,* realized gains or losses are reported in income net of tax. In addition, an interest maintenance reserve (IMR) is maintained that results in the deferral and amortization of certain realized gains and losses as prescribed by the NAIC. Under GAAP, realized gains and losses are reported on a pre-tax basis. Also, under GAAP, there is no deferral and amortization of realized gains and losses.

Reinsurance in unauthorized companies – Under SSAP No. 61, *Life, Deposit-Type and Accident & Health Reinsurance*, a liability is established to offset credit taken in various balance sheet accounts for reinsurance ceded to unauthorized reinsurers. Under GAAP, reinsurance credits are allowed, subject to tests of recoverability.

Surplus notes – Under SSAP No. 41, *Surplus Notes*, surplus notes meeting certain requirements are considered as surplus. Under GAAP, surplus notes are considered to be debt.

In addition to the review of Holding Company filings and SEC filings, which include financial statements prepared based on GAAP, the analyst should also consider requesting and analyzing GAAP financial statements from other insurers as well. Although GAAP financial statements are not required for most insurers that are not publicly traded, many of these insurers do prepare GAAP financial statements for internal analysis. Comparing financial results based on SAP to those based on GAAP for an insurer can provide meaningful information to the analyst regarding the insurer's profitability on a going-concern basis.

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I. Introduction – F. Prioritization of Work

The NAIC Policy Statement on Financial Regulation Standards indicates that a state insurance department's financial analysis process should be priority based to ensure that potential problem insurers are reviewed promptly and that the prioritization scheme should utilize the NAIC Insurance Regulatory Information System (IRIS) and/or a state insurance department's own system.

To facilitate the financial analysis process, state insurance departments should establish a system to prioritize or classify insurance companies according to each insurer's relative stability and the perceived need for analysis. This prioritization system may be either formal, including the assignment of priority designations, or informal in nature. States with a small number of domestic insurers may consider all of their domestic insurers to be priority companies. However, states with a larger number of domestic insurers generally have more formal prioritization systems. In these states, prioritization is necessary because a state insurance department's financial analysts are not able to thoroughly analyze the financial condition of all insurers immediately upon receipt of the Annual Financial Statement, Quarterly Financial Statement and the supplemental filings.

An insurer's priority level should be reconsidered as the result of each review performed to determine whether the designation is still appropriate. However, changes in priority levels should only be made after approval by senior insurance department personnel.

Although prioritization is, to a large extent, subjective, a state insurance department should establish guidelines to assist in the consistent assignment of priority designations to its insurers. Factors which should be given consideration in the state insurance department's prioritization system include, but are not limited to, the following:

1. Results of the prior year analysis (including the analysis of the Annual Financial Statement, Quarterly Financial Statements and the various supplemental filings)
2. Whether the insurer was a validated "Level A" or "Level B" company in the prior year by the Analyst Team
3. Adequacy of the insurer's capital and surplus
4. Significant changes in the insurer's capital and surplus
5. Negative trends in income and/or cash flow
6. IRIS ratio results and the NAIC Analyst Team Reports
7. Annual and quarterly Scoring System results
8. Changes in the insurer's management or board of directors
9. Results of the Annual Financial Analysis Handbook, Level 1 Procedure
10. Analysis performed by the NAIC Financial Analysis Working Group
11. Examination reports issued (financial condition and market conduct)
12. Information from other divisions or areas of the insurance department
13. Independent rating organization ratings and reports
14. Impact on the public of an insurer's insolvency

As a general rule, financial statements and other materials pertaining to those insurers that are deemed a high priority should be reviewed before those materials pertaining to lower priority insurers. In addition, the review of high priority insurers might be more in-depth than the review of lower priority insurers.

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II. Financial Analysis Framework

Overview of the Financial Analysis Process

Financial analysis is an on-going process which can be divided into annual cycles, each of which includes the analysis of the Annual Financial Statement, Quarterly Financial Statements and the various supplemental filings including the Statement of Actuarial Opinion, Management's Discussion and Analysis (MD&A), Audited Financial Reports, and Holding Company Filings. The financial analysis process is designed to assist the analyst in reviewing and analyzing insurers throughout the annual cycle in a logical manner, focusing on areas of concern pertaining to the particular insurers being analyzed. The end result of this process is a financial analysis of each insurer specifically tailored to the concerns of that insurer as a result of its unique investments, underwriting, reserving and operations. Some of the financial analysis procedures are to be completed for all domestic insurers, while other procedures will only be completed if concerns are noted.

Procedure Description	Complete for All Domestics	Complete if Further Concern
Level 1 Annual Procedures, Annual Financial Statement, Annual Scoring, Financial Profile Report, IRIS	√	
Level 2 Annual Procedures	*	√
Level 3 Procedures		√
Supplemental Procedures:		
Audited Financial Reports	**	√
Statement of Actuarial Opinion	**	√
Mgmt's Discussion & Analysis (MD&A)	**	√
Holding Company Analysis		√
Forms A, B**, D, E & Extraordinary Dividends		√
Quarterly Procedures, Quarterly Financial Statement, Quarterly Scoring, Financial Profile Report	√	

* As discussed on the following page, the state should determine, based on the characteristics of its domestic industry, when and to what extent the Level 2 Procedures for Annual and Quarterly, or any similar analyses designed to meet the same objectives, should be used. Some Level 2 Annual Procedures or similar analysis should be performed for areas significant to the insurer.

** The completion of Supplemental Procedures or similar analysis is recommended for all multi-state insurers.

The following provides an overview of the Handbook's analysis process for an annual cycle, which focuses on the various documents filed with the insurance department by an insurer. The annual cycle is also presented in flowchart format at the end of the chapter.

NOTE: All references throughout this Handbook to the risk-focused surveillance approach, Insurer Profile Summary and Supervisory Plan apply only to states that have adopted and implemented the risk-focused surveillance approach. The ownership and responsibility for updates to the Insurer Profile Summary may vary from state to state between the analysis and examination departments.

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Annual Financial Statement

An insurer is required to file an Annual Financial Statement with the state of domicile, the NAIC and all states in which the insurer is authorized to transact business, by March 1 of each year or for the 12 months ended December 31 of the previous year. The Annual Financial Statement information is loaded onto the NAIC database, at which time the Annual Scoring System and IRIS ratios are calculated, and the NAIC Annual Financial Profile Reports and Handbook results are generated. All of this information is available to the state insurance departments via I-SITE.

The analysis of the Annual and Quarterly Financial Statements has been divided into three levels. The Level 1 analysis is to be performed for all domestic insurers. Level 2 and Level 3 analyses may be completed as a result of concerns identified in Level 1 at the department's discretion, based on the materiality of the concerns noted and their prior knowledge of the domestic insurer. At any level of analysis, the department may determine there is no further concern, or proceed directly to regulatory action. Following is a detailed discussion of each level of Annual Financial Statement analysis.

Level 1 Annual Analysis

The Level 1 analysis, which is to be performed for all domestic insurers, consists of an overall analysis of the insurer and its operations. As part of the Level 1 analysis, the analyst should review the NAIC's I-SITE Analyst Team System Report, Annual Scoring System Report, IRIS ratios and the information included in the Annual Financial Profile Report for the insurer. In addition, the analyst should perform the Level 1 Procedures (See Section IV. A) or any similar analysis designed to meet the same objectives. Level 1 Procedures require the analyst to review the analysis performed during the prior year and to perform an overall review of the Annual Financial Statement, including a review of the General Interrogatories and Notes to Financial Statements. Other reports to be reviewed are the Audited Financial Report, Statement of Actuarial Opinion, MD&A, Holding Company filings, and examination report and findings when they are filed.

The analyst should ensure that those insurers, that have been identified as having significant concerns as a result of the Level 1 analysis or other levels, if performed, would be subsequently analyzed on a priority basis for their future filings. The analyst should consider utilizing these prioritization tools: Analyst Team System Report, Annual Scoring System Report, Risk-Based Capital (RBC) report, and IRIS ratios. The analyst should also consider the results of the completion of the Level 1 Annual Procedures, similar analysis, or department policy.

There are five elements of the risk-focused surveillance cycle:

- The first element is Risk-Focused Examination, which addresses the need to identify key functional activities, risks, controls, and establish procedures and conduct an examination.
- The second element is Off-Site Focused Financial Analysis, which includes the use of all financial tools, such as ratio analysis.
- The third element is Internal/External Changes, which reviews any overall modifications to the insurer, such as corporate structure or management changes.
- The fourth element addresses the use of a Priority System to establish a priority of insurer reviews.
- The final element is the Supervisory Plan, which addresses the overall oversight of the insurer.

As part of the risk-focused surveillance approach, the analyst should work with the examination staff to assess the quality and reliability of corporate governance in order to identify, assess and manage the risk environment facing the insurer. This assessment will assist in identifying current or prospective solvency risk areas. Refer to Analyst Reference Guide for Level 1 Analysis for further discussion on prospective risk. By understanding the corporate governance structure and assessing the "tone at the top," the analyst will obtain information on the quality of

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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. To assist in this assessment, analysts may utilize:

1) Board and audit committee minutes.
2) List of critical management and operating committees, their members and meeting frequencies.
3) Examination findings related to the insurer's risk assessment and risk management activities.
4) Sarbanes-Oxley filings and similar filings through the NAIC Model Audit Rule, as applicable

At the conclusion of the Level 1 analysis, the analyst must determine whether to proceed to the Level 2 analysis. This determination should be approved in accordance with departmental procedure. States can make this decision in a variety of ways. For example, in some states, Level 2 analysis may be completed for all domestic insurers. Other states may require certain portions (e.g., investments, reserves and reinsurance) of the Level 2 analysis to be completed for all domestic insurers. Still other states may require Level 2 analyses to be completed only for those domestic insurers that meet certain criteria established by the state. The department may also proceed directly to the additional procedures listed in Level 2, Level 3 or other regulatory action authorized or required by state insurance law, regulation or department policy. Alternatively, the analysis may be concluded with only the Level 1 review. The analyst should also document any correspondence or follow-up with the insurer as a result of the Level 1, 2, 3 or Supplemental Procedures. At the completion of the analysis process, including any Level 1, 2, 3 or Supplemental Procedures, the analyst should update Insurer's Profile Summary, if applicable (see Level 1 Analyst Reference Guide).

Level 2 Annual Analysis

Because of the importance of financial analysis in the state's overall financial regulation and solvency surveillance process, the NAIC recommends that consideration be given to performing some portion of the Level 2 analysis for multi-state domestic insurers. The NAIC believes the Level 2 analysis (or applicable sections of that analysis) should be performed for multi-state domestic insurers with unresolved concerns identified as a result of prior analysis performed. Other factors, such as an insurers past regulatory history, accuracy of filing, age of insurer, stability of business plan, and knowledge of insurer's operations, may affect the extent to which Level 2 procedures are considered necessary.

The Level 2 analysis consists of the completion of the Level 2 Annual Procedures. These procedures have been designed to identify potential areas of concern regarding the financial position and operations of the insurer primarily through the use of ratio and trend analysis. The Level 2 Annual Procedures are divided into sections, each of which focuses on a key area (e.g., investments, reserves, reinsurance, income statement and surplus, affiliated transactions, the use of MGAs and TPAs, etc.) and utilizes information available from the Annual Financial Statement filed by the insurer. Each section includes one or more procedures focusing on a particular potential concern and each procedure includes one or more questions designed to assist the analyst in determining whether there is a concern that requires additional analysis in that area. If the analyst has questions regarding procedures included in any of the sections of the Level 2 Annual Procedures, reference should be made to the Analysts Reference Guide for a discussion of the procedures.

At the end of each section of the Level 2 Annual Procedures, the analyst is asked to do the following: 1) develop and document an overall conclusion regarding the section; 2) determine if one or more of the procedures in the Level 3 Procedures for this section should be completed; and 3) describe the rationale for this recommendation or recommend proceeding directly to other regulatory action. It may be appropriate that this information should be reviewed and approved prior to the analyst completing any of the procedures in the Level 3 Procedures. In addition, at the conclusion of an analysis, a management report that summarizes the results of the analysis performed, including the priority level assigned to each insurer, should be prepared and distributed to senior personnel.

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Level 3 Analysis

For those areas where concerns are identified as a result of the completion of the Level 2 Annual Procedures, Level 3 analysis could be performed. The Level 3 analysis consists of the completion, by the analyst, of one or more procedures in the Level 3 Procedures for those areas where concerns exist. The suggested procedures for the analyst to consider are keyed to specific concerns identified as a result of completion of procedures in the Level 2 Annual Procedures, and are designed to assist the analyst in focusing on those areas. If the analyst has questions regarding procedures included in any of the Level 3 Procedures, reference should be made to the Analysts Reference Guide. Some of the procedures in the Level 3 Procedures require the analyst to obtain additional information from the insurer that is not available from the filed Annual Financial Statement. Therefore, it is important that the analyst's proposed procedures be discussed with and approved by the analyst's supervisor prior to completion of the procedures. At this time, consideration of more substantive regulatory action or a more efficient utilization of department resources may be warranted

At the end of the Level 3 Procedures for each area, the analyst is asked to develop and document an overall conclusion regarding the area and to indicate recommendations for further action, if any. Recommendations for further action might include contacting the insurer for explanations or additional information, obtaining the insurer's business plan, requiring additional interim reporting from the insurer, referring concerns to the examination section for a targeted examination, engaging an independent expert to assist in determining whether a problem exists, meeting with the insurer's management, obtaining a corrective plan from the insurer, etc. At the conclusion of the Level 3 Procedures, a management report should be prepared and distributed to senior insurance department personnel. As discussed above, the management report should summarize the results of the analysis performed, any recommendations for further action and any adjustment to the priority level.

It is important for the analyst's supervisor to be actively involved in each level of the financial analysis performed on the Annual Financial Statement. It is also important that the review and supervision be performed on a timely basis.

Quarterly Financial Statements

An insurer is required to file Quarterly Financial Statements for the first, second and third quarters with the state of domicile, the NAIC and, in most instances, all states in which the insurer is authorized to do business by May 15, Aug. 15 and Nov. 15, respectively. The Quarterly Financial Statement is loaded onto the NAIC database, at which time the Quarterly Scoring System ratios and the Quarterly Financial Profile Report are generated. This information is available to the state insurance departments via I-SITE.

The Quarterly Financial Statement Level 1 analysis is to be completed for all domestic insurers. As part of the Quarterly Level 1 analysis, the analyst should review the Annual Financial Statement Level 1, Level 2 and Level 3 Procedures that were prepared and any quarterly procedures that had previously been completed for the insurer. In addition, the analyst should review the NAIC Quarterly Financial Profile Report, Quarterly Scoring System Report and the Quarterly Financial Statement. The Quarterly Level 1 Procedures are designed to identify potential areas of concern regarding the financial position and operations of the insurer, primarily through the use of ratio and trend analysis to indicate significant fluctuations from the prior quarter, prior year quarter, or prior year-end. The analyst will make the same determinations as for the Annual Level 1 Procedures whether to proceed with additional analysis or other procedures.

The Level 2 Quarterly Procedures are divided into sections, each of which focus on a key area for more in-depth review (similar to the Annual), and utilizes information available from the Quarterly Financial Statements. Each section includes one or more procedures designed to assist the analyst in determining whether there is a concern in a particular area that requires additional in-depth analysis and a determination similar to those required in the Level 2 Annual Procedures. If the analyst has questions regarding procedures included in any of the sections of the Level 2 Quarterly Procedures, references should be made to the Analysts Reference Guide.

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As part of the risk-focused surveillance approach, the analyst should work with the examination staff to assess the quality and reliability or corporate governance as discussed in the Annual Financial Statement section above.

At the end of each section of the Level 2 Quarterly Procedures, the analyst is asked to: 1) develop and document an overall conclusion regarding the section; 2) recommend whether one or more of the procedures in the Level 3 Procedures for this section should be completed (if not completed during the annual analysis); and 3) describe the rationale for this recommendation or recommend other substantive regulatory action. The analyst should also document any correspondence or follow-up with the insurer. It may be appropriate that this information be reviewed and approved prior to the analyst completing any of the procedures in the Level 3 Procedures. For a discussion of the completion of the Level 3 Procedures, refer to the discussion of the Annual Financial Statement Level 3 Analysis above. In addition, at the conclusion of an analysis, a management report that summarizes the results of the analysis performed, including the priority level assigned to each insurer should be prepared and distributed to senior personnel.

Audited Financial Report

Virtually all insurers are required to file, as a supplement to the Annual Financial Statement, an Audited Statutory Financial Report completed by an independent auditor; the auditor's letter of qualifications; and, if applicable, a report of significant deficiencies in the insurer's internal control structure with the state of domicile, the NAIC and all states in which the insurer is authorized to do business by June 1 of each year as of and for the 12 months ended December 31 of the previous year.

The Audited Financial Report review is to be completed for all domestic insurers if the Level 1 analysis indicated further procedures were necessary. The analyst should review any Level 2 and Level 3 Annual Procedures performed and complete the Audited Financial Report Supplemental Procedures. The Audited Financial Report Supplemental Procedures are designed to assist the analyst in reviewing the Audited Financial Report, the CPA's letter of qualifications and other reports filed to determine if they meet the requirements of the NAIC *Annual Financial Statement Instructions*; to ensure that amounts per the Audited Financial Report agree with the Annual Financial Statement filed with the insurance department; and to identify significant information and explanatory language included in the CPA's opinion or the Notes to the Audited Financial Report.

At the end of the Audited Financial Report Supplemental Procedures, the analyst is asked to develop and document an overall conclusion and to indicate recommendations for further action. Recommendations for further action might include contacting the insurer for explanations or additional information from either the insurer or the independent CPA, obtaining the insurer's business plan, requiring additional interim reporting, referring concerns to the examination section for a targeted examination, meeting with the insurer's management, or obtaining a corrective plan.

Statement of Actuarial Opinion

Virtually all insurers are required to file, as a supplement to the Annual Financial Statement, a Statement of Actuarial Opinion with the state of domicile, the NAIC and all states in which the insurer is authorized to transact business, by March 1 of each year covering the reserves as of December 31 of the previous year. The Statement of Actuarial Opinion must be completed by a qualified actuary.

The Statement of Actuarial Opinion review is to be completed for all domestic insurers as part of the Level 1 analysis and, if indicated, the analyst should complete the Statement of Actuarial Opinion Supplemental Procedures. If the Level 1 analysis indicates further procedures are necessary, the analyst could review the reserves and reinsurance sections of the Level 2 and Level 3 Annual Procedures. The Statement of Actuarial Opinion Procedures have been designed to assist the analyst in reviewing the Statement of Actuarial Opinion to determine that it meets the requirements of the NAIC Annual *Financial Statement Instructions*, that reserve amounts per the Statement of Actuarial Opinion agree with the reserve amounts per the Annual Financial

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Statement filed with the insurance department, and to identify significant information and explanatory language regarding the insurer that has been emphasized by the qualified actuary.

At the end of the Statement of Actuarial Opinion Supplemental Procedures, the analyst is asked to develop and document an overall conclusion and to indicate recommendations for further action. Recommendations for further action might include contacting the insurer for explanations or additional information, obtaining the insurer's business plan, requiring additional interim reporting from the insurer, referring concerns to the examination section for a targeted examination, consulting with an in-house actuary, engaging an independent actuary to assist in determining whether a problem exists, meeting with the insurer's management, or obtaining a corrective plan from the insurer.

Management's Discussion and Analysis

An insurer is required to file, as a supplement to the Annual Financial Statement, an MD&A with the state of domicile, the NAIC and all states in which the insurer is authorized to do business, by April 1 of each year. The purpose of this narrative document is to assist the analyst in understanding the insurer's financial position, prospective information, material changes, liquidity (i.e., asset/liability matching and capital resources), loss reserves, off-balance-sheet arrangements, participation in high yield financings, highly leveraged transactions or non-investment grade loans and investments, and preliminary merger/acquisition negotiations.

The MD&A review may be completed for all domestic insurers if Level 1 analysis indicated further procedures were necessary. The analyst should review the Level 2 and Level 3 Annual Procedures, if completed, and complete the MD&A Supplemental Procedures. The MD&A Procedures are designed to assist the analyst in reviewing the MD&A to determine that the information included meets the requirements of the NAIC *Annual Financial Statement Instructions* and to identify concerns.

At the end of the MD&A Procedures, the analyst is asked to develop and document an overall conclusion and to indicate recommendations for further action. Recommendations for further action might include contacting the insurer for explanations or additional information, obtaining the insurer's business plan, requiring additional interim reporting, referring concerns to the examination section for a targeted examination, meeting with the insurer's management or obtaining a corrective plan from the insurer.

Flow Charts

The following flow chart illustrates the annual cycle of the financial analysis process. The flow chart generally indicates that a "Yes" response results in further analysis. However, if an insurer's RBC is below 200 percent, a state insurance department may determine it is necessary to take the required legal action immediately, prior to any further analysis.

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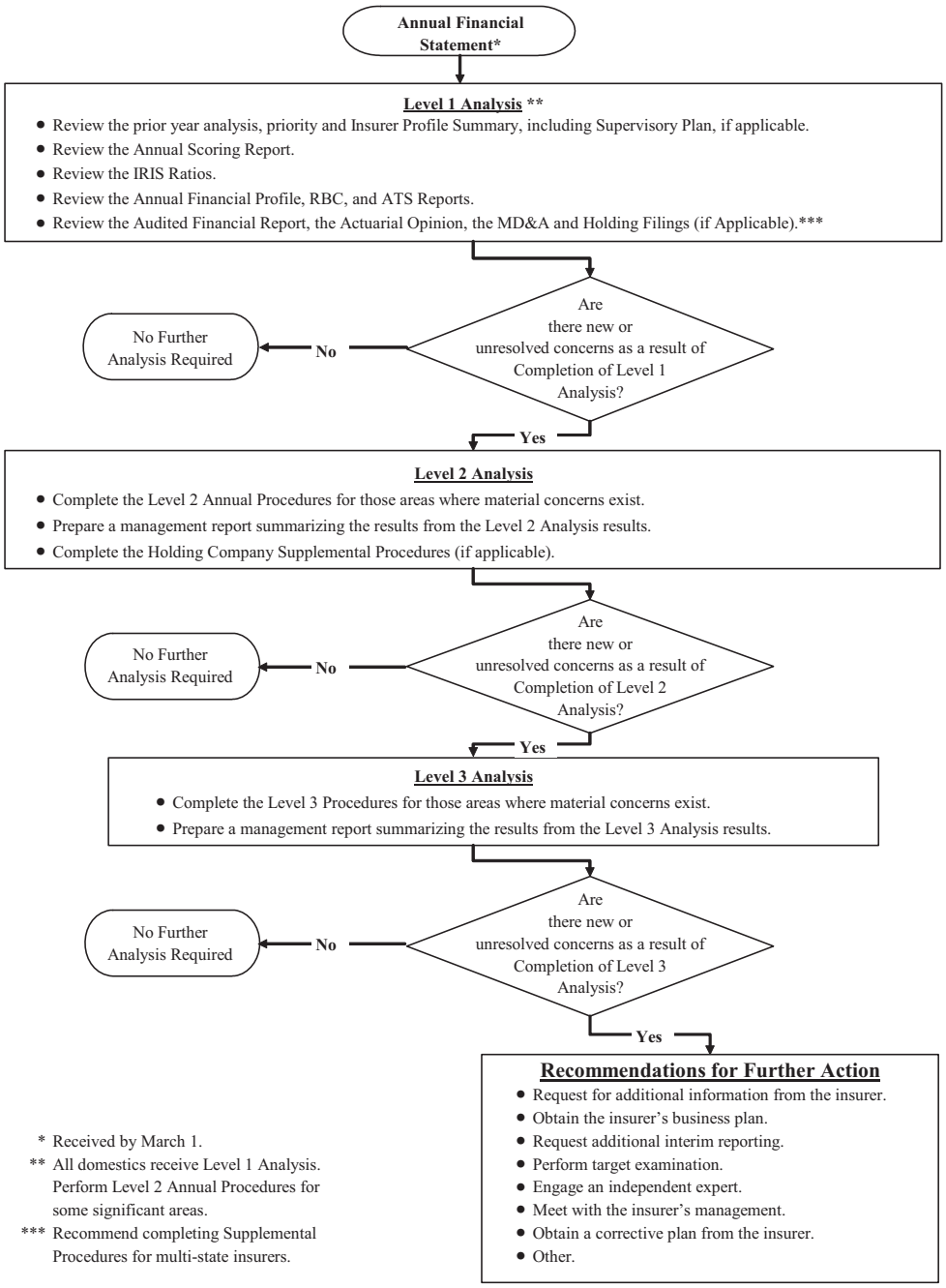
II. Financial Analysis Framework – Overview of Financial Analysis Process



* Received by March 1.
** All domestics receive Level 1 Analysis. Perform Level 2 Annual Procedures for some significant areas.
*** Recommend completing Supplemental Procedures for multi-state insurers.

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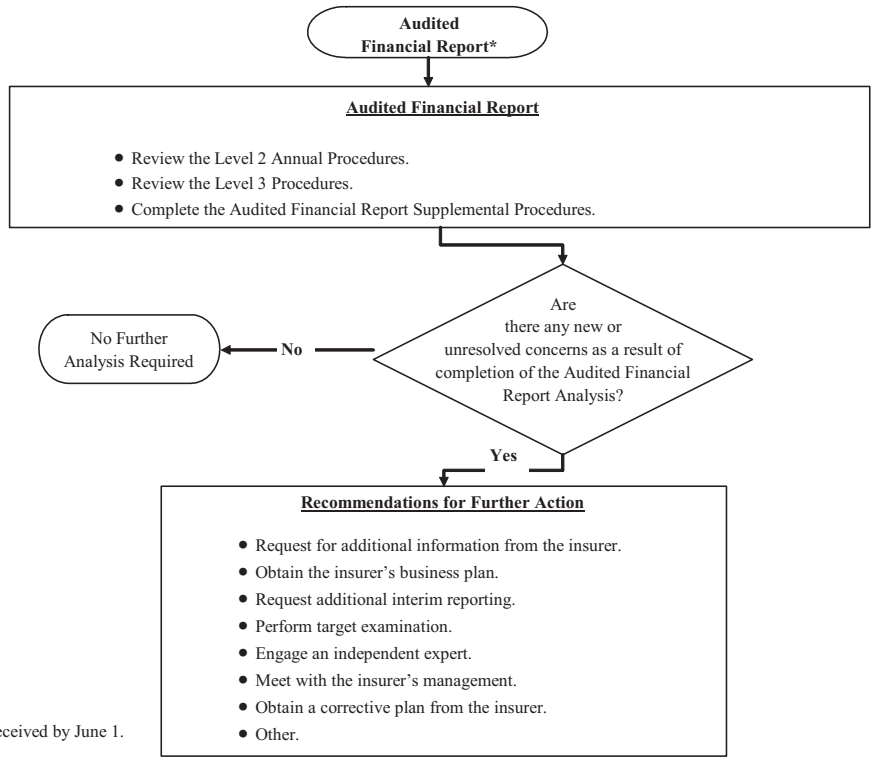
II. Financial Analysis Framework – Overview of Financial Analysis Process



* Received by June 1.

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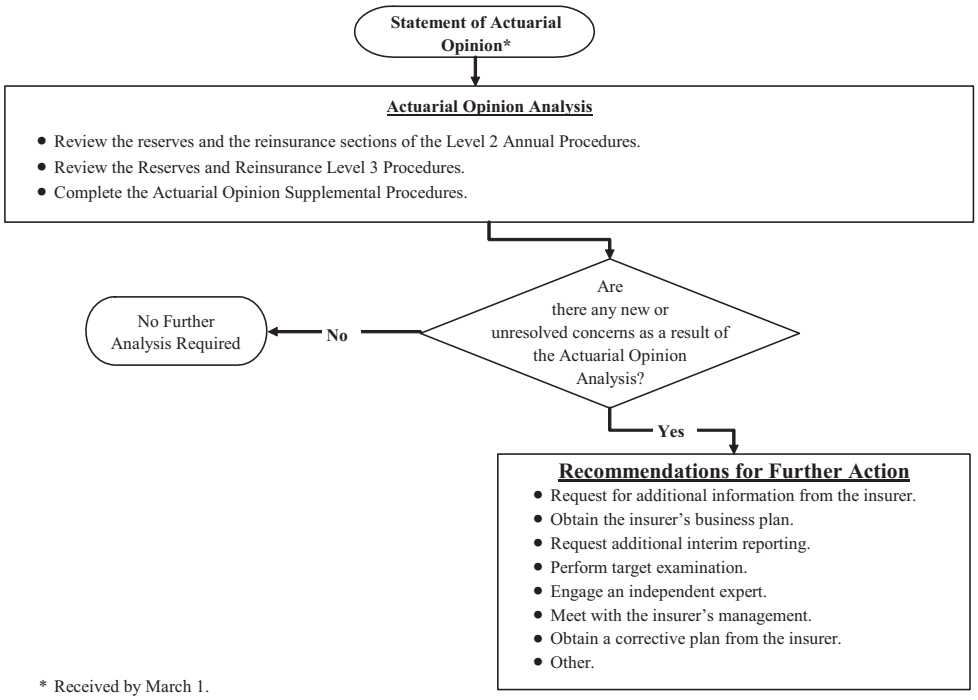
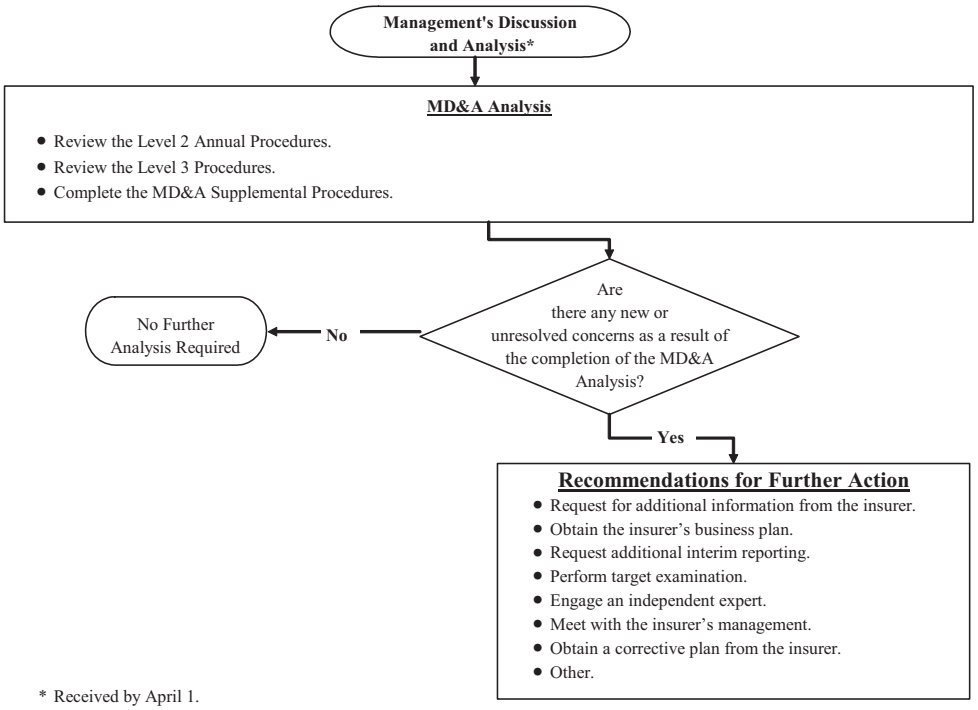
II. Financial Analysis Framework – Overview of Financial Analysis Process



* Received by March 1.

II. Financial Analysis Framework – Overview of Financial Analysis Process



* Received by April 1.

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Other Financial Procedures

The Holding Company Analysis Supplemental Procedures review may be completed for domestic insurers if the Level 1 analysis indicated further holding company analysis was necessary. The Holding Company Analysis Supplemental Procedures encompass the following analysis areas:

- Understanding the holding company structure
- Lead state and interstate communication
- Financial condition of the holding company

Depending on the level of concern, the Holding Company Analysis Supplemental Procedures may need to be completed in part or in total.

The following checklists are included within the Holding Company Analysis Supplemental Procedures.

Forms A, D, E 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
The Form A review is to be completed for all acquisitions, mergers or changes in control. Form A is filed with the domestic state of each insurer in the group. The analyst should review the transaction and all applicable documents and complete the Form A Procedures, when necessary.

Form B
The Form B review is to be completed for all insurers that are members of a holding company system if Level 1 analysis indicated further procedures were necessary. The analyst should review the affiliated transactions section of the Level 2 and Level 3 Annual Procedures, if completed, and complete the Form B Procedures. The Form B Procedures are designed to assist the analyst in reviewing Form B to determine that the appropriate information has been filed and whether concerns exist regarding the financial position of the ultimate controlling person or any of the affiliated transactions or agreements.

Form D
The Form D review is to be completed for all prior notices of material transactions. Form D must be filed with the domestic state. The analyst should review the transaction and all applicable documents and complete the Form D Procedures, when necessary.

Form E or Other Required Informtion on Competitive Impact
The Form E or other review of competivie impact is to be completed for all pre-acquisition notifications regarding the potential competitive impact of a proposed merger or acquisition by a non-domiciliary insurer doing business in the state or by a domestic insurer. Form E or other required information must be filed with the domestic state. The insurer may also be required to file documents with the Federal Trade Commission under the Hart-Scott-Rodino Act. The analyst should review the transaction and all applicable documents, and complete the Form E Procedures, when necessary.

Extraordinary Dividends/Distributions
The extraordinary dividend review is to be completed for any domestic insurers planning to pay any extraordinary dividend or make any other extraordinary distribution to its their shareholders. Such dividends and distributions must receive proper prior regulatory approval. The analyst should review the transaction and all applicable documents, and complete the Extraordinary Dividends Procedures, when necessary.

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At the end of the Holding Company Analysis Supplemental Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the information reviewed and to indicate recommendations for further action, if any, based on the procedures performed. Recommendations for further action might include contacting the insurer seeking explanations or additional information, obtaining the insurer's business plan, requiring additional interim reporting, referring concerns to the examination section for a targeted examination, meeting with the insurer's management, or obtaining a corrective plan from the insurer.

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III. Analysts Reference Guide

Level 1

A. Level 1 Procedures

Level 2 & 3

B.1. Investments

B.1A. Investments – Appendix – Derivatives

B.2. Life Reserves

B.3. Accident and Health Reserves

B.4. Annuity Reserves

B.5. Income Statement and Surplus

B.6. Risk-Based Capital

B.7. Cash Flow and Liquidity

B.8. Reinsurance

B.9. Affiliated Transactions

B.10. MGAs and TPAs

B.11. Separate Accounts

Supplemental

C.1. Audited Financial Statement

C.2. Statement of Actuarial Opinion

C.3. Management's Discussion and Analysis

C.4. Holding Company Analysis

Fraternal

D.1. Level 1 Procedures

III. Analysts Reference Guide – A. Level 1 Procedures

Financial Analyst Role

During the risk-focused surveillance approach, the financial analyst role is to provide continuous off-site monitoring of an insurer's financial condition, monitoring internal/external changes relating to all aspects of the insurer, maintaining a prioritization system and working with the examination staff to develop an ongoing Supervisory Plan, as well as update the Insurer Profile Summary, if applicable.

Overview of Level 1 Procedures

The objective of the Level 1 Procedures is to perform a sufficient level of analysis of all domestic insurers in order to derive an overall assessment that highlights areas where a more detailed analysis, as found in the Level 2 Procedures, may be necessary. As part of the Level 1 Analysis, the analyst will review the insurer's Annual Scoring System Report, IRIS ratios, Analyst Team Validated Level, RBC results, and the information included in the Financial Profile Report. The Level 1 Procedures require the analyst to review the prior year's analysis of the insurer and to perform a general review of the current year's Annual Financial Statement, along with an assessment of supplemental filings, including the Audited Financial Report, Statement of Actuarial Opinion, Management's Disscussion & Analysis (MD&A), and the various holding company filings (e.g., 10-K, Form A, etc.).

The analyst should have a firm understanding of the following risk classifications:

- **Credit -** Amounts actually collected or collectible are less than those contractually due.
- **Market -** Movement in market rates or prices (such as interest rates, foreign exchanges rates or equity prices) adversely affects the reported and/or market value of investments.
- **Pricing/Underwriting -** Pricing and underwriting practices are inadequate to provide for risks assumed.
- **Reserving -** Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.
- **Liquidity -** Inability to meet contractual obligations as they become due because of an inability to liquidate assets or obtain adequate funding without incurring unacceptable losses.
- **Operational -** Operational problems such as inadequate information systems, breaches in internal controls, fraud or unforeseen catastrophes resulting in unexpected losses.
- **Legal -** 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.
- **Strategic -** 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.
- **Reputational -** Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.

A prospective risk is a residual risk that impacts future operations of an insurer. These anticipated risks arise due to assessments of company management and/or operations or risks associated with future business plans. Types of risks may include underwriting, investments, claims, and reinsurance. The analyst's understanding of the above nine risk classifications includes an assessment of the level of that risk and the ability of the insurer to appropriately manage the risk during the current period and prospectively. These prospective risks require assessment and identification of how they may evolve related to the insurer's overall risk profile. Understanding how risks that may or may not appear urgent now will potentially impact future operations and how management plans to address those risks is key to prospective risk analysis. The assessment of these nine risk classifications both currently and prospectively should be part of the quantitative and qualitative analysis completed within the Level 1, 2, 3 and Supplemental procedures. The *Financial Condition Examiners Handbook* provides guidance on prospective risks within Exhibit O—Examples of Risks and Exhibit V—Prospective Risk Assessment.

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III. Analysts Reference Guide – A. Level 1 Procedures

At the conclusion of the Level 1 Procedures, the analyst is asked to document an overall summary and conclusion regarding the financial condition of the insurer, as well as the insurer's strengths and weaknesses, and to determine whether the insurer be considered a priority company, and whether one or more of the procedures in the Level 2 Procedures should be completed. Because some items, such as the Audited Financial Report and the various holding company filings are not required to be filed until after most of the annual review is completed, the analyst will document a conclusion based on the Level 1 Annual Procedures and the current analysis of the insurer. The Audited Financial Report and various holding company filings should be reviewed upon receipt and, if additional concerns are noted, the conclusion or the first quarter conclusion should be revised to reflect the most recent information. Similarly, as the analyst completes the Level 2 Procedures, the Level 1 conclusion should be reviewed and revised as necessary with any follow-up information or similar updates made to the first quarter conclusion. At the completion of the analysis process, including any Level 1, 2, 3 or Supplemental Procedures, the analyst should update the Insurer Profiles Summary, if applicable, and communicate with financial examination staff.

Insurer Profile Summary

The Insurer Profile Summary is a "living document" maintained by the state of domicile to "house" summaries of risk-focused examinations, financial analysis, internal and external changes, priority scores, supervisory plans, and other standard information.

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 insurer. The analyst should work with the examination staff to update the Insurer Profile Summary, including the Supervisory Plan, if applicable. The Supervisory Plan should be developed using the most recent examinations and annual and quarterly analysis results. 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 Supervisory Plan should include the type of surveillance planned, the resources dedicated to the oversight, and the coordination with other states.

Continual Review Process

The above-mentioned review of the Annual Financial Report and the Holding Company Analysis Procedures highlights the importance of a continual review process. This ongoing review process is obvious in these cases but is also necessary in other areas. For example, to the extent that an analyst completes the Level 1 Procedures for an insurer and has concerns with its reserves, the analyst would complete the Level 2 Procedures for Reserves. Upon completion of the Level 2 Procedures, the analyst may have additional concerns and would complete the Level 3 Procedures for Reserves. This analysis may result in questions posed to the insurer and additional information being supplied to the analyst.

In some cases, the state may choose to perform a more in-depth analysis of the insurer's reserves, such as a targeted examination. This is just one of the many recommendations that could result from the ongoing analysis of an insurer. Other recommendations include 1) requesting additional information from the insurer, 2) obtaining the insurer's business plan, 3) requesting additional interim reporting, 4) engaging an independent expert, 5) meeting with the insurer's management, and 6) obtaining a corrective action plan from the insurer. These specific recommendations are included in the Financial Analysis Framework section of the Handbook and represent just a few of the potential actions that could result from the ongoing analysis of an insurer.

Regardless of the final outcome, the results of the ongoing analysis of the insurer should be documented in the appropriate level of the analysis, including the Level 1 conclusion, if applicable.

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Financial Examination Assessment

In performing the procedures related to financial examinations, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments is crucial during the consideration of these procedures. The analyst 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 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 should be structured and written to communicate to regulatory officials examination findings of regulatory importance. This type of communcation includes management letter comments and performace audit comments, where appropriate.

These comments are similar to management letter comments frequently made by CPA firms as a result of their audit. Many insolvencies have been caused by mismanagement. When examiners identify systems, or operational or management problems that exist, performance audit comments are an opportunity to alert management and other readers of the financial examination report to problems that, if left uncorrected, could ultimately lead to insolvency.

Performance audit comments generally contain the following information: 1) a concise statement of the problem found; 2) the factors which caused or created the problem; 3) the materiality of the problem and its effect on the financial statements; 4) the financial condition of the insurer or the insurer's operations; and 5) the examiner's recommendation to the insurer 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 domiciliary state insurance department. Periodically, after a financial examination report has been issued, inquiries should be made to the insurer to determine the extent to which corrective actions have been taken on report recommendations and criticisms. Because the examiners have usually moved on to another examination, many states utilize the financial analysts to perform this function. A lack of satisfactory corrective action by the insurer may be cause for further regulatory action.

Risk-Focused Examinations

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 which are anticipated to arise or extend past the point of completion of the examination. Risks in addition to the financial reporting risks may be reviewed as part of the examination process.

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—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.

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- Phase 4 – Determine Residual Risk—Once this risk is determined, the examiner can determine where to focus resources most effectively.
- Phase 5 – Establish/Conduct Examination Procedures—Upon completion of risk assessment, determine nature and extent of the examination.
- 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 Based on Findings—Incorporate into the examination report and management letter the results and observations noted during the examination.

The goals of the risk-focused examinations are to:

- Assess 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 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. To assist in this assessment, examiners may utilize board and audit committee minutes; list of critical management and operating committees, their members and meeting frequencies; and Sarbanes-Oxley filings and initiatives, as applicable.
- Assess the risk that a company's surplus is materially misstated.

Discussion of Level 1 Annual Procedures

Level 1 Annual Procedures are designed to identify potential areas of concern. As noted above, the principal areas of focus in the Level 1 Annual Procedures include the overall analysis of the insurer and its operations. The following provides a brief description of the purpose of each procedure.

Background Analysis

Procedure #1 provides guidance to the analyst in determining if any conclusions reached in the prior year analysis of the insurer should be considered in the work to be completed in the current year. Areas of concern noted in the prior year should be reviewed carefully in the current year. Insurers who were classified as priority companies in the prior year—either by the state's priority designation, the Scoring System results, the Analyst Team System Validated Level, or the RBC ratio—should be reviewed carefully in the current year. The analyst should review the Insurer Profile Summary, including the Supervisory Plan, if applicable, for any concerns or risks that may require additional attention during the current analysis being performed.

Procedure #2 alerts the analyst to review all inter-departmental communciation, as well as communication with other state insurance departments and the insurer. Internal communication may include departments such as examination, licensing and admissions, consumer affairs, rate filings, policy/forms analysis, agents' licensing, legal, and market conduct. It may be necessary to communicate with other state departments if a multi-state domestic insurer writes a significant amount of business in other states. Additional communciation with the insurer throughout the year should be reviewed to identify any items or areas that may require special attention during the analysis process. Refer to the introductory chapters for further discussion on internal and external communication.

Procedure #3 directs the analyst to determine if significant changes in the insurer's organizational structure or management have occured. Changes such as these can have a significant impact on the ongoing operations of the insurer. While organizational and management changes alone may not indicate a problem, knowledge of these changes may help the analyst understand other changes and potential problems, such as a significant growth in premiums written. Additionally, the analyst should verify that Form A or additional filings have been approved.

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Procedure #4 requires the analyst to review General Interrogatories, Part 1, #6.1 and #6.2, to determine whether the insurer had any Certificates of Authority, licenses or registrations (including corporate registration if applicable) suspended or revoked by any governmental entity during the reporting period and investigate the reason(s) for the action(s).

Procedure #5 directs the analyst to identify if there are recent changes in the state's statutes and regulations that could have an impact on the insurer's financial results or business profile. If so, to the extent that information is available regarding the new statute or regulation, the analyst should determine if the insurer has complied with any new state statutes and/or regulations that have been enacted during the period.

Procedure #6 requires the analyst to review the most recent rating agency report. In many cases, a rating agency downgrade may have an impact on the insurer's ability to generate new business or to retain existing business. The significance of the impact of a downgrade is generally dependent upon the type of product sold by the insurer and the level of the rating given by the agency.

Procedure #7 directs the analyst to review any industry reports, news releases or any emerging issues that have the potential to negatively impact the insurer. An example might include regulatory or media scrutiny of certain insurance lines of business, whether related to market conduct or financial issues. Another example would be changes in the economic environment that may negatively impact investment returns or result in material capital losses.

Procedure #8 directs the analyst to review the business plan of the insurer if it is available from recent surveillance activity, such as previous analysis or examinations, and if a review of the business plan is considered necessary based on the insurer's priority designation and financial condition. If reviewed, the analyst should assess if the plan is consistent with current operations and expectations of projected results. For example, consider if the insurer is writing more or less premium or different lines of buiness than outlined in the plan. Consider if the plan is consistent with changes in the makets or geographical areas where business is being written, or new licenses obtained to write business. The analyst should assess significant variances in the business plan through review of the plan and/or through communication with the insurer. If a business plan is not available or current and, based on the analysis performed, the analyst feels it is necessary to request a business plan and recommend further analysis in this area, a procedure exists at the end of Level 1 within the Recommendations for Further Analysis section.

Management Assessment

Procedure #9 assists the analyst in determining if changes in the insurer's management or board of directors have occurred. Changes such as these can have a significant impact on the ongoing operations of the insurer and management philosophy. Changes in the board of directors may also indicate changes in the audit committee. When assessing management, the analyst should take into consideration not only the changes in management but also the analyst's and examiner's knowledge about the current management team and any concerns that may exist regarding management. While management changes alone may not indicate a problem, knowledge of these changes may help the analyst understand other potential problems.

With regard to corporate governance, there are many aspects that require consideration such as: adequate competency; independent and adequate involvement of the board of directors; multiple channels of communication; code of conduct between the board and management; sound strategic and financial objectives; support from relevent business planning; reliable risk management processes; sound principles of conduct; reporting of findings to the board; adoption of Sarbanes-Oxley provisions; and board oversight and approval of executive compensation and performance evaluations.

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The analyst should review the biographical affidavit for any new officers, directors or trustees; follow up on any unusual items or areas of concern; and consider whether changes identified will alter management philosophy. The analyst should pay close attention to responses regarding any suspensions, revocations, or non-approval of licenses, conflicts of interest, civil actions, or criminal violations, and follow-up on any areas of concern. Communication with other state insurance departments may be necessary if the officer previously worked for an insurer domiciled in another state.

Balance Sheet Assessment

Procedure #10 directs the analyst in identifying significant changes in an insurer's assets, liabilities, and capital and surplus. Significant changes identified in procedure #7 should be explained, to the extent possible. The procedure also assists the analyst in determining if the overall amount of capital and surplus continues to meet Risk Based Capital (RBC) requirements. RBC creates a minimum standard for capital and surplus. Generally, an analyst should be careful not to extend the use of the RBC beyond its intent. For example, an insurer with a 600 percent RBC ratio is not necessarily stronger than an insurer with a 500 percent RBC ratio.

Operations Assessment

Procedure #11 assists the analyst in identifying significant changes in an insurer's Statement of Income. Shifts in net income could indicate a change in premium earned, a change in benefits incurred, or other more complex issues that require further investigation. For this reason, it is critical that the analyst understand material changes within each income and expense category.

Procedure #12 assists the analyst in identifying unusual results in an insurer's Cash Flow. During the review of the cash flow statement, the analyst should understand shifts in cash inflows and cash outflows that impact cash from operations. The analyst should also investigate investment acquisitions and dispositions, the insurer's investment strategies, and the origin of other sources of cash.

Procedure #13 requires the analyst to identify material ceded reinsurance as reported in Schedule S, Part 3– Reinsurance Ceded, and review all General Interrogatories and Notes to Financial Statements pertaining to reinsurance. The analyst should understand the insurer's reinsurance programs and identify any credit risks. In addition, the analyst should be aware of the types of collateral held for reinsurance with unauthorized reinsurers.

Investment Practices

Procedure #14 assists the analyst in identifying unusual investment management practices of the insurer. These steps are specifically designed to assist the analyst in determining if the insurer has the proper control over its investments.

Procedure #15 requires the analyst to review the Summary Investment Schedule to determine if the insurer uses any unusual methods for valuing its invested assets. The Summary Investment Schedule provides a comparison between the gross investment holdings, as valued in accordance with the *AP&P Manual,* and the admitted assets, as valued in accordance with the state of domicile's basis of accounting. This schedule should be reviewed in conjunction with Note #1 of the Annual Financial Statement, *Summary of Significant Accounting Policies*, Section A.

Procedure #16 requires the analyst to review the Supplemental Investment Risks Interrogatories to determine whether the insurer's investment portfolio is adequately diversified with the appropriate level of liquidity to meet cash flow requirements.

Procedure #17 assists the analyst in determining the amount of assets held as deposits with the states. These deposits are placed with the states to secure the settlement of the insurer's obligations to policyholders, claimants and others. Insurers with greater than 10 percent of their assets held as deposits with states may hold greater liquidity risk in certain situations.

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III. Analysts Reference Guide – A. Level 1 Procedures

Review of Disclosures

Procedure #18 requires the analyst to review the Notes to Financial Statements to assist in identifying any relevent quantitative and qualitative information.

Procedure #19 requires the analyst to review the General Interrogatories to assist in identifying any unusual responses.

Assessment of Latest Examination Report and Results

Procedures #20, 21 and *22* assist the analyst in gathering specific information related to the insurer's most recent financial examination. During a review of the examination report, the analyst should note any items or areas that indicate further review is necessary. This might include such things as internal controls issues, risk management, information technology or other issues that could impact the insurer's priority. The analyst should also review the management letter comments, which may include risks or progress on issues that the analyst should give attention to the current analysis being performed. Effective communication between the analyst and the examination staff can be very important in developing a good understanding of the insurer's management and financial position. As an example, the examination staff may have specific information on the reliability of the insurer's financial reporting. In addition, the analyst may want to utilize the Exam Tracking System on I-SITE. The analyst should consider the impact, if any, of the Financial Examination Report findings on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (i.e., complete additional supplemental procedures).

Assessment of Results from Prioritization and Analytical Tools

Procedure #23 requires the analyst to review and comment on the Annual Scoring System ratio results of the insurer, which can assist in identifying any unusual financial results.

Procedure #24 requires the analyst to review the IRIS ratio results of the insurer, which can assist in identifying any unusual financial results.

Unusual IRIS ratios and Annual Scoring ratio results should be explained, to the extent possible, by the analyst. If changes cannot be explained or if certain changes appear to be inconsistent with the analyst's understanding of the insurer and its operations, additional analysis is suggested.

Procedure #25 requires the analyst to review and understand the assigned Analyst Team System Validated Level, documented within the ATS Report and the ATS Validated Level Report on I-SITE. In addition, the analyst can reference the ATS Procedures Manual and ATS Level Definitions documents on I-SITE. The Analyst Team typically completes the validation process by mid-April.

Procedure #26 requires the analyst to review the Annual Financial Profile Report, which can assist in identifying unusual trends and results.

Procedure #27 alerts the analyst to review communication they have engaged in with the market analysis unit of the Department, including the results of market conduct exams as well as information drawn from the review of market analysis tools available on I-SITE. Market analysis tools available on I-SITE include Market Analysis Profile (MAP), Examination Tracking System (ETS), Market Analysis Review System (MARS), Regulatory Information Retrieval System (RIRS), Special Activities Database (SAD), Market Initiative Tracking System (MITS) and the Complaints Database. Analysts should review any market conduct issues identified by market analysis staff or I-SITE tools and consider the financial implications those issues may have on the insurer. For example, large fines levied by states, suspensions or revokations of licenses, market conduct exam settlements (whether financial or other), or other regulatory actions taken based on market conduct violations, may have a material impact on the financial solvency of the insurer.

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Assessment of Supplemental Filings

Procedure #28 requires the analyst to review the Statement of Actuarial Opinion to assess the adequacy of the insurer's reserves. See the Statement of Actuarial Opinion Supplemental Procedures for additional guidance in this area.

Procedure #29 requires the analyst to review the MD&A, which can provide additional information to the analysis of the insurer. See the MD&A Supplemental Procedures for additional guidance in this area.

Procedure #30 requires the analyst to review the Audited Financial Report, which helps to assess the reliance placed on the validity of the insurer's financial statements. The Audited Financial Report also contains additional financial information that is generally not included in the Annual Financial Statement and can be helpful to the analyst. See the Audited Financial Report Supplemental Procedures for additional guidance in this area.

Procedure #31 requires the analyst to review the most recent financial statement of the holding company, as filed in the SEC 10-K Report. In addition, the analyst should review Forms A, B, D, E and Extraordinary Dividends/Distributions, if available.

Discussion of Level 1 Quarterly Procedures

The Level 1 Quarterly Procedures are designed to help the analyst perform a general review of the insurer and its operations. The quarterly procedures are similar to the annual procedures because they are mostly broad-based questions; however, the quarterly procedures include questions that focus primarily on changes from the prior year. At the conclusion of the quarterly Level 1 Procedures, the analyst is asked to do the following: 1) develop and document an overall summary and conclusion regarding the financial condition of the insurer; 2) determine whether the insurer be condisered a priority company; and 3) indicate whether one or more of the procedures in the Level 2 Quarterly Procedures should be completed. As with the annual review, the quarterly Level 1 conclusion should be reviewed and revised as necessary when subsequent procedures and follow-up with the insurer are completed.

Discussion of Non-Routine Analysis

The Handbook contains procedures that assist an analyst in deriving an overall assessment of the insurer's financial condition; however, situations may exist when it is necessary to perform additional procedures and analysis not contained in the Handbook for one or more insurer.

On occasion, events or situations outside of the normal course of business occur that may have a material impact on the overall financial condition of an insurer. During these occasions, state insurance regulators may need to perform non-routine analysis, which may require additional reporting from a specific insurer or from a group of insurers. A few examples of these occasions may include significant financial events such as material investment defaults, credit market stress, or catastrophic events. Non-routine analysis may also be appropriate and necessary in situations impacting a single insurer, a group, or a small group of insurers. For example, when permitted practices are granted, there may be a need to perform follow-up analysis of the situation requiring the permitted practice, including assessing the realizablity of deferred tax assets. The state may conduct this analysis themselves or enter into an agreed-upon procedures audit with a CPA firm to assist in the assessment and analysis of the projected future deferred tax assets and the impact to surplus.

The following are a few examples of types of non-routine analysis that may be appropriate in an economic downturn, investment defaults, and changes in the credit markets (Note that some or all of these may be applicable in other non-market or investment related situations as well).

- Focused analysis on asset quality where insurers hold higher amounts of riskier assets. The analyst should not only consider exposure to individual default events but also aggregate exposure. Additional review or

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explanation from the insurer may be requested when high amounts of other-than-temporary impairments, unrealized losses and/or large variances between book and market value are reported. The analyst should review the value of affiliated investments and assess indirect exposure to economic events that may result in the decline in the affiliated holdings. Analysts may consider other sources of analysis or information to assist in the review of investments. For example, an analyst might consider requesting a Portfolio Analysis Memorandum from the NAIC Securities Valuation Office.

- Analysts should consider the impact of tightened short-term credit markets on insurers or groups who depend on commercial paper, overnight repos, dollar repos, etc. Another area that could be impacted by changes in credit markets is the insurer's ability to obtain letters of credit (LOC) provided for XXX (life reserves) or other reinsurance reserves, and the costs of those LOCs for an insurer dependent on LOCs.
- If the insurer engages in securities lending, the analyst may consider requesting detailed information about the program to review the types of assets (risk and duration match) within the program, gain an understanding of the structure and terms of the program, and, if material, monitor monthly changes in the program.
- Certain insurance products may be impacted more than others in an economic downturn. The analyst should consider the impact to an insurer that writes a material amount of products that are more likely to be accelerated (e.g., funding agreements, guaranteed interest contract–GICs) or where the liability can be accelerated (e.g., variable annuities, living benefit/death benefit on variable annuities).
- The analyst should consider the level of sensitivity of the insurer to ratings downgrades and the possible impact on the insurer or the group. For example, its ability to market new business or the impact of rating downgrades on any debt covenants. If an insurer is downgraded, the analyst may consider monitoring surrenders, new business sales, and any changes in the insurer's business plans.
- Where liquidity is a concern, the analyst may also consider requesting interim reporting from the insurer on areas of risk specific to that insurer. For example, surrender activity, high-risk investment exposures, GICs, capital and surplus, available liquidity, available credit facilities and capital losses.
- Where significant concerns exist, the state may consider requesting the insurer to perform stress testing on the possible future impacts of additional equity losses, defaults, or other areas relevant to the situation.

Examples of types of non-routine analysis that may be appropriate in catastrophic events:

- Implement disaster reporting requests to appropriate insurers and monitor claims exposure during future periods following the event.
- Identify insurers and reinsurers with material exposure.
- Implement appropriate procedures to identify fraudulent activities.
- Perform an in-depth analysis of liquidity to ensure timely payment of claims.
- Engage legal staff to ensure appropriate claims payment practices.

Additional Reference Sources

1. *Financial Condition Examiners Handbook*, NAIC

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III. Analysts Reference Guide – B.1. Investments

Overview of Investments

Insurers receive premiums from policyholders today in exchange for a promise to pay covered benefits 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 they are needed to pay benefits. 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, and 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. A shift to higher yield investments may result in the 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. 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. 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 insurers invested in long-term bonds with stable interest rates and predictable cash flows. However, with the advent of interest sensitive products, where one of the principal focuses of the product is on the investment aspect, investment returns became more important. This change in focus has prompted insurers to turn to assets of higher risk and lower quality in exchange for higher investment yields. Many insurers currently have significant investments in non-investment grade bonds, privately placed bonds, and multi-class residential mortage-backed securities (MRMBSs) and other multi-class securities. Investments today are also much more complex and sophisticated than they were 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 the analyst in reviewing an insurer's investment portfolio are these: 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

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valued at cost or amortized cost, except for common stocks and perpetual preferred stocks which are valued at their fair value. However, the analyst should be alert for investments which should be written down to fair value due to other than temporary declines in value. Fifth, the analyst should be alert for investment portfolios with cash in-flows which do not match with projected liability cash out-flows.

Discussion of the Level 2 Annual Procedures

The 14 procedures included in the Investments section of the Level 2 Annual Procedures are designed to identify potential areas of concern. As noted above, the principal areas of concern regarding an insurer's investment portfolio are diversification, liquidity, quality and valuation. Most of the procedures are designed to assist the analyst in identifying undue concentrations of investments by type or issue and investments which have been improperly valued in the Annual Financial Statement.

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 of directors.

Procedure #1 assists the analyst in determining whether the insurer's investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type or issue. The ratios of the various types of investments to total admitted assets (excluding separate accounts) are a measure of the diversity of the insurer's investment portfolio by type of investment. The results of these ratios may also provide some indication of the insurer's liquidity. Ratios are included for most types of investments except for government and agency bonds and cash and short-term investments, which are generally very liquid. In addition, the ratio of the investment in any one issue or issuer to total admitted assets (excluding separate accounts) is a measure of the diversity of the insurer's investment portfolio by issue.

Procedure #2 assists the analyst in determining whether all purchases and sales of investments are approved or authorized by the insurer's board of directors and whether all securities are owned by the insurer, are under the control of the insurer and are in the insurer's possession. Most states require investment transactions to be approved by the insurer's board of directors or a subordinate committee thereof, and General Interrogatory #14 indicates whether this has been done. General Interrogatory #22 indicates whether the stocks, bonds, or other securities, of which the insurer has exclusive control (defined by the NAIC as the exclusive right by the insurer to dispose of an investment at will, without the necessity of making a substitution therefore), are in the actual possession of the insurer. If the insurer owns securities, which are not in its possession, they should be held by a custodian under a properly executed custodial agreement in order to be considered admitted assets. General Interrogatory #23 indicates whether any of the stocks, bonds or other assets of the insurer are not exclusively under its control. Assets which are not under the insurer's control might not meet the state's requirements to be considered admitted assets.

Procedure #3 assists the analyst in determining whether the securities owned by the insurer have been valued in accordance with the standards promulgated by the NAIC SVO. Beginning in 2004, the provisional exemption (PE) in the *SVO Purposes and Procedures Manual* (*SVO P&P Manual*) was changed to filing exempt (FE). This change expands the exemption to preferred stocks and all NAIC equivalent designations and removes several of the optionality requirements. In conjunction with this change, the SVO compliance certificate was changed to a general interrogatory in the investment section. According to NAIC requirements, all securities purchased that are not filing exempt per the *SVO P&P Manual* should be submitted to the SVO for valuation within 120 days of the purchase. In accordance with the *NAIC Annual Statement Instructions*, if the SVO provides an NAIC designation

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or price, that designation or price should be utilized. Insurers are required to complete the general interrogatory on compliance filing requirements of the *SVO P&P Manual* and list exceptions as a component of the Annual Financial Statement. This interrogatory should indicate the following: 1) all prices or NAIC designations for the securities owned by the insurer that appear in the VOS product have been obtained directly from the SVO, 2) all securities previously valued by the insurer and identified with a "Z" suffix (which indicates that the security is not filing exempt, does not appear in the SVO *Valuations of Securities Publication (VOS)* product or has not been reviewed and approved in writing by the SVO) have either been submitted to the SVO for a valuation or disposed of, and 3) all necessary information on securities which have previously been designated NR (not rated due to lack of current information) by the SVO has been submitted to the SVO for a valuation or that the securities have been disposed. In addition, the analyst should review Schedule D – Part 1 - Bonds and Schedule D – Part 2 - Preferred Stocks and Common Stocks to determine whether it appears that the insurer is complying with the requirement to submit securities to the SVO for valuation. There should be no securities which were acquired prior to the current year that have a "Z" suffix after the NAIC designation.

Procedure #4 assists the analyst in determining whether the statement value of bonds and redeemable preferred stocks is significantly greater than their fair value. General Interrogatories Part 1, #28 shows the aggregate statement value and the aggregate fair value of bonds and preferred stocks owned and requires the insurer to indicate how the fair values were determined. If the statement value of bonds and redeemable preferred stocks is significantly greater than their fair value, the insurer could realize significant losses if it were forced to sell these investments to cover unexpected cash flow needs due to larger than anticipated policy surrenders or claims. In determining whether there is a concern regarding the excess of the statement value of bonds or redeemable preferred stocks over their fair value, the analyst should also consider the insurer's interest maintenance reserve and the results of its cash-flow testing.

Procedure #5 assists the analyst in determining whether the cost of common stocks is significantly greater than their fair value. Schedule D – Part 2 – Section 2 shows the insurer's common stock portfolio and indicates the cost and fair value of each issue. If the cost of common stocks is significantly greater than the fair value, the insurer could realize significant losses if it were forced to sell these investments to cover unexpected cash flow needs. Furthermore, increases and decreases in net unrealized gains/losses impact capital and surplus. If the stock market declines significantly, the cost of common stocks could be significantly greater than the fair value, and the insurer's capital and surplus could be significantly impacted. In determining whether there is a concern regarding the excess of the cost of common stocks over their fair value, the analyst should also consider the insurer's asset valuation reserve and more specifically, the equity component of this reserve.

Procedure #6 assists the analyst in determining whether concerns exist due to significant purchases or sales of securities near the beginning and/or end of the year. The analyst can identify significant purchases or sales of securities by reviewing Schedule D – Part 3 - Long-Term Bonds and Stocks Acquired During Current Year, Schedule D – Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year and Schedule D – Part 5 - Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year. If significant purchases or sales of securities occurred near the beginning and/or end of the year, the insurer might have "rented securities" or engaged in "window dressing" of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring the same or similar lower quality investments after year-end) in an attempt to avoid asset valuation reserve (AVR) and other penalties and additional regulatory scrutiny which would have occurred with the insurer's lower rated investment portfolio.

Procedure #7 assists the analyst in determining whether concerns exist due to the level of investment turnover. The analyst can identify significant turnover by reviewing Schedule D – Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year and Schedule D – Part 5 - Long Term Bonds and Stocks Acquired and Disposed of During Year. The turnover ratio represents the degree of trading activity in long-term bonds, preferred and common stock investments that has occurred during the year. Investment turnover is an indication of whether a buy-and-hold or sell based on short-term fluctuation strategy is utilized. A high

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turnover of investments generally leads to greater transaction costs, operating expenses and the acceleration of realized capital gains. Sales result from securities reaching a price objective, anticipated changes in interest rates, changes in credit worthiness of insurers or general financial or market developments.

Procedures #8 through *#14* assist the analyst in determining whether concerns exist regarding the level of investment in certain types of investments which tend to be riskier and/or less liquid than publicly-traded bonds and stocks and cash and short-term investments. In addition to the steps for the types of investments included in procedures #8 through #14, the analyst should review procedures #3 and #4 in the Affiliated Transactions section of the Level 2 Annual Procedures and procedure #3 in the Level 3 Procedures for Affiliated Transactions for procedures regarding investments in affiliates.

Procedure #8 assists the analyst in determining whether concerns exist due to the level of investment in non-investment grade bonds. Bonds which have NAIC designations of 3, 4, 5 or 6 are considered non-investment grade bonds and represent a significantly higher credit or default risk to the insurer than do investments in investment grade bonds. In addition, the prices of non-investment grade bonds are frequently more volatile than the prices of investment grade bonds. The NAIC has adopted a Model Regulation on Investments in Medium Grade and Lower Grade Obligations. The Model Regulation establishes limitations on the concentration of non-investment grade bonds, because of concerns that changes in economic conditions and other market variables could adversely affect insurers having a high concentration of these types of bonds.

Procedure #9 assists the analyst in determining whether concerns exist due to the level of investment in multi-class securities. Multi-class securities include the following: 1) loan-backed bonds, 2) multi-class residential mortgage-backed securities (MRMBSs), and 3) other multi-class securities. Of the multi-class securities, MRMBSs are generally the most complex and volatile. MRMBSs convert a pool of mortgage loans into a series of securities that have expected maturities which vary significantly from the underlying pool as a result of slicing the pool into numerous tranches with different repayment characteristics. MRMBSs, either issued or backed by the U.S. government, carry very little credit risk and the insurer will most likely receive the par value of the MRMBS. As a result, many MRMBSs have been designated category 1 by the SVO. However, the credit rating does not consider the prepayment or interest rate risk inherent in the MRMBS investment. If the underlying mortgage loans are repaid by the borrowers faster or slower than anticipated, the MRMBS repayment streams will be affected and the expected durations will either contract or extend. Thus the cash flows on these investments are much more unpredictable than those for more traditional bonds and for mortgage pass-through certificates. If the MRMBS prepayments are significantly faster than anticipated and the insurer had paid a large premium for the MRMBS when it was acquired, the insurer could experience a significant loss on the investment even though the par value was received. In addition, cash flows on MRMBSs are harder to match with corresponding payments on policy liabilities which leads to the risk that prepayments may not be able to be reinvested in investments earning comparable yields in order to support the liability payment streams.

Procedure #10 assists the analyst in determining whether concerns exist due to the level of investment in private placement bonds. Significant investments in privately-placed bonds may cause the analyst to have concerns regarding the insurer's liquidity because many of these types of investments cannot be resold, while those that can be resold frequently have restrictions on who they can be sold to. There is no structured market for privately-placed bonds like there is for publicly-traded bonds. Therefore, even if the privately-placed bonds can be sold, it may be difficult to find a willing buyer. Insurance companies commonly purchase these debt obligations in order to avoid the uncertainties of the market, to engage in private negotiations, and avoid Securities and Exchange Commission (SEC) restrictions.

Procedure #11 assists the analyst in determining whether concerns exist due to the level or quality of investment in real estate and mortgage loans. These investments are less liquid than many other types of investments. In addition, the analyst may also have concerns regarding the fair value of the real estate whether it is the underlying investment or the collateral for a mortgage loan. Real estate in certain parts of the country has experienced

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significant declines in fair values from time to time. Most states restrict mortgage loan investments to first liens on property, with some states allowing second liens in instances where the insurer also owns the first lien. Second liens are more risky because, in the event of default, the holder of the first lien would be repaid out of any proceeds from the sale of the underlying property prior to the holder of the second lien.

Procedure #12 assists the analyst in determining whether concerns exist due to the level of investment in other invested assets (Schedule BA). The types of investments included in Schedule BA include collateral loans, joint ventures and partnerships, oil and gas production and mineral rights. Joint ventures and partnerships typically involve real estate. These types of assets also tend to be fairly illiquid and may contain significant credit risk.

Procedure #13 assists the analyst in determining whether concerns exist due to the level of investment in collateral loans. The analyst should review Schedule BA - Other Invested Assets and Schedule DA - Short-Term Investments. In most states, collateral loans are required to be secured or collateralized by assets which have a value in excess of the amount of the loan and which are considered admitted assets for an insurer. While the underlying collateral may be very liquid, the collateral loan itself is generally illiquid. In addition, the analyst may also have concerns regarding the quality or value of the underlying collateral for the loans.

Procedure #14 assists the analyst in determining whether concerns exist due to the level of investment in derivative instruments. A derivative instrument is a financial market instrument which has a price, performance, value, or cash flow based primarily on the actual or expected price, performance, value, or cash flow of one or more underlying interests. Derivative instruments (which consist of options, caps, floors, collars, swaps, forwards, and futures) are used by some insurers to hedge against the risk of a change in value, yield, price, cash flow, or quantity or degree of exposure with respect to its assets, liabilities, or anticipated future cash flows. If an insurer invests in derivative instruments, it is important for the analyst to understand the impact that these derivative instruments have on the risk return profile of the insurer's cash market investment portfolio under different scenarios. For insurers with significant investments in derivative investments, this will probably require the analyst to obtain the assistance of an actuary.

Discussion of the Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for the investments section are designed to identify the following: 1) whether the insurer's investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type or issue, 2) whether the insurer has a significant portion of its assets invested, or has significantly increased its holdings since the prior year-end, in certain types of investments that tend to be riskier and/or less liquid than publicly-traded bonds and stocks and cash and short-term investments, 3) whether the insurer has significantly increased its holdings since the prior year-end in derivatives that tend to be riskier and/or less liquid than publicaly traded bonds, stocks, cash and short-term investments, 4) whether any of the insurer's assets have been loaned or otherwise made available for use by another person during the quarter, and 5) whether the insurer has complied with the requirements of the *SVO P&P Manual*, which requires all securities to be valued in accordance with standards promulgated by the SVO.

Discussion of the Level 3 Procedures

The Level 3 Procedures for Investments are designed to assist the analyst in further investigating potential problems and concerns that are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate further, and how far to probe.

Procedure #1 suggests additional steps the analyst may perform if there are concerns regarding whether the insurer's investment portfolio is adequately diversified to avoid an undue concentration of investments by type or issue. The analyst should consider determining whether the insurer's investment portfolio is in compliance with the investment limitations and diversification requirements per the state's insurance laws. The analyst might also

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review the Percentage Distribution of Assets in the Financial Profile Report for significant shifts in the mix of investments owned during the past five years. The analyst should compare the insurer's distribution of invested assets to industry averages to determine significant deviations from the industry averages. In addition, the analyst might also 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 analyst might also review Schedule D – Part 1A - Quality and Maturity Distribution of all Bonds Owned and consider the liquidity of the insurer's investments to help determine whether the insurer's investment portfolio appears reasonable based on the types of business written. If the analyst has concerns regarding liquidity or cash flows, he or she should consider reviewing the Statement of Actuarial Opinion and memorandum for comments regarding cash-flow testing performed and the results obtained (For a detailed discussion of cash-flow testing performed as a part of the Statement of Actuarial Opinion review, see section III.C.2. regarding actuarial opinions.) or having a cash flow analysis performed by an actuary.

Procedure #2 suggests additional steps the analyst may perform if there are concerns regarding investment approval or control and possession. If there are concerns regarding investment approval, the analyst should consider requesting a copy of the insurer's formal adopted investment plan to determine who is authorized to purchase and sell investments and what approvals are required for investment transactions. If there are concerns regarding investments which are held by someone other than the insurer, the analyst should consider reviewing General Interrogatory #22 in more detail to determine the reason the securities are not in the insurer's possession and who holds the securities in order to evaluate whether they qualify as admitted assets of the insurer under the state insurance laws or whether there are concerns regarding the insurer's ability to have access to the securities when needed. If there are concerns regarding investments which are not under the insurer's exclusive control, the analyst should consider reviewing General Interrogatory #23 in more detail to determine the reason the assets are not under the insurer's exclusive control (e.g., loaned to others, subject to repurchase or reverse repurchase agreements, pledged as collateral, placed under option agreements) and who holds the assets in order to evaluate whether they qualify as admitted assets for the insurer under the state insurance laws or whether there are other concerns.

Procedure #3 suggests additional steps the analyst may perform if there are concerns regarding whether securities have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office. The analyst should consider reviewing Schedule D – Part 1 - Bonds to determine whether all bonds with an NAIC designation of 6 (bonds in or near default) have been valued at the lower of cost or fair value and all other bonds have been valued at their amortized cost value in accordance with the NAIC *Accounting Practices and Procedures Manual (AP&P Manual)*. The analyst should also consider reviewing Schedule D – Part 2 - Preferred Stocks and Common Stocks to determine whether redeemable preferred stocks have been valued at their cost and all other stocks have been valued at their fair value in accordance with the *AP&P Manual*. For those securities listed in Schedule D – Part 1 - Bonds or Schedule D – Part 2 - Preferred stocks and Common Stocks with a "Z" suffix after the NAIC designation, the analyst might request verification from the insurer that the securities are filing exempt or have been submitted to, and subsequently valued by, the SVO and compare the price or designation subsequently received from the SVO to that included in the Annual Financial Statement for significant securities. The analyst should also consider using Examination Jumpstart investment analysis (available on I-SITE) to compare the CUSIP number, NAIC designation, and fair value for each of the securities listed in Schedule D – Part 1 - Bonds, Schedule D – Part 2 - Preferred Stocks and Common Stocks, and Schedule DA - Short-Term Investments to information on the SVO master file.

Procedure #4 suggests additional steps the analyst may perform if there are concerns regarding the significance of any excess of the book/adjusted carrying value over the fair value of bonds and redeemable preferred stocks. The analyst should consider reviewing Schedule D – Part 1 - Bonds and Schedule D – Part 2 - Preferred Stocks and Common Stocks or requesting information from the insurer to determine which individual bonds and redeemable preferred stocks have a book/adjusted carrying value significantly in excess of their fair value. The analyst should

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be aware that the value for those securities with an "AV" (amortized value) designation in the rate used to obtain the value column in Schedule D does not represent a true fair value for the securities. For those securities with a book/adjusted carrying value significantly in excess of their fair market value, the analyst might consider verifying the NAIC designation assigned and determine whether it has recently been reviewed by the SVO, determine the current rating by a nationally recognized statistical rating organization and evaluate whether there has been an other than temporary decline in fair value. For bonds and redeemable preferred stocks with other than temporary declines, the analyst should consider whether the investment should be written down to its fair value to properly reflect the value of the investment. If the insurer has experienced negative cash flows or has other liquidity problems, the analyst should consider requesting information from the insurer regarding investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of their fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

Procedure #5 suggest additional steps the analyst may perform if there are concerns regarding the significance of any excess of cost over fair value of common stocks owned. The analyst should consider reviewing Schedule D – Part 2 – Section 2 - Common Stocks to determine which individual common stocks have a cost significantly in excess of their fair value. The analyst should also determine whether the stock is listed on a national exchange and verify the price per stock and the total fair value listed in the statement. If the NAIC designation of the stock is "A," (unit price of the share of common stock is determined analytically by the SVO) review the date that the price per share was last analyzed by the SVO. The analyst should also consider whether the common stock has had an other than temporary decline in its value. The analyst should consider requesting the Audited Financial Statement and other documents necessary to support the value of the common stock. The analyst should also consider requesting information from the insurer regarding investment strategies and short-term cash flow needs.

Procedure #6 suggests additional steps the analyst may perform if there are concerns regarding significant purchases or sales of securities near the beginning and/or end of the year. The analyst should consider reviewing Schedule D – Part 3 - Long-Term Bonds and Stocks Acquired During Current Year, Schedule D – Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year and Schedule D – Part 5 - Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year to determine the types of securities purchased and sold at or near the beginning and the end of the year, the vendors used for investment purchases, and the purchasers of investments sold. This information can then assist the analyst in determining whether the insurer might have engaged in "window dressing" of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring lower quality investments after year end) in an attempt to avoid AVR and other penalties and additional regulatory scrutiny which would have occurred with the insurer's lower rated investment portfolio.

Procedure #7 suggests additional steps the analyst may perform if there are concerns regarding investment turnover. The analyst should consider reviewing Schedule D – Part 3 - Long-Term Bonds and Stocks Acquired During the Current Year, Schedule D – Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Year and Schedule D – Part 5 - Long Term Bonds and Stocks Acquired and Disposed of During Year to determine the types of securities purchased and sold. This information can assist the analyst in determining the types of securities sold and acquired, as well as the length of time each security was held and the quality of the security. The analyst should also review realized capital gains from the sale of securities to determine any reliance on these gains. The analyst should also consider having a specialist review the insurer's investment program. The analyst should also review the Statement of Actuarial Opinion and memorandum to determine whether any concerns about investment turnover are noted.

Procedures #8 through #14 suggest additional steps the analyst may perform if there are concerns regarding the level of investment in certain types of investments which tend to be riskier and/or less liquid than publicly traded bonds and stocks and cash and short-term investments. In addition to the steps for the types of investments included in supplementary procedures #8 through #14, the analyst should consider reviewing procedures #3 and

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#4 in the Affiliated Transactions section of the Level 2 Annual Procedures and Level 3 Procedure #3 for Affiliated Transactions for procedures regarding investments in affiliates.

Procedure #8 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in non-investment grade bonds. The analyst should consider reviewing Schedule D – Part 1A – Section 1 - Quality and Maturity Distribution of all Bonds Owned and compare the insurer's holdings of non-investment grade bonds to the limitations included in the *NAIC Investments in Medium Grade and Lower Grade Obligations Model Regulation* by NAIC designation. The insurer should have a plan for investing in non-investment grade bonds that has guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, and geographic location. The analyst might consider requesting a copy of this plan from the insurer to determine whether the insurer appears to be adhering to its plan for investing in non-investment grade bonds. For the more significant non-investment grade bonds, the analyst might also consider requesting from the insurer audited financial statements and a rating agency report for the issuer of the bonds to assess the issuer's current financial position and ability to repay its debt.

Procedure #9 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in multi-class residential mortgage backed securities (MRMBSs). The analyst should consider reviewing the multi-class securities categories in Schedule D – Part 1 - Bonds for bonds with a book/adjusted carrying value significantly in excess of par value, which could result in a loss being realized if bond prepayments occur faster than anticipated. The analyst should also consider reviewing a listing of the effective yield on each of the insurer's multi-class securities. The effective yield on most debt securities is generally linked to its credit risk and duration. However, significant prepayment risk can also increase the effective yield.

There are many different types of MRMBSs, each of which have different characteristics and inherent risks. Therefore, the analyst might consider requesting information from the insurer regarding the amount of each type held (e.g., Planned Amortization Class (PACs), support bonds, interest only (IOs) and principal only (POs)) to help evaluate the riskiness of the portfolio. A glossary of various CMO terms is available within the link at the top of the Financial Analysis Handbook Reports page on I-SITE. The document is "An Investors Guide to CMO's".

The analyst might consider requesting information from the insurer regarding estimated prepayment speeds on its MRMBSs. Several standardized forms of calculating the rate of prepayments of a mortgage security exist in the market. The Constant Prepayment Rate (CPR) and the Standard Prepayment Model of the Bond Market Association (PSA curve) are the most common methods used to measure prepayments. For further discussion of prepayment speeds and other items that impact the interest rate risk and valuation risk of a mortgage backed security, see the "Mortgage Backed Securities" document included in the "Detailed Discussion of CMOs" link at the top of the Financial Analysis Handbook Reports page on I-SITE. The analyst should consider further analysis in those instances that prepayment risk appears high.

This additional analysis might include a review of the insurer's Life Risk-Based Capital (RBC) formula or its Statement of Actuarial Opinion and memorandum. The Life RBC formula includes a C-3 Interest Rate Risk Component that charges insurer's for securities that have not been cash flow tested. The insurer is charged 0.5 times the excess of the statement value over the value of the security if all of the collateral was immediately repaid. Alternatively, or in addition to this procedure, the Statement of Actuarial Opinion and memorandum should be reviewed for comments regarding the modeling of the MRMBS portfolio in the cash-flow testing performed. The analyst might also consider having the MRMBSs modeled by an independent actuary as a part of an independent cash flow analysis.

The rationale behind parts c, d and e of the procedure is to provide the analyst with some insight regarding the level of prepayment risk the insurer holds in its MRMBS portfolio and the measurement and monitoring tools the insurer uses to manage this risk. Parts c and d ask the insurer to break down its MRMBS portfolio by general definitional classes, each of which has its own relative level of prepayment and cash flow volatility risk.

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Individual insurers may use different measures and monitoring techniques. If an insurance company cannot supply this data with reasonable ease, the analyst may want to look more closely at the management and monitoring systems in place for the MRMBS portfolio.

Procedure #10 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in private placement bonds. The analyst should consider reviewing Schedule D – Part 1A – Section 1 - Quality and Maturity Distribution of all Bonds Owned to determine the amount, issue type, NAIC designations, maturity distribution of privately-placed bonds owned, and the amount of privately-placed bonds which are freely tradeable under Securities and Exchange Commission (SEC) Rule 144 or qualified for resale under SEC Rule 144A. For the more significant privately-placed bonds, the analyst should also consider requesting from the insurer current audited financial information regarding the issuer to evaluate the issuer's financial position and ability to repay its debt.

Procedure #11 suggests additional steps the analyst may perform if there are concerns regarding the level or quality of investment in real estate and mortgage loans. If there are concerns regarding real estate owned, the analyst should consider reviewing Schedule A – Part 1 - Real Estate Owned to determine whether updated appraisals should be obtained for any of the properties owned based on the location of the property, the book/adjusted carrying value and reported fair value of the property, and the year of the last appraisal. In addition, for those properties with book values in excess of fair value, the analyst might consider whether the asset should be written down. The analyst should also consider investigating any instances where a property has a book/adjusted carrying value in excess of its cost and requesting information from the insurer regarding any increases in book/adjusted carrying value during the year. If there are concerns regarding mortgage loans, the analyst should consider reviewing Schedule B - Mortgage Loan Owned to determine the amount of each type of mortgage loan owned. Commercial mortgages have historically been riskier investments than farm mortgages and residential mortgages. The analyst might also consider comparing the book/adjusted carrying value of each loan to the value of the land and buildings mortgaged. The analyst should determine whether the mortgage loans are adequately collateralized and whether any of the mortgage loans are to officers, directors, or other affiliates of the insurer. For those loans which have had an increase in book/adjusted carrying value during the year, the analyst might consider requesting information from the insurer regarding the increase to determine whether the increase should be considered an admitted asset. In addition, for those loans with interest overdue or which are in process of foreclosure, the analyst should consider reviewing the year of last appraisal of the underlying land and buildings to determine whether updated appraisals should be required.

Procedure #12 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in other invested assets (Schedule BA). The analyst should consider reviewing Schedule BA to determine the amount and types of other invested assets owned and to determine whether they are properly categorized as other invested assets. Information might be requested from the insurer to support any increases by adjustment in book/adjusted carrying value during the year. In addition, the analyst should consider requesting current audited financial statements and other documents (e.g., partnership agreements, etc.) necessary to support the book/adjusted carrying value of the insurer's investment in partnerships and joint ventures and information to support the book/adjusted carrying value of significant other invested assets (e.g., other than partnerships and joint ventures).

Procedure #13 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in collateral loans. The analyst should consider reviewing Schedule BA - Other Invested Assets and Schedule DA - Short-Term Investments to determine whether the collateral for the loan is an acceptable asset and whether any of the collateral loans are to officers, directors or other affiliates of the insurer. The analyst should also consider comparing the fair value of the collateral to the amount loaned to determine whether the loan is adequately collateralized. In those instances where the underlying collateral is comprised of securities, the analyst might consider verifying the rate used to obtain the fair value of the securities by referencing the SVO *Valuations of Securities Manual*.

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Procedure #14 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in derivative instruments. The analyst 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 could be evaluated to determine whether it appears to result in hedges which 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, the analyst 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 *AP&P Manual* have been met. The analyst 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.

Additional Reference Sources

1. NAIC *Accounting Practices and Procedures Manual*, NAIC
2. *Annual Statement Instructions for Life, Accident and Health Insurance Companies*, NAIC
3. *Purposes and Procedures Manual of the NAIC Securities Valuation Office*, NAIC

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III. Analysts Reference Guide – B.1A. Investments Appendix – Primer on Derivatives

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, *Accounting for Derivative Instruments and Hedging Activities* (SSAP No. 86) of the *AP&P Manual.*

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 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, indicies, 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 indexed 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) as measured from the date of

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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 percent, semi-annually and receive a floating rate LIBOR (London Inter Bank Offer Rate) for example, plus a spread. Each six months, the insurer would pay the counterparty 3 percent times the notional amount, $10,000,000 for example, and would receive an amount equal to $10,000,000 times the then current LIBOR 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 LIBOR 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

A cap is an agreement obligating the seller to make payments to the buyer. Each payment under which 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 stike/cap rate or price. A floor is an agreement obligating the seller to make payments to the buyer. Each payment under which 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

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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 traded 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.

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 and income generation transactions are included in the NAIC *Model Investment Law (Defined Limits Version)* 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.

Some insurance companies that sell Guaranteed Investment Contracts (GICs) guarantee to the GIC contract 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" (i.e., 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.

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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 percent coupon per year. The insurer can enter into a swap transaction with another party in which the insurer receives 2 percent 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 Schedule DB of the statutory financial statement. Options, caps and floors owned by the insurer are reported in Part A. Options, caps and floors written by the insurer are reported in Part B. Collar, Swap and Forward contracts are reported in Part C, Futures are reported in Part D and Replications are reported in Part F.

Schedule DB parts A through D contain the following four sections: 1) Section 1 identifies the contracts open as of the accounting date, 2) Section 2 identifies contracts opened during the year, 3) Section 3 identifies contracts terminated during the year, and 4) Section 4 is a reconciliation of the book value from the prior year to the current year.

Schedule DB Part E 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 Blanks Instructions.

Schedule DB, Part F, Section 1, contains the underlying detail of replicated assets owned at the end of the year. Section 2 of Schedule DB, Part F is a reconciliation between years of replicated assets. The assumption underlying the NAIC RBC formula, that all derivative instruments are used for hedging purposes, is one of the central issues that the NAIC is exploring in its research on the subject of replication transactions.

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 Part B – 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*. Beginning in 2003, accounting guidance for derivative transactions will vary based on the transaction or modification date of the transaction. For derivative transactions effective Jan. 1, 2003 and after, SSAP No. 86 will apply. 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.

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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 exsist regarding an insurer's derivative activity it may be necessary to obtain a comprehensive description of the insurer's derivative program, a procedure included in the Level 3 Procedures.

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.
  - 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.

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III. Analysts Reference Guide – B.2. Life Reserves

Overview of Life Reserves

Life insurance reserves represent the liability established by the insurer to pay future policy benefits such as a death benefit (payable if the insured dies within a specific period of time), an endowment benefit (if the policy is an endowment policy and is continued until the maturity date), and a cash surrender value upon policy surrender. Theoretically, life reserves represent the present value of future guaranteed benefits reduced by the present value of expected future net premiums. The insurance policy is a unilateral contract whereby the insured can cancel the agreement to pay premiums at any time. However, the insurer is "locked in" regardless of future experience and cannot forfeit on its guarantees as long as the premiums are paid. Life reserves are required in order to ensure that commitments made to policyholders and their beneficiaries will be met, even though the obligations may not be due for many years. Since the primary purpose of life reserves is to pay claims when they become due, life reserves must be adequate and the funds must be safely invested.

The NAIC *Accounting Practices and Procedures Manual (AP&P Manual)* prescribes the minimum standards to be used in determining reserves. Appendix A-820, *Minimum Life & Annuity Reserves Standards*, of the *AP&P Manual* defines the minimum standards for all types of policy reserves, including life & annuity policies. Insurers may establish life reserves, which equal or exceed these minimum standards. These minimum life reserve standards specify 1) a given mortality table, 2) a maximum rate of interest, and 3) a valuation method. The valuation method used to define minimum life reserves for statutory accounting purposes is referred to as the Commissioners Reserve Valuation Method (CRVM). The mortality rate assumptions are substantially higher than what the insurer can expect to realize from medically underwritten insurance policies. The interest rate assumptions are intended to be significantly lower than current money and capital market yields. Thus, the life reserves developed are generally conservative.

There are three general valuation methods used to value life reserves. The net level premium method does not provide for a first-year acquisition cost allowance in determining life reserves. Therefore, this method results in the most conservative, or highest, life reserve valuation of the three methods. The preliminary term method is the CRVM method. This method permits a first-year expense allowance and then assumes that the remaining premium stream is used to cover policy benefits. This method allows for a lower life reserve valuation than the net level premium method in the earlier years of the policy term. The modified preliminary term method is a variation of the two methods described above and results in a reserve valuation between the net level premium and preliminary term methods.

As described below, the type of life insurance policy dictates the amount of the life reserve that must be established and the duration for maintaining the reserve. In addition, special situations arise which require unique reserving techniques. The following summarizes the major types of life insurance policies, and the related reserving implications:

1. **Ordinary Life Reserves**

   Under a whole life plan of insurance, the insurer is obligated to maintain a reserve until the death of the insured. Term life insurance provides coverage only for the period that is specified in the policy. Under a term insurance plan, the insurer must maintain a reserve, which reduces to zero upon expiration of the term period. Similar to term insurance, endowment life insurance provides coverage for a period specified in the policies. Unlike term insurance, the proceeds of endowment insurance are payable if the insured lives to the end of the period. Policies, which permit flexible premium payments, are referred to as "universal life" policies and those with fixed premiums are referred to as "interest sensitive" policies. Universal life policies are accumulation type policies where the current account value is determined based upon the accumulation of premiums less mortality charges and expense charges, plus a current interest rate credit. The account value less surrender charges is the cash value. Because of the unique features of universal life and interest sensitive types of policies, unique reserving requirements are specified for them in Appendix A-585, *Universal Life Insurance*, of the *AP&P Manual*. The minimum standard for universal

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life reserves consider guarantees within the policy at the time of issue, present value of future guaranteed benefits, account value and cash value.

2. **Group Life Reserves**

Most group life insurance is monthly renewable term insurance. For these policies, gross premiums are typically recalculated periodically, most often annually, using the age and sex census of the group along with experience adjustments. Therefore, the reserve is usually calculated as the unearned premiums or a percentage thereof to estimate the claim exposure. However, some group life insurance policies provide permanent or longer term benefits analogous to individual coverages. In these cases, the reserving methods are similar to those employed for individual insurance, using appropriate mortality tables. Appendix A-820 does not specify a mortality table for group life insurance but leaves that to the discretion and approval of the domiciliary state.

3. **Industrial Life Reserves**

Industrial life insurance is unique in that it involves higher unit premiums, smaller face amount policies and higher mortality expectations. The minimum standards for reserves are the same as the traditional life insurance except that a unique mortality table is used.

4. **Life Reserves Relating to Riders**

Life insurance policies frequently include riders for additional benefits such as accidental death and disability. The minimum valuation standards for reserves are the same as for the base life insurance except that specialized mortality tables are used and the net level premium valuation method is required.

5. **Miscellaneous Life Reserves**

There are various other special situations involving life reserves. First, a deficiency reserve may be required in situations where the actual policy premium is less than the net level premium valuation. This situation occurs when pricing assumptions are used that are different from the minimum reserve valuation standards. This does not necessarily indicate that the policy is being sold at a loss by the insurer, but rather is a reflection of the highly conservative nature of the minimum reserve valuation standards. Second, there may be unusual situations where the cash surrender value of a life insurance policy is greater than the minimum reserve standard. In these situations, life reserves must be increased by the amount of this excess. Finally, as a result of the asset adequacy analysis conducted by the qualified actuary, the actuary may conclude that the insurer's assets are not adequate to cover future reserves. When this occurs, reserves must be increased by the estimated deficiency resulting from asset adequacy testing.

Due to the complexity in determining life reserves, insurers must rely on actuaries to assist with valuation of these reserves. Insurers are required to annually obtain an opinion regarding the reasonableness of the reserves by a qualified actuary. In the aggregate, policy reserves for all life insurance policies that are reported in the statutory financial statements must equal or exceed reserves calculated by using the assumptions and methods that produce the minimum formula standard valuation.

Discussion of the Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst should also consider the insurer's corporate governance which includes the assessment of the risk environment

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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 three procedures included in the life reserves section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. While the underlying actuarial techniques relating to life reserves are quite complicated, the analyst should remember that there are two basic objectives regarding life reserves. The first objective is that the insurer's life reserves are accurately calculated in accordance with the minimum formula statutory valuation standards, and the second objective is that the insurer's assets are adequate to support the future policy obligations.

- *Procedure #1* assists the analyst in determining whether the insurer's life reserves are valued in accordance with the minimum formula statutory valuation standards. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary.
- *Procedure #2* assists the analyst in determining whether any changes in life reserve valuation bases during the year were proper. From time to time, an insurer may decide to change the valuation basis for a particular segment of the business. The insurer may change the mortality table used, the rate of interest or the valuation method. Reserve strengthening occurs when the insurer substitutes a more conservative basis of valuation for any given block of business. Reserve weakening may also occur but normally requires approval of the domiciliary state.
- *Procedure #3* assists the analyst in determining whether the insurer's underlying assets are adequate to support the future obligations of its life insurance policies. If the insurer filed a Statement of Actuarial Opinion based on an asset adequacy analysis, then the Statement of Actuarial Opinion itself, and the supporting actuarial memorandum, if requested, can provide the analyst with comfort in this regard. If a Statement of Actuarial Opinion that does not include an asset adequacy analysis is filed, the analyst can review net interest spread ratios for insights regarding the relationship of investment income with tabular interest.

Discussion of the Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures are intended to identify significant changes in life reserves that have occurred since the prior year Annual Financial Statement, or the prior Quarterly Financial Statement.

Discussion of the Level 3 Procedures

The Level 3 Procedures for Life Reserves are designed to assist the analyst in further investigating potential problems and concerns that are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate further, and how far to probe.

Procedures #1 and #2 suggest additional steps the analyst may perform if there are concerns regarding the valuation of life reserves or changes in valuation bases. The additional steps described essentially involve testing the actual reserve calculations for a sampling of individual life insurance policies to ensure that the minimum statutory valuation standards have been met.

Procedure #3 suggests additional steps the analyst may perform if there are concerns as to the adequacy of the insurer's underlying assets to support life reserves. If an actuarial memorandum is available, this will provide the analyst with substantial analyses with regard to asset adequacy. If an actuarial memorandum is not available, the analyst should consider the need to have an independent asset adequacy analysis conducted.

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III. Analysts Reference Guide – B.2. Life Reserves

Additional Reference Sources

1. *Annual Statement Instructions for Life, Accident and Health Insurance Companies*, NAIC
2. NAIC *Accounting Practices and Procedures Manual*
3. NAIC *Accounting Practices and Procedures Manual Appendix A-820*
4. NAIC *Accounting Practices and Procedures Manual Appendix A-822*
5. NAIC *Accounting Practices and Procedures Manual Appendix A-585*
6. NAIC *Accounting Practices and Procedures Manual Appendix C*
7. *Life-Health Insurance Accounting*, IASA, 1988

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III. Analysts Reference Guide – B.3. Accident and Health Reserves

Overview of Accident and Health Reserves

The purpose of accident and health (A&H) insurance is to protect the insured against economic losses resulting from accident and/or sickness. There are many different types of A&H policies issued by insurers. The economic losses covered, and the types of benefits provided, vary with the different types of A&H policies. For example, a medical insurance policy may provide reimbursement for hospital, surgical, medical and drug expenses and a dental insurance policy may cover dental expenses. Another type of A&H insurance policy issued is disability insurance which provides monthly benefits for loss of income due to disability on either a short-term or long-term basis. A&H insurance is provided through individual policies, group policies and certain special types of policies such as credit disability insurance.

A&H reserves are complex and difficult to analyze because of the wide variety of types of coverage included in the A&H lines of business and the diversity of benefits which must be reserved for. A&H reserves are comprised of two separate liability line items in the Annual Financial Statement 1) the aggregate reserve for A&H policies and 2) the A&H policy and contract claims liability. These liabilities are discussed in more detail below.

1. **Aggregate Reserve for A&H Policies**

   The aggregate reserve for A&H policies consists of two different components 1) policy reserves and 2) claim reserves.

   a. **Policy Reserves**

      Policy reserves are required in recognition of the fact that premiums cover future liabilities as well as current claims and expenses. Policy reserves include unearned premium reserves, additional contract and actuarial reserves, reserves for future contingent benefits, and reserves for rate credits. The various types of policy reserves are discussed in more detail below.

      Unearned premium reserves represent the amount of the premium applicable to coverage which extends beyond the valuation date (date of the statement). The unearned portion of the premium is generally computed on a pro rata basis.

      Additional contract reserves are required for those policies with level premiums where the risk of loss increases with the age of the insured. For these policies, the insurer is required to set aside a portion of the current premium to pay claims that experience indicates will be incurred as the policy continues in force. These reserves are actuarially determined and are similar in concept to life reserves with the added requirement to consider morbidity assumptions as well as mortality and interest assumptions. The NAIC *Accounting Practices and Procedures Manual (AP&P Manual)* prescribes the minimum standards used in determining the A&H policy reserves. Insurers may establish A&H policy reserves which equal or exceed these minimum standards. These minimum A&H policy reserve standards for most types of A&H insurance include 1) a given morbidity table, 2) a maximum rate of interest, and 3) a valuation method. In no event, however, may the aggregate reserve for all policies be less than the unearned gross premiums under such policies. For financial statement purposes, the additional contract reserves represent the excess of the required A&H policy reserves over the unearned gross premiums on A&H policies. The insurer is required to attach, to the Annual Financial Statement, a description of the valuation standards used in calculating the additional contract reserves, specifying the reserve bases, interest rates and methods.

      Additional actuarial reserves are additional reserves required as a result of actuarial cash-flow testing and asset adequacy analysis. (See section III.C.2 for a discussion of asset adequacy analysis).

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If the A&H policy provides for future contingent benefits, a portion of the current premium must also be reserved for such coverage. For example, some A&H policies provide for deferred maternity benefits (which cover medical expenses incurred in childbirth for approximately nine months after the cessation of premium payments, even though the policy has been canceled, so long as conception occurred prior to the policy being canceled). An actuarially determined estimate of the costs associated with this future contingent benefit must be reserved for out of the current premium.

Some A&H policies provide for rate credits based on policy year experience. For these policies, a reserve is required to be established for the rate credits based on the amount of the expected credit as of the valuation date. The reserve for rate credits is a difficult liability to establish because many policy years do not end on the valuation date (date of the statement) and subsequent experience may cause the rate credit to be greater or less than the liability established. However, the liability established must be reasonable under the circumstances and consistently calculated.

b. **Claim Reserves**

Claim reserves (sometimes referred to as disabled life reserves) are required for claims which involve continuing loss. The claim reserves represent the actuarially determined present value of future benefits or future covered benefits not yet due as of the valuation date (date of the statement) which are expected to arise under claims which have been incurred as of the statement date. However, although the liability for future covered benefits which are expected to arise under claims which have been incurred as of the statement date on medical insurance policies should be included in claim reserves according to SSAP No. 55, *Unpaid Claims, Losses and Loss Adjustment Expenses*, some insurers include this liability in the A&H policy and contract claims liability which is discussed below.

2. **A&H Policy and Contract Claims Liability**

The A&H policy and contract claims liability includes 1) due and unpaid claims, 2) claims in the course of settlement, and 3) incurred but not reported (IBNR) claims.

a. **Due and Unpaid Claims**

Due and unpaid claims are those which are complete except for the payment of the amount due. The amount of an insurer's due and unpaid claims is generally very small and this liability is generally determined on an exact inventory basis of claims ready to be paid.

b. **Claims in the Course of Settlement**

Claims in the course of settlement include claims which have not been paid because all of the required information has not yet been received as of the statement date, resisted claims and the accrued portion (amount that is payable as of the statement date) of the next periodic payment on disability claims. The unaccrued portion of the next periodic payment on disability claims would be included in claim reserves discussed above. The liability for claims in the course of settlement, other than disability claims, may be determined based on estimates for each outstanding claim or the development of average claim factors or formulas based on historical experience.

c. **IBNR Claims**

IBNR claims are those claims which have occurred but have not yet been reported to the insurer. Since neither the number nor dollar amount of IBNR claims are known as of the statement date, the liability for IBNR claims is difficult to estimate. The liability for IBNR claims is generally estimated based on an actuarial analysis of past experience or on the development of lag studies using historical experience.

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III. Analysts Reference Guide – B.3. Accident and Health Reserves

Due to the variety of types of A&H policies issued and the complexity of determining the aggregate reserve for A&H policies and the A&H policy and contract claims liability, most insurers rely on actuaries or individuals with actuarial training to assist in estimating these liabilities. Although some insurers do not use actuaries to actually set the A&H reserves, insurers are required to annually obtain an opinion regarding the reasonableness of the established A&H reserves by a qualified actuary. Therefore, qualified actuaries are involved in setting and/or reviewing the A&H reserve liabilities established for virtually all insurers.

Discussion of the Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 two procedures included in the A&H reserves section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The purpose of this section is primarily to assist the analyst in identifying those insurers that might have understated their A&H reserve liabilities.

Procedure #1 assists the analyst in determining whether an understatement of A&H reserves would be significant to the insurer. The ratios of gross and net A&H reserves to capital and surplus are leverage ratios which are calculated gross and net of reinsurance ceded. The net A&H reserves to capital and surplus ratio indicates the margin of error an insurer has in estimating its A&H reserves. For an insurer with a net A&H reserves to capital and surplus ratio of 300 percent, a 33 percent understatement of its A&H reserves would eliminate its entire surplus. In evaluating these leverage ratios, the analyst should also consider the nature of the insurer's business. For example, an insurer which has written primarily A&H business for many years and has proven that it can manage the business profitably is probably not as risky as an insurer which has just begun writing A&H business, even if both insurers have the same leverage ratio results.

Procedure #2 assists the analyst in determining whether A&H policies appear to have been adequately reserved. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary. Therefore, the analyst should review the results of the Statement of Actuarial Opinion Supplemental Procedures to determine whether any concerns were noted regarding the valuation of the insurer's A&H reserves in accordance with Appendix A-010 of the *AP&P Manual*. The ratio of A&H reserve deficiency measures the adequacy of A&H reserves established in the prior year. A positive result for this ratio represents additional or "adverse" development on the reserves originally established by the insurer (the amount by which the A&H reserves originally established have proved to be understated based on subsequent activity). If the insurer's ratio results consistently show additional development, this could be an indication that the insurer is intentionally understating its A&H reserves. The A&H loss ratio is also reviewed as a part of this procedure. Significant increases in this ratio might be indicative of additional A&H reserves being established due to prior understatements while significant decreases might be indicative of current A&H reserve understatements. Other steps included in this procedure include the review of Exhibit 5A of the Annual Financial Statement to determine whether there has been a change in the valuation basis of the A&H policies during the year which resulted in a decrease in A&H reserves in an amount greater than 5 percent of capital and surplus.

Discussion of the Level 2 Quarterly Procedures

The five procedures included in the A&H reserves section of the Level 2 Quarterly Procedures are intended to identify significant changes in A&H reserves or A&H benefits that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.

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III. Analysts Reference Guide – B.3. Accident and Health Reserves

Discussion of the Level 3 Procedures

The Level 3 Procedures for A&H Reserves are designed to assist the analyst in further investigating potential problems and concerns that are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized in the Level 3 Procedures, the analyst should always use good judgement in determining which areas to investigate, and how far to probe.

Procedure #1 suggests additional steps the analyst may perform if there are concerns regarding whether A&H policies have been adequately reserved. The analyst should consider reviewing Schedule H - Accident and Health Exhibit to determine which A&H lines of business are being written and which A&H lines of business had positive development in reserves during the year. The analyst should also consider 1) reviewing the insurer's A&H insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits and 2) contacting the policy forms section of the insurance department and inquiring as to whether the insurer has filed any new and unusual A&H policy forms during the past year. In addition, the analyst could review the insurer'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 insurer's description of the valuation standards used is required to be attached to the filed Annual Financial Statement). The analyst might want to contact the qualified actuary who signed the insurer's Statement of Actuarial Opinion to discuss the nature and scope of A&H valuation procedures performed and/or request a copy of the qualified actuary's actuarial memorandum to review for comments regarding the analysis of A&H reserves performed and the conclusions reached.

Other steps for the analyst to consider in Level 3 procedure #1 include the analyst reviewing the A&H loss ratio for the past five years for unusual fluctuations or trends between years and, if the loss ratio appears unusual, comparing it to the industry average loss ratio to determine any significant deviations from the industry average. The analyst might also consider requesting that the field examination staff request a valuation listing of A&H reserves by policy and testing a sample of policies to determine that the reserve factors were appropriate and that the reserves were correctly computed. If the adequacy of claim liabilities is a concern, the analyst might want to request information from the insurer 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 insurer. If there was a change in the valuation basis of A&H policies during the year, the analyst should consider the following: 1) obtaining information regarding the reason for the change in the valuation basis, 2) determining whether the amount of the change in the actuarial reserve as a result of the change in the valuation basis is reasonable, and 3) determining whether the change in the valuation basis was approved by the domiciliary state insurance department, if required.

Additional Reference Sources

1. NAIC *Accounting Practices and Procedures Manual*
2. *Annual Statement Instructions for Life, Accident and Health Insurance Companies*, NAIC
3. NAIC *Accounting Practices and Procedures Manual Appendix A-010*
4. *Life-Health Insurance Accounting*, IASA, 1988

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III. Analysts Reference Guide – B.4. Annuity Reserves

Overview of Annuity Reserves

Annuity reserves represent the liability established by the insurer to pay future policy benefits. While life insurance provides protection from the loss arising from dying too soon, an annuity protects against the loss from living too long. Theoretically, annuity reserves represent the present value of future guaranteed benefits reduced by the present value of expected future net premiums. An annuity can be in either an accumulation mode or a payout mode. Annuity policies take three forms 1) annual premium deferred annuity, 2) single premium deferred annuity, and 3) single premium immediate annuity. Under an annual premium deferred annuity, annual premiums are paid during an accumulation period until such time as the policyholder (i.e., annuitant) receives income, surrenders the policy, or it terminates upon death. These annual premiums may be a specified amount or subject to the discretion of the owner under "flexible premium" annuities. Even if premiums are discontinued, the cash value of the policy will continue to accumulate until income is elected or the policy is otherwise terminated for its value. At income commencement, the annuitant receives the monthly income based upon cash value of the policy at that time and the annuity factor guaranteed in the policy or currently being applied, if more favorable, for the annuitant's attained age. The single premium deferred annuity also accumulates until such time as the annuitant desires to take income or the policy is otherwise terminated. However, only a single premium is paid at the time the annuity is purchased.

NAIC *Accounting Practices and Procedures Manual (AP&P Manual)* prescribes the minimum standards to be used in determining reserves. Appendix A-820*, Minimum Life & Annuity Reserve Standards* of the *AP&P Manual* defines the minimum standards for all types of policy reserves, including life & annuity policies. Insurers may establish annuity reserves, which equal or exceed these minimum standards. These minimum annuity reserve standards specify 1) a given mortality table (if applicable), 2) a maximum rate of interest, and 3) a valuation method. The valuation method used to define minimum annuity reserves for statutory accounting purposes is referred to as the Commissioners Annuity Reserve Valuation Method (CARVM). The mortality rate assumptions, if applicable, are substantially lower than what the insurer can expect to realize from medically underwritten insurance policies. The interest rate assumptions are intended to be significantly lower than current money and capital market yields. Thus, the annuity reserves developed are generally conservative.

As described below, the type of annuity dictates the amount of the annuity reserve that must be established and the duration for maintaining the reserve. In addition, special situations arise which require unique reserving techniques. The following summarizes the major types of annuities, and the related reserving implications:

1. **Deferred Annuities (Annual Premium and Single Premium)**

   All deferred annuities are reserved using the CARVM method. The reserve on any specific valuation date requires a calculation of the present value of future guaranteed benefits less the present value of future required net premiums for the current duration of the policy and for each future duration. For purposes of calculating this series of "excesses," premiums are only considered to be payable for the specific duration for which the excess is being calculated. The reserve is the greatest of these excesses. Reserves for guaranteed benefits must consider all contractual guarantees including cash values, death benefits, annuity income, etc. Cash values are those actually guaranteed under the policy provisions.

2. **Immediate Annuities**

   Immediate annuities are those that are in a payout mode. Reserves are determined using the CARVM method, except that, in the case of supplemental contracts without life contingencies, mortality tables are not used.

3. **Guaranteed Interest Contracts (GICs)**

   GICs represent a type of funding vehicle used where group deferred annuities are involved. Under a basic GIC, the insurer accepts a single deposit from the plan sponsor (i.e., the employer) for a specified period

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of time, such as five years. Interest earned during the period may be accumulated until the period expires, or the earned interest may be paid out annually. At the end of the period, the account balance, including any accumulated interest, is returned to the plan sponsor. Numerous variations of this basic guaranteed interest contract have been developed which 1) allow the plan sponsor to make monthly contributions, rather than the single deposit and 2) provide that the principal and interest can be paid out in installments to make benefit payments to plan participants.

4. **Structured Settlements**

   Structured settlements are a form of immediate annuity generally established in connection with the settlement of a property/casualty claim wherein a predetermined future benefit stream is desired. Reserves are determined using the CARVM method with special actuarial guidelines that prescribe specialized mortality tables and govern the use of lump sum balloon payments.

5. **Variable Annuities**

   Variable annuities are annuities where the amount of each benefit payment is not specified in the annuity contract, but rather fluctuates according to the earnings of a separate account fund. The primary concern relating to variable annuities reserves relates to the treatment of the CARVM expense allowance in the general account. The CARVM method is generally used, but the current thinking is that CARVM may not be appropriate for certain types of variable annuities that do not include guaranteed benefits.

Due to the complexity in determining annuity reserves, insurers must rely on actuaries to assist with valuation of these reserves. Insurers are required to annually obtain an opinion regarding the reasonableness of the reserves by a qualified actuary. In the aggregate, policy reserves for all annuity policies that are reported in the statutory financial statements must equal or exceed reserves calculated by using the assumptions and methods that produce the minimum standard valuation.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 four procedures included in the annuity reserves section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. While the underlying actuarial techniques relating to annuity reserves are quite complicated, the analyst should remember that there are two basic objectives regarding annuity reserves. The first objective is that the insurer's annuity reserves are accurately calculated in accordance with the minimum formula statutory valuation standards and the second objective is that the insurer's assets are adequate to support the future policy obligations.

Procedure #1 assists the analyst in determining whether the insurer's annuity reserves are valued in accordance with the minimum formula statutory valuation standards. In this regard, the analyst must rely, to a large extent, on the opinion provided by the qualified actuary. The analyst can also gain comfort in this regard by evaluating the change in reserves in relation to increases or decreases in premiums during the year.

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Procedure #2 assists the analyst in determining whether any changes in annuity reserve valuation bases during the year were proper. From time to time, an insurer may decide to change the valuation basis for a particular segment of the business. The insurer may change the mortality table used, the rate of interest or the valuation method. Reserve strengthening occurs when the insurer substitutes a more conservative basis of valuation for any given block of business. Reserve weakening may also occur but normally requires approval of the domiciliary state.

Procedure #3 assists the analyst in determining whether the insurer's underlying assets are adequate to support the future obligations of its annuity policies. If the insurer filed a Statement of Actuarial Opinion based on an asset adequacy analysis, then the actuarial opinion itself, and the supporting actuarial memorandum, if requested, can provide the analyst with comfort in this regard. If a Statement of Actuarial Opinion that does not include an asset adequacy analysis is filed, the analyst can review net interest spread ratios for insights regarding the relationship of investment income with tabular interest.

Procedure #4 assists the analyst in identifying other areas of concern. For example, annuities can have a significant impact on the insurer's liquidity position, particularly significant levels of guaranteed interest contracts or amounts subject to withdrawal at minimal or no surrender charge.

Discussion of Level 2 Quarterly Procedures

The procedures described in the Level 2 Quarterly Procedures are intended to identify significant changes in annuity reserves that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.

Discussion of the Level 3 Procedures

The Level 3 Procedures for annuity reserves are designed to assist the analyst in further investigating potential problems and concerns that are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate further, and how far to probe.

Procedures #1 and *#2* suggest additional steps the analyst may perform if there are concerns regarding the valuation of annuity reserves or changes in valuation bases. The additional steps described essentially involve testing the actual reserve calculations for a sampling of individual annuity policies to ensure that the minimum statutory valuation standards have been met.

Procedure #3 suggests additional steps the analyst may perform if there are concerns as to the adequacy of the insurer's underlying assets to support annuity reserves. If an actuarial memorandum is available, this will provide the analyst with substantial analyses with regard to asset adequacy. If an actuarial memorandum is not available, the analyst should consider the need to have an independent asset adequacy analysis conducted.

Additional Reference Sources

1. *Annual Statement Instructions for Life, Accident and Health Insurance Companies*, NAIC
2. NAIC *Accounting Practices and Procedures Manual*
3. NAIC *Accounting Practices and Procedures Manual Appendix A-820*
4. NAIC *Accounting Practices and Procedures Manual Appendix A-822*
5. NAIC *Accounting Practices and Procedures Appendix C*
6. *Life-Health Insurance Accounting*, IASA, 1988

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III. Analysts Reference Guide – B.5. Income Statement and Surplus

Overview of the 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 an integral part of the financial analysis process. Income statement analysis primarily focuses on the operating performance of an insurer. 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, and 6) realized capital gains and losses. The return on capital and surplus, which considers net income as a percent of capital and surplus, is another important measure of overall operating performance.

Fluctuations and trends in the individual line items shown in the income statement are also important indicators of potential financial problems and concerns. For example, significant increases in premiums may be an indication of an insurer's entrance into new lines of business or sales territories which might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums may also indicate that an insurer is engaging in cash flow underwriting to cover current losses, particularly if the insurer primarily writes accident and health (A&H) insurance.

In assessing financial condition, considerable emphasis is placed on the adequacy of an insurer's capital and surplus (See section III.B.6 for a detailed discussion of Risk-Based Capital (RBC)). Capital and surplus provides protection (or "cushion") for policyholders against adverse underwriting results, inadequate policy reserve levels, insolvency of reinsurers, and fluctuations in the value of investments. In addition, capital and surplus provides underwriting capacity and allows an insurer to expand its business. The RBC formula (discussed in section III.B.6) is designed to calculate a minimum threshold measure of capital and surplus adequacy based on each insurer's unique mix of asset risk, insurance risk, interest rate risk, and business risk.

The components of capital and 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 capital and 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 at interest and sometimes (dependent 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. 41, *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 Annual Financial Statement 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

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department. Information regarding surplus notes must be reported in the Annual Financial Statement Notes to Financial Statements.

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, payments 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 the Financial Statements, 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, the analyst 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.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 four procedures listed in the Income Statement and Surplus section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The purpose of this section is primarily to assist the analyst in reviewing and analyzing the insurer's operating performance with emphasis on the level of, and change in, the insurer's premiums, policy surrender activity, investment income and net income, and changes in other components of the income statement and in capital and surplus. In addition, significant amounts of activity related to capital and surplus notes are identified. Separate sections of the Level 2 Annual Procedures provide specific guidance with respect to RBC, loss reserves and reinsurance.

Procedure #1 assists the analyst in determining whether concerns exist regarding the insurer's income statement or operating performance. One of the most common measures of 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). Six principal factors affect the insurer's net gain, as reflected in this ratio 1) mortality and morbidity experience, 2) adequacy of investment income, 3) commissions and expenses, 4) reinsurance transactions, 5) the relationship of statutory reserve requirements to prevailing interest and mortality rates, and 6) realized capital gains and losses. This ratio is an indicator of the insurer's overall profitability and operating performance without consideration of realized gains and losses. Another important measure of the insurer's operating performance is the return on capital and surplus, which considers net income as a percent of capital and surplus. Other steps are designed to assist the analyst in identifying unusual relationships and fluctuations in the insurer's income statement, which could have an impact on operating performance.

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III. Analysts Reference Guide – B.5. Income Statement and Surplus

Procedure #2 assists the analyst in determining whether concerns exist regarding changes in the volume of premiums and deposit-type funds or changes in the insurer's mix of business (lines of business written and/or geographic location of premium written). Significant increases or decreases in premiums written may indicate a lack of stability in the insurer's operations. In addition, a significant increase in premiums written may be an indication of the insurer's entrance into new lines of business or sales territories that might result in financial problems if the insurer does not have expertise in these new lines of business or sales territories. Significant increases in premiums might also be an indication that the insurer is engaging in cash flow underwriting to increase cash income in order to cover current benefit payments, particularly if the insurer primarily writes A&H insurance.

Procedure #3 assists the analyst in determining whether the insurer is excessively leveraged due to its volume of A&H business. Capital and surplus can be considered as underwriting capacity, and the ratios of gross (direct plus assumed reinsurance) A&H premiums to capital and surplus and net (gross less reinsurance ceded) A&H premiums to capital and surplus measure the extent to which that capacity is being utilized and the adequacy of the insurer's capital and surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A gross A&H premiums to capital and surplus ratio greater than 500 percent may indicate that the insurer is excessively leveraged and special attention should be given to the adequacy of the insurer's reinsurance protection and the quality of the reinsurers. A net A&H premiums to surplus ratio greater than 300 percent may also indicate that the insurer is excessively leveraged and lacks sufficient capital and surplus to finance the A&H business currently being written. In evaluating these leverage ratios, the analyst should also consider the nature of the insurer's business. For example, an insurer that has written primarily A&H business for many years and has proven that it can manage the business profitably is probably not as risky as an insurer, which has just begun writing A&H business, even if both insurers have the same leverage ratio results.

Procedure #4 assists the analyst in evaluating the underwriting performance of the Medicare Part D Prescription Drug coverage. The procedures utilize data in the Medicare Part D Coverage Supplement and calculates the loss ratio, expense ratio and combined ratio. If the results are outside the benchmarks, the analyst should consider if the insurer writes an enhanced benefit plan that may contain more exposure to losses. While Medicare business is funded through contracted government rates, risk exists when utilization and benefit costs exceed that which was anticipated when the contract was made. If the insurer is reporting unusual results, the analyst should consider if any delays in payments from the Centers for Medicare and Medicaid Services (CMS) are impacting results.

Procedure #5 assists the analyst in determining whether concerns exist regarding the amount of the insurer's capital and surplus. The RBC formula (which is discussed in detail in section III.B.6) is designed to calculate a minimum threshold of capital and surplus based on each insurer's unique mix of asset risk, insurance risk, interest rate risk, and business risk. The level of, and changes in, premiums (procedure 3 above), reserves (sections III.B.2, III.B.3 and III.B.4) and reinsurance (section III.B.8) must also be considered in evaluating the amount of an insurer's capital and surplus. Another measure of capital and surplus adequacy that is commonly considered is the ratio of capital and surplus and asset valuation reserve (AVR) to total assets (excluding separate accounts). AVR is included in this ratio because it is commonly considered "de facto" surplus. The purpose of AVR is to limit fluctuations in the insurer's surplus due to changes in the value of its invested assets. The net and gross change in capital and surplus IRIS ratios measure the improvement or deterioration in the insurer's financial condition from the prior year. The net change in capital and surplus does not include capital and surplus paid in during the year whereas the gross change in capital and surplus does include capital and surplus paid in during the year. Even increases in the change in capital and surplus ratio, when significant, may indicate instability or mask financial problems attributable to fundamental changes in the insurer.

Another step is designed to assist the analyst in identifying dividend payments or declarations, to determine if any necessary approvals were obtained. Other steps in procedure #5 are designed to assist the analyst in identifying significant amounts of capital and surplus notes and write-ins for special and other than special surplus funds. Also, significant changes in capital and surplus due to changes in the following: 1) net unrealized capital

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gains/losses, 2) foreign exchange capital gain/loss, 3) net deferred taxes, 4) nonadmitted assets, 5) the liability for unauthorized reinsurance, 6) reserve valuation basis, 7) AVR, 8) surplus notes, or 9) change in accounting principle are reviewed. The final step in procedure #5 is designed to assist the analyst in identifying other activity during the year related to capital and surplus notes.

Discussion of Level 2 Quarterly Procedures

The four procedures included in the income statement and surplus section of the Level 2 Quarterly Procedures are designed to identify 1) significant changes in net income or capital and surplus; 2) significant levels of policy surrenders, commissions and administrative expenses, and aggregate write-ins for miscellaneous income or deductions; 3) significant changes in the volume of premiums or the insurer's mix of business (lines of business written and/or geographic location of premiums written); or 4) any changes in capital or surplus notes that have occurred or dividends paid to stockholders since the prior year Annual Financial Statement or prior Quarterly Financial Statement.

Discussion of Level 3 Procedures

The procedures included in the Income Statement and Surplus Level 3 Procedures are designed to assist the analyst in further investigating potential problems and concerns that are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate further, and how far to probe.

Procedure #1 suggests additional steps the analyst may perform if there are concerns regarding the insurer's income statement or operating performance. The analyst should consider reviewing the summary of the individual income and expense items for the past five years for unusual fluctuations or trends between years. In addition, the analyst might compare the ratio of return on capital and surplus to industry average results to determine any significant deviation from the industry average. By reviewing the Analysis of Operations by Lines of Business in the Annual Financial Statement, the analyst could determine which lines of business had significant surrender activity during the year, which lines of business were profitable and which lines of business generated a loss, and whether commissions and expenses on any lines of business appear excessive based on the volume of premiums and deposit type funds. If the ratio of commissions and expenses to premiums appears high or if the ratio of investment yield appears unusual, the analyst should consider 1) reviewing these ratio results for the past five years for unusual fluctuations or trends between years and 2) comparing the ratio results to industry averages to determine any significant deviations from the industry averages. If write-ins for miscellaneous income or deductions are significant, the analyst should consider reviewing the individual components of these amounts for reasonableness. In addition, the detail of investment income may be reviewed if there are concerns regarding the investment yield to determine if there are significant invested assets that are not producing an adequate return. The analyst might also review the detail of realized capital gains and losses and consider their impact on the insurer's profitability. As a part of this review, the analyst should consider evaluating the impact of the insurer's interest maintenance reserve (IMR) established to capture the realized capital gains and losses on investments sold prior to maturity. These capital gains and losses are amortized over the remaining life of the investments sold rather than being recognized immediately.

Procedure #2 suggests additional steps the analyst may perform if there are concerns regarding changes in the volume of premiums and deposit-type funds or changes in the insurer's mix of business (lines of business written and/or geographic location of the premiums written). The analyst should consider reviewing the insurer's mix of business to determine 1) which lines of business are being written, 2) which lines of business have increased or decreased significantly, and 3) whether any new lines of business are being written. The analyst should also consider verifying that the insurer is authorized to write all lines of business being written. If new lines of business are being written or if premiums are being written in new states, the analyst should consider determining whether the insurer has expertise in the new lines of business or new sales territories. This would include expertise in distribution, underwriting, claims and reserving. There is no information in the Annual Financial Statement to assist the analyst in making this determination. However, there may be helpful information in the

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insurer's Managements Discussion and Analysis. Otherwise, information may be requested from the insurer. The analyst should also consider determining if, as a result of changes in the mix of business, the insurer's business is concentrated in specific geographic areas, which could result in the insurer being potentially exposed to catastrophic losses.

Procedure #3 suggests additional steps the analyst may perform if there are concerns regarding whether the insurer may be excessively leveraged due to its volume of A&H business. The analyst should consider comparing the ratios of gross A&H premiums to capital and surplus and net A&H premiums to capital and surplus to industry averages to help evaluate the insurer's leverage. The analyst might also want to review Schedule H-Accident and Health Exhibit and/or obtain information from the insurer to determine the specific types of A&H policies written, determine whether the A&H lines of business have historically been profitable for the insurer and determine whether A&H loss reserve adequacy has been maintained. As noted previously, an insurer which has historically written primarily A&H business might not be considered excessively leveraged, even though it has higher leverage ratio results, because the risk of significant underpricing or adverse underwriting results is less than for an insurer which has just begun writing A&H business.

Procedure #4 suggests additional steps the analyst may perform if there are concerns regarding the Medicare Part D business. Medicare Part D business is contracted with CMS. The contract sets a fixed income from CMS for the period of one year. The insurer may also offer enhanced benefit plans that fill coverage gaps that exist in basic plans. If the policyholder's utilize more benefits than were projected in the contract, the insurer may experience losses since the income from CMS is set for a full year. The analyst should consider obtaining and reviewing information on the contracted benefits, premium and cost sharing with CMS. The analyst should also evaluate a comparison of premiums, reserves, expected utilization and benefit costs to actual experience on each plan.

Procedure #5 suggests additional steps the analyst may perform if there are concerns regarding the amount of the insurer's capital and surplus. If there are concerns regarding the adequacy of the insurer's capital and surplus, the analyst should consider reviewing the procedures in the Level 3 Procedures for RBC. In addition, the ratio of capital and surplus and AVR to total assets (excluding separate accounts) may be compared to industry average capital and surplus to assets to determine any significant deviation from the industry average. If the insurer has issued surplus notes that are significant, the analyst should consider reviewing the information regarding the surplus notes in Note to Financial Statements #13. If surplus notes were either issued or repaid or if interest was paid during the year, the analyst should consider determining that these transactions were approved by the domiciliary state insurance department. In addition, if surplus notes represent a significant portion of capital and surplus, the analyst should consider recalculating important ratios excluding the surplus notes to determine their affect on the ratio results. If the insurer has issued capital notes which are significant, the analyst should consider reviewing the information in Note to Financial Statements #11 for pertinent information such as repayment, redemption price or interest features. Other steps to consider in supplemental procedure #5 include the review of the detail of unrealized gains or (losses) and the review of other components of capital and surplus for reasonableness.

Additional Reference Sources

1. NAIC *Accounting Practices and Procedures Manual*
2. *Annual Statement Instructions for Life, Accident and Health Insurance Companies*, NAIC
3. *Insurance Regulatory Information System Ratio Results*, NAIC

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III. Analysts Reference Guide – B.6. Risk-Based Capital

Overview of Risk-Based Capital

Beginning with the 1993 Annual Financial Statement, life and health insurers became subject to a new Annual Financial Statement requirement that they calculate and report an estimated level of capital, depending upon the insurer's risk profile. The basic formula compares Total Adjusted Capital to Authorized Control Level Risk-Based Capital. An insurer's Risk-Based Capital (RBC) requirement is calculated by applying risk factors to various asset, premium and reserve 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 its Total Adjusted Capital (i.e., actual capital) divided by its Authorized Control Level Risk-Based Capital (i.e., required capital). States that enact the Risk-Based Capital for Insurers Model Act 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 generally did not consider the risk profile of the insurer. The new Model Act supplements the system of absolute minimums and considers the risk profile of each individual insurer.

The RBC formula and Model Act were the result of several years of work by insurance regulators, actuaries and other industry representatives. The formula is detailed and lengthy, but in concept is quite simple. There are five major categories of risk requirements: 1) asset risk-affiliates, 2) asset risk-other, 3) insurance risk, 4) interest rate risk and health credit risk, and 5) business risk. Each is summarized below.

1. **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 thirteen categories of subsidiary and affiliated investments that are subject to an RBC requirement for common and preferred stock. Off-balance sheet items are included in this risk component and include non-controlled assets, guarantees for affiliates, contingent liabilities, etc.

2. **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 non-investment grade bonds are assigned a high factor. Similar factors are assigned to other asset categories.

3. **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.

4. **Interest Rate Risk and Health Credit 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.

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

5. **Business Risk**

Business risk represents other potential risks that are not effectively covered by the previous three categories. The key area addressed here is premium income subject to guaranty fund assessments.

The Model Act requires a comparison between Total Adjusted Capital and Authorized Control Level Risk-Based Capital. The Model Act then determines 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. For example, one of the levels is called the "company action level," because an insurer must take action if its Total Adjusted Capital falls below that level. The various levels are related to one another by fixed percentages. The levels are as follows:

1.	**≥ 250%**	**No action level**
2.	**≥ 200% to <250%**	**Trend test level**
3.	**≥ 150% to < 200%**	**Company action level**
4.	**≥ 100% to < 150%**	**Regulatory action level**
5.	**≥ 70% to < 100%**	**Authorized control level**
6.	**< 70%**	**Mandatory control level**

Every insurer, regardless of the level in which it falls, is required to file a "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 250 percent of the Authorized Control Level is in no action level. Other than filing the RBC report, no further action is required by the insurer. An insurer that falls within or below the trend test level may trigger an action level if the insurer reports a declining RBC ratio. An insurer that falls within or below the Company Action Level is required to file a RBC plan with the domiciliary state. The plan must include proposals for corrective steps by the insurer. The Risk-Based Capital Model Act provides that the plan is confidential. If an insurer's Total Adjusted Capital is within the regulatory action level, the insurance commissioner must perform whatever examination of the insurer is deemed necessary 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 insurer if that step is 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 insurer; however, that step may be forgone if there is a reasonable expectation that the circumstances causing the insurer to be within that level will be eliminated within 90 days.

Discussion of the Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 procedures included in the RBC section of the Level 2 Annual Procedures are designed to identify potential areas of concern regarding RBC.

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Procedure #1 assists the analyst in identifying whether the current RBC Ratio is near Company Action Level. 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 percent 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. The procedure also identifies significant changes in the RBC Ratio components compared to the prior year. The analyst should document the leading underlying causes for the changes in the authorized control level and total adjusted capital.

Procedure #2 determines for the analyst whether the insurer failed the RBC Trend Test. The RBC Trend Test is triggered when total adjusted capital is between 2.0 and 2.5 times the authorized control level, 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 1.9 times authorized control level would trigger a Company Action Level RBC regulatory action.

Procedure #3a directs the analyst to obtain and review a copy of the insurer's RBC plan if the insurer has triggered an action level RBC event. If applicable in your state, the analyst may participate in the review and approval process of the RBC plan. The RBC plan is a comprehensive financial plan which 1) identifies the conditions in the insurer which contribute to the Company Action Level Event; 2) contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the Company Action Level Event; 3) provide 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) identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and 5) identify 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.

Procedure #3b The analyst 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 the 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 a subsequent RBC Ratio that will remove the insurer from Action Level status.

Additional Reference Sources

1. *Annual Statement Instructions for Life, Accident and Health Insurance Companies*, NAIC
2. Risk-Based Capital Model Act, NAIC

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III. Analysts Reference Guide – B.7. Cash Flow and Liquidity

Overview of Cash Flow and Liquidity

The Statement of Cash Flow is one of several core financial statements presented in the Annual Financial Statement of every life/health insurer. It provides information about the primary sources of cash (inflow) and applications of cash (outflow). The Statement of Cash Flow is organized to readily identify the net cash flow from operations separately from the net cash flow from investments sold or acquired. Other important sources and applications of cash are also shown such as net transfers to or from separate accounts and dividends to stockholders. The net change in cash and short-term investments as reflected on the Statement of Cash Flow reconciles to the change in the balance sheet accounts cash and short-term investments for the year.

While the Statement of Cash Flow provides information about historical sources and applications of cash, the analyst should analyze the liquidity of the balance sheet in order to evaluate the insurer's ability to fund policyholder benefits and other demands for cash in the future. One common way of accomplishing this is to compare the total liabilities of the insurer in relation to its liquid assets available to fund the liabilities.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 birectors and the effectiveness of management, including the code of conduct established by the board of directors.

The two procedures included in the cash flow and liquidity section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. One concern relates to identifying situations where negative cash flow is being generated, in large amounts in the current year, or less amounts sustained over a longer period of time. Another concern relates to evaluating the liquidity of the insurer's balance sheet in terms of its ability to fund future liabilities.

Procedure #1 assists the analysts in identifying situations where the insurer's operations are generating negative cash flow. It is important for the analyst to focus on specific components of the insurer's operation. The analyst should evaluate negative cash flow from operations closely, as well as any negative trends. The analyst should also closely evaluate significant net transfers to or from separate accounts since this could provide insights regarding potential financial problems. Additional steps the analyst may perform if there are concerns regarding the insurer's cash flow from operations include an evaluation of line items within cash flows, including transfers to or from separate accounts.

Procedure #2 assists the analyst in determining if the insurer is exposed to greater than normal liquidity risk with respect to special deposits. Special deposits are segregated into two sections, "for the benefit of all policyholders" and "not for the benefit of all policyholders." Deposits for the benefit of all policyholders are deposits held by individual states but are aggregated on one summary line. Deposits not held for the benefit of all policyholders must be itemized by security. The assets comprising these deposits are held on the various investment schedules in the financial statement. However, the assets are not held in custody of the insurer and restrictions are placed on their disposal. In a situation of a rehabilitating or troubled insurer, these restrictions on assets may cause concerns, particularly those not held for the benefit of all policyholders. Additional steps the analyst may perform are intended to assist the analyst in determining if the domiciliary state may have difficulty in calling deposits that are deemed "not for the benefit of all policyholders." These procedures specifically apply when the level of deposits not for the benefit of all policyholders as a percentage of total assets is high or in cases when the insurer has been determined to be troubled. The analyst may consider this assessment necessary in either of those cases because once the insurer is moved into rehabilitation, the cash flow position of the insurer may deteriorate rapidly.

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Procedure #3 assists the analyst in evaluating concerns relating to liquidity. The primary method of accomplishing this is to review changes in the insurer's liquid assets. Additional steps the analyst may perform if there are concerns regarding the insurer's liquidity include reviewing the insurer's cash flow and liquidity results against industry averages, or peer insurers in the Peer Financial Profile report.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for cash flow and liquidity are intended to identify significant changes in cash flow and liquidity that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.

Additional Reference Sources

1. *Annual Statement Instructions for Life, Accident and Health Insurance Companies,* NAIC

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Overview of Reinsurance

Reinsurance is a form of insurance for an insurance company. Under a reinsurance contract, the primary insurer 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. The reinsurer, for a premium, agrees to indemnify or reimburse the ceding insurer for all or part of the loss that the ceding insurer may sustain from claims. Reinsurers may, in turn, transfer or "retrocede" some of the risk they assume 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.

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 presented 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. Once an insurer has decided to reinsure amounts in excess of its desired retention, it may proceed on one of several basic modes.

1. **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 also is used for nonparticipating policies, particularly in 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.

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2. **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 December 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.

3. **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.

4. **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.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 six procedures included in the reinsurance section of the Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. Reinsurance is a complicated and potentially high-risk area for the insurer. While there are many legitimate business uses for reinsurance, it can be used to mask an insurer's financial problems or expose the insurer to significant collectibility, or credit risk.

Procedure #1 assists the analyst in determining whether significant errors exist relating to the accounting for reinsurance. Generally, the major concern will relate to the manner in which the insurer accounts for credits, or reductions in, the liability for reserves relating to recognition of estimated reinsurance recoverables. SSAP No. 61, *Life, Deposit-Type & Accident and Health Reinsurance* (SSAP No. 61), defines the specific circumstances when the insurer can record such a credit, or reduction in, the liability for loss reserves. In summary, a credit for reinsurance can be recorded when the assuming insurer is authorized (i.e., licensed or approved by the ceding insurer's state of domicile, or accredited). When the assuming insurer is unauthorized (i.e., neither licensed or approved by the ceding insurer's state of domicile, nor accredited), then a credit for reinsurance may only be recorded when adequate security exists in the form of trust accounts, letters of credit, etc. A second important accounting issue relates to the liability for reinsurance in unauthorized companies. Under SSAP No. 61, the insurer must establish a liability by formula that considers the amount of reinsurance recoverable on paid losses due and credits from unauthorized companies.

Procedure #2 assists the analyst in determining whether reinsurance recoverables and receivables are significant and if so, whether the amounts involved are collectible. Under a reinsurance contract, the primary insurer transfers or "cedes" to another insurer (the "reinsurer") all or part of the financial risk of loss for claims incurred under

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insurance policies sold to the policyholder. 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. As a result, evaluating the collectibility of the recoverables and receivables, as well as the overall credit-worthiness of the reinsurers, is a key concern. Evaluating the collectibility of reinsurance recoverables and receivables requires an understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented towards the type of reinsurer from whom the reinsurance was obtained. Reinsurance is generally obtained from one of the following categories of insurers:

1. Professional Reinsurers - In the United States, there are approximately 25 professional reinsurers whose main business is assuming reinsurance from non-affiliated insurers. In general, the large and well-capitalized professional reinsurers will not pose a serious collectibility concern.
2. Reinsurance Departments of Primary Insurers - Many insurers assume reinsurance from non-affiliates, but also write significant business on a direct basis. These types of insurers may pose a larger collectibility concern than professional reinsurers since the specialized reinsurance expertise may not be as strong.
3. Alien Insurers - Reinsurers domiciled in another country generally pose the most significant collectibility concern.

Procedure #3 assists the analyst in identifying whether reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another. 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. 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. 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.

Procedure #4 assists the analyst 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 under priced 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 #5 assists the analyst in determining whether any significant and/or unusual reinsurance intermediary or reinsurance assumed agreements exist. While some major professional reinsurers are direct marketers, intermediaries (brokers, managers, or managing general agents) may arrange reinsurance agreements between a ceding insurer and a reinsurer in exchange for commissions or fees. A reinsurance broker negotiates agreements for a ceding insurer 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 insurer. An intermediary, either a broker, manager, or managing general agent, 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

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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, under priced risks. The intermediary bears no financial risk in the event of under priced or poor underwriting or placement with a troubled reinsurer. But poor performance by an intermediary can affect both ceding insurers and reinsurers.

Procedure #6 assists the analyst in identifying 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 insurer 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 insurer may not account for it as a reinsurance recoverable. Determining whether a contract involves the transfer of risk requires a complete understanding of the contract between the ceding insurer 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 by either the analyst or a reinsurance expert. A 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.

The analyst should be particularly alert to three unusual types of transactions such as bulk reinsurance, surplus relief and assumption reinsurance. Bulk reinsurance 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 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, SSAP No. 61 does not allow a credit to surplus until the risk has been transferred.

Assumption reinsurance agreements 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.

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They may also indicate financial difficulties of the ceding insurer and may be motivated by pressure to generate surplus.

Discussion of the Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures are intended to identify significant changes in reinsurance that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.

Discussion of the Level 3 Procedures

The Level 3 Procedures are designed to assist the analyst in further investigating potential problems that are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate further, and how far to probe.

Procedure #2, and selected aspects of most of the remaining supplemental procedures, suggests additional steps the analyst may perform if collectibility concerns exist. The fundamental issue involved with evaluating collectibility is an assessment of the financial stability of the underlying reinsurers, and, if applicable, specific retrocessionaires involved throughout the chain of reinsurance. To evaluate the collectibility of reinsurance recoverables, the analyst should consider the need to collect as much financial information as possible about the reinsurers, including various regulatory and governmental filings, rating agency reports and financial analyses available from industry analysts.

The I-SITE application, Global Receivership Information Database (GRID), allows the regulator to review the status of a receivership (i.e., conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post receivership data, creditor class/claim data, legal, financial and reporting data. Receivables and recoverables due from companies in liquidation proceedings may be partially collected; however, collection will likely be delayed. It is practically certain that balances due at the time a liquidation is closed (the last action date that may be entered in GRID) will never be collected. Evaluating the collectibility of reinsurance recoverables requires understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented towards the type of reinsurer from whom the reinsurance was obtained.

Procedure #6 assists the analyst in evaluating significant or unusual reinsurance transactions, such as bulk reinsurance, surplus relief and assumption reinsurance. Material transactions involving the sales of blocks of business are becoming more commonplace in the life/health insurance industry. The analyst 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, the analyst should evaluate the impact of the transaction on future financial performance of the insurer.

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Additional Reference Sources

1. *Troubled Insurance Company Handbook*, NAIC
2. *Annual Statement Instructions for Life, Accident and Health Insurance Companies*, NAIC
3. NAIC *Accounting Practices and Procedures Manual*
4. *Insurance Regulatory Information System Ratio Results*, NAIC
5. *Examiners Handbook*, NAIC
6. NAIC *Accounting Practices and Procedures Manual Appendix A-785, Credit for Reinsurance*
7. NAIC *Accounting Practices and Procedures Manual Appendix A-791, L&H Reinsurance Agreements*
8. *Assumption Reinsurance Model Act*, NAIC
9. *Disclosure of Material Transactions Model Act*, NAIC
10. *Fronting Disclosure and Regulation Act*, NAIC
11. *Reinsurance Intermediary Model Act*, NAIC
12. NAIC *Accounting Practices and Procedures Manual Appendix A-225, Managing General Agents*

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Overview of Affiliated Transactions

SSAP No. 25, *Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties* (SSAP No. 25), defines an affiliate as an entity that is within the holding company system that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity. Control is defined as the possession, directly or indirectly, of the power to direct or cause the direction of management and policies of a person or entity through the ownership of voting securities. Control should be presumed to exist if a reporting entity and its affiliates, directly or indirectly, own, control, hold with the power to vote, or hold proxies, representing 10 percent or more of the voting securities.

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 arms-length transaction, which results in the transfer of risks and rewards of ownership and represents a consummated act. An arms-length transaction is defined as one in which willing parties, each being reasonably aware of all relevant facts and neither under compulsion to buy, sell or loan, would be 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 which results in the mere inflation of surplus without any other demonstrable and measurable improvement is not an economic transaction.

Determining that the risks and rewards of ownership have been transferred to the buyer requires an examination of the underlying facts and circumstances. The following circumstances from SSAP No. 25 may raise questions about the transfer of risks.

1. 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.
2. 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.
3. Repayment of debt that constitutes the principal consideration in the transaction dependent on the generation of sufficient funds from the asset transferred.
4. Limitations or restrictions on the purchaser's use of the asset transferred or on the profits from it.
5. 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 were initiated for the purpose of inflating (deflating) a particular insurer's financial statement, including effects on the balance sheet or income statement.

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

1. Economic based transfers between affiliates should be recorded at prevailing fair values at the date of the transfer.
2. Non-economic based transfers between affiliated insurers should be recorded at the lower of existing book values or prevailing fair values at the date of the transfer.
3. Non-economic based transfers 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 transfer. However, to the extent that the transfer results in a gain, that gain should be deferred until such time as permanence can be verified.
4. 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.
5. 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.
6. 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.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 Level 2 Annual Procedures for affiliated transactions contains five procedures designed to identify potential areas of concern to the analyst. The challenge to the analyst in this area is to understand, in substance, the various transactions between affiliates and recognize those transactions that are intended to circumvent existing regulations. Many of the procedures may require a prior knowledge of the insurer or a past knowledge of the holding company structure. A review of the insurer's holding company files may assist in this regard.

Procedure #1 assists the analyst in understanding the insurer's corporate structure. Significant changes in corporate structure may materially impact the insurer's future financial condition and generally require prior regulatory approval. The analyst should closely analyze changes in corporate structure in order to understand the motivation for the change. By understanding the corporate structure in which the insurer operates, the analyst may be able to foresee future problems and take appropriate action. For example, a common corporate structure the analyst may encounter involves a holding company whose only significant asset is the stock of the insurer. The holding company may have financed the acquisition of the insurer through bank financing or other debt where the debt service by the holding company is completely dependent upon dividends paid by the insurer. This type of corporate structure warrants close attention by the analyst to ensure that dividends are valid and in compliance with the applicable dividend restrictions, and that any other payments by the insurer to the holding company are legitimate, rather than dividends in disguise. The analyst should also be alert to a corporate structure that includes affiliated brokers or intermediaries that may be recording unusual or significant levels of commissions and fees. When a corporate structure is involved that includes multiple tiers of affiliates where significant levels of surplus are comprised of investments in affiliates, the analyst should focus on the level of real surplus that exists on a consolidated basis.

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Procedure #2 assists the analyst in understanding and evaluating the summary of transactions reported in Schedule Y – Part 2. Eight major types of affiliated transactions are reported in Schedule Y – Part 2 and explanatory comments are provided in Notes to Financial Statements #10, Information Concerning Parent, Subsidiaries and Affiliates. The analyst should refer to both sources of information in order to develop an understanding of the underlying affiliated transactions.

The following briefly describes the key concerns to the analyst for several of the major affiliated transactions. For shareholder dividends, the major concern relates to whether the level of dividend is within the regulatory guidelines, and whether the dividend should be considered extraordinary, and therefore require prior regulatory approval. For capital contributions from the insurer to another affiliate, the analyst should determine that such contribution does not substantially impact the financial condition of the insurer. For non-cash capital contributions into the insurer, the analyst should determine that the infusion is recorded at fair value so as to not arbitrarily inflate surplus. In the case of purchases, sales or exchanges of loans, securities, real estate, mortgage loans or other investments, the concern to the analyst is primarily one of valuation. These types of transfers should be at arms-length and recorded at fair value. The analyst should also be alert to possible abuses regarding the transfer of assets between property/casualty and life/health affiliates merely to impact the Risk-Based Capital calculation of the affiliates. For management agreements and service contracts, the main concerns to the analyst relate to the type of service being performed and the reasonableness of the cost. This is a common area for abuse when parent companies desire to withdraw funds from the insurer, but do not want to, or would not be permitted to, classify it as a shareholder dividend. The analyst should understand why the parties were motivated to enter into such contracts, and particularly, the benefit to the insurer.

Procedures #3 and *#4* assist the analyst in determining whether investments in affiliates are significant 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 investment may be substantially overvalued.

Procedure #5 assists the analyst in evaluating all other affiliated transactions. The analyst's primary objective in this area is to understand the substance of the transactions and to determine whether they are economic-based. The analyst should review the extent of transactions with officers and directors to ensure that the transactions are at arms-length and are not detrimental to the financial condition of the insurer. The analyst should closely monitor other affiliated transactions to ensure that the insurer is not exposed to significant collectibility risk. For example, if the insurer is included in a consolidated federal income tax return and a significant asset for Federal Income Tax Recoverable is recorded on the financial statements of the insurer, the analyst should closely review the financial statements of the parent to determine the parent's ability to repay the receivable. Structured settlements acquired from an affiliated life insurance company may also represent a collectibility risk to the insurer. When the amounts of structured settlements are significant, the analyst should review and understand the financial statements of the life insurance affiliate.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures for affiliated transactions are intended to identify 1) significant changes in the corporate structure; 2) whether affiliated transactions that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement are economic-based; 3) whether the transactions are significant, legitimate and properly accounted for; or 4) other significant or unusual transactions with affiliates.

Discussion of Level 3 Procedures

The Level 3 Procedures for affiliated transactions are designed to assist the analyst in further investigating potential problems that are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized throughout the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate further, and how far to probe.

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Procedure #1 suggests additional steps the analyst may perform if the insurer's corporate structure elevates concerns about affiliated transactions. The primary objective is to understand the financial position of the parent company. By understanding the financial commitments of the Parent, the analyst will be able to better understand the Parent's motivation for entering into transactions with the insurer or other affiliates. Financial statements of affiliates may reveal unauthorized transactions in progress.

Procedures #2 and *#4* suggests additional steps the analyst may perform when there are concerns that transactions with affiliates may not be economic-based or at arms-length. For those services provided by an affiliate where a market already exists, such as data processing, actuarial, or investment management, an effective way for the analyst to determine whether an arms-length transaction exists is to contact one of the vendors and request a proposal or fee estimate for a similar service.

Procedure #3 suggests additional steps the analyst may perform when investments in affiliates are significant and the valuation of such investments is a concern. In particular, the analyst should review the level of return on the investment in affiliate, including the source of the investment income (i.e., cash or merely an increase in the accrual). The analyst should not only be alert to the level of investments in affiliate, but also the level of accrued interest relating to investments in affiliate.

The I-SITE application, Global Receivership Information Database (GRID), allows the regulator to review the status of a receivership (i.e., conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post receivership data, creditor class/claim data, legal, financial and reporting data. Receivables and recoverables due from companies in liquidation proceedings may be partially collected; however, collection will likely be delayed. It is practically certain that balances due at the time a liquidation is closed (the last action date that may be entered in GRID) will never be collected. Evaluating the collectibility of reinsurance recoverables requires understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented towards the type of reinsurer from whom the reinsurance was obtained.

Additional Reference Sources

1. *Annual Statement Instructions for Life, Accident and Health Insurance Companies*, NAIC
2. NAIC *Accounting Practices and Procedures Manual*
3. NAIC *Accounting Practices and Procedures Manual Appendix A-440, Insurance Holding Companies*
4. *An Act Concerning Insider Trading of Domestic Stock Insurance Company Equity Securities*, NAIC
5. *Regulation Regarding Proxies, Consents, and Authorizations of Domestic Stock Insurers*, NAIC
6. *Stockholders Information Supplement Schedule (Schedule SIS)*, NAIC

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Overview of MGAs and TPAs

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. (See Analyst Reference Guide for a detailed discussion of reinsurance including reinsurance intermediaries, fronting, etc.) Insurers are required to have written contracts with MGAs and TPAs which set forth the specific responsibilities of each party. MGAs and TPAs 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 that is delegated to MGAs and TPAs, 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 and TPAs between writing quality business and being compensated by commissions based on the volume of business written. When MGAs and TPAs are compensated based on the volume of business written, their incentive is to write as much business as possible which may result in bad risks being written. These types of conflicts have played a significant part in the failure of several insurers. It is important that the insurer actively supervise, control and monitor the performance of MGAs and TPAs on an ongoing basis to help avoid abuses.

To effectively monitor MGAs and TPAs, insurers should obtain and review annual independent financial examinations and financial reports of the MGAs and TPAs utilized. In addition, the NAIC model acts regarding MGAs and TPAs require insurers to periodically perform on-site reviews of the underwriting and claims processing operations of each MGA and TPA utilized.

The NAIC Model Managing General Agents Act *(NAIC Model 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 percent 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 *NAIC Model Act* exempts certain persons from being considered MGAs for purposes of the Act, 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.

The NAIC Model Third-Party Administrator Statute *(NAIC Model Statute)* defines a TPA as any person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from or adjusts or settles claims in connection with life or health insurance coverage, annuities or workers' compensation insurance. However, the *NAIC Model Statute* exempts certain persons from being considered TPAs, including, among others: insurers, licensed agents whose activities are limited exclusively to the sale of insurance, licensed adjusters whose activities are limited to the adjustment of claims, and MGAs.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 of directors.

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III. Analysts Reference Guide – B.10. MGAs and TPAs

The Annual Financial Statement contains information regarding the MGAs and TPAs utilized, the types and amount of direct premiums written by each, and the types of authority granted to each by the insurer. The Level 2 Annual Procedures for TPAs, IPAs, and MGAs are designed to assist the analyst in identifying those insurers which may have problems due to significant reliance on MGAs and TPAs.

Procedure #1 assists the analyst in determining whether a significant amount of the insurer's direct premiums are being written through MGAs and TPAs. While the amount of direct premiums written by MGAs and TPAs is not necessarily an indication of a problem or concern, this procedure provides an indication to the analyst of the insurer's exposure to potential abuse by MGAs and TPAs. MGAs and TPAs who had been delegated significant authority without insurer oversight have played a major role in the insolvency of several large insurers.

Discussion of Level 2 Quarterly Procedures

The procedure included in the MGAs and TPAs section of the Level 2 Quarterly Procedures is intended to identify any significant changes regarding the terms of any agreements with MGAs or TPAs that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.

Discussion of Level 3 Procedures

The procedure included in Level 3 Procedures for MGAs and TPAs is designed to assist the analyst in further investigating potential problems and concerns regarding MGAs and TPAs which are identified in either the Annual or Quarterly Level 2 Procedures. As emphasized in the Level 3 Procedures, the analyst should always use good judgment in determining which areas to investigate further, and how far to probe.

Procedure #1 suggests additional steps the analyst may perform if there are concerns regarding the insurer's use of MGAs and TPAs. The analyst should consider reviewing the information in Notes to Financial Statements #19 - Direct Premiums written by Managing General Agents/Third-Party Administrators in more detail than was done as a part of the Level 2 Annual Procedures review to determine which MGAs and TPAs are being utilized (and whether any of the MGAs or TPAs are affiliated with the insurer), the types and amount of direct premiums written by each, and the types of authority granted to each by the insurer.

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

The more authority that is delegated to an MGA or TPA, the more important it is for the insurer to provide active ongoing oversight into the MGA's or TPA's operations. To evaluate the insurer's oversight of significant MGAs and TPAs, the analyst should consider requesting from the insurer copies of its contracts with the MGAs and TPAs to determine compliance with the minimum contract provisions per the *NAIC Model Act* and the NAIC Model Statute and/or the applicable provisions of the Insurance Code. The analyst should also consider requesting from the insurer copies of financial statements for the significant MGAs and TPAs and documentation supporting the insurer's periodic (at least semi-annual) review of the underwriting and claims processing systems. If there are

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concerns regarding the business placed with the insurer by an MGA or TPA, the analyst should consider determining if other insurers are utilizing the same MGA or TPA and comparing the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether they are similar (i.e., contain the same commission rates). The analyst should also consider comparing the insurer's loss and loss adjustment expense ratios on the business placed by the MGA or TPA with those of the other insurers utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the insurer may be receiving a disproportionate amount of "bad" business from the MGA or TPA.

Additional Reference Sources

1. *Annual Statement Instructions for Life, Accident and Health Insurance Companies*, NAIC
2. *Troubled Insurance Company Handbook*, NAIC
3. *Managing General Agents Act*, NAIC
4. *Third-Party Administrator Statute*, NAIC

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III. Analysts Reference Guide – B.11. Separate Accounts

Overview of 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. The financial experience on these separate accounts is reported in the Annual Financial Statement of separate accounts business.

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.

This chapter 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.

1. **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.

2. **Modified Guaranteed Annuities**

   Modified Guaranteed Annuities were developed in the 1980s and are a hybrid between a book 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.

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3. **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.

4. **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 zero percent. Termination of the contract is generally at true fair value, or paid out over time.

5. **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.

6. **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. Virtually 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.

7. **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 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

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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.

Discussion of Level 2 Annual Procedures

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 three procedures included in the Level 2 Annual Procedures for separate accounts are designed to identify potential areas of concern to the analyst. Separate accounts, while segregated from the general account of the insurer, can have a significant impact on the financial condition of the insurer.

Procedure #1 assists the analyst in determining whether the insurer maintains separate accounts. Many life/health insurers do not maintain separate accounts. In these situations, the entire separate accounts section of the Handbook is not applicable and the analyst should proceed with the next financial analysis topic.

Procedure #2 assists the analyst in identifying situations where separate accounts products may be creating contingent liabilities to the general account. This is largely a function of the types of separate accounts products offered by the insurer and the analyst should rely on general knowledge of the insurer's products at this stage of the analysis.

Procedure #3 assists the analyst in determining whether accounting activity between the general account and the separate accounts is proper. All separate accounts activity reaches the Separate Accounts Annual Financial Statement through the general account Annual Financial Statement. Premiums are recorded on the general account and then "transferred to" the Separate Accounts Financial Statement through the item Net Transfers to or from Separate Accounts (referred to as "above the line" activity). Once the premiums have been moved to the separate accounts, all direct investment activity and reserve changes are recorded on the Separate Accounts Annual Financial Statement. Seed money is "contributed to or withdrawn from" the Separate Accounts Financial Statement through the item, Surplus (contributed to) withdrawn from Separate Accounts during period, (referred to as "below the line" activity).

Discussion of Level 2 Quarterly Procedures

The procedures described in the Level 2 Quarterly Procedures for separate accounts are intended to identify significant changes in separate accounts that have occurred since the prior year Annual Financial Statement, or the prior Quarterly Financial Statement.

Discussion of Level 3 Procedures

The Level 3 Procedures for separate accounts are designed to assist the analyst in further investigating potential problems that are identified in either the Annual or Quarterly Level 2 Procedures.

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III. Analysts Reference Guide – B.11. Separate Accounts

Procedure #1 assists the analyst in determining that contingent liabilities to the general account of the insurer created by separate accounts assets are properly recorded. Guarantees included with separate accounts products must be recorded as a liability of the general account.

Procedure #2 assists the analyst in determining that the accounting for activity between the separate accounts and the general accounts is proper. The primary concern here is to properly classify such activity as to "above the line" (i.e., recorded on the Net Transfers to or (from) Separate Accounts line on the general account) or "below the line" activity (i.e., recorded on the Change in Surplus in Separate Accounts Statement on the general account). See additional discussion in the Level 2 Annual Procedures for Separate Accounts Analysts Reference Guide. An additional area the analyst should investigate in this regard is the level of investment management fees charged to the separate accounts. The Securities and Exchange Commission has set maximums for the level of such fees. Common industry practice is for this fee to range between 125 and 140 basis points on separate accounts assets.

Additional Reference Sources

1. *Annual Statement Instructions for Life, Accident and Health Insurance Companies*, NAIC
2. NAIC *Accounting Practices and Procedures Manual*
3. *Model Variable Annuity Regulation*, NAIC
4. *Model Guaranteed Annuity Regulation*, NAIC
5. *Model Variable Contract Law*, NAIC
6. *Variable Life Insurance Model Regulation*, NAIC
7. *Guideline Concerning Variable Life Insurance Separate Account Investments*, NAIC
8. NAIC *Accounting Practices and Procedures Manual Appendix C*
9. *Life-Health Insurance Accounting*, IASA, 1988

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Overview of Audited Financial Reports

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 their 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 Reports can provide comfort to the analyst regarding the accuracy of the financial information in the Annual Financial Statement.

Per the NAIC *Annual Financial Statement Instructions for Life/Health Companies*, insurers are required to file an Audited Fianncial Report by June 1 each year, which includes an opinion by an independent certified public accountant or accounting firm (hereinafter referred to as CPA) regarding the financial statements audited. The independent CPA's opinion may be unqualified, unqualified with explanatory language added, qualified or adverse, or there may be a disclaimer of opinion. If the financial statements included in the Audited Financial Report include amounts different from the filed Annual Financial Statement, a reconciliation of the differences and a description of the nature of the differences is required to be included 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 unqualified opinion, additional explanatory language included in the opinion may flag a potential problem. For example, the CPA might issue an unqualified 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 expressing substantial doubt by the CPA 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, transactions with affiliates, contingent liabilities and, if applicable, the amount and nature of differences between the Audited Financial Reports and the Annual Financial Statement that was filed by the insurer.

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 letter further states that the CPA will agree to make all workpapers 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 which 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.

The independent CPA is required to notify the board of directors of an insurer 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 capital and surplus 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.

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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 ten 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 Procedures are designed to assist the analyst in reviewing the Audited Financial Report and identifying significant information and explanatory language regarding the insurer, which has been emphasized by the independent CPA. In addition, the Audited Financial Report Procedures includes procedures for the review of the independent CPA's letter of qualifications and, if applicable, the report of significant deficiencies in the insurer's internal control structure.

Procedures Related to Level 1 Annual Procedures

Generally an Audited Financial Report will not be available at the time of the Annual Financial Statement review. There is one question within the Level 1 Annual Procedures that is used to identify if any unusual items were noted in the Audited Financial Report, if indeed it was received. However, an analyst should consider performing a review of information related to the potential filing of an Audited Financial Report that is available within the Annual Financial Statement itself. Any unusual responses at this preliminary stage should be noted within the Level 1 Annual Procedures at this point. The Annual Financial Statement Supplemental Exhibits and Schedules of Interrogatories ask whether the insurer will file an Audited Financial Report by June 1 and requires an explanation if an Audited Financial Report will not be filed. Every insurer required to file an Annual Financial Statement is also required to file an Audited Financial Report by an independent CPA as a supplement to the Annual Financial Statement on or before June 1. However, there are two exemptions from this requirement, which are as follows:

1. Insurers having direct premiums written less than $1 million nationwide in any calendar year <u>and</u> fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of the calendar year shall be exempt from this requirement for that year (unless the domiciliary Commissioner makes a specific finding that compliance is necessary for the domiciliary Commissioner to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of $1 million or more will not be so exempt.
2. The domiciliary Commissioner may grant an exemption from compliance with this requirement, upon written application from an insurer, if the domiciliary Commissioner finds that compliance with this requirement would constitute a financial or organizational hardship upon the insurer.

Discussion of Supplemental Procedures

The analysis of the Audited Financial Report is documented on the separate Audited Financial Report Supplemental Procedures rather than the Level 2 Annual Procedures due to its significance and due to the timing of the receipt of the Audited Financial Reports on June 1 rather than on March 1 with the Annual Financial Statement. Audited Financial Report Supplemental Procedures are broken down into three parts 1) review of the Audited Financial Reports; 2) review of the CPA's letter of qualifications; and 3) other, including review of the report of significant deficiencies in internal control, if applicable, and the letter regarding any disagreements with the former CPA in the event of a change in CPA.

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Audited Financial Report

Procedure #1 assists the analyst in determining that the financial statements included in the Audited Financial Report have been prepared in conformity with statutory accounting practices prescribed, or otherwise permitted, by the domiciliary state insurance department. The insurer may not file Audited Fianncial Reports prepared in conformity with generally accepted accounting principles (GAAP).

Procedure #2 assists the analyst in determining whether the financial statements included in the Audited Financial Report are those of the insurer on a separate company stand-alone basis. While most insurers are required to file Audited Financial Reports on a separate company stand-alone basis, an insurer may make written application to the domiciliary Commissioner to file audited consolidated or combined financial statements if the insurer is a part of a group of insurance companies which utilizes a pooling or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool.

Procedure #3 should be completed in those instances where audited consolidated or combined financial statements are filed. This procedure assists the analyst in determining that the domiciliary Commissioner approved the insurer's application to file on a consolidated or combined basis due to a pooling or 100 percent reinsurance agreement and that a consolidating or combining worksheet has been included with the financial statements. This worksheeet shows amounts for each insurer separately, includes explanations for consolidating and eliminating entries, and includes a reconciliation for any differences between the amounts shown for an individual insurer and the amounts per the insurer's Annual Financial Statement. This allows the analyst to reconcile from the audited consolidated or combined financial statements to the Annual Financial Statement filed by the individual insurer being analyzed.

Procedure #4 assists the analyst in determining the type of audit opinion which was issued by the independent CPA. The opinion may be unqualified, unqualified with explanatory language added to the independent CPA's standard report, qualified, adverse or there may be a disclaimer of opinion. The following is a discussion of each of these types of audit opinions:

1. Unqualified Opinion

   An unqualified opinion states that the financial statements present fairly, in all material respects, the financial position, results of operations, changes in capital and surplus and cash flows of the insurer in conformity with the accounting practices prescribed or permitted by the domestic state insurance department. (This is the standard "clean" opinion.)

2. Unqualified Opinion With Explanatory Language Added

   Certain circumstances, while not affecting the independent CPA's unqualified opinion, may require that the independent CPA add an explanatory paragraph or other explanatory wording to the report. This explanatory paragraph may either precede or follow the opinion paragraph in the independent CPA's report. Examples of circumstances which may require the independent CPA to add explanatory language to the report include the following: the financial statements are affected by uncertainties concerning future events, the outcome of which cannot be reasonably estimated as of the date of the independent CPA's report; there is substantial doubt about the insurer's ability to continue as a going concern; there has been a material change in accounting practices or in the method of their application between periods being reported on; or that the independent CPA's opinion is based in part on the report of another auditor.

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3. Qualified Opinion

A qualified states that, except for the effects of the matter or matters to which the qualification relates, the financial statements present fairly, in all material respects, the financial position, results of operations, changes in capital and surplus and cash flows of the insurer in conformity with the accounting practices prescribed or permitted by the domestic state insurance department. When the independent CPA issues a qualified opinion, the reasons for the qualification are disclosed in one or more separate explanatory paragraphs preceding the opinion paragraph of the report and these paragraphs are referenced in the opinion paragraph. Qualified opinions are issued when 1) there is a lack of sufficient competent evidential matter or there are restrictions on the scope of the audit that have led the independent CPA to conclude that an unqualified opinion cannot be expressed and a conclusion has been made not to disclaim an opinion; or 2) the independent CPA believes, as a result of the audit, that the financial statements contain a departure from accounting practices prescribed or permitted by the domestic state insurance department, the effect of which is material, and the independent CPA has concluded not to express an adverse opinion.

4. Adverse Opinion

An adverse opinion states that the financial statements do not present fairly the financial position, results of operations, changes in capital and surplus and cash flows of the insurer in conformity with accounting practices prescribed or permitted by the domestic state insurance department. When the independent CPA issues an adverse opinion, the reasons for the adverse opinion and the principal effects of the subject matter of the adverse opinion on the financial position, results of operations, changes in capital and surplus and cash flows, if practicable, are disclosed in one or more separate explanatory paragraphs preceding the opinion paragraph in the CPA's report and these paragraphs are referenced in the opinion paragraph. If the effects are not reasonably determinable, this should be indicated in the independent CPA's report. Adverse opinions are issued when, in the independent CPA's judgment, the financial statements are not presented in conformity with accounting practices prescribed or permitted by the domestic state insurance department.

5. Disclaimer of Opinion

A disclaimer of opinion states that the independent CPA does not express an opinion on the financial statements and is issued when the independent CPA has not performed an audit sufficient in scope to allow the CPA to form an opinion on the financial statements. When the independent CPA issues a disclaimer of opinion because of a scope limitation, the reasons why the audit did not comply with generally accepted auditing standards should be disclosed in one or more separate paragraphs and the report should state that the scope of the audit was not sufficient to warrant the expression of an opinion on the financial statements.

Procedure #5 should be completed in those instances where the independent CPA's audit opinion is other than the standard unqualified "clean" opinion. The analyst will document the reason(s) for the deviation. The analyst's comments should be as detailed as possible based on information in the audit opinion and in the Notes to Financial Statements and should include the effect of the cause of the deviation, if applicable, on the insurer's financial position.

Procedure #6 assists the analyst in determining that total assets, net income and capital and surplus per the Audited Financial Report agree with the amounts per the insurer's Annual Financial Statement which has previously been analyzed. The analyst should compare these amounts between the Audited Financial Reports and the Annual Financial Statement which was filed with the state insurance department. If

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differences exist, the independent CPA is required to include, in the Notes to Financial Statements, a reconciliation of the differences between the Audited Financial Reports and the Annual Financial Statement along with a written description of the nature of these differences.

Procedure #7 should be completed in those instances where differences exist between the Audited Financial Reports and the Annual Financial Statement. This procedure requires the analyst to document these differences and the reasons for the differences, based on a review of the independent CPA's reconciliation in the Notes to Financial Statements. The analyst should also consider the impact of the audit adjustments made by the independent CPA on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (e.g., complete additional supplemental checklists for items impacted by the audit adjustments) on the Annual Financial Statement information.

Procedure #8 assists the analyst in reviewing the Notes to Financial Statements included in the Audited Financial Report and commenting on any items of significance, including, but not limited to: investments (e.g., fair value and duration/maturity of bonds, realized and unrealized gains and losses), reserves (e.g., variability of reserves, the impact of any estimated salvage and subrogation and/or discounting), reinsurance (e.g., reserve credits taken, recoverables, transfer of risk, collectibility), transactions with affiliates (e.g., pooling, administrative agreements and fees, dividends, transfers), and contingent liabilities (e.g., litigation, assessments). The information included in the Notes to Financial Statements is an integral part of the information included in the Audited Financial Report and should be closely scrutinized by the analyst. The comments included by the analyst in Procedure #8 should focus on all significant items noted and not just those with a negative impact on the insurer's current financial position.

Procedure #9 should be completed in those instances where transactions with affiliates are significant. This procedure suggests that the analyst consider comparing information regarding affiliated relationships and transactions per the Audited Financial Report to information reported by the insurer in the Annual Financial Statement and in the various holding company filings (Form B – Annual Registration Statement, Form C – Summary of Registration Statement, Form D – Prior Notice of a Transaction, Form E (or Other Required Information) – Pre-Acquisition Notification regarding Potential Competitive Impact of a Proposed Merger or Acquisition, and Extraordinary Dividend/Distribution) to verify the information in these other filings and to determine that all appropriate filings were made by the insurer.

Internal Controls

In addition to the Audited Financial Report, insurers are required to furnish the domiciliary state insurance department with a written report by the independent CPA describing significant deficiencies in the insurer's internal control structure as noted by the independent CPA during the audit, if applicable. Such report is not required if the CPA does not identify significant deficiencies. In those instances where significant deficiencies are noted, the insurer is also required to provide a description of remedial actions taken or proposed to correct the significant deficiencies, if such actions are not described in the Audited Report.

Procedure #10 assists the analyst in documenting the review of the report of significant deficiencies, if applicable (the report is only prepared if the insurer is an SEC registrant or significant deficiencies are noted by the CPA during the audit), and the improvements made or proposed by the insurer. In addition to commenting on any deficiencies noted, the analyst should also comment on the adequacy of the improvements made or proposed by the insurer to correct the deficiencies.

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CPA's Letter of Qualifications

This section of the Audited Financial Reports Procedures should be completed whenever there has been a change in the independent CPA from the prior year and may be completed annually whether or not there has been a change in independent CPA.

Procedure #11 should be completed in order to determine if the independent CPA must also furnish to the insurer, in connection with and for inclusion in the filing of the Audited Financial Report, a letter of qualifications which includes all of the statements listed in the procedure. The analyst should verify that the independent CPA included all of the statements in the letter of qualifications (especially those included in *Procedures #1b, #1c, and #1f*).

Procedure #12 assists the analyst in documenting any deviations or omissions from the required statements in the independent CPA's letter of qualifications. In addition, if the analyst has concerns regarding the independent CPA's qualifications, these concerns should also be documented as a part of this procedure.

Change in CPA

Procedure #13 assists the analyst in determining whether the independent CPA who issued the opinion on the insurer's financial statements is the same CPA who issued the opinion in the prior year. 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 ten business days of the previous notification stating whether, in the 24 months preceding such event, there were any disagreements with the former independent CPA on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, and which disagreements, if not resolved to the satisfaction of the former independent CPA, would have caused the CPA to make reference to the disagreement in connection with the opinion. In addition, the insurer is further required to furnish a letter from the former independent CPA stating whether the independent CPA agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he or she does not agree.

Procedure #14 is to be completed in those instances where the CPA who issued the opinion on the insurer's financial statements in the current year is different from the CPA in the prior year. This procedure assists the analyst in determining whether the domiciliary state insurance department was notified of the change and whether the letters from the insurer and the former CPA regarding any disagreements were filed.

Procedure #15 should be completed in those instances where disagreements were noted in the letter from either the insurer or the former CPA. This procedure directs the analyst to comment on the disagreements noted. In commenting on the disagreements noted, the analyst should consider the impact of the disagreements on any other analysis of the insurer performed by the analyst.

Audit Committee

Procedure #16 is intended to verify that the insurer has established an audit committee as required at January 1, 2010. As of this date, every insurer required to file an audited financial report shall also be required to have designated an audit committee. The procedures also ask the analyst to verify that the audit committee membership meets state requirements.

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Revisions to the Annual Financial Reporting Model Regulation (Model Audit Rule) – Effective January 1, 2010

Amendments to the Annual Financial Reporting Model Regulation, commonly known as the Model Audit Rule, become effective January 1, 2010. The purpose of this regulation is to improve a state's surveillance of the financial condition of insurers by requiring an independent annual audit of the financial statements by Certified Public Accountants. The revisions deal primarily with three areas: auditor independence, corporate governance and internal control over financial reporting.

Auditor Independence

Significant revisions to the model related to auditor independence are as follows:

- The lead audit partner may not serve in that capacity for more than five consecutive years and may not rejoin in that capacity for a period of more than five consecutive years. Previously, the requirement was seven and two years, respectively.

- Includes various non-audit services that, if performed by the auditor, 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 engagement may not serve as a member of the Board of Directors, President, Chief Executive Officer, Controller, Chief Financial Officer or other similar position of the insurer if employed by the independent public accounting firm that audited the insurer during the one-year period that preceded the most current statutory opinion.

Corporate Responsibility/Governance

Significant revisions to the model related to corporate responsibility/governance are as follows:

- Every insurer required to file an audited financial report shall also be required to have an audit committee that is directly responsible for the appointment, oversight and compensation of the auditor. Insurers with less than $500 million in direct and assumed premium may apply for a waiver from this requirement based on hardship.

- Based on various premium thresholds, a certain percentage of the audit committee members must be independent from the insurer. However, if domiciliary law requires board participation by otherwise non-independent members, such law shall prevail and such members may participate in the audit committee.

Internal Control over Financial Reporting

Significant revisions to the model related to internal control over financial reporting are as follows:

- Management of insurance companies with more than $500 million in direct and assumed premium shall file a report with the state insurance department regarding its assessment of internal control over financial reporting. This report will include a statement by management whether these controls are effective to provide reasonable assurance regarding the reliability of the statutory financial statements and disclosure of any unremediated material weaknesses in internal control over financial reporting. At this premium threshold, nearly 90% of all premiums are captured with only 40% of companies needing to comply with the requirements, a vast majority of which are already SEC registrants. In fact, at this premium threshold, only 6% of non-public companies would have to comply with the proposed internal control reporting requirements. That is only 190 companies out of a population of 3,061.

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- No CPA attestation (or opinion) will be required of management's assessment. This CPA attestation can be costly, and the elimination of such emphasizes the regulator's understanding of the need to balance the costs and benefits.

With the exception of Audit Committee requirements as discussed in procedure #16 above, these amendments do not impact 2009 annual *Financial Analysis Handbook* procedures. However, analysts should be aware that changes to the 2010 annual *Financial Analysis Handbook* guidance and procedures are anticipated.

2010 annual statement instructions will refer to state statutes or regulations that require an annual audit of their insurance companies by an independent certified public accountant based on the NAIC's Annual Financial Reporting Model Regulation. For guidance regarding this model, see the Implementation Guide for the Annual Financial Reporting Model Regulation in Appendix G of the *Accounting Practices and Procedures Manual.*

Additional Reference Sources

1. *Annual Statement Instructions for Life, Accident and Health Insurance Companies*, NAIC
2. Annual Financial Reporting Model Regulation, *Model Laws, Regulations and Guidelines*, NAIC
3. *Accounting Practices and Procedures Manual*, NAIC

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III. Analysts Reference Guide – C.2. Statement of Actuarial Opinion

Overview of Statement of Actuarial Opinion

Life insurers required to file an Annual Financial Statement are also required to file a Statement of Actuarial Opinion as a supplement to the Annual Financial Statement. The specific requirements for the Statement of Actuarial Opinion are described in the NAIC Model Act Actuarial Opinion and Memorandum (AOMR). The Statement of Actuarial Opinion must be issued by a qualified actuary. A qualified actuary is an individual who is a member in good standing of the American Academy of Actuaries, or an individual who has otherwise demonstrated his or her actuarial competence to the satisfaction of the domiciliary state insurance department.

During 2001, the NAIC adopted revisions to the Statement of Actuarial Opinion and Memorandum Regulation (AOMR). The most significant revision to the AOMR was the requirement that all companies perform an asset adequacy analysis. This revision eliminates the current Section 7 opinion that was allowed for certain insurers. This AOMR revision impacts this Handbook because the Statement of Actuarial Opinion Supplemental Procedures currently has two different sets of procedures; one that can be used when an asset adequacy analysis opinion is required and another when the asset adequacy opinion is not required. In addition to the deletion of the Section 7 opinion, the revised AOMR includes an executive summary, which is referred to below.

Without regard to the above changes made to the AOMR, in general, there are two types of actuarial opinions. A Statement of Actuarial Opinion that does not include an asset adequacy analysis (section 7 opinion) is required for all life insurers that meet certain exemption eligibility tests. Those life insurers that do not meet certain exemption eligibility tests are required to file a more comprehensive Statement of Actuarial Opinion based on an asset adequacy analysis (Section 8 opinion). A Section 8 opinion is supported by an actuarial memorandum. The actuarial memorandum includes the results of the qualified actuary's asset adequacy analysis. This analysis may include cash flow testing, sensitivity testing or applications of risk theory, and it documents the qualified actuary's analyses conducted in concluding whether the assets held by the insurer, including the related investment earnings, will adequately support the insurer's future policy obligations. While the Statement of Actuarial Opinion must be filed with the Annual Financial Statement, the actuarial memorandum is only provided to the regulator upon request. The exemption eligibility tests, which determine whether a Section 7 or Section 8 actuarial opinion is required, are described below in the Discussion of Level 2 Annual Procedures for the Statement of Actuarial Opinion and were designed to identify those life insurers with significant levels of non-investment grade bonds or significant levels of annuities and deposits. In addition to a Section 7 or Section 8 actuarial opinion, the insurer must also file a non-guaranteed elements opinion if policies containing non-guaranteed elements are currently being issued or are in-force. The specific requirements for the non-guaranteed elements opinion are described in the NAIC *Annual Financial Statement Instructions for Life, Accident and Health Insurance Companies*.

The Statement of Actuarial Opinion should consist of a paragraph identifying the qualified actuary, a scope section identifying the subjects on which an opinion is to be expressed and describing the scope of the qualified actuary's work, and an opinion paragraph expressing the qualified actuary's opinion with respect to such subjects. If there has been a material change in the actuarial assumptions from those previously employed, that change should be described in either the Annual Financial Statement or in a paragraph of the Statement of Actuarial Opinion. In addition, the scope paragraph should list those items and amounts to which the qualified actuary is expressing an opinion, including 1) aggregate reserve for life contracts (Exhibit 5), 2) aggregate reserve for accident and health contracts (Exhibit 6), 3) aggregate reserve for deposit-type contracts (Exhibit 7), and 4) policy and contract claims – liability end of current year (Exhibit 8, part 1). If the actuary has not examined the underlying records, but has relied upon listings and summaries of policies in force prepared by the company, the scope paragraph should include a sentence to this effect.

If the qualified actuary is unable to form an opinion, the actuary should issue a statement specifically stating the reason(s) why an opinion cannot be formed. If the qualified actuary's opinion is adverse or qualified, the actuary should issue an adverse or qualified actuarial opinion specifically stating the reason(s) for such an opinion. An

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adverse opinion is one in which the item amounts reviewed do not satisfy one or more of the six criteria listed in the opinion paragraph of the Statement of Actuarial Opinion.

Discussion of Level 1 Annual Procedures

In most instances proper review and analysis of the Statement of Actuarial Opinion will require a greater in-depth knowledge of actuarial science. In order to achieve this as a part of the financial review process, most opinions will be reviewed in detail by actuarial staff members. Their review should encompass procedures discussed in the next section covering the Level 2 Annual Procedures for the Statement of Actuarial Opinion.

However, if the Annual Financial Statement is received, a cursory review of the opinion should be performed to identify if any extraordinary item is detailed in the opinion. The primary goal of the Level 1 Procedures for the Statement of Actuarial Opinion is to determine if a Statement of Actuarial Opinion was to be filed. And if so, was it received and available for later review.

Every life insurer must file either a Section 7 or Section 8 actuarial opinion. Financial criteria exists which determine the appropriate type of opinion. Life insurers that meet the following criteria are normally exempt from filing the more comprehensive Section 8 Statement of Actuarial Opinion including an asset adequacy analysis, and are required to file a Section 7 Statement of Actuarial Opinion not including an asset adequacy analysis. However, the domiciliary state may, notwithstanding the criteria specified below, still require the insurer to file a Statement of Actuarial Opinion including an asset adequacy analysis.

1. Admitted assets are less than $20 million and:
    a. The ratio of capital and surplus to cash and invested assets is greater than or equal to 10 percent and
    b. The ratio of reserves and liabilities for annuities and deposits to admitted assets is less than 30 percent and
    c. The ratio of non-investment grade bonds to capital and surplus is less than 50 percent and

2. Admitted assets are greater than $20 million but less than or equal to $100 million and:
    a. The ratio of capital and surplus to cash and invested assets is greater than or equal to 7 percent and
    b. The ratio of reserves and liabilities for annuities and deposits to admitted assets is less than 40 percent and
    c. The ratio of non-investment grade bonds to capital and surplus is less than 50 percent and

3. Admitted assets are greater than $100 million but less than or equal to $500 million and:
    a. The ratio of capital and surplus to cash and invested assets is greater than or equal to 5 percent and
    b. The ratio of reserves and liabilities for annuities and deposits to admitted assets is less than 50 percent and
    c. The ratio of non-investment grade bonds to capital and surplus is less than 50 percent and
    d. The insurer has filed a Statement of Actuarial Opinion including an asset adequacy analysis within the past three years.

All life insurers with admitted assets greater than $500 million are required to file a section 8 actuarial opinion. When a section 8 actuarial opinion is required, an actuarial memorandum, which supports the findings expressed in the Statement of Actuarial Opinion, is available upon request by the regulator.

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If the insurer presently issues or has in-force policies that contain non-guaranteed elements, then a Non-guaranteed Elements Actuarial Opinion must also be filed.

Discussion of Supplemental Procedures

The analysis of the Statement of Actuarial Opinion, although filed with the Annual Financial Statement, is documented on the separate Supplemental Procedures for the Statement of Actuarial Opinion because of its significance. The Supplemental Procedures for the Statement of Actuarial Opinion are broken down into three parts A) review of the Statement of Actuarial Opinion not including an asset adequacy analysis (if applicable), B) review of the Statement of Actuarial Opinion based on an asset adequacy analysis (if applicable), and C) non-guaranteed elements opinion (if applicable). The analyst will complete either part A or part B, depending upon the required Statement of Actuarial Opinion. In addition, the analyst may also need to complete part C if the insurer is also required to file a non-guaranteed elements opinion.

Statement of Actuarial Opinion Not Including an Asset Adequacy Analysis (if applicable)

Procedures #1, #2, and *#3* assist the analyst in determining that the Statement of Actuarial Opinion was prepared by a qualified actuary and that the reserve amounts agree with the Annual Financial Statement.

Procedure #4 assists the analyst in determining that the insurer's qualified actuary has concluded that a section 7 actuarial opinion is required and not the more comprehensive section 8 actuarial opinion including an asset adequacy analysis. It is also important for the qualified actuary to document the reasons for this conclusion.

Procedures #5 and *#6* assist the analyst in determining that the insurer's policy reserves were calculated properly in accordance with the minimum standards required by the NAIC Model Standard Valuation Law.

Statement of Actuarial Opinion Based On An Asset Adequacy Analysis (if applicable)

Procedures #7, #8, and *#9* assist the analyst in determining that the Statement of Actuarial Opinion was prepared by a qualified actuary and that the reserve amounts agree with the Annual Financial Statement.

Procedures #10, #11, and *#12* assist the analyst in determining that the insurer's policy reserves were calculated properly in accordance with the minimum standards required by the NAIC Model Standard Valuation Law, **and** that the insurer's assets will adequately support the insurer's future policy obligations. The qualified actuary's opinion that the insurer's assets are adequate with regard to policy reserves provides significant comfort to the analyst that policy obligations will be met in the future.

Actuarial Memorandum

Procedures #13, #14, and #15 assist the analyst in reviewing the actuarial memorandum that supports the Statement of Actuarial Opinion. The actuarial memorandum is a comprehensive document that provides an understanding of the insurer's reserves, the assets available to support the reserves, and the projected impact on the insurer's financial condition of varying economic and interest rate projection scenarios. It is not automatically filed with the Annual Financial Statement, but is provided to the regulator only upon request. The decision as to whether to request the actuarial memorandum is an important one. The actuarial memorandum should be requested for insurers with known financial problems, significant changes in product mix or investment strategy, or significant growth in a particular product line. The NAIC has recently adopted a Regulatory Asset Adequacy Issues Summary, which is filed with the Annual Financial Statement and is designed to assist the regulatory actuary in determining whether to request the actuarial memorandum. Under the currently proposed format of the MES, it would include the following eight data requests:

1) The amount necessary to eliminate all negative ending surplus values on a market value basis under each of the Required Interest Scenarios.

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2) The extent to which the appointed actuary uses assumptions in the asset adequacy analysis which are materially different than the assumptions used in the previous asset adequacy analysis.

3) The amount of reserves and the identity of the product lines which have been subject to asset adequacy analysis in the prior opinion but were not subject to such analysis for the current opinion.

4) The number of additional interest rate scenarios that were tested identifying separately the number of deterministic scenarios and stochastic scenarios. Also identify the number of such scenarios which produced ending negative surplus values on market value basis.

5) If sensitivity testing was performed, identify the assumptions tested and describe the variation in ending surplus values on a market value basis from the base case values.

6) Comments should be provided on any interim results that may be of significant concern to the appointed actuary.

7) The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested.

8) Whether the actuary has verified that all options embedded in fixed income securities and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

The threshold of 95 percent in procedure #13 is a recommendation and the standard of materiality may vary between actuaries.

Non-Guaranteed Elements Opinion (if applicable)

Procedures #16 and #17 assist the analyst in determining that a qualified actuary prepared the non-guaranteed elements opinion.

Procedure #18 assists the analyst in reviewing the non-guaranteed elements opinion in order to determine that the insurer's reserves were determined in a manner that considered the non-guaranteed elements for individual life and annuities policies.

Additional Reference Sources

1. *Annual Statement Instructions for Life, Accident and Health Insurance Companies*, NAIC
2. *Standard Valuation Law*, NAIC
3. *Actuarial Opinion and Memorandum Regulation*, NAIC
4. *Actuarial Standards of Practice (ASOP) #22*, Actuarial Standards Board, 1993
5. *Actuarial Standards of Practice (ASOP) #23*, Actuarial Standards Board, 1993
6. *Actuarial Compliance Guidelines #4*, Actuarial Standards Board, 1993
7. NAIC *Accounting Practices and Procedures Manual Appendix C*

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Overview of Management's Discussion and Analysis

The Management's Discussion and Analysis (MD&A) requirements are intended to provide, in one section, material historical and prospective textual disclosure enabling regulators to assess the financial condition and results of operations of the reporting entity. There is a need for a narrative explanation of the financial statements, because a numerical presentation and brief accompanying footnotes alone may be insufficient for analysts to judge the quality of earnings and the likelihood that past performance is indicative of future performance. The MD&A is intended to give the 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 MD&A shall be of the Annual Financial Statements and of other statistical data that the insurer believes will enhance the analyst's understanding of its financial condition, changes in financial condition and results of operations. Generally, the discussion shall cover the two-year period covered by the Annual Financial Statements and shall use year-to-year comparisons or any other formats that, in the insurer's judgment, will enhance the analyst's understanding. However, where trend information is relevant, reference to the Five-Year Historical Data pages in the Annual Financial Statement may be necessary.

The purpose of the MD&A shall be to provide analysts with information relevant to an assessment of the financial condition and results of operations of the insurer as determined by evaluating the amounts and certainty of cash flows from operations and from outside sources. The information provided pursuant to this MD&A need only include that which is available to the insurer without undue effort or expense and which does not clearly appear in the insurer's Annual Financial Statements.

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 condition. This would include descriptions and amounts of 1) matters that would have an impact on future operations and have not had an impact in the past and 2) matters that have had an impact on reported operations and are not expected to have an impact upon future operations.

Discussion of Supplemental Procedures

The analysis of the MD&A is documented on the separate MD&A Supplemental Procedures due to its significance and due to the timing of the filing of the report on April 1 rather than on March 1 with the Annual Financial Statement.

Procedure #1 assist the analyst in evaluating the overall completeness of the MD&A. Specifically, it should address the two-year period covered by the insurer's Annual Financial Statement and should discuss material changes in the insurer's financial statement.

Procedure #2 assists the analyst in determining if the insurer was required to prepare the MD&A on a non-consolidated basis, unless the following conditions were met: 1) The insurer is part of a consolidated group of insurers that utilizes a pooling arrangement or a one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if they have less than $1,000,000 total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5 percent of the company's capital and surplus. 2) The insurer's state of domicile permits audited consolidated financial statements.

Procedure #3 assists the analyst in determining if results of operations have been disclosed. Insurers should describe any unusual or infrequent events or transactions or any significant economic changes that materially affected the amount of reported net income or other gains/losses in surplus and, in each case, indicate the extent to

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which net income or surplus was so affected. In addition, describe any other significant components of income that, in the insurer's judgment, should be described in order to understand the insurer's results of operations.

Insurers should describe any known trends or uncertainties that have had or are reasonably probable to have a material favorable or unfavorable impact on premiums, net income, or other gains/losses in surplus. If the insurer knows of events that will cause a material change in the relationship between expenses and premium, the change in the relationship shall be disclosed.

To the extent that the Annual Financial Statements disclose material increases in premium, reporting entities should provide a narrative discussion of the extent to which such increases are attributable to increases in prices or to increases in the volume or amount of existing products being sold or to the introduction of new products.

Procedure #4 assists the analyst in determining if results of prospective information have been disclosed. Insurers are encouraged to supply forward-looking information. The MD&A may include discussions of "known trends or any known demands, commitments, events or uncertainties that will result in or that are reasonably likely to result in the reporting entity's liquidity increasing or decreasing in any material way." Further, descriptions of known material trends in the insurer's capital resources and expected changes in the mix and cost of such resources should be included. Disclosure of known trends or uncertainties that the insurer reasonably expects will have a material impact on premium, net income, or other gains/losses in surplus is also encouraged.

Procedure #5 assists the analyst in determining if material changes have been disclosed. Insurers are required to provide adequate disclosure of the reasons for material year-to-year changes in line items, or discussion and quantification of the contribution of two or more factors to such material changes. An analysis of changes in line items is required where material and where the changes diverge from changes in related line items of the Annual Financial Statement, where identification and quantification of the extent of contribution of each of two or more factors is necessary to an understanding of a material change, or where there are material increases or decreases in net premium.

Procedure #6 assists the analyst in determining if liquidity, asset/liability matching and capital resources have been disclosed. The discussion of liquidity shall include a discussion of the nature and extent of restrictions on the ability of subsidiaries to transfer funds to the reporting entity in the form of cash dividends, loans, or advances and the impact such restrictions may, if any, have on the ability of the reporting entity to meet its cash obligations. Generally, short-term liquidity and short-term capital resources cover cash needs up to 12 months into the future. These cash needs and the sources of funds to meet such needs relate to the day-to-day operating expenses of the reporting entity and material commitments coming due during that 12-month period.

The discussion of long-term liquidity and long-term capital resources must address material expenditures, significant balloon payments, or other payments due on long-term obligations, and other demands or commitments, including any off-balance sheet items, to be incurred beyond the next 12 months, as well as the proposed sources of funding required to satisfy such obligations. Insurers should identify any known trends or any known demands, commitments, events, or uncertainties that will result in or that are reasonably likely to result in the reporting entity's liquidity increasing or decreasing in any material way. If a material decline in liquidity is identified, indicate the course of action that the insurer has taken or proposes to take to remedy the decline. Also, identify and separately describe internal and external sources of liquidity, and briefly discuss any material unused sources of liquid assets. Insurers should describe any known material trends, favorable or unfavorable, in the insurer's capital resources. Indicate any expected material changes in the mix and relative cost of such resources. The discussion shall consider changes between equity, debt, and any off-balance sheet financing arrangements. Insurers should present a balanced discussion dealing with cash flows from operations, investing, and financing activities.

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Procedure #7 assists the analyst in determining if loss reserves have been disclosed. The MD&A should include a discussion of those items that affect the insurer's volatility of loss reserves, including a description of those risks that contribute to the volatility.

Procedure #8 assists the analyst in determining if off-balance sheet arrangements have been disclosed. Insurers should consider the need to provide disclosures concerning transactions, arrangements, and other relationships with entities or other persons that are reasonably likely to affect materially liquidity or the availability of, or requirements for, capital resources. Material sources of liquidity and financing, including off-balance sheet arrangements and transactions with limited purpose entities, should be discussed.

Procedure #9 assists the analyst in determining if participation in high yield financing, highly leveraged transactions, or non-investment grade loans and investments have been disclosed. In view of these potentially greater returns and potentially greater risks, disclosure of the nature and extent of an insurer's involvement with high yield or highly leveraged transactions and non-investment grade loans and investments may be required, if such participation or involvement has had or is reasonably likely to have a material effect on financial condition or results of operations. For each such participation or involvement or grouping thereof, there shall be identification, consistent with the Annual Financial Statement schedules or detail; description of the risks added to the reporting entity; associated fees recognized or deferred; amount, if any, of loss recognized; the insurer's judgment whether there has been material negative effects on the insurer's financial condition; and the insurer's judgment whether there will be a material negative effect on the financial condition in subsequent reporting periods.

Procedure #10 assists the analyst in determining if preliminary merger/acquisition negotiations have been disclosed.

Additional Reference Sources

1. *Annual Statement Instructions for Life, Accident and Health Insurance Companies*, NAIC

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III. Analysts Reference Guide –C.4. Holding Company Analysis

Overview

The following information is intended to provide guidance for state insurance regulators to analyze holding companies. For additional information, regulators may download the NAIC *Framework for Insurance Holding Company Analysis* from I-SITE Utilities or the NAIC StateNet Web site.

State insurance regulators examine and analyze the financial condition of individual insurers domiciled or licensed in their respective states based on individual state's statutes, regulations, policies and procedures, and in accordance with the handbooks and other tools developed and adopted by the NAIC. Consistent with state law and the related regulatory structure, exam and analysis procedures are more focused on the legal entity level rather than on the overall holding company system. Notwithstanding the structural need to focus on the legal entity level, state regulators have for years recognized that individual company analysis may require a more broad understanding of the overall insurance group. Also, as more companies merge and consolidate, and insurance reporting becomes more complex, the need to further understand the group organizational structure becomes greater.

The purpose of this section is to provide state insurance regulators with a common set of tools and the related guidance necessary to gain an understanding of the holding company structure and the impact its management, business practices, and financial condition have on the insurance subsidiaries. The information provided will assist in analyzing holding companies and their insurance subsidiaries and supplement the efforts among state regulators to more fully coordinate regulatory activities.

Holding Company Structure

A holding company may consist of one company, which 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. In the case of a stock company, the holding company may own any percentage of another company's stock as long as it is sufficient to provide the holding company control over the operations of the company. The controlling entity often delegates operational functions to subsidiaries so it can focus on the management of the overall group. Some holding company structures are established to hold only insurance operations and others may be more complex while engaged in multiple types of businesses.

In order to identify a holding company with insurance subsidiaries, refer to statutory filings submitted to state insurance regulators and/or the NAIC. Some examples of the filings include initial applications for licensure, holding company registration statements (Form B), or organizational charts (Schedule Y). It is important to identify all insurance subsidiaries within a holding company structure and to identify all the states responsible for regulating those subsidiaries.

There can be variations as to how a holding company is classified. The most common types of holding company structures are described below.

<u>Public Holding Company</u>
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. Holding company stock can be purchased via a public securities exchange market. Transactions that result from the public holding company are approved by a board of directors. Public holding companies may be obligated to pay dividends in order to maintain expectations of the shareholders. Additionally, these companies are subject to reputational risk should they suffer a decline in financial performance.

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Private Holding Company
A private holding company is a separate legal entity designed to hold either investment 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.

Mutual Insurers
Mutual insurance companies are formed and bound by their policyholders. Mutual insurers do not issue stock and therefore do 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 a holding company system. It may also create a subsidiary to act as a holding company for other downstream affiliates.

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, including through the issuance of stock. Such a conversion is subject to the approval of the policyholders and the domiciliary state's commissioner.

Understanding the Holding Company Structure

It is important for the analyst to gain a thorough understanding of the organizational structure in order to properly analyze how each subsidiary in the holding company operates. Organizational structures can vary significantly between 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. Smaller holding company systems may be closely held and maintain only a few subsidiaries. Others may be partially held by different individuals and companies or have indirect ownership relationships.

The most readily available source for gaining an understanding of holding company structure is through review of the statutory filings submitted by insurers. Insurers are required to submit an organizational chart and details of affiliated transactions in Schedule Y—Information Concerning Activities of Insurer Members of a Holding Company. Schedule Y – Part 1, includes the organizational chart that illustrates the relationships within the holding company group to the ultimate controlling person(s) or entity. Additionally, all insurers are required to report their state of domicile. This schedule provides valuable insight into the ownership structure, insurance holdings, locale, and affiliated relationships within the holding company.

Under guidance from SSAP 25, *Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties*, insurers are also required to provide detailed information on related party transactions and relationships in Note 10—Information Concerning Parent, Subsidiaries, and Affiliates. Refer to Section V., Guidance for Note to Financials in the Handbook.

The statutory Management's Discussion and Analysis (MD&A) and Audited Statutory Financial Statement also contain information on the holding company structure. These annual 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, products lines, marketing systems and actions such as corporate restructuring, acquisitions and dispositions.

The Audited Statutory Financial statement provides background, operational information, affiliated transactions, mergers, and subsidiary holdings. Several of the footnotes (e.g., 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 interactions. These footnotes provide disclosures on such issues as affiliated transactions, agreements,

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guarantees, reinsurance transactions, capital contributions, and organizational structure that allow the analyst to gain an understanding of how the different entities within the holding company operate together.

Disclosures on non-insurance entities found within the holding company may be limited. For publicly traded companies, the analyst can also reference reports filed with the Securities and Exchange Commission (SEC) to gain insight on the 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 10-K that may provide valuable background information include:

Business: This section includes a general discussion of the entity's business, financial information and industry segments. The industry segment section allows the analyst to assess the organization as a whole by its major operating business segments.

Directors and Executive Officers: This section helps the analyst 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: The analyst can find discussion on affiliated transactions and business relationships in this section.

Form 10-Q is used to report quarterly financial data. Form 10-Q is much more limited in scope than Form 10-K, but 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.

Understanding the Lead State Role

It is important for the analyst to understand the concept of a lead state in order to determine how states coordinate regulatory activities in their reviews of insurance groups. Typically, the lead state is the state where the parent company is domiciled or, if there is no insurance parent, the state where the largest (by direct written premium volume as reported in the most recently filed Annual Financial Statement) insurance subsidiary is domiciled. The passage of the Gramm-Leach-Bliley Act (GLBA), stresses the importance of a lead state. Also, it may be necessary for other financial regulators, including the Federal Reserve and other federal and state banking agencies and securities regulators, to identify a central point of contact. State regulators should communicate with federal regulators if the insurance company is affiliated with a bank, thrift or security firm that reports to a federal agency. Communication between state and federal regulators will allow for more effective and efficient regulation on key issues impacting the insurer or financial institution.

The concept of a lead state is not intended to relinquish the authority of any state, nor increase any state's statutory authority nor to put any state at any disadvantage. It is intended to facilitate efficiencies when one or more state(s) coordinate the regulatory processes of all states involved.

Factors that may be considered when determining the lead state:

- State with the largest number of domestic insurance companies in the group.
- State with large or largest premium volume or exposure.
- Domiciliary state 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.
- Expertise in the area of concern and expertise of staff in like situations.
- State whose regulatory requirements have driven the design of the organization's infrastructure.

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III. Analysts Reference Guide –C.4. Holding Company Analysis

The NAIC *Lead State Summary Report* is a valuable resource available on I-SITE, within Summary Reports. The Report provides each state a listing of the insurance groups and their respective lead state(s). The Report also provides up-to-date information on the direct premium, gross premium, admitted assets, and last examination date for each company. The Report can be run on a particular NAIC group code to determine the lead state.

The role of the lead state encompasses many responsibilities, which may vary depending upon the situation creating the need for regulatory coordination of activities of the regulators involved. However, of utmost importance is maintaining confidentiality of all information, which includes implementing confidentiality arrangements with other states and regulators. The lead state and other interested states also perform a review of the consolidated group, which includes an analysis of the group's financial results and overall business strategy.

The operations of an insurance company often are not limited to one state. In some cases, when multiple states are involved in monitoring the activities or approving the transactions of a company or group of companies, multiple states may coordinate regulatory efforts. These coordinated efforts have increased over the last few years as the insurance industry has consolidated and as insurance holding companies with insurers domiciled in more than one state have increased.

These coordinated activities may include:

- The establishment of procedures to communicate information regarding troubled insurers with other state insurance departments.
- The participation on joint examinations of insurers.
- Consensus assignment of specific regulatory tasks to different state insurance departments in order to achieve efficiency and effectiveness in regulatory efforts and to share personnel resources and expertise.
- The establishment of a task force consisting of personnel from various state insurance departments to carry out coordinated activities.

These types of coordinated efforts may be effective for both regulators and the insurance companies involved.

Once the lead state or states are determined, there are a number of responsibilities the state must assume in order for the oversight process to function effectively and efficiently. These responsibilities may include designating a lead person involved in the specific transaction or monitoring. If necessary, the lead state should contact other identified states to establish points of contact and to determine the amount of interest in participating in the multi-state coordination. The lead state should then establish lines of communication and serve as regulatory contact with top management of the organization.

Procedures should be established as to how information will be shared with other states and regulators. This step is critical in establishing the lead state as a coordinator by supplying states and other regulators with pertinent information. When necessary, verbal or written briefings arranged by the lead state in conjunction with company management have been the most effective.

Early in the oversight process, the lead state should collect information on the status of company filings, analysis, examinations and other activity from each of the other states.

The lead state should also obtain information on the group as a whole. In order to gain this understanding, the lead state should focus on the holding company and subsequently on the underlying affiliated relationships. This information will be helpful in preparing for discussions with insurance company and holding company management.

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Data Collection

There are a number of sources of information available to assist the analyst in analyzing holding companies. The most useful sources include the insurance company statutory financial statements, GAAP financial statements filed with the SEC, MD&A, the Audited Statutory Financial Statement and the holding company's annual shareholder's report. However, other external sources of information exist, including rating reports and analysis from Nationally Recognized Statistical Rating Organizations (NRSRO), press releases from the holding company, and news and other analytical profiles from various financial and news organizations.

Sources of Information

The *Statutory Financial Statements* contain information on the financial condition of the insurance company. Schedule Y, the General Interrogatories and Notes to Financial Statements provide holding company information, such as the holding company structure, the ultimate controlling person(s), affiliated relationships, investments, and other transactions.

Form 10-K, 10-Q, 8-K and other SEC filings can be accessed via the SEC Web site. Refer to Section 1-D, *External Information* in this Handbook for more discussion on the information available in these SEC filings. The report of the independent public accountant should include not only a report on the Audited Financial Statements, but also a report on the assessment of internal controls and management's assessment of internal controls. Also, included should be a statement of management's responsibility for establishing and maintaining adequate internal control over financial reporting for the company, a statement identifying the framework used by management to evaluate the effectiveness of this internal control, management's assessment of the effectiveness of this internal control as of the end of the insurer's most recent fiscal year, and a statement that its auditor has issued an attestation report on management's assessment.

Shareholder's Reports are generally available on a holding company's Web site. The scope of the shareholder's report may vary between companies, but generally it is reported on a consolidated GAAP basis and may contain segment information. A holding company'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 Web site can be obtained from the Jurat page of the insurer's annual statutory financial statement. Links to company Web sites can also be obtained from the rating agency Web sites, as well as other financial Web sites or through tools such as Bloomberg Financial.

The *Internet* offers a variety of Web sites that contain information on the financial background for publicly traded companies. Some financial Web sites 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 includes MD&A, Audited Statutory Financial Reports, NRSROs, NAIC Database, I-SITE, prior analysis performed on the group, 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.

International Data Sources

When a holding company is domiciled in a foreign country, it is necessary to determine the supervisory authority in that country and the filing requirements for the holding company. 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 Canadian Web site can provide the annual report for publicly traded insurance companies domiciled in Canada. When information is not readily available through a

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government source, the company's shareholder's report or other information may be available on the company's Web site.

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 Web sites.

Holding Company Analysis

The following process can be followed in analyzing a holding company system or insurance group.

Scope

Review the holding company structure and flowchart to determine how much detail is relevant in the group analysis. Obtain a thorough understanding of the insurance company and its relationships and interdependencies with its affiliates. Utilize statutory filings, specifically Schedule Y. Determine the scope of the review by selecting the companies and/or entities based on the material segments within the group.

A thorough review of a holding company's 10-K or other filings assists the analyst in understanding the factors and/or segments driving adverse results in the organization. The analyst should concentrate on identifying the legal entities within the holding company structure that have contributed significantly to the adverse results of the organization.

Rating Agencies

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 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.

Consolidated GAAP Financial Information

Review the holding company's 10-K filing for consolidated GAAP financial information, including total assets, liabilities, debt, stockholder's equity, revenues, expenses, net income, and net cash provided by operations, if applicable. If a 10-K filing is unavailable, research Internet sources or directly contact the group's management. Compare current-year results with prior-year results, noting any positive or negative trends.

Stock Price Evaluation

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. The analyst should strive to determine the factors impacting 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.

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History of the Holding Company and Insurer

Utilize the financial filings and the Internet to determine the group's organizational history and corporate structure. Include relevant information regarding mergers and/or acquisitions, and consider potential effects on the stability of the group. The analyst should become familiar with geographic diversification, dates of organization and relevant changes made to the holding company structure.

Plan of Operation

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 if 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 that 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.
- Management's Philosophy – Gain an understanding of the group's culture, management's expertise, and management's future vision of the group.

Reinsurance

Determine whether the reinsurance programs in place appear to 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 collectibility. Identify whether reinsurance between affiliates within the group involves 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.

Recent News

Research recent news events relevant to the group. Press releases and publications may provide valuable information 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 lay-offs, losses of key personnel, and issues with customers or providers.

For the following analysis sections, consider both the financial review of insurance and non-insurance entities within the group. In certain cases the review of non-insurance entities may be mitigated by the lack of interdependence of the entities.

Assets

Review 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.

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Analyze 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 recoverables and receivables and miscellaneous balances. Also, assess the risk related to any miscellaneous assets such as goodwill or other intangible assets.

Liabilities

Review the liabilities of the group, noting any significant increases or decreases from the prior reporting period. Assess reserves and reserve development to determine the trending and historical accuracy. Determine if debt exists at the holding company level, which may be 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.

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 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. The analyst should take note of the trend over past reporting periods and the factors that have significantly influenced an increase or decline.

Profitability

The profitability of a holding company is measured by its ability to generate earnings, and is reported on a consolidated basis as net earnings (loss). The earnings statement includes revenues and expenses and their contributing factors to net earnings (loss). 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 earnings drain on the holding company. These operations should be investigated thoroughly to identify the types of operations involved, expected durations and their impact on holding company earnings.

Operations

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/loss, total revenue and total assets. This information is helpful because it provides the analyst 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) – Identifies business produced by MGAs or TPAs. For additional information regarding MGAs and TPAs, the analyst should refer to the Analyst Reference Guide section of this Handbook.

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The analyst should focus on the overall profitability of the segments as well as the stability of earnings over a period of time. To the extent the segment has reported inconsistent earnings, or has reported any losses, the analyst may wish to obtain a greater understanding of the causes.

Cash Flow and Liquidity

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 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 continued negative trend could present a drain on assets.

The analyst should assess the level of liquid assets to current liabilities to determine the proper matching of assets to claims obligations. The analyst should also assess the material risk associated with low-quality assets and understated reserves.

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 of these holding companies, financial information is not readily available through a government sponsored source similar to the SEC. The analyst may find that the investor's page on publicly held international holding companies' Web sites 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 Economic Community organizations, accounting treatment and reporting is somewhat consistent and is improving due to the efforts of many groups working with the International Accounting Standards Board. However, for many organizations domiciled in offshore countries like Ireland, those located in the Caribbean, and others, no regulation regarding public financial reporting exists.

The analyst 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. The analyst 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 than similar transactions between two domestic entities.

Foreign holding companies invest in their U.S. subsidiaries to nurture profitable operations, to compliment existing operations, or to add to existing capacity. As opposed to their U.S. counterparts, foreign holding companies may not be under the same obligation to ensure the continued viability of their U.S. enterprises. 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.

The analyst should be aware of a holding company's stated commitment to ensure the continued stability of U.S. operations. This commitment may include written or verbal parental guarantee.

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 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.

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Discussion of Supplemental Procedures – Holding Company Analysis

The analysis of the Holding Company is documented in the separate Holding Company Supplemental Procedures due to its significance and due to the difference in the timing of holding company financial data.

The procedures may be completed in part or in total at the discretion of the analyst depending on the level of concern, the area in which the risk was identified, and the degree of interdependence within the holding company entities.

Procedures #1–15 assist the analyst in identifying and understanding the type of holding company system in which the group operates. Various documents are available as a resource in helping to understand the historical formation of the group and its business purpose.

Procedures #16–19 assist the analyst in determining the lead state and establishing lines of communication between states. Refer to the NAIC *Framework for Insurance Holding Company Analysis* in I-SITE Utilities.

Procedures #20–43 guide the analyst through procedures for reviewing the primary sections of a holding company's financial statements. The primary sections include assets, liabilities, equity, profitability, writings, and cash flow.

Procedures #44–46 offers procedures to identify the foreign supervisory authority, establish communication, and convert foreign currency.

Procedure #47 and the Supplemental Form Procedures assist the analyst in reviewing Forms A, B, D, E (or Other Required Information) and Extraordinary Dividend/Distribution.

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 NAIC *Insurance Holding Company System Regulatory Act* (the Holding Company Act) outlines specific filing requirements for persons 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 of 1999 (GBLA) is limited to 60-days prior to the effective date of the transaction. Under Section 104(c)(2) of the GLBA, 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

The Holding Company Act is the model that defines insurance holding companies and the related registration, disclosure, and approval requirements. Form B is the insurance holding company system annual registration statement. The Holding Company Act 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.

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An insurance holding company system consists of two or more affiliated persons, one or more of which is an insurer. An affiliate is an entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, another entity. Control is presumed to exist when an entity or person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies, representing 10 percent or more of the voting securities.

Form D – Prior Notice of a Transaction

The Holding Company Act 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 percent of the insurer's admitted assets or 25 percent of policyholder's surplus, and for life insurers, 3 percent of the insurer's admitted assets, each as of the most recent prior December 31st. Some states have stricter definitions of materiality in their holding company regulations.

Holding company regulations require that affiliated transactions be fair and reasonable to the interests of the insurer. Generally, affiliated management or service agreements should be based on actual cost in order to meet the fair and reasonable standard.

The appropriate Statement of Statutory Accounting Principle should be reviewed within the NAIC *Accounting Practices and Procedures Manual* to ensure proper accounting.

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

The Holding Company Act 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 the Holding Company Act and the applicable state regulations should be considered.

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 Section 104(c)(2) of the GLBA, 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

The Holding Company Act mandates 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 with the 30 day period.

Each state has its own definition of "extraordinary"; however, the Holding Company Act 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:

1) Ten percent of the insurer's surplus as regards to policyholders as of December 31st of the prior year; or

2) For life insurers, net gain from operations and for non-life insurers, net income, excluding realized capital gains for the twelve months ending December 31st of the prior year. This should not include pro-rata distributions of any class of the insurer's own securities.

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Discussion of Supplemental Procedures for Forms A, B D, E (or Other Required Information) and Extraordinary Dividend/Distribution

The analysis of Forms A, B, D, E (or Other Required Information) and Extraordinary Dividend/Distribution are documented in the separate Holding Company Supplemental Procedures due to the significance of the filings and the timing of these filings.

Form A

Procedures # 1–19 assist the analyst in reviewing the Form A filing for completeness. It guides the analyst through each of the major items of information required by Form A.

Procedures # 20–32 assist the analyst in assessing the impact of the acquisition or merger on the domestic insurer and policyholders.

Form B

Procedure # 1 assists the analyst in reviewing Form B for completeness. It guides the analyst through each of the major items of information required by Form B.

Procedure # 2 assists the analyst in determining whether dividends to shareholders were proper and in accordance with regulatory guidelines. The analyst should be particularly alert to extraordinary dividends, which require prior regulatory notification.

Procedure # 3–5 assists the analyst in reviewing other types of transactions involving the insurer and other entities in its holding company system. It guides the analyst through each type of transaction that requires prior regulatory notification. The analyst should identify disclosures about the holding company that may potentially affect the insurer. The analyst should focus specifically on shareholders that may also have a relationship with the insurer and on litigation or administrative proceedings involving the holding company that may affect the insurer, such as bankruptcy, receivership, or other corporate reorganizations. The analyst 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. The analyst 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.

Form D

Procedures #1–15 assist the analyst in reviewing the Form D filing for completeness and helps guide the analyst through major items of information required by Form D.

Form E (or Other Required Information)

Procedures #1 and #2 provide the analyst with names and addresses of all of the parties involved with the proposed merger or acquisition.

Procedures #3–#6 assist the analyst in gaining a clear understanding of the rationale and goals of the proposed merger or acquisition.

Extraordinary Dividend/Distribution

Procedures #1– #5 assist the analyst in ensuring that any extraordinary dividend or distribution was approved by all of the appropriate channels and was fair and reasonable.

Additional Reference Sources

1. *Insurance Holding Company System Regulatory Act*, NAIC
2. *Framework for Insurance Holding Company Analysis*, NAIC
3. *Accounting Practices and Procedures Manual,* NAIC

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III. Analysts Reference Guide – D. Level 1 Procedures for Fraternal Societies

Financial Analyst Role

During the risk-focused surveillance approach, the financial analyst role is to provide continuous off-site monitoring of a society's financial condition, to monitor internal/external changes relating to all aspects of the society, to maintain a prioritization system and to work with the examination staff to develop an ongoing Supervisory Plan, as well as updating the Insurer Profile Summary, if applicable.

Overview of Level 1 Procedures

The objective of the Level 1 Procedures is to perform a sufficient level of analysis of all domestic societies in order to derive an overall assessment that highlights areas where a more detailed analysis, as found in the Level 2 Procedures, may be necessary. As part of the Level 1 Analysis, the analyst will review the society's IRIS ratios, Analyst Team Validated Level, and RBC results, if available, and the information included in the Financial Profile Report. The Level 1 Procedures require the analyst to review the prior year's analysis of the society and to perform a general review of the current year's Annual Financial Statement, along with an assessment of supplemental filings, including the Audited Financial Report, Statement of Actuarial Opinion, Management's Disscussion & Analysis (MD&A), and the various holding company filings (e.g., 10-K, Form A, etc.).

The analyst should have a firm understanding of the following risk classifications:

- **Credit -** Amounts actually collected or collectible are less than those contractually due.
- **Market -** Movement in market rates or prices (such as interest rates, foreign exchanges rates or equity prices) adversely affects the reported and/or market value of investments.
- **Pricing/Underwriting -** Pricing and underwriting practices are inadequate to provide for risks assumed.
- **Reserving -** Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.
- **Liquidity -** Inability to meet contractual obligations as they become due because of an inability to liquidate assets or obtain adequate funding without incurring unacceptable losses.
- **Operational -** Operational problems such as inadequate information systems, breaches in internal controls, fraud or unforeseen catastrophes resulting in unexpected losses.
- **Legal -** 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.
- **Strategic -** 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.
- **Reputational -** Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.

A prospective risk is a residual risk that impacts future operations of a society. These anticipated risks arise due to assessments of company management and/or operations or risks associated with future business plans. Types of risks may include underwriting, investments, claims, and reinsurance. The analyst's understanding of the above nine risk classifications includes an assessment of the level of that risk and the ability of the society to appropriately manage the risk during the current period and prospectively. These prospective risks require assessment and identification of how they may evolve related to the society's overall risk profile. Understanding how risks that may or may not appear urgent now will potentially impact future operations and how management plans to address those risks is key to prospective risk analysis. The assessment of these nine risk classifications both currently and prospectively should be part of the quantitative and qualitative analysis completed within the Level 1, 2, 3 and Supplemental procedures. The *Financial Condition Examiners Handbook* provides guidance on prospective risks within Exhibit O—Examples of Risks and Exhibit V—Prospective Risk Assessment.

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III. Analysts Reference Guide – D. Level 1 Procedures for Fraternal Societies

At the conclusion of the Level 1 Procedures, the analyst is asked to document an overall summary and conclusion regarding the financial condition of the society, as well as the society's strengths and weaknesses, and to determine whether the society be considered a priority company, and whether one or more of the procedures in the Level 2 Procedures equivalent to the Life/A&H Handbook should be completed. Because some items, such as the Audited Financial Report and the various holding company filings are not required to be filed until after most of the annual review is completed, the analyst will document a conclusion based on the Level 1 Annual Procedures and the current analysis of the society. The Audited Financial Report and various holding company filings should be reviewed upon receipt and, if additional concerns are noted, the conclusion or the first quarter conclusion should be revised to reflect the most recent information. Similarly, as the analyst completes the Level 2 Procedures, the Level 1 conclusion should be reviewed and revised as necessary with any follow-up information or similar updates made to the first quarter conclusion. At the completion of the analysis process, including any Level 1, 2, 3 or Supplemental Procedures, the analyst should update the Insurer Profiles Summary, if applicable, and communicate with financial examination staff.

Insurer Profile Summary

The Insurer Profile Summary is a "living document" maintained by the state of domicile to "house" summaries of risk-focused examinations, financial analysis, internal and external changes, priority scores, supervisory plans, and other standard information.

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 society. The analyst should work with the examination staff to update the Insurer Profile Summary, including the Supervisory Plan, if applicable. The Supervisory Plan should be developed using the most recent examinations and annual and quarterly analysis results. 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 society under its jurisdiction). The Supervisory Plan should include the type of surveillance planned, the resources dedicated to the oversight, and the coordination with other states.

Continual Review Process

The above-mentioned review of the Annual Financial Report and the Holding Company Analysis Procedures highlights the importance of a continual review process. This ongoing review process is obvious in these cases but is also necessary in other areas. For example, to the extent that an analyst completes the Level 1 Procedures for a society and has concerns with its reserves, the analyst would complete additional procedures equivalent to Life/A&H Procedures for Reserves. Upon completion of the Level 2 Procedures, the analyst may have additional concerns and would complete the the equivalent of Life/A&H Level 3 Procedures for Reserves. This analysis may result in questions posed to the society and additional information being supplied to the analyst.

In some cases, the state may choose to perform a more in-depth analysis of the society's reserves, such as a targeted examination. This is just one of the many recommendations that could result from the ongoing analysis of a society. Other recommendations include: 1) requesting additional information from the society; 2) obtaining the society's business plan; 3) requesting additional interim reporting: 4) engaging an independent expert: 5) meeting with the society's management: and, 6) obtaining a corrective action plan from the society. These specific recommendations are included in the Financial Analysis Framework section of the Handbook and represent just a few of the potential actions that could result from the ongoing analysis of a society.

Regardless of the final outcome, the results of the ongoing analysis of the society should be documented in the appropriate level of the analysis, including the Level 1 conclusion, if applicable.

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Financial Examination Assessment

In performing the procedures related to financial examinations, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments is crucial during the consideration of these procedures. The analyst should also consider the society's corporate governance, which includes the assessment of the risk environment facing the society 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 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 should be structured and written to communicate to regulatory officials examination findings of regulatory importance. This type of communcation includes management letter comments and performace audit comments, where appropriate.

These comments are similar to management letter comments frequently made by CPA firms as a result of their audit. Many insolvencies have been caused by mismanagement. When examiners identify systems—or operational or management problems—that exist, performance audit comments are an opportunity to alert management and other readers of the financial examination report to problems that, if left uncorrected, could ultimately lead to insolvency.

Performance audit comments generally contain the following information: 1) a concise statement of the problem found; 2) the factors that caused or created the problem; 3) the materiality of the problem and its effect on the financial statements; 4) the financial condition of the society or the society's operations; and 5) the examiner's recommendation to the society 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 domiciliary state insurance department. Periodically, after a financial examination report has been issued, inquiries should be made to the society to determine the extent to which corrective actions have been taken on report recommendations and criticisms. Because the examiners have usually moved on to another examination, many states utilize the financial analysts to perform this function. A lack of satisfactory corrective action by the society may be cause for further regulatory action.

Risk-Focused Examinations

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. Risks in addition to the financial reporting risks may be reviewed as part of the examination process.

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—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.

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- Phase 4 – Determine Residual Risk—Once this risk is determined, the examiner can determine where to focus resources most effectively.
- Phase 5 – Establish/Conduct Examination Procedures—Upon completion of risk assessment, determine nature and extent of the examination.
- 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 Based on Findings—Incorporate into the examination report and management letter the results and observations noted during the examination.

The goals of the risk-focused examinations are to:

- Assess the quality and reliability of corporate governance to identify, assess and manage the risk environment facing the society 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 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. To assist in this assessment, examiners may utilize board and audit committee minutes; lists of critical management and operating committees, their members and meeting frequencies; and Sarbanes-Oxley filings and initiatives, as applicable.
- Assess the risk that a company's surplus is materially misstated.

Discussion of Level 1 Annual Procedures

Level 1 Annual Procedures are designed to identify potential areas of concern. As noted above, the principal areas of focus in the Level 1 Annual Procedures include the overall analysis of the society and its operations. The following provides a brief description of the purpose of each procedure.

Background Analysis

Procedure #1 provides guidance to the analyst in determining if any conclusions reached in the prior year analysis of the society should be considered in the work to be completed in the current year. Areas of concern noted in the prior year should be reviewed carefully in the current year. Societies who were classified as priority companies in the prior year—either by the state's priority designation, the Scoring System results, the Analyst Team System Validated Level, or the RBC ratio—should be reviewed carefully in the current year (RBC calculated as total adjusted capital divided by 50% of calcualted risk-based capital amount shown in the Annual Financial Statement Five-Year Historical Data). The analyst should review the Insurer Profile Summary, including the Supervisory Plan, if applicable, for any concerns or risks that may require additional attention during the current analysis being performed.

Procedure #2 alerts the analyst to review all inter-departmental communciation, as well as communication with other state insurance departments and the society. Internal communication may include departments such as examination, licensing and admissions, consumer affairs, rate filings, policy/forms analysis, agents' licensing, legal, and market conduct. It may be necessary to communicate with other state departments if a multi-state domestic society writes a significant amount of business in other states. Additional communciation with the society throughout the year should be reviewed to identify any items or areas that may require special attention during the analysis process. Refer to the introductory chapters for further discussion on internal and external communication.

Procedure #3 directs the analyst to determine if significant changes in the society's organizational structure or management have occured. Changes such as these can have a significant impact on the ongoing operations of the society. While organizational and management changes alone may not indicate a problem, knowledge of these

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changes may help the analyst understand other changes and potential problems, such as a significant growth in premiums written. Additionally, the analyst should verify that Form A or additional filings have been approved.

Procedure #4 requires the analyst to review General Interrogatories, Part 1, #6.1 and #6.2, to determine whether the society had any Certificates of Authority, licenses or registrations (including corporate registration if applicable) suspended or revoked by any governmental entity during the reporting period and investigate the reason(s) for the action(s).

Procedure #5 directs the analyst to identify if there are recent changes in the state's statutes and regulations that could have an impact on the society's financial results or business profile. If so, to the extent that information is available regarding the new statute or regulation, the analyst should determine if the society has complied with any new state statutes and/or regulations that have been enacted during the period.

Procedure #6 requires the analyst to review the most recent rating agency report. In many cases, a rating agency downgrade may have an impact on the society's ability to generate new business or to retain existing business. The significance of the impact of a downgrade is generally dependent upon the type of product sold by the society and the level of the rating given by the agency.

Procedure #7 directs the analyst to review any industry reports, news releases or any emerging issues that have the potential to negatively impact the society. An example might include regulatory or media scrutiny of certain insurance lines of business, whether related to market conduct or financial issues. Another example would be changes in the economic environment that may negatively impact investment returns or result in material capital losses.

Procedure #8 directs the analyst to review the business plan of the society if it is available from recent surveillance activity, such as previous analysis or examinations, and if a review of the business plan is considered necessary based on the society's priority designation and financial condition. If reviewed, the analyst should assess if the plan is consistent with current operations and expectations of projected results. For example, consider if the society is writing more or less premium or different lines of buiness than outlined in the plan. Consider if the plan is consistent with changes in the markets or geographical areas where business is being written, or new licenses obtained to write business. The analyst should assess significant variances in the business plan through review of the plan and/or through communication with the society. If a business plan is not available or current and, based on the analysis performed, the analyst feels it is necessary to request a business plan and recommend further analysis in this area, a procedure exists at the end of Level 1 within the Recommendations for Further Analysis section.

Management Assessment

Procedure #9 assists the analyst in determining if changes in the society's management or board of directors have occurred. Changes such as these can have a significant impact on the ongoing operations of the society and management philosophy. Changes in the board of directors may also indicate changes in the audit committee. When assessing management, the analyst should take into consideration not only the changes in management but also the analyst's and examiner's knowledge about the current management team and any concerns that may exist regarding management. While management changes alone may not indicate a problem, knowledge of these changes may help the analyst understand other potential problems.

With regard to corporate governance, there are many aspects that require consideration, such as: adequate competency; independent and adequate involvement of the board of directors; multiple channels of communication; code of conduct between the board and management; sound strategic and financial objectives; support from relevent business planning; reliable risk management processes; sound principles of conduct; reporting of findings to the board; adoption of Sarbanes-Oxley provisions; and board oversight and approval of executive compensation and performance evaluations.

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The analyst should review the biographical affidavit for any new officers, directors or trustees; follow up on any unusual items or areas of concern; and consider whether changes identified will alter management philosophy. The analyst should pay close attention to responses regarding any suspensions, revocations, or non-approval of licenses, conflicts of interest, civil actions, or criminal violations, and follow up on any areas of concern. Communication with other state insurance departments may be necessary if the officer previously worked for a society domiciled in another state.

Balance Sheet Assessment

Procedure #10 directs the analyst in identifying significant changes in a society's assets, liabilities, and surplus. Significant changes identified in procedure #10 should be explained, to the extent possible. The procedure also assists the analyst in determining if the overall amount of surplus continues to meet Risk-Based Capital (RBC) requirements. RBC creates a minimum standard for surplus. Generally, an analyst should be careful not to extend the use of the RBC beyond its intent. For example, a society with a 600 percent RBC ratio is not necessarily stronger than a society with a 500 percent RBC ratio.

Operations Assessment

Procedure #11 assists the analyst in identifying significant changes in a society's Statement of Income. Shifts in net income could indicate a change in premium earned, a change in benefits incurred, or other more complex issues that require further investigation. For this reason, it is critical that the analyst understand material changes within each income and expense category.

Procedure #12 assists the analyst in identifying unusual results in a society's Cash Flow. During the review of the cash flow statement, the analyst should understand shifts in cash inflows and cash outflows that impact cash from operations. The analyst should also investigate investment acquisitions and dispositions, the society's investment strategies, and the origin of other sources of cash.

Procedure #13 requires the analyst to identify material ceded reinsurance as reported in Schedule S, Part 3–Reinsurance Ceded, and review all General Interrogatories and Notes to Financial Statements pertaining to reinsurance. The analyst should understand the society's reinsurance programs and identify any credit risks. In addition, the analyst should be aware of the types of collateral held for reinsurance with unauthorized reinsurers.

Investment Practices

Procedure #14 assists the analyst in identifying unusual investment management practices of the society. These steps are specifically designed to assist the analyst in determining if the society has the proper control over its investments.

Procedure #15 requires the analyst to review the Summary Investment Schedule to determine if the society uses any unusual methods for valuing its invested assets. The Summary Investment Schedule provides a comparison between the gross investment holdings, as valued in accordance with the *AP&P Manual,* and the admitted assets, as valued in accordance with the state of domicile's basis of accounting. This schedule should be reviewed in conjunction with Note #1 of the Annual Financial Statement, *Summary of Significant Accounting Policies*, Section A.

Procedure #16 requires the analyst to review the Supplemental Investment Risks Interrogatories to determine whether the society's investment portfolio is adequately diversified with the appropriate level of liquidity to meet cash flow requirements.

Procedure #17 assists the analyst in determining the amount of assets held as deposits with the states. These deposits are placed with the states to secure the settlement of the society's obligations to policyholders, claimants and others. Societies with greater than 10 percent of their assets held as deposits with states may hold greater liquidity risk in certain situations.

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Review of Disclosures

Procedure #18 requires the analyst to review the Notes to Financial Statements to assist in identifying any relevent quantitative and qualitative information.

Procedure #19 requires the analyst to review the General Interrogatories to assist in identifying any unusual responses.

Assessment of Latest Examination Report and Results

Procedures #20, #21 and *#22* assist the analyst in gathering specific information related to the society's most recent financial examination. During a review of the examination report, the analyst should note any items or areas that indicate further review is necessary. This might include such things as internal controls issues, risk management, information technology or other issues that could impact the society's priority. The analyst should also review the management letter comments, which may include risks or progress on issues that the analyst should give attention to the current analysis being performed. Effective communication between the analyst and the examination staff can be very important in developing a good understanding of the society's management and financial position. As an example, the examination staff may have specific information on the reliability of the society's financial reporting. In addition, the analyst may want to utilize the Exam Tracking System on I-SITE. The analyst should consider the impact, if any, of the Financial Examination Report findings on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (i.e., complete additional supplemental procedures).

Assessment of Results from Prioritization and Analytical Tools

Procedure #23 requires the analyst to review the IRIS ratio results of the society, which can assist in identifying any unusual financial results.

Unusual IRIS ratios and Annual Scoring ratio results should be explained, to the extent possible, by the analyst. If changes cannot be explained or if certain changes appear to be inconsistent with the analyst's understanding of the society and its operations, additional analysis is suggested.

Procedure #24 requires the analyst to review and understand the assigned Analyst Team System Validated Level, documented within the ATS Report and the ATS Validated Level Report on I-SITE. In addition, the analyst can reference the ATS Procedures Manual and ATS Level Definitions documents on I-SITE. The Analyst Team typically completes the validation process by mid-April.

Procedure #25 requires the analyst to review the Annual Financial Profile Report, which can assist in identifying unusual trends and results.

Procedure #26 alerts the analyst to review communication they have engaged in with the market analysis unit of the Department, including the results of market conduct exams as well as information drawn from the review of market analysis tools available on I-SITE. Market analysis tools available on I-SITE include Market Analysis Profile (MAP), Examination Tracking System (ETS), Market Analysis Review System (MARS), Regulatory Information Retrieval System (RIRS), Special Activities Database (SAD), Market Initiative Tracking System (MITS) and the Complaints Database. Analysts should review any market conduct issues identified by market analysis staff or I-SITE tools and consider the financial implications those issues may have on the society. For example, large fines levied by states, suspensions or revokations of licenses, market conduct exam settlements (whether financial or other), or other regulatory actions taken based on market conduct violations may have a material impact on the financial solvency of the society.

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Assessment of Supplemental Filings

Procedure #28 requires the analyst to review the Statement of Actuarial Opinion to assess the adequacy of the society's reserves. See the Statement of Actuarial Opinion Supplemental Procedures for additional guidance in this area.

Procedure #28 requires the analyst to review the MD&A, which can provide additional information to the analysis of the society. See the MD&A Supplemental Procedures for additional guidance in this area.

Procedure #29 requires the analyst to review the Audited Financial Report, which helps to assess the reliance placed on the validity of the society's financial statements. The Audited Financial Report also contains additional financial information that is generally not included in the Annual Financial Statement and can be helpful to the analyst. See the Audited Financial Report Supplemental Procedures for additional guidance in this area.

Procedure #30 requires the analyst to review the most recent financial statement of the holding company, as filed in the SEC 10-K Report. In addition, the analyst should review Forms A, B, D, E and Extraordinary Dividends/Distributions, if available.

Discussion of Level 1 Quarterly Procedures

The Level 1 Quarterly Procedures are designed to help the analyst perform a general review of the society and its operations. The quarterly procedures are similar to the annual procedures because they are mostly broad-based questions; however, the quarterly procedures include questions that focus primarily on changes from the prior year. At the conclusion of the quarterly Level 1 Procedures, the analyst is asked to do the following: 1) develop and document an overall summary and conclusion regarding the financial condition of the society; 2) determine whether the society be considered a priority company; and 3) indicate whether one or more of the procedures in the Level 2 Quarterly Procedures equivalent to the Life/A&H Handbook should be completed. As with the annual review, the quarterly Level 1 conclusion should be reviewed and revised as necessary when subsequent procedures and follow-up with the society are completed.

Discussion of Non-Routine Analysis

The Handbook contains procedures that assist an analyst in deriving an overall assessment of the society's financial condition; however, situations may exist when it is necessary to perform additional procedures and analysis not contained in the Handbook for one or more society.

On occasion events or situations outside of the normal course of business occur that may have a material impact on the overall financial condition of a society. During these occasions state insurance regulators may need to perform non-routine analysis, which may require additional reporting from a specific society or from a group of societies. A few examples of these occasions may include significant financial events such as material investment defaults, credit market stress, or catastrophic events. Non-routine analysis may also be appropriate and necessary in situations impacting a single society, a group, or a small group of societies. For example, when permitted practices are granted, there may be a need to perform follow-up analysis of the situation requiring the permitted practice, including assessing the realizablity of deferred tax assets. The state may conduct this analysis themselves or enter into an agreed-upon procedures audit with a CPA firm to assist in the assessment and analysis of the projected future deferred tax assets and the impact to surplus.

The following are a few examples of types of non-routine analysis that may be appropriate in an economic downturn, investment defaults, and changes in the credit markets (Note some or all of these may be applicable in other non-market or investment related situations as well).

- Focused analysis on asset quality where societies hold higher amounts of riskier assets. The analyst should not only consider exposure to individual default events but also aggregate exposure. Additional

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review or explanation from the society may be requested when high amounts of other-than-temporary impairments, unrealized losses and/or large variances between book and market value are reported. The analyst should review the value of affiliated investments and assess indirect exposure to economic events that may result in the decline in the affiliated holdings. Analysts may consider other sources of analysis or information to assist in the review of investments. For example, an analyst may consider requesting a Portfolio Analysis Memorandum from the NAIC Securities Valuation Office.

- Analysts should consider the impact of tightened short-term credit markets on societies or groups who have dependency on commercial paper, overnight repos, dollar repos, etc. Another area that could be impacted by changes in credit markets is the society's ability to obtain letters of credit (LOC) provided for XXX (life reserves) or other reinsurance reserves, and the costs of those LOCs for societies dependent on LOCs.

- If the society engages in securities lending, the analyst may consider requesting detailed information about the program to review the types of assets (risk and duration match) within the program, gain an understanding of the structure and terms of the program and, if material, monitor monthly changes in the program.

- Certain insurance products may be impacted more than others in an economic downturn. The analyst should consider the impact to a society that writes a material amount of products that are more likely to be accelerated (e.g. funding agreements, guaranteed interest contract–GICs) or where the liability can be accelerated (e.g., variable annuities, living benefit/death benefit on variable annuities).

- The analyst should consider the level of sensitivity of the society to ratings downgrades and the possible impact on the society or the group. For example, its ability to market new business or the impact of rating downgrades on any debt covenants. If a society is downgraded, the analyst may consider monitoring surrenders, new business sales as well as any changes in the society's business plans.

- Where liquidity is a concern, the analyst may also consider requesting interim reporting from the societies on areas of risk specific to that society. For example, surrender activity, high risk investment exposures, GICs, capital and surplus, available liquidity, available credit facilities and capital losses.

- Where significant concerns exist, the state may consider requesting the society to perform stress testing on the possible future impacts of additional equity losses, defaults, or other areas relevant to the situation.

Examples of types of non-routine analysis that may be appropriate in catastrophic events:

- Implement disaster reporting requests to appropriate societies and monitor claims exposure during future periods following the event
- Identify societies and reinsurers with material exposure
- Implement appropriate procedures to identify fraudulent activities
- Perform an in-depth analysis of liquidity to ensure timely payment of claims
- Engage legal staff to ensure appropriate claims payment practices

Additional Reference Sources

1. *Financial Condition Examiners Handbook*, NAIC

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IV. Annual Procedures

A. Level 1 Annual Procedures

B. Level 2 Annual Procedures

C. Level 3 Procedures

D. Fraternal Level 1

IV. Level 1 Annual Procedures

Background Analysis

1. Review the analysis performed on the insurer for the prior year and prior quarters.
   a. Indicate the state's priority designation or any prioritization tool result as of the last review and start of the current review:

      State's Priority Designation _____
      Scoring System Total _____
      IRIS System Results _____
      Analyst Team System Validated Level _____
      RBC Ratio and Trend Test _____

   b. Were there any issues or concerns noted in previous annual or quarterly analysis completed in the prior year? If "yes," discuss the issues or concerns, the follow-up conducted, and include any correspondence with the insurer, along with any conclusions.
   c. As the domestic regulator, review the Insurer Profile Summary, including the Supervisory Plan, if applicable, and document any areas of concern that impact the current analysis.

2. Review any inter-departmental communication, as well as communication with other state insurance departments and the insurer. Note any unusual items or areas that indicate further review or follow-up is necessary.

3. Review General Interrogatory #5.1 and #5.2. Has the insurer been a party to a merger or consolidation? If yes, review the list of the companies involved in the merger/consolidation, noting any observations. Also, ensure Form A or additional filings have been approved.

4. Review General Interrogatory #6.1 and #6.2. Has the insurer had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? If yes, review the reason(s) stated for the revocation or suspension, noting any observations.

5. Are there any changes in the state's statutes and/or regulations that could impact the insurer's financial position and reporting? If yes, to the extent information is available, has the insurer failed to comply with the state's statutes and regulations enacted during the period?

6. Review the most recent report from a nationally recognized rating agency. Also note the current financial strength and credit rating, and briefly discuss the explanation of the rating or any change in the rating.

7. Review any industry reports, news releases and emerging issues that have the potential to negatively impact the insurer.

8. Review the most recent business plan and financial projections, if available from recent surveillance activity and if considered necessary based on the insurer's priority designation and financial condition.
   a. If significant changes in business plan or philosophy have occurred, assess the insurer's ability to attain the expectations of the business plan.
   b. Are actual results consistent with management's expectations?

Management Assessment

9. Review the Annual Financial Statement Jurat page (page 1).
   a. Did the insurer fail to properly execute and notarize the Jurat page?

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b. Has there been any change(s) in officers, directors or trustees since the previous Annual Financial Statement filing (indicated by a "#" after the name)? If yes, indicate the positions in which the changes have occurred. Review the Biographical Affidavit(s) for any new officers, directors, or trustees indicated above and note any areas of concern that would indicate further review is necessary.

- ☐ President
- ☐ Secretary
- ☐ Treasurer
- ☐ Vice Presidents (number: ____)
- ☐ Directors or Trustees (number: ____)
- ☐ Other

c. Assess any significant corporate governance changes and determine whether these changes appear to indicate a shift in management philosophy, or whether management has made any changes in business culture or business plan.

Balance Sheet Assessment

10. Review the Annual Financial Statement Assets (page 2) and Liabilities, Capital and Surplus and Other Funds (page 3).

a. Is capital and surplus below the statutory minimum capital and surplus required?

b. Is capital and surplus less than 5 percent of total admitted assets excluding separate accounts?

c. Has capital and surplus changed by greater than +/-20 percent from the prior year?

d. Is the RBC ratio (total adjusted capital divided by authorized control level risk-based capital shown in the Annual Financial Statement Five-Year Historical Data) less than or equal to 250 percent?

e. Did the insurer fail the RBC Trend Test?

f. Has there been any change in capital notes compared to the prior year-end? If yes, indicate the current and prior year-end balances and the amount of the change. Also comment on any notes issued, principal or interest paid, or any other changes that have been made and whether any necessary approvals were obtained.

g. Has there been any change in surplus notes compared to the prior year-end? If yes, indicate the current and prior year-end balances and the amount of the change. Also comment on any notes issued, principal or interest paid, or any other changes that have been made and whether any necessary approvals were obtained.

h. Is the amount of any individual non-invested asset category greater than 10 percent of total admitted assets? If yes, indicate the asset category and amount.

i. Has any individual asset category, which is greater than 5 percent of total assets (excluding separate accounts), changed by greater than +/-20 percent from the prior year? If yes, indicate the asset category, current year-end balance and the percentage change from the prior year. The analyst should also consider shifts within individual asset categories, such as between investment-grade and non-investment-grade bonds, and between publicly traded and privately placed securities.

j. Is the amount of any individual liability category, other than aggregate reserves for life policies and contracts, aggregate reserves for accident and health policies and liability for deposit-type contracts, greater than 10 percent of total liabilities (excluding separate accounts)? If yes, indicate the liability category and amount.

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k. Has any individual liability category, which is greater than 5 percent of total liabilities (excluding separate accounts), changed by greater than +/-20 percent from the prior year? If yes, indicate the liability category, current year-end balance and the percentage change from the prior year.

Operations Assessment

11. Review the Annual Financial Statement Summary of Operations (page 4).

    a. If the absolute value of net income (loss) exceeds 5 percent of capital and surplus, has net income (loss) decreased by more than 20 percent or increased by more than 40 percent from the prior year?

    b. Has any individual income or expense category, for which the current or prior year balance exceeded 5 percent of capital and surplus, changed by more than +/-20 percent from the prior year? If yes, indicate the income or expense category, current year-end balance, and the percentage change from the prior year.

    c. Has any individual capital and surplus account category changed by more than +/-10 percent from prior year-end? If yes, indicate the capital and surplus category, current year-end balance change and the percent change from the prior year.

    d. Are net unrealized capital gains/(losses) more than 10 percent of prior year-end capital and surplus?

12. Review the Annual Financial Statement of Cash Flow (page 5). Is net cash from operations negative?

13. Evaluate any material ceded reinsurance as reported in Schedule S, Part 3 - Reinsurance Ceded and review all General Interrogatories and Notes to Financials pertaining to reinsurance and note any areas of concern.

Investment Practices

14. Evaluate the insurer's investment management practices.

    a. Review General Interrogatory #14. Has the purchase or sale of any investments not been approved by the board of directors or a subordinate committee thereof?

    b. Review General Interrogatory #22.1 and #22.2. Were any securities owned, over which the insurer has exclusive control, not in the actual possession of the insurer, except as shown by the Schedule of Special Deposits?

    c. Review General Interrogatory #23.1 and #23.2. Were any assets owned by the insurer not exclusively under the control of the insurer? If yes, indicate the amount at December 31 of current year.

    d. Review General Interrogatory #19.1 and #19.2. Were any assets subject to a contractual obligation to transfer to another party without the liability for such obligation being reported? If yes, indicate the amount at December 31 of the current year.

15. Review the Annual Financial Statement Summary Investment Schedule (page 20). Note any unusual items or areas that indicate further review is warranted.

16. Review the Supplemental Investment Risks Interrogatories. Note any unusual items that would indicate a nondiversified portfolio or inappropriate liquidity.

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IV. Level 1 Annual Procedures

17. Review the Annual Financial Statement Schedule E, Part 3 - Special Deposits. Is the book/adjusted carrying value of total special deposits greater than 10 percent of assets?

Review of Disclosures

18. Review the Annual Financial Statement Notes to Financial Statements (page 19).
    a. Have any notes required per the NAIC's *Annual Statement Instructions for Life and Health Insurance Companies* been omitted?
    b. Provide an explanation for any unusual or significant items noted.

19. Review the Annual Financial Statement General Interrogatories (page 21) and note any unusual responses.

Assessment of Latest Examination Report and Results

20. Review General Interrogatory #3 and determine if a financial examination report was released by the domiciliary state since the last review.
    a. As of what balance sheet date is/was the latest financial examination of the insurer?
    b. As of what balance sheet date is the latest financial examination report available from either the state of domicile or the insurer?
    c. As of what release date is the latest financial examination report available from either the state of domicile or the insurer?
    d. Have any financial statement adjustments within the latest financial examination report not been accounted for in a subsequent financial statement filed with the Department?
    e. Have any of the recommendations within the latest financial examination report not been complied with?

       If yes, or if follow-up was required from the review of the examination report in a previous analysis period, complete the following procedures.

    f. If the answers to 20.d. or 20.e. are yes, follow up with the insurer regarding the implementation of recommendations in the Financial Examination Report.
    g. Assess the current and future impact of any financial statement adjustments on the insurer's financial condition.

21. During the review of the latest state examination report, the results from that examination and communication with the examiner-in-charge (for domestic insurers), did the analyst note any items or areas that indicate further review is warranted?

22. Follow up and document on any management letter comments that should be addressed in the current period, if applicable.

Assessment of Results from Prioritization & Analytical Tools

23. Review the insurer's NAIC Annual Scoring System results.
    a. Indicate the insurer's total annual score.
    b. Provide an explanation on each individual ratio result that received a score of 50 points or more.

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IV. Level 1 Annual Procedures

24. Review the insurer's IRIS ratio results.
    a. Indicate the number of ratio results that fall outside the usual range.
    b. Provide an explanation on each of the ratios that fall outside the usual range.

25. Review and understand the assigned Analyst Team System Validated Level.

26. Review the NAIC Annual Financial Profile Report, and provide an explanation for any unusual or significant fluctuations or trends noted.

27. Review any market conduct information, including information available from the state's market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee), and the NAIC market analysis tools and databases (MAP, ETS, MARS, RIRS, SAD, MITS, and Complaints). The analyst should note any unusual items that translate into financial risks or indicate further review and/or additional communication is needed with the Department's market analysis staff.

Assessment of Supplemental Filings

28. During the review of the Statement of Actuarial Opinion, did the analyst note any unusual items or areas that indicate further review is warranted?

29. During the review of the Management's Discussion and Analysis, did the analyst note any unusual items or areas that indicate further review is warranted (April 1st Filing)?

30. During the review of the Audited Financial Report, did the analyst note any unusual items or areas that indicate further review is warranted (June 1st Filing)?

31. Review the most recent Annual Financial Statement of the insurer's holding company and its subsidiaries and holding company filings (such as Forms A, B, D, E (or Other Required Information) and Extraordinary Dividend/Distribution and SEC forms 10-K and 8-K) if available.
    a. During the review, did the analyst note any new or unusual items or areas of concern that may potentially impact the insurer?
    b. If other insurers within the group exist, note any communication with the domestic state insurance departments for those affiliated insurers.

Recommendation for Further Analysis

Based on the Level 1 procedures performed, do you recommend that the Level 2, 3 or Supplemental Annual Procedures or other procedures listed below be completed? If yes, indicate the sections that you recommend be completed:

A. Perform Level 2 and/or Level 3 Procedures:

All Sections
Investments
Life Reserves
Accident and Health Reserves
Annuity Reserves
Income Statement and Surplus
Risk-Based Capital
Cash Flow and Liquidity

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Reinsurance
Affiliated Transactions
MGAs and TPAs
Separate Accounts

B. Perform Supplemental Procedures:

Annual Audited Financial Reports
Statement of Actuarial Opinion
Management's Discussion and Analysis
Holding Company Analysis
- Form A
- Form B
- Form D
- Form E, (or Other Required Information)
- Extraordinary Dividend/Distribution

C. Request and review the current business plan and financial projections.

i. If significant changes in the business plan or philosophy have occurred, assess the insurer's ability to attain these expectations.

ii. Determine if actual results are tracking with projection and note any significant variances and the reason(s).

Summary and Conclusion

After completion of any Level 2 or subordinate procedures, develop and document an overall summary and conclusion based on the findings. In developing a conclusion, the analyst should consider the above procedures, as well as any other factors that, in the analyst's judgment, are relevant to evaluating the insurer's overall financial condition. The summary and conclusion should include details regarding the insurer's strengths and weaknesses. In addition, update the Insurer Profile Summary, including the Supervisory Plan, if applicable, for the results of the analysis performed.

Do you recommend that the insurer be designated a priority as a result of the procedures performed? If yes, indicate the recommended priority designation and rationale.

Describe the rationale for these recommendations.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

Correspondence

The analyst should document any follow-up regarding the Level 1, 2, 3, and Supplemental Procedures.

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IV.B. Level 2 Annual Procedures

1. Investments
2. Life Reserves
3. Accident and Health Reserves
4. Annuity Reserves
5. Income Statement and Surplus
6. Risk-Based Capital
7. Cash Flow and Liquidity
8. Reinsurance
9. Affiliated Transactions
10. MGAs and TPAs
11. Separate Accounts

IV. Level 2 Annual Procedures – B. 1. Investments

1. Determine whether the insurer's investment portfolio appears to be adequately diversified to avoid any undue concentration of investments by type or issue.
   a. Are the total of industrial and miscellaneous bonds (unaffiliated) and credit tenant loans owned greater than 50 percent of total admitted assets (excluding separate accounts)?
   b. Are multi-class securities owned greater than 20 percent of total admitted assets (excluding separate accounts)?
   c. Are foreign bonds owned greater than 5 percent of total admitted assets (excluding separate accounts)?
   d. Are preferred stocks owned greater than 5 percent of total admitted assets (excluding separate accounts)?
   e. Are common stocks owned greater than 10 percent of total admitted assets (excluding separate accounts)?
   f. Are mortgage loans owned greater than 20 percent of total admitted assets (excluding separate accounts)?
   g. Is real estate owned (before encumbrances), including home office real estate, greater than 10 percent of total admitted assets (excluding separate accounts)?
   h. Are total derivatives greater than 1 percent of total admitted assets (excluding separate accounts)?
   i. Is the counterparty exposure or potential exposure of derivative instruments open greater than 1 percent of total admitted assets (excluding separate accounts)?
   j. Are collateral loans in force greater than 5 percent of total admitted assets (excluding separate accounts)?
   k. Are other invested assets (Schedule BA) greater than 5 percent of total admitted assets (excluding separate accounts)?
   l. Are aggregate write-ins for invested assets greater than 5 percent of total admitted assets (excluding separate accounts)?
   m. Are investments in affiliates greater than 10 percent of total admitted assets (excluding separate accounts)?
   n. Is any one single investment (excluding federal issues and affiliated investments) greater than 3 percent of total admitted assets (excluding separate accounts)?
   o. Has the insurer failed to comply with state specific investment laws, regulations or guidelines for diversity and limitations?

2. Determine whether the board of directors approves all purchases and sales of investments and whether all securities owned are under the control of the insurer and in the insurer's possession.
   a. Review General Interrogatory, Part 1 #14. Has the purchase or sale of any investments not been approved by the board of directors or a subordinate committee thereof?
   b. Review General Interrogatory, Part 1 #22.1. Were any securities owned, over which the insurer has exclusive control, not in the actual possession of the insurer, except as shown by the Schedule of Special Deposits?
   c. Review General Interrogatory, Part 1 #23.1. Were any assets owned by the insurer not exclusively under the control of the insurer?

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d. Review General Interrogatory, Part 1 #19.1. Were there any assets reported subject to a contractual obligation to transfer to another party without the liability for such obligation being reported? If yes, comment on the purpose and the amount.

3. Determine whether securities owned have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office.

   a. Review General Interrogatory for Investments Part 1, #30.

      i. Has the insurer failed to follow the filing requirements of the *Purposes and Procedures Manual* of the NAIC Securities Valuation Office?

      ii. If the answer to 3.a.i is yes, document the exceptions listed in General Interrogatory Part 1, #30.2.

   b. Review Schedule D - Part 1 (Bonds) and Schedule D - Part 2 (Preferred Stocks and Common Stocks). Does it appear that the insurer has failed to comply with the requirement to submit securities that are not filing exempt to the SVO for a valuation (i.e., there are securities which were acquired prior to the current year with a "Z" suffix after the NAIC designation and/or there is a significant number of securities which were acquired during the current year with a "Z" suffix after the NAIC designation)?

4. Determine whether the statement value of bonds and sinking fund preferred stocks is significantly greater than their fair value.

   a. Review General Interrogatory Part 1, #28 (which shows the aggregate statement value and the aggregate fair value of bonds and preferred stocks owned). Is the aggregate excess of the statement value over the fair value of bonds and preferred stocks owned greater than 10 percent of the statement value of bonds and preferred stocks owned?

   b. Is the aggregate excess of the statement value over the fair value of bonds and preferred stocks owned greater than 20 percent of capital and surplus and AVR?

5. Determine whether the fair value of common stock is significantly greater than or less than the cost.

   a. Review Schedule D - Part 2 - Section 2, (Common Stocks). Is the aggregate fair value of common stocks below the actual cost?

      i. If 5.a. is yes, is the difference greater than 10 percent of capital and surplus?

   b. Review Schedule D - Part 2-Section 2, (Common Stocks). Is the aggregate actual cost of common stocks below the fair value?

      i. If 5.b. is yes, is the difference greater than 10 percent of capital and surplus?

   c. If an investment in one issue of common stock exceeds 5 percent of invested assets, does the fair value of the common stock exceed the actual cost by greater than 30 percent or is the fair value less than the actual cost by greater than -20 percent?

6. Determine whether concerns exist due to significant purchases or sales of securities near the beginning and/or end of the year.

   a. Scan Schedule D - Part 3 (Long-Term Bonds and Stocks Acquired During Current Year). Were significant amounts of bonds or stocks purchased near the beginning or the end of the year?

   b. Scan Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year). Were significant amounts of bonds or stocks disposed of near the beginning or the end of the year?

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c. Scan Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year). Were significant amounts of bonds or stocks acquired near the beginning of the year and disposed of near the end of the year?

7. Determine whether concerns exist due to significant turnover of long-term bonds, preferred stocks or common stocks during the year.

   a. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired and Disposed of During Year). Is the long-term bond turnover ratio greater than 50 percent?

   b. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired and Disposed of During Year). Is the stock turnover ratio greater than 50 percent?

   c. Review Schedule D - Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Year) and Schedule D - Part 5 (Long-Term Bonds and Stocks Acquired and Disposed of During Year). Is the total long-term bond and stock turnover ratio greater than 50 percent?

8. Determine whether there are concerns due to the level of investment in non-investment grade bonds.

   a. For non-health insurers, is the weighted ratio of non-investment grade bonds and non-investment grade short-term investments to capital and surplus greater than 25 percent?

   b. If investments in non-investment grade bonds and non-investment grade short term investments currently exceed 3.5 percent of invested assets, have such investments increased by greater than 15 percent over the prior year?

9. Review Schedule D - Part 1A - Section 2 to determine whether there are concerns due to level of investment in multi-class securities.

   a. Is the ratio of all multi-class securities (residential, commercial and other) owned to capital and surplus and AVR greater than 200 percent?

   b. If investments in all multi-class securities currently exceed 15 percent of cash and invested assets, have these investments increased by greater than 20 percent over the prior year?

   c. Is the ratio of multi-class residential mortgage backed securities to cash and invested assets greater than 5 percent?

10. Determine whether there are concerns due to the level of investment in private placement bonds.

    a. Is the ratio of private placement bonds owned to capital and surplus and AVR greater than 100 percent?

    b. If the ratio of investments in private placement bonds to invested assets is greater than 5 percent, have such bonds increased by greater than 15 percent over the prior year?

11. Determine whether there are concerns due to the level or quality of investment in real estate and mortgage loans.

    a. For non-health companies, is the ratio of total real estate and mortgage loans to capital and surplus and AVR greater than 150 percent?

    b. If the ratio of total real estate and mortgage loans to cash and invested assets exceeds 10 percent, have such investments increased by greater than 15 percent over the prior year?

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c. For non-health companies, is the ratio of problem real estate and mortgage loans to capital and surplus and AVR greater than 15 percent?

d. Scan Schedule A - Part 1 (Real Estate Owned). Is real estate owned concentrated in one or a few geographical areas?

e. Review General Interrogatory question #11.1. Does the insurer own any securities of a real estate holding company or otherwise hold real estate indirectly?

f. Scan Schedule B - Part 1 (Mortgage Loans Owned). Are mortgage loans concentrated in one or a few geographical areas?

g. Scan the Assets on page 2. Are there any "other than first liens" included in total admitted mortgage loans?

h. Is the ratio of commercial mortgages to total mortgages greater than 50 percent?

12. Determine whether there are concerns due to the level of investment in other (Schedule BA) invested assets.

a. Is the ratio of Schedule BA assets to capital and surplus and AVR greater than 10 percent?

b. If the ratio of investments in Schedule BA assets to cash and invested assets is greater than 3.5 percent, have such assets increased by greater than 10 percent over the prior year?

13. Determine whether there are concerns due to the level of investment in collateral loans.

a. Is the ratio of collateral loans to capital and surplus and AVR greater than 20 percent?

b. If the ratio of investments in collateral loans to cash and invested assets is greater than 3.5 percent, have such investments increased by greater than 10 percent over the prior year?

14. Determine whether there are concerns due to the level of investment in derivative instruments.

a. Review the Notes to Financial Statements #1 #5, and #8; General Interrogatory #22-24; the write-ins for assets and liabilities; Exhibit of Net Investment Income, line 7; Exhibit of Capital Gains (Losses), line 7; Schedule DB, all parts; the MD&A; and the Audited Financial Report. Is the insurer engaging in derivative activity?

If no, do not proceed with the derivative procedure and skip to the conclusion of the investment section.

b. Determine whether derivative holdings at year-end are significant. Review Schedule DB, Parts A, B, C, D and E, Section 1. Is the total statement value at year-end greater than 5 percent or less than -5 percent of capital and surplus and AVR? If yes, list total statement value and percentage of capital and surplus and AVR for hedging, income generation, other and total derivative transactions.

c. Determine whether derivative activity during the year is significantly greater than holdings at prior year-end.

i. Review Schedule DB - Parts A, C, and D. For each part, is the total cost (original value) of derivatives acquired or opened during the year as reported in Section 2 greater than 150 percent of the cost (original value) of derivatives owned or open at year-end as reported in Section 1?

ii. Review Schedule DB - Part B. Is the consideration received on options, caps, and floors written during the year as reported in Section 2 greater than 150 percent of the

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consideration received for derivatives written and in force at year-end as reported in Section 1?

d. Review the Exhibit of Net Investment Income. Is the ratio of gross derivative investment income (Line 7) to net investment income greater than 2 percent or less than -2 percent?

e. Review the Exhibit of Capital Gains (Losses) on Investments for derivatives.

   i. Is the amount of realized capital loss attributed to derivatives (Line 7) greater than the amount of any gain attributed to derivatives?

   ii. If 14.e.i. above is yes, is the amount of realized capital loss attributed to derivatives (Line 7) greater than 3 percent of capital and surplus and AVR?

f. Review Schedule DB, Parts A, B, C, Section 3, columns 14, 15 & 16, and Part D, Section 3, columns 11, 12 & 13. Is the sum of the aggregate losses greater than 10 percent of capital and surplus and AVR? If yes, list the net gain (loss) (i) amount and (ii) percentage of capital and surplus and AVR for recognized, used to adjust basis, deferred and aggregate gain (loss).

g. Review Schedule DB - Part E, Section 1- Counterparty Exposure for Derivative Instruments Open. Is the ratio of total off balance sheet exposure to capital and surplus and AVR greater than 5 percent?

h. Review the AVR Default Component Calculation to determine the quality of derivative instruments. Is the percentage of derivative instruments reported as medium quality or below (NAIC designation 3 - 6) greater than 20 percent of total derivative instruments?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the insurer's investments under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for investments be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B. 2. Life Reserves

1. Determine whether the insurer's life reserves are valued in accordance with the minimum formula statutory valuation standards.
   a. Review the results of the Actuarial Opinion Procedures. Were any concerns noted regarding the valuation of the insurer's life reserves in accordance with minimum formula statutory valuation standards?
   b. Review Note to Financial Statements #30, Reserves for Life Contracts and Deposit-Type Contracts. Are any unusual items noted regarding the valuation of life reserves?

2. Determine whether any changes in life and annuity reserve valuation bases during the year were proper.
   a. Review Exhibit 5A - Changes in Basis of Valuation during the year. Has there been a weakening of reserves resulting from a change in the basis of valuation during the year which resulted in an increase in capital and surplus greater than 5 percent of current year capital and surplus?
   b. Did changes in life and annuity reserve valuation bases receive appropriate regulatory approval if required?

3. Determine whether the insurer's underlying assets are adequate to support the future obligations of its life insurance policies.
   a. If the insurer filed a statement of actuarial opinion based on an asset adequacy analysis, review the results of the Actuarial Opinion Procedures. Were any concerns noted regarding the adequacy of the insurer's underlying assets to support future life insurance policy obligations?
   b. Is the net interest spread on life reserves (net investment income, less tabular interest, divided by average life reserves) less than 2 percent?
   c. If available, review the Memorandum Executive Summary. Were the responses to the questions satisfactory?
   d. Is the Change in Asset Mix (IRIS Ratio 11) greater than 5 percent?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding life reserves. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst's judgment, are relevant to evaluating life reserves under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for life reserves be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B. 3. Accident and Health Reserves

1. Determine whether an understatement of A&H reserves would be significant.
   a. For non-life insurers, is the ratio of gross A&H reserves to capital and surplus greater than 300 percent?
   b. Is the ratio of net A&H reserves to capital and surplus greater than 150 percent?
2. Determine whether A&H policies appear to have been adequately reserved.
   a. Review the results of the Actuarial Opinion Procedures. Were any concerns noted regarding the valuation of the insurer's A&H reserves in accordance with minimum statutory valuation standards?
   b. For non-life insurers, is the ratio of A&H reserve deficiency greater than 5 percent?
   c. Review the Schedule H claims test. Has there been an adverse trend or unusual fluctuation of one year A&H loss development during the last five years?
   d. Has there been a significant point change in the A&H loss ratio from the prior year (+/- 20 points)?
   e. Review Exhibit 5A - Changes in Basis of Valuation during the year. Has there been a weakening of reserves resulting from a change in the basis of valuation during the year that resulted in an increase in capital and surplus greater than 5 percent of current year capital and surplus?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding A&H reserves. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating A&H reserves under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for A&H reserves be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B. 4. Annuity Reserves

1. Determine whether the insurer's annuity reserves are valued in accordance with the minimum formula statutory valuation standards.
   a. Review the results of the Actuarial Opinion Supplemental Procedures. Were any concerns noted regarding the valuation of the insurer's annuity reserves in accordance with minimum formula statutory valuation standards?
   b. Is the change in individual annuity reserves for the year as a percent of individual annuity premiums (plus annuity investment income less annuity benefits and other fund withdrawals) greater than 120 percent or less than 50 percent?
   c. Is the change in group annuity reserves as a percent of group annuity premiums (plus annuity investment income less annuity benefits and other fund withdrawals) greater than 120 percent or less than 50 percent?
   d. Review Note to Financial Statements #30, Reserves for Life Contracts and Deposit-Type Contracts. Are any unusual items noted regarding the valuation of annuity reserves (surrender values promised in excess of the reserve, significant changes in components of reserves, etc.)?
2. Determine whether any changes in life and annuity reserve valuation bases during the year were proper.
   a. Review Exhibit 5A - Changes in Basis of Valuation during the year. Has there been a weakening of reserves resulting from a change in the basis of valuation during the year that resulted in an increase in capital and surplus greater than 5 percent of current year capital and surplus?
   b. Did changes in life and annuity reserve valuation basis receive appropriate regulatory approval if required?
3. Determine whether the insurer's underlying assets are adequate to support the future obligations of its annuity policies.
   a. If the insurer filed a statement of actuarial opinion based on an asset adequacy analysis, review the results of the Actuarial Opinion Supplemental Procedures. Were any concerns noted regarding the adequacy of the insurer's underlying assets to support future annuity policy obligations?
   b. Is the net interest spread (net investment income, less tabular interest, divided by average annuity reserves) on individual annuity reserves less than 0.5 percent?
   c. Is the net interest spread (net investment income, less tabular interest, divided by average annuity reserves) on group annuity reserves less than 0.25 percent?
   d. If available, review the Memorandum Executive Summary. Were the responses to the questions satisfactory?
   e. Is the Change in Asset Mix (IRIS Ratio 11) greater than 5 percent?
4. Determine whether any other concerns exist regarding the insurer's annuity reserves.
   a. Are guaranteed interest contracts greater than 25 percent of capital and surplus?
   b. Are annuity benefits, surrenders and other fund withdrawals for individual and group annuities greater than 50 percent of capital and surplus?
   c. Did annuity benefits, surrenders and other fund withdrawals for individual and group annuities and deposits, as a percent of premiums, change by greater than +/- 25 points from the prior year?
   d. Review Note to Financial Statements #31, Analysis of Annuity Actuarial Reserves and Deposit Liabilities. Are significant amounts subject to withdrawal without any surrender charge or market

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value adjustment; (i.e., amounts greater than 5 percent of capital and surplus)? If yes, list amount and percentage of total annuity reserves and deposit liabilities.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding annuity reserves. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating annuity reserves under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for annuity reserves be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B. 5. Income Statement and Surplus

1. Determine whether concerns exist regarding the insurer's income statement or operating performance.
   a. Is the ratio of Net Income to Total Income (Including Realized Capital Gains and Losses) (IRIS Ratio 3) less than or equal to zero?
   b. Is the ratio of Net Income to Total Income (Before Realized Capital Gains and Losses) less than zero?
   c. When the absolute value of the change in net income exceeds 3 percent of capital and surplus, is the ratio of change in net income less than -30 percent?
   d. Review net income in the Annual Financial Profile Reports. Has there been a net loss in two or more of the last three years?
   e. Is the ratio of return on capital and surplus less than 5 percent or greater than 20 percent?
   f. For non-health insurers, is the ratio of surrenders to net premiums greater than 30 percent?
   g. For non-health insurers, if group annuity surrenders exceed 20 percent of total surrenders, is the ratio of group surrenders to net group premiums in group annuities greater than 50 percent?
   h. For non-life insurers, is the ratio of commissions and administrative expenses to gross premiums greater than 30 percent?
   i Does the company's A&H loss ratio exceed 85 percent?
   j. Is the ratio of investment income to cash and invested assets greater than 10 percent or less than 4.5 percent?
   k. Is the ratio of Adequacy of Investment Income (IRIS Ratio 4) less than 125 percent?
   l. If the absolute value of net realized capital gains or losses exceeds 3 percent of capital and surplus, is the ratio of net realized capital gains to net income greater than +/- 25 percent?
   m. Review the Summary of Operations in the Annual Financial Statement.
      i. If aggregate write-ins for miscellaneous income exceed 3 percent of capital and surplus, is the ratio of aggregate write-ins for miscellaneous income to net income greater than +/- 25 percent?
      ii. If aggregate write-ins for deductions exceed 3 percent of capital and surplus, is the ratio of aggregate write-ins for deductions to net income greater than +/- 25 percent?

2. Determine whether concerns exist regarding changes in the volume of premiums written and deposit type funds or changes in the insurer's mix of business (lines of business written and/or geographic location of premiums written).
   a. Is the ratio of change in net premiums, annuity considerations and deposit-type funds greater than +/-30 percent?
   b. For non-health insurers, is the ratio of change in direct and assumed annuities and deposit-type funds greater than +/- 50 percent?
   c. Is the ratio of Change in Product Mix (IRIS Ratio 10) greater than 5 percent?
   d. Review the Direct Premium Written by State.
      i. Has there been a significant change (+/-50 percent) in direct premiums written in any one state in which current or prior year direct premium exceeds 10 percent of total direct premium?

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ii. Are premiums being written in any new state where that state's premiums exceed 10 percent of total direct premiums written?

3. Determine whether the insurer may be excessively leveraged due to its volume of accident and health (A&H) business.

   a. Is the ratio of A&H business to net premiums, & annuity considerations greater than 75 percent?

   b. If the response to a. above is yes, is the ratio of gross A&H premiums to capital and surplus greater than 500 percent?

   c. If the response to a. above is yes, is the ratio of net A&H premiums to capital and surplus greater than 300 percent?

4. Review the Annual Statement Medicare Part D Coverage Supplement.

   a. Did the insurer report an underwriting loss of either group or individual coverage?

   b. Did the insurer report a medical loss ratio greater than 85 percent on either group or individual coverage?

   c. Did the insurer report an expense loss ratio greater than 15 percent on either group or individual coverage?

   d. Did the insurer report a combined ratio greater than 100 percent on either group or individual coverage?

5. Determine whether concerns exist regarding the amount of the insurer's capital and surplus.

   a. Review the Five-Year Historical Data in the Annual Financial Statement. Is the ratio of Total Adjusted Capital to Authorized Control Level Risk-Based Capital less than 250 percent?

   b. Is the ratio of capital and surplus and AVR to total assets (excluding separate accounts) less than 7 percent?

   c. Is the ratio of Net Change in Capital and Surplus (IRIS Ratio 1) greater than 50 percent or less than -10 percent?

   d. Is the ratio of Gross Change in Capital and Surplus (IRIS Ratio 2) greater than 50 percent or less than -10 percent?

   e. Review the Five-Year Historical Data in the Annual Financial Statement. Is the current year-end capital and surplus position of the company 10 percent less than the ending balance for any of the prior four years?

   f. Did the insurer declare dividends to stockholders during the year?

      i. If the answer to 5.f. above is yes, was the amount of the stockholder dividend at a level that required prior regulatory approval or notification?

      ii. If the answer to 5.f.i. above is yes, did the insurer fail to obtain proper prior regulatory approvals?

   g. Is the ratio of capital and/or surplus notes to capital and surplus greater than 10 percent?

   h. Are write-ins for special surplus funds and/or write-ins for other than surplus funds greater than 10 percent of capital and surplus?

   i. Does the absolute value of the current year change exceed 3 percent of current year capital and surplus for any of the following items: 1) net unrealized capital gains/losses, 2) foreign exchange

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capital gains/losses, 3) net deferred taxes, 4) nonadmitted assets, 5) the liability for unauthorized reinsurance, 6) reserve valuation basis, 7) AVR, 8) surplus notes, or 9) change in accounting principle?

j. Review footnote (h) in the Exhibit of Net Investment Income. Did the insurer report interest expense on capital or surplus notes during the year?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the insurer's income statement and surplus. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the insurer's income statement and surplus under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for the income statement and surplus be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B. 6. Risk-Based Capital

1. Determine whether concerns exist regarding the insurer's Risk-Based Capital (RBC) position.
   a. Review the Annual Financial Statement, Five-Year Historical Data Schedule, RBC Analysis and/or the RBC filing, and consider the following:
      i. Is the ratio of Total Adjusted Capital divided by Authorized Control Level (RBC Ratio) less than or equal to 250 percent?
      ii. If the current RBC Ratio is less than or equal to 300 percent, has there been a significant change (+30 points/-20 points) in the RBC Ratio from the prior year?
      iii. Has the RBC Ratio declined each of the past two years? If yes, show the percentage point decline over the two years and the current-year RBC Ratio.
      iv. Has the Total Adjusted Capital declined by 15 percent or greater from the prior year?
      v. Has the Authorized Control Level increased by 15 percent or greater from the prior year? If yes, review the five RBC risk factors for material changes from the prior year and document the leading underlying causes for the changes.
2. Did the insurer fail the RBC trend test? If yes, discuss the plans to address the RBC Trend Test failure.
3. If the insurer has triggered an action level RBC event and if authorized by statute:
   a. Obtain and review a copy of the insurer's RBC plan, if authorized by statute.
   b. Monitor the insurer's RBC plan and overall progress in implementing plan initiatives and improving the RBC level.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding RBC. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating RBC.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B. 7. Cash Flow and Liquidity

1. Determine whether concerns exist regarding the insurer's cash flow from operations. Review the Statement of Cash Flow.

    a. Is net cash from operations negative? If yes, calculate:

        i. Net cash from operations to premium income.

        ii. Net cash from operations to capital and surplus.

    b. Review the trend in cash flow from operations for the past five years and note any unusual fluctuations or negative trends between years.

    c. Are net transfers to or from separate accounts greater than 20 percent of capital and surplus?

    d. Has the line item other cash provided (applied) changed by greater than +/- 10 percent of capital and surplus?

    e. Is the line item other cash provided (applied) greater than 10 percent of capital and surplus?

    f. Is the line item other cash provided (applied) greater than +/- 150 percent of net cash from operations?

    Additional procedures that may be considered if further concerns exist:

    g. Review the trend in line items within cash flow for the past five years and note any unusual fluctuations or negative trends between years.

    h. Review the trend in net transfers to or from separate accounts for the past five years for unusual fluctuations such as:

        i. Significant reliance on cash provided from separate accounts.

        ii. Significant trends in providing cash to separate accounts.

    i. Compare cash flow from operations with the industry and peer group (Peer Financial Report) in order to identify significant deviations.

2. Review Schedule E Part 3 and determine whether concerns exist regarding the insurer's special deposits.

    a. Is the book adjusted carrying value of all other special deposits, (not for the benefit of all policyholders), greater than 50 percent of total special deposits?

    b. Is the difference between the book adjusted carrying value of total special deposits to the fair value of total special deposits greater than 5 percent?

    Additional procedures that may be considered if further concerns exist:

    c. Review the listing of special deposits held by the insurer not for the benefit of all policyholders and consider:

        i. The number of states in which the insurer has these types of deposits. The greater the number, the more difficult it may be for the domiciliary state to call on these deposits in a rehabilitation.

        ii. The amount of concentration in any one particular state.

    d. Contact the domiciliary state or perform research to determine if any of the states have restrictions on the ability of those deposits to be called by the domiciliary state during a rehabilitation.

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3. Determine whether concerns exist regarding the insurer's overall level of liquidity.

   a. Is the change in liquid assets less than negative 15 percent or greater than 80 percent?

   b. Is the ratio of surrender benefits and withdrawals on deposit-type contracts to net premiums and deposits on deposit-type contracts greater than 50 percent?

   c. Are surrender benefits and withdrawals on deposit-type contracts greater than 20 percent of capital and surplus?

   Additional procedures that may be considered if further concerns exist:

   d. Compare the insurer's cash flow and liquidity results to industry and peers in the Peer Financial Profile in order to identify significant deviations.

   e. Review Schedule D – Part 1 and determine the extent to which the fair value of bonds varies from the amortized cost (B.1. Investments procedure #5) and assess the impact of such variance on the insurer's overall liquidity.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding cash flow and liquidity. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst's judgment, are relevant to evaluating cash flow and liquidity under the specific circumstances involved.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B. 8. Reinsurance

1. Determine whether the insurer's accounting treatment for reinsurance is proper and in accordance with the Annual Financial Statement Instructions.
   a. Briefly scan the individual reinsurers listed in Schedule S - Part 3 - Section 1 (Life and Annuities) and Schedule S - Part 3 - Section 2 (Accident and Health). Do any of the reinsurers classified as authorized appear to be improperly classified as such?
   b. Review Schedule S - Part 4. Is the liability for reinsurance in unauthorized companies to the sum of reserve credits taken, paid and unpaid losses and other debits greater than 25 percent?
   c. Review Schedule S - Part 4 (Reinsurance in Unauthorized Companies). Are there any concerns about the appropriateness of reinsurance credits taken?
   d. Are there any concerns in the Statement of Actuarial Opinion regarding the insurer failing to properly establish a reserve relating to reinsurance assumed from another reinsurer for accident and health?
   e. Briefly scan the Annual Financial Statement pages relating to Assets; Liabilities, Surplus and Other Funds; and Summary of Operations. Are any unusual items noted relating to write-ins or significant changes or inconsistencies from prior years regarding reinsurance activities?

2. Determine whether amounts recoverable (both paid and unpaid losses on claims and reserve credits) or amounts receivable from reinsurers are significant and collectible.
   a. Are reinsurance amounts recoverable on paid and unpaid losses on claims greater than 10 percent of surplus?
   b. Are reserve credits (Life, Accident and Health, and Annuities) greater than 25 percent of surplus?
   c. Review Schedule S - Part 3 - Section 1 (Life and Annuities) and Schedule S - Part 3 - Section 2 (Accident and Health). Are any unusual items noted regarding the types of reinsurance and their relative significance, or the specific reinsurers involved?
   d. Are other amounts receivable under reinsurance contracts greater than 10 percent of capital and surplus?

3. Determine whether reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another.
   a. Review Schedule S - Part 1 - Section 1 (Life and Annuities) and Schedule S - Part 1 - Section 2 (Accident and Health).
      i. Are assumed premiums from affiliates to gross premiums greater than 25 percent?
      ii. Is there a significant change in the above ratio from the prior year (+/- 25 percent) or over the past five years (+/- 50 percent)?
   b. Review Schedule S - Part 3 - Section 1 (Life and Annuities) and Schedule S - Part 3 - Section 2 (Accident and Health).
      i. Are affiliated ceded premiums written greater than 25 percent of gross premiums written?
      ii. Is there a significant change in the above ratio from the prior year (+/- 25 percent) or over the past five years (+/- 50 percent)?
   c. Review Schedule S - Part 2 (Amounts Recoverable on Paid and Unpaid Losses for Claims), Schedule S - Part 3 - Section 1 (Life and Annuities) and Schedule S - Part 3 - Section 2 (Accident and Health). Are reinsurance recoverables from affiliates to capital and surplus greater than 15 percent?

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d. Is there a significant increase in the above ratio from the prior year, 15 percent, or over the past five years, 25 percent?

e. Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10 percent or controlled, either directly or indirectly, by the insurer or any representative, officer, trustee, or director of the insurer (Notes to Financials - Note 22A, Ceded Reinsurance Report - Section 1 - General Interrogatory Part 1)? If the answer is yes, proceed with the following questions, otherwise, proceed to procedure #3f.

i. Review Schedule S - Part 2. Are any unusual items noted regarding the nature or magnitude of non-affiliated relationships?

ii. Review Schedule S - Part 3 - Section 1. Are any unusual items noted regarding the nature or magnitude of non-affiliated relationships?

iii. Review Schedule S - Part 3 - Section 2. Are any unusual items noted regarding the nature or magnitude of non-affiliated relationships?

f. 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 Financials - Note 22A, Ceded Reinsurance Report - Section 1 - General Interrogatory Part 2)?

4. Determine whether reinsurance is being used for fronting purposes and, if so, whether any potential abuses exist.

a. Is the ratio of ceded premiums written to gross premiums written greater than 50 percent?

b. Is the ratio of ceded premiums to gross premiums for any significant line of business (defined as a line of business where gross premium is greater than 25 percent of total gross premiums) greater than 50 percent?

5. Determine whether any significant and/or unusual reinsurance intermediary or reinsurance assumed agreements exist.

a. Is the ratio of assumed premiums written to gross premiums written greater than 50 percent?

b. Is the ratio of 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 percent of total gross premiums) greater than 50 percent?

c. Does any agent, general agent, or broker control a substantial part of new or renewal business (General Interrogatories # 4.11 & 4.12)?

6. Determine whether any significant and/or unusual reinsurance transactions were completed during the year.

a. Did the insurer enter into any assumption reinsurance agreements whereby the responsibility for the insurer's policyholder obligations passes to an assuming insurer?

b. Is Surplus Relief to Surplus (IRIS Ratio 8) greater than 10 percent?

c. Briefly scan the individual reinsurers listed in Schedule S - Part 4. Are there any unusual items noted such as significant amounts of reinsurance with alien or "off-shore" reinsurers?

d. Are there any concerns expressed in the actuarial opinion relating to surplus relief reinsurance?

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e. Did the insurer report during the year, in accordance with the Disclosure of Material Transaction Model Act, any material nonrenewals, cancellations, or revisions of ceded reinsurance agreements?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding reinsurance. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating reinsurance under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for reinsurance be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B. 9. Affiliated Transactions

1. Determine whether the insurer is a member of a holding company group and, if so, whether the corporate structure, or any changes in the corporate structure, elevate concerns about affiliated transactions.

   a. Review General Interrogatory Part 1 #1.1

      i. Is the insurer a member of an insurance holding company system consisting of two or more affiliates, one or more of which is an insurer? If yes, what is the name of the ultimate controlling person or entity as reported on the holding company system registration statement?

      ii. Is the answer for 1.a.i above different from the prior year?

      iii. Review Schedule Y, Part 1 and Part 2, along with the General Interrogatories and Notes to Financial Statements. Is there any information noted that contradicts the response in 1.a.i. above?

      iv. Is the company required to file a holding company registration statement with the Department statement?

If 1.a.i.-1.a.iv. are all "no," do not proceed with the remaining Affiliated Transactions procedures and skip to the next financial analysis procedure.

   b. Review General Interrogatory Part 1 #1.2. Did the insurer fail to file a registration statement in accordance with the Model Insurance Holding Company System Regulatory Act?

   c. Review Schedule Y - Information Concerning Activities of Insurer Members of the Holding Company Group, Part 1 - Organizational Chart for the current and the prior year.

      i. Were there any significant changes to the corporate structure during the year (i.e., acquisitions, divestitures, and mergers)?

      ii. If the answer to 1.c.i above is yes, and the change involved ownership of the insurer or a transaction with an affiliate, did the insurer fail to receive proper regulatory approvals?

      iii. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company?

      iv. Does the insurer have an agency or brokerage subsidiary?

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

   a. Review Schedule Y - Information Concerning Activities of Insurer Members of the Holding Company Group, Part 2 - Summary of Insurer's Transactions with Any Affiliates.

      i. Are any unusual items noted, such as significant new affiliated transactions from the prior year, or significant increases in transaction amounts?

      ii. On a selected basis, review Schedule Y - Part 2 for other affiliates. Does it appear that a different schedule is included for the other affiliates?

      iii. Has the insurer forwarded funds greater than 15 percent of the insurer's surplus to any one affiliate?

      iv. Were management fees paid to affiliates, as identified in footnotes to Exhibit 2, greater than 15 percent of the total incurred general expenses reported in Exhibit 2?

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b. Review Note to Financial Statements #10, Information Concerning Parent, Subsidiaries and Affiliates.

i. Were any unusual items noted, such as significant new affiliated transactions from the prior year, or significant increases in transaction amounts?

ii. Do any transactions described appear to conflict with the transactions disclosed in Schedule Y, Part 2?

iii. Are any transactions disclosed with an affiliate that is not listed on Schedule Y, Part 1?

iv. Do affiliated business ventures resulting in a contingent liability to the insurer involve financial exposure greater than 25 percent of surplus?

v. Review the description of management and services agreements. Is an allocation basis involved other than one designed to estimate actual cost?

vi. Was the amount of the shareholder dividend at a level that required prior regulatory approval or notification?

vii. If the response to 2.b.vi. above is yes, did the insurer fail to obtain proper prior regulatory approvals?

viii. Does the amount of the dividend differ from the amount reflected on the Statement of Cash Flow?

c. Review Note to Financial Statements #13, Capital and Surplus and Shareholder's Dividend Restrictions and Quasi-Reorganizations. Are any unusual items noted?

3. Determine whether investments in affiliates are significant.

a. Is the total of all investments in affiliates (Five-Year Historical Data) greater than 20 percent of capital and surplus?

b. Has the total of all investments in affiliates changed by greater than +/- 20 percent from the prior year-end?

c. Has there been any change in any category of affiliated investments greater than +/- 10 percent from the prior year-end?

d. Are affiliated investments in violation of state statutes?

4. Determine whether investments in affiliates are properly valued in accordance with statutory accounting practices.

a. If investments in common stocks of parents, subsidiaries and affiliates involve publicly traded securities, is the investment valued on a basis other than market valuation?

b. If investments in Common Stocks of Parents, Subsidiaries and Affiliates do not involve publicly traded securities, is the investment valued on a basis other than the Statutory Equity of GAAP Equity methods?

5. Determine whether other affiliated transactions are legitimate and properly accounted for.

a. Review the balance sheet asset receivable from parent, subsidiaries and affiliates, as well as the liability payable to parent, subsidiaries and affiliates. Are either of these items greater than 10 percent of capital and surplus?

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b. Review Schedule E.

   i. Were any open depositories a parent, subsidiary or affiliate?

   ii. Based upon a review of the holding company financial statements, are there any holding company lenders that appear as open depositories of the insurer?

c. Review Note to Financial Statements #9, Income Taxes.

   i. Is the insurer included in a consolidated federal income tax return?

   ii. If the answer to 5.c.i is yes, are there any concerns about the manner in which federal income taxes are allocated to the insurer?

   iii. Are Federal Income Tax Recoverables greater than 5 percent of capital and surplus?

      a) If the answer to 5.c.iii above is yes, are Federal Income Tax Recoverables due from an affiliate?

d. Review General Interrogatory Part1, #7.1. Does any foreign entity control 10 percent or more of the insurer, either directly or indirectly, through a holding company?

   i. If the response to 5.d. above is yes, did the insurer fail to properly disclose the investment on Schedule Y, Part 1?

e. Review General Interrogatory Part 1, #18.1 and #18.2.

   i. Was the total amount loaned during the year to directors, other officers or stockholders greater than 10 percent of statutory net income?

   ii. Was the total amount of loans outstanding at the end of the year to directors or stockholders greater than 5 percent capital and of surplus?

f. Review General Interrogatory #16. Has the insurer failed to establish a conflict of interest disclosure policy?

g. Is there any evidence that activities of directors, officers or shareholders were in violation of state statutes?

h. Review Schedule SIS, Stockholder Information Supplement. Are any unusual items noted regarding transactions with, or compensation to, directors and officers?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding affiliated transactions. In developing a conclusion, the analyst should consider all procedures, including the ones above that are relevant to evaluating affiliated transactions under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for affiliated transactions be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B. 10. MGAs and TPAs

1. Determine whether concerns exist due to a significant amount of the insurer's direct premiums being written through Managing General Agents (MGAs) and Third Party Administrators (TPAs).

   a. Review General Interrogatories #4.1 & 4.2. Did any agent, general agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the insurer) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of either the sale of new business or renewals?

   b. Review Note to Financial Statements #19 - Direct Premiums Written produced by Managing General Agents/Third Party Administrators. Was the aggregate amount of direct premiums written through MGAs and TPAs greater than 10 percent of total direct premiums written?

Summary and Conclusion

Develop and document a summary and conclusion regarding whether concerns exist due to a significant amount of the insurer's direct premiums being written through MGAs and TPAs. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the insurer's use of MGAs and TPAs under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for MGAs and TPAs be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV. Level 2 Annual Procedures – B. 11. Separate Accounts

1. Determine whether the insurer maintains Separate Accounts.
   a. Review General Interrogatory Part 2 #3.1. Does the insurer have separate accounts?
   b. Review the balance sheet asset and liability items relating to separate accounts business. Are there balances in either of these categories?

If the answers to both 1.a and 1.b above are "no," do not proceed with the Separate Accounts procedures and skip to the next financial analysis topic.

2. Determine whether separate account assets are backing products having guaranteed features that may create a contingent liability to the general account of the insurer.
   a. Review Note to Financial Statements #33A, Separate Accounts.
      i. Do any of the separate accounts have guarantees that are designed to mirror an established index?
      ii. Do any of the separate accounts have non-indexed guarantees greater than 4 percent?
   b. Review the results of the Actuarial Opinion Supplemental Procedures.
      i. Was there any indication of contingent liabilities created by the separate accounts for the general account?
      ii. Were separate accounts assets and liabilities subject to asset adequacy analysis?
      iii. If the response to b.ii. above is no, did the actuarial opinion explain why?
   c. Based upon an overall understanding of the insurer's separate accounts products, is there evidence that such products may be creating contingent liabilities to the general account with product features such as minimum guaranteed death benefits, minimum guaranteed interest rates, etc.?

3. Determine whether the accounting for activity between the general account and the separate accounts is proper.
   a. Is the portion of capital and surplus funds of the company covered by assets in the Separate Accounts Financial Statement greater than 5 percent of capital and surplus?
   b. Review General Interrogatory Part 2 #3.3. Is the portion of such capital and surplus <u>not</u> distributable from the Separate Accounts to the general account for use by the general account greater than 5 percent?
   c. Compare the amounts recorded on page 4, line 20 of the Separate Accounts Financial Statement, contributed surplus, to page 4, line 46 of the General Account Financial Statement, surplus (contributed to) withdrawn from separate accounts during period. Do the amounts fail to reconcile?
   d. Are other changes in surplus in the Separate Accounts Financial Statement greater than 5 percent of capital and surplus?
   e. Review the Notes To Financial Statement #33B, Separate Accounts.
      i. Do the amounts transferred between the general accounts and separate accounts statements reconcile?
      ii. Are any reconciling adjustments noted?
      iii. Is the net amount of all reconciling items greater than 10 percent of statutory net income?

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IV. Level 2 Annual Procedures – B. 11. Separate Accounts

Summary and Conclusion

Develop and document an overall summary and conclusion regarding separate accounts. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the insurer's separate accounts under the circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for separate accounts be completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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IV.C. Level 3 Procedures

1. Investments
2. Life Reserves
3. Accident and Health Reserves
4. Annuity Reserves
5. Income Statement and Surplus
6. Reinsurance
7. Affiliated Transactions
8. MGAs and TPAs
9. Separate Accounts

IV. Level 3 Procedures – C. 1. Investments

1. If there are concerns regarding whether the insurer's investment portfolio is adequately diversified to avoid an undue concentration of investments by type or issue (Level 2 Annual Procedure #1), consider performing one or more of the following procedures:

   a. Determine whether the insurer's investment portfolio is in compliance with the investment limitations and diversification requirements per the state's insurance laws.

   b. Review the Percentage Distribution of Total Assets in the Annual Financial Profile Report for significant shifts in the mix of investments owned during the past five years.

   c. Compare the insurer's distribution of invested assets per the Percentage Distribution of Total Assets in the Annual Financial Profile Report to industry averages to determine any significant deviations from the industry averages.

   d. Request a copy of the insurer's investment plan which 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 which are appropriate for the insurer based on the types of business written and its liquidity and cash flow needs.

      ii. Determine whether the insurer appears to be adhering to the investment plan.

   e. Review the maturity distribution of bonds in Schedule D – Part 1A – Section 1 (Quality and Maturity Distribution of all Bonds Owned) and consider the liquidity of the insurer's investments to determine whether the insurer's investment portfolio appears reasonable based on the types of business written.

   f. If the insurer's investments include a significant amount of foreign bonds, consider the insurer's potential foreign currency exposure from holding bonds denominated in a foreign currency.

   g. If there are concerns regarding liquidity or cash flows, review the Statement of Actuarial Opinion for comments regarding cash-flow testing performed and the results obtained. (See Procedure B in the Statement of Actuarial Opinion Supplemental Procedures.)

2. If there are concerns regarding investment approval or control and possession (Level 2 Annual Procedure #2), consider performing one or more of the following procedures:

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

   b. If the insurer has securities under its exclusive control which are not in its actual possession, review General Interrogatory #22.1 and 22.2 to determine the reason the securities are not in the insurer's possession, who holds the securities and whether they qualify as admitted assets of the insurer.

   c. If the insurer owns assets which are not under its exclusive control, review General Interrogatory #23.1, 23.2, and 23.3 to determine the reason the assets are not under the insurer's exclusive control, who holds the assets and whether they qualify as admitted assets of the insurer.

3. If there are concerns regarding whether securities have been valued in accordance with the standards promulgated by the NAIC Securities Valuations Office (Level 2 Annual Procedure #3), consider performing one or more of the following procedures:

   a. Review Schedule D – Part 1 (Bonds) to determine whether all bonds with an NAIC designation of 6 (bonds in or near default) have been valued at lower of amortized cost or fair value and all other bonds have been valued at their amortized cost.

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b. Review Schedule D – Part 2 (Preferred Stocks and Common Stocks) to determine whether redeemable preferred stocks have been valued at their cost and all other stocks have been valued at their fair value.

c. If securities are listed in Schedule D – Part 1 (Bonds) or Schedule D – Part 2 (Preferred Stocks and Common Stocks) with a "Z" suffix after the NAIC designation:

i. Request verification from the insurer that the securities, if not filing exempt, have been submitted to, and subsequently valued by, the SVO.

ii. If the securities do not qualify as filing exempt, compare the price or designation actually received from the SVO to that included in the Annual Financial Statement for significant securities.

d. For each of the securities listed in Schedule D – Part 1 (Bonds), Schedule D – Part 2 (Preferred Stocks and Common Stocks) and Schedule DA (Short-Term Investments), compare the CUSIP number, NAIC designation and fair value included in the Annual Financial Statement to information on the VOS master file using Examination Jumpstart investment analysis and contact the insurer to follow up on any exceptions noted.

4. If there are concerns regarding the significance of any excess of the statement value over the fair value of bonds and redeemable preferred stocks owned (Level 2 Annual Procedure #4), consider performing one or more of the following procedures:

a. Review Schedule D – Part 1 (Bonds) and Schedule D – Part 2 (Preferred Stocks and Common Stocks) or request additional information from the insurer to determine which individual securities have a book/adjusted carrying value significantly in excess of their fair value. For those securities:

i. Verify the NAIC designation assigned and, if not filing exempt, determine whether it has been updated recently by the SVO.

ii. If filing exempt, determine the current rating by a recognized rating agency (Moody, Standard and Poors, or Fitch Investors Service).

iii. Determine whether there has been an other than temporary decline in fair value.

b. Request information from the insurer regarding investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of their fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

5. If there are concerns regarding the significance of any excess of the cost over the fair value of common stocks owned (Level 2 Annual Procedure #5), consider performing one or more of the following procedures:

a. Review Schedule D – Part 2 – Section 2 (Common Stocks) or request additional information from the insurer to determine which individual common stocks have a cost significantly in excess of their fair value. For those securities:

i. If the stock is listed on a market or an exchange (designated by the symbol L or U) such as the New York Stock Exchange, the American Stock Exchange, the NASDAQ National Market System, or a foreign exchange, verify the price and total market value.

ii. If the stock is designated A, analytically determined by the SVO, determine whether it has been updated recently by the SVO.

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iii. Determine whether there has been an other than temporary decline in the fair value of the common stock.

b. Request information from the insurer regarding investment strategies and short-term cash flow needs to determine whether common stock with a cost that is significantly in excess of fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

6. If there are concerns regarding significant purchases or sales of securities near the beginning and/or the end of the year (Level 2 Annual Procedure #6), consider performing one or more of the following procedures:

a. Review Schedule D – Part 3 (Long-Term Bonds and Stocks Acquired During Current Year) and Schedule D – Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year) to determine the types of securities purchased at or near the beginning and the end of the year and the vendors used for those purchases.

b. Review Schedule D – Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year) and Schedule D – Part 5 (Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year) to determine the types of securities sold at or near the beginning and the end of the year and the purchasers of those securities.

c. Based on the results of a. and b. above, determine whether the insurer might have engaged in "window dressing" of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring lower quality investments after year-end).

7. If there are concerns regarding the level of turnover of long-term bonds, and both preferred and common stock (Level 2 Annual Procedure #7), consider performing one or more of the following procedures:

a. Determine that all brokers used by the company for investment transactions are licensed and in good standing with the Securities Exchange Commission.

b. Review Schedule D – Part 4 (Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Year) and Schedule D – Part 5 (Long Term Bonds and Stocks Acquired and Disposed of During Year) to determine the amount of bonds and stocks disposed of during the current year.

i. Review Schedule D – Part 3 (Long-Term Bonds and Stocks Acquired During Year). Determine the quality of bonds acquired, noting any "Z" rated (not rated by the SVO) securities. Also note any NAIC designations of 3, 4, 5 or 6 (noninvestment grade bonds).

ii. Review Schedule D – Part 3 (Long-Term Bonds and Stocks Acquired During Year). Determine the quality of preferred and common stocks acquired. Evaluate any "U" (unlisted) or "A" (analytically determined) rated stocks.

c. High turnover of investments can result in realized capital gains. Review the Exhibit of Capital Gains (Losses) to determine the degree of reliance on capital gains to increase surplus.

d. Review the Statement of Actuarial Opinion. Determine whether any concerns about investment turnover are noted.

8. If there are concerns regarding the level of investment in non-investment grade bonds (Level 2 Annual Procedure #8), consider performing one or more of the following procedures:

a. Review Schedule D – Part 1A – Section 1 (Quality and Maturity Distribution of all Bonds Owned) and compare the insurer's holdings of non-investment grade bonds to the limitations

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included in the NAIC Investments in Medium Grade and Lower Grade Obligations Model Regulation:

i. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 3, 4, 5, or 6 is less than 20 percent of total admitted assets (excluding separate accounts).

ii. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 4, 5 or 6 is less than 10 percent of total admitted assets (excluding separate accounts).

iii. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 5 or 6 is less than 3 percent of total admitted assets (excluding separate accounts).

iv. Determine whether the aggregate amount of all bonds owned which have an NAIC rating of 6 is less than 1 percent of total admitted assets (excluding separate accounts).

b. Request a copy of the insurer's plan for investing in non-investment grade bonds and review the guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity and geographic location.

c. Determine whether the insurer appears to be adhering to its plan for investing in non-investment grade bonds.

d. For the more significant non-investment grade bonds, request the following current information regarding the issuer from the insurer to determine the issuer's financial position and ability to repay its debt:

i. Audited Financial Statements.

ii. Report from a recognized rating agency (Moody's Investors Service, Standard and Poor's, or Fitch).

9. If there are concerns regarding the level of investment in multi-class securities (Level 2 Annual Procedure #9), consider performing one or more of the following procedures:

a. Review the multi-class securities categories in Schedule D – Part 1 (Bonds) for bonds with a book/adjusted carrying value significantly in excess of par value, which could result in a loss being realized if bond prepayments occur faster than anticipated.

b. Review the multi-class securities categories in Schedule D – Part 1 for bonds with an unusually high effective yield.

c. Request information from the insurer regarding the percentage distribution and amounts of each type of multi-class residential mortgage-backed security held; Planned Amortization Class (PACs), support bonds, interest only (IO) tranches, principle only (PO) tranches to evaluate the level of prepayment risk in the portfolio.

d. Request and examine information from the insurer regarding the estimated prepayment speeds on its MRMBSs.

A document is available in the link at the top of the Financial Analysis Handook Reports page on I-SITE that discusses mortgage backed securities and their pricing/valuation, prepayment models, measures of prepayments, extension risk and contraction risk, average life, option adjusted spread (OAS), effective duration and convexity.

e. Request information from the insurer regarding the background and expertise in structured securities of its investment advisors (in-house and/or contractual) and its analytical systems capabilities. Determine whether the advisors and systems are adequate to allow the insurer to continuously monitor its structured securities investments.

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f. Review the calculation of the insurer's C-3 Interest Rate Risk Component of its Risk-Based Capital formula.

g. Review the Statement of Actuarial Opinion for comments regarding the modeling of the multi-class residential mortgage-backed security portfolio in the cash-flow testing performed.

h. Consider having the multi-class securities modeled by an independent actuary as a part of an independent cash flow analysis.

10. If there are concerns regarding the level of investment in private placement bonds (Level 2 Annual Procedure #10), consider performing one or more of the following procedures:

a. Review Schedule D – Part 1A – Section 1 (Quality and Maturity Distribution of all Bonds Owned) and determine the following:

i. The total amount of privately-placed bonds owned.

ii. The types of issues with privately-placed bonds.

iii. The NAIC designations of the privately-placed bonds.

iv. The maturity distribution of the privately-placed bonds.

v. The amount of total privately-placed bonds which are freely tradeable under SEC Rule 144 or qualified for resale under SEC Rule 144A.

b. For the more significant privately-placed bonds, request current audited financial information regarding the issuer from the insurer and evaluate the issuer's financial position and ability to repay its debt.

11. If there are concerns regarding the level of investment in real estate and mortgage loans (Level 2 Annual Procedure #11), consider performing one or more of the following procedures:

a. Review Schedule A – Part 1 (Real Estate Owned) to determine whether updated appraisals should be obtained for any of the properties owned based on the location of the property, the book/adjusted carrying value and reported fair value of the property and the year of last appraisal.

b. Review Schedule A – Part 1 (Real Estate Owned) and:

i. Investigate any instances where a property has a book/adjusted carrying value in excess of its cost.

ii. Request information from the insurer regarding any increases by adjustment in book/adjusted carrying value during the year.

c. Review Schedule A – Part 1 (Real Estate Owned) for any properties owned which have a book/adjusted carrying value in excess of fair value and determine whether the asset should be written down.

d. Review Schedule B – Part 1 (Mortgage Loans Owned) and:

i. Determine the amount of each type of mortgage loan owned.

ii. Compare the book value/recorded investment of each loan to the value of the land and buildings mortgaged to determine whether the mortgage loans are adequately collateralized.

iii. Review the date of last appraisal or valuation to determine whether updated appraisals should be obtained.

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iv. Request information from the insurer regarding any increases by adjustment in book value/recorded investment during the year.

v. Determine whether any of the mortgage loans are to an officer, director, parent, subsidiary or affiliate.

12. If there are concerns regarding the level of investment in other (Schedule BA) invested assets (Level 2 Annual Procedures #12), consider performing one or more of the following procedures:

a. Review Schedule BA (Other Invested Assets Owned) to determine the amount and types of other invested assets owned and to determine whether they are properly categorized as other invested assets.

b. Review Schedule BA to determine if a significant amount of BA assets have NAIC ratings of 3 or 6 or have a "Z" designation.

c. Request information from the insurer to support significant increases by adjustment in book/adjusted carrying value during the year.

d. Request current Audited Financial Statements and other documents (partnership agreements, etc.) necessary to support the value of the insurer's investment in partnerships and joint ventures.

e. Request information necessary to support the value of significant other invested assets other than partnerships and joint ventures.

f. Request information necessary to determine the fair value of collateral to the amount loaned to ensure the loan is adequately collateralized.

13. If there are concerns regarding the level of investment in collateral loans (Level 2 Annual Procedure #13), consider performing one or more of the following procedures:

a. Review Schedule BA (Other Invested Assets Owned) and Schedule DA (Short-term Investments) and perform the following for each such loan:

i. Determine whether the collateral for the loan is an acceptable asset.

ii. Compare the fair value of the collateral to the amount loaned thereon to determine whether the loan is adequately collateralized.

iii. Determine whether the collateral loan is to an officer, director, parent, subsidiary or affiliate.

b. Verify the rate used to obtain the fair value of the securities held as collateral for the loans by reference to the SVO *Valuations of Securities Manual*.

14. If there are concerns regarding the level of investment in derivative instruments (Level 2 Annual Procedure #14), consider performing one or more of the following procedures:

a. Obtain and review 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 assets, liabilities or future cash flows which the insurer has acquired or incurred or anticipates acquiring or incurring and:

i. Evaluate whether the hedge program appears to result in hedges which are appropriate for the insurer based on its assets, liabilities and cash flow risks.

ii. Determine whether the insurer appears to be adhering to the description of the hedge program.

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b. Review Schedule DB (Derivative Instruments). For significant derivative instruments which are open at year-end, request the following information from the insurer:

   i. A description of the methodology used to verify the continued effectiveness of the hedge provided.

   ii. A description of the methodology to determine the fair value.

   iii. A description of the determination of the statement value.

c. 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.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments based on the additional procedures performed in the Level 3 Annual Procedures.

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

- ❑ Contact insurer seeking explanations or additional information
- ❑ Obtain the insurer's business plan
- ❑ Require additional interim reporting from the insurer
- ❑ Refer concerns to examination section for targeted examination
- ❑ Engage independent appraiser to value particular investments
- ❑ Meet with the insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

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IV. Level 3 Procedures – C. 2. Life Reserves

1. If there are concerns that life reserves may not be valued in accordance with the minimum formula statutory valuation standards (Level 2 Annual Procedure #1), consider completing one or more of the following procedures:
   a. Contact the qualified actuary to discuss the nature and scope of the life reserve valuation procedures performed.
   b. Review the insurer's life insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits.
   c. Request that the field examination staff request a valuation listing by plan and issue year and test a sample of individual policy reserves from each of the major life insurance plans for accuracy.
   d. Contact the policy forms section of the Department and inquire as to whether the insurer filed any new and unusual policy forms during the past twelve months.
   e. Contact the Department's actuary for assistance in completing the analysis.

2. If there are concerns that changes in life reserve valuation bases are proper (Level 2 Annual Procedure #2), consider completing one or more of the following procedures:
   a. Review the specific changes in valuation bases noted in Exhibit 5A – Changes in Bases of Valuation During the Year, and determine that individual changes in specific mortality tables, interest rates or valuation methods meet the minimum statutory valuation standards.
   b. Test check the calculations involved in applying a change in valuation basis.

3. If there are concerns that the insurer's underlying assets are not adequate to support the future obligations of its life insurance policies (Level 2 Annual Procedure #3), consider completing one or more of the following procedures:
   a. Request a copy of the Statement of Actuarial Opinion and review the actuary's comments regarding the analysis performed and conclusions reached.
   b. Conduct an independent asset adequacy analysis.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding life reserves based on the additional procedures performed in the Level 3 Procedures.

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

- ❑ Contact insurer seeking explanations or additional information
- ❑ Obtain the insurer's business plan
- ❑ Require additional interim reporting from the insurer
- ❑ Refer concerns to examination section for targeted examination
- ❑ Engage independent actuary to conduct a valuation of life reserves
- ❑ Engage independent actuary to conduct an asset adequacy analysis
- ❑ Meet with the insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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IV. Level 3 Procedures – C. 3. Accident and Health Reserves

1. If there are concerns regarding whether A&H policies have been adequately reserved (Level 2 Annual Procedure #2), consider performing one or more of the following procedures:
   a. Review Schedule H – Accident and Health Exhibit and perform the following:
      i. Determine which A&H lines of business are being written by the insurer.
      ii. Review Part 3 – Test of Previous Year's Claim Reserves and Liabilities to determine which A&H lines of business had positive development during the year.
   b. Review the insurer's A&H insurance plan descriptions and/or policy forms to better understand the types of plans offered and the specific features and benefits.
   c. Contact the policy forms section of the insurance department and inquire as to whether the insurer has filed any new and unusual A&H policy forms during the past year.
   d. Review the insurer's description of the valuation standards used in calculating the additional contract reserves (which is required to be attached to and filed with the Annual Financial Statement) and consider whether the reserve bases, interest rates and methods appear reasonable.
   e. Contact the qualified actuary who signed the insurer's Statement of Actuarial Opinion to discuss the nature and scope of the A&H reserve valuation procedures performed.
   f. Request a copy of the qualified actuary's Statement of Actuarial Opinion and review the actuary's comments regarding the analysis performed and conclusions reached regarding A&H reserves.
   g. Review the A&H loss percent ratio for unusual fluctuations or trends between years.
   h. Compare the A&H loss percent ratio to the industry average to determine any significant deviations from the industry average.
   i. Request that the field examination staff request a valuation listing of A&H policy reserves by policy and test a sample of policies to determine that the reserve factors used were appropriate and that the reserves were correctly computed.
   j. Obtain information from the insurer regarding A&H claims paid after year-end which were incurred prior to year-end and test the reasonableness of the year-end claim liabilities established by the insurer.
   k. If there was a change in the valuation basis of the A&H policies during the year, consider performing the following:
      i. Obtain information regarding the reason for the change in valuation basis and support the change in the actuarial reserve as a result of the change in valuation basis.
      ii. Determine whether the change in valuation basis was approved by the domiciliary state insurance department, if required.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding A&H reserves based on the additional procedures performed in the Level 3 Procedures.

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

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IV. Level 3 Procedures – C. 3. Accident and Health Reserves

- ❑ Refer concerns to examination section for targeted examination
- ❑ Engage independent actuary to review insurer's A&H reserves
- ❑ Meet with the insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

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Comments as a result of supervisory review.

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IV. Level 3 Procedures – C. 4. Annuity Reserves

1. If there are concerns that annuity reserves may not be valued in accordance with the minimum formula statutory valuation standards (Level 2 Annual Procedure #1), consider completing one or more of the following procedures:
   a. Contact the qualified actuary to discuss the nature and scope of the annuity reserve valuation procedures performed.
   b. Review the insurer's annuity plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits.
   c. Request that the field examination staff request a valuation listing by plan and issue year and test a sample of individual policy reserves from each of the major annuity plans for accuracy.
   d. Contact the policy forms section of the Department and inquire as to whether the insurer filed new and unusual policy forms during the past twelve months.

2. If there are concerns that changes in annuity reserve valuation bases are proper (Level 2 Annual Procedure #2), consider completing one or more of the following procedures:
   a. Review the specific changes in valuation bases noted in Exhibit 5A – Changes in Bases of Valuation During the Year, and determine that individual changes in specific mortality tables, interest rates or valuation methods meet the minimum statutory valuation standards.
   b. Test check the calculations involved in applying a change in valuation basis.

3. If there are concerns that the insurer's underlying assets are not adequate to support the future obligations of its annuity policies (Level 2 Annual Procedure #3), consider completing one or more of the following procedures:
   a. Request a copy of the Statement of Actuarial Opinion and review the actuary's comments regarding the analysis performed and conclusions reached.
   b. Conduct an independent asset adequacy analysis.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding annuity reserves based on the additional procedures performed in the Level 3 Procedures.

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

- ❑ Contact insurer seeking explanations or additional information
- ❑ Obtain the insurer's business plan
- ❑ Require additional interim reporting from the insurer
- ❑ Refer concerns to examination section for targeted examination
- ❑ Engage independent actuary to conduct a valuation of annuity reserves
- ❑ Engage independent actuary to conduct an asset adequacy analysis
- ❑ Meet with the insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

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Comments as a result of supervisory review.

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IV. Level 3 Procedures – C. 5. Income Statement and Surplus

1. If there are concerns regarding the insurer's income statement or operating performance (Level 2 Annual Procedure #1), consider performing one or more of the following procedures:
   a. Review the Summary of Operations (Annual Financial Profile Reports) for the past five years for unusual fluctuations or trends between years in income or expense items.
   b. Compare the ratio of return on capital and surplus to industry average return on surplus to determine any significant deviation from the industry average.
   c. Review the Analysis of Operations by Lines of Business in the Annual Financial Statement and:
      i. Determine which lines of business had significant surrender activity during the year.
      ii. Determine which lines of business were profitable for the insurer and which lines of business generated a loss.
      iii. Determine whether commissions and expenses on any lines of business appear excessive based on the volume of premiums.
   d. Review the ratio of commissions and administrative expenses to premiums (Annual Financial Profile Reports) for unusual fluctuations or trends between years.
   e. Compare the ratio of commissions and administrative expenses to premiums (Annual Financial Profile Reports) to industry average commission and expense ratios to determine any significant deviations from industry averages.
   f. Review General Interrogatory #32.1 and 32.2.
      i. Investigate any legal expenses paid if any such payment represented 25 percent or more of total legal payments made during the year.
      ii. Compare legal expenses with industry averages.
   g. Review the detail of investment income in Exhibit of Net Investment Income and the detail of realized gains or (losses) in the Exhibit of Capital Gains (Losses) for reasonableness.
   h. Review the ratio of investment income to cash and invested assets (Annual Financial Profile Reports) for unusual fluctuations and trends between years.
   i. Compare the ratio of investment income to cash and invested assets (Annual Financial Profile Reports) to the industry average investment yield to determine any significant deviation from the industry average.
   j. Review the components of the Annual Financial Statement Summary of Operations line items Aggregate Write-ins for Miscellaneous Income and Aggregate Write-ins for Deductions for reasonableness.
2. If there are concerns regarding changes in the volume of premiums or changes in the insurer's product mix (Level 2 Annual Procedure #2), consider performing one or more of the following procedures:
   a. Review the Mix of Business in the Annual Financial Profile Reports and:
      i. Determine which lines of business are being written.
      ii. Determine whether there has been a significant increase or decrease in direct premiums written for any line of business.
      iii. Determine whether any new lines of business are being written.
   b. Verify that the insurer is authorized to write all lines of business written.

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c. Determine whether the insurer has expertise (distribution network, underwriting, claims and reserving) in the lines of business written. (Consider reviewing the insurer's Management's Discussion and Analysis and/or seeking additional information from the insurer to determine the insurer's expertise in the lines of business written.)

3. If there are concerns regarding whether the insurer may be excessively leveraged due to its volume of accident and health (A&H) business (Level 2 Annual Procedure #3), consider performing one or more of the following procedures:

   a. Compare ratios of Gross A&H Premiums Written to Surplus and Net A&H Premiums to Surplus to industry averages to determine any significant deviations from the industry averages.

   b. Review Schedule H – Accident and Health Exhibit and/or obtain information from the insurer to determine the specific types of A&H policies written.

   c. Review Schedule H - Accident and Health Exhibit to determine whether the A&H lines of business are profitable and whether A&H reserve adequacy has been maintained.

   d. Review the accident and health loss percentage ratio (Annual Financial Profile Reports) for unusual fluctuations or trends between years.

4. If there are concerns regarding the amount of the insurer's Medicare Part D business (Level 2 Annual Procedure #4), consider performing one or more of the following procedures:

   a. Obtain and reviewinformation regarding the contracted benefits, premium and cost sharing with the Centers for Medicare and Medicaid Services.

   b. Review the types of products being written, including any enhanced benefit products.

   c. Request information on and review the assumptions for reserves, utilization and benefit costs projected in the development of the contract.

5. Review the procedures in the Risk-Based Capital Level 3 Annual Procedure. If there are concerns regarding the amount of the insurer's capital and surplus (Level 2 Annual Procedure #5), consider performing one or more of the following procedures:

   a. Review the Level 3 Annual Procedures for Risk-Based Capital.

   b. Compare the ratio of capital and surplus and AVR to total assets (excluding separate accounts) to industry average capital and surplus to assets to determine any significant deviation from the industry average.

   c. If the insurer has outstanding surplus notes issued, review Note to Financial Statements #13 - Capital and Surplus, Shareholders Dividend Restrictions and Quasi-Reorganizations and consider the following:

      i. Date issued

      ii. Interest rate

      iii. Amount of note and current value

      iv. Interest paid-current year and in total

      v. Accrued interest

      vi. Date of maturity

      vii. Name of holder (and indication of whether holder is affiliated entity)

      viii. Description of assets received

      ix. Repayment conditions or restrictions

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d. If the insurer has outstanding debt issued, review Note to Financial Statements #11 - Debt and consider the following:

   i. Date issued
   ii. Interest rate
   iii. Amount of note and current value
   iv. Interest paid-current year and in total
   v. Accrued interest
   vi. Date of maturity
   vii. Name of holder (and indication of whether holder is affiliated entity)
   viii. Description of assets received
   ix. Repayment conditions or restrictions

e. If capital or surplus notes were issued during the year, determine whether they were approved by the domiciliary state insurance department.

f. If principal was repaid and/or interest was paid on surplus notes during the year, determine that the principal repayments and/or the interest payments were approved by the domiciliary state insurance department.

g. If surplus notes represent a significant portion of capital and surplus, recalculate important ratios excluding the amount of surplus notes to determine the effect of surplus notes on the ratio results.

h. Review the write-ins for special surplus funds and for other than special surplus funds for reasonableness.

i. Review the Capital and Surplus Analysis (roll forward) for unusual fluctuations or trends in the changes in the individual components of capital and surplus between years.

j. Review the detail of unrealized gains or (losses) in the Exhibit of Capital Gains (Losses) for reasonableness.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding income statement and surplus based on the additional procedures performed in the Level 3 Procedures.

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
- ❑ Refer concerns to examination section for targeted examination
- ❑ Meet with the insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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IV. Level 3 Procedures – C. 6. Reinsurance

1. If there are concerns regarding the insurer's accounting treatment for reinsurance (Level 2 Annual Procedure #1), consider completing one or more of the following procedures:

   a. Further investigate whether specific reinsurers classified as authorized throughout Schedule S – Part 3 – Section 1 (Life and Annuities), Schedule S – Part 3 – Section 2 (Accident and Health), and Schedule S – Part 4 (Unauthorized Companies) are, in fact, authorized.

      i. Select the five largest individual reinsurers based on the total reinsurance recoverables amount and determine that they are authorized.

      ii. On a test basis, as considered necessary, select a sample from among the remaining reinsurers and determine that they are authorized.

   b. Review, by individual reinsurer, the amounts shown as security. Identify any unusual trends and determine the need to examine the underlying security in more detail, or confirm letters of credit, to ensure its validity.

   c. Generate Examination Jumpstart analysis to determine whether ceding company credits are appropriately "mirrored" by the reinsurer, after considering the impact of normal timing delays.

   Develop and document an overall conclusion regarding the accounting treatment for reinsurance.

2. If there are concerns regarding the significance or collectibility of reinsurance recoverables and receivables from significant individual reinsurers (Level 2 Annual Procedure #2), consider completing one or more of the following procedures:

   a. Determine the current ratings of the reinsurer from the major rating agencies and investigate significant changes during the past twelve months.

   b. Review the reinsurer's current and prior year Analyst Team priority designations for any reinsurer that has received a Validated Level "A" or "B", request a copy of the reinsurance agreement[s] and confirm amounts included on Schedule S - Part 4.

   c. Review information about the reinsurer available from industry analysts and benchmark capital adequacy with top performers and peer groups.

   d. Request a copy of the insurer's A.M. Best Supplemental Ratings Questionnaire, and review the reinsurance section for unusual items.

   e. Obtain and review the Audited Financial Report and the Annual Financial Statement of the reinsurer for additional insight regarding collectibility.

   f. Review SEC filings of the reinsurer, if applicable, for insight regarding collectibility.

   g. Obtain and review the Statement of Actuarial Opinion of the reinsurer for additional insight regarding collectibility.

   h. Determine whether adequate levels of collateral (letters of credit, etc.) are being maintained to secure outstanding losses.

   i. Contact the domiciliary state to determine whether any regulatory actions are pending against the reinsurer.

   j. Review the reinsurer's history of payments of recoverables and determine compliance with NAIC Regulation on Life and Health Reinsurance Agreements regarding quarterly settlements of payments due from reinsurers.

   k. Using the Global Receivership Information Database (GRID) within I-SITE, review the status of any relevant multi-state, single state or alien reinsurance company departmental or jurisdictional supervised receivership (i.e., conservatorship, rehabilitation, or liquidation proceedings).

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l. Determine whether the reinsurance transactions involved going "in and out" of treaties in such a manner that, in substance, the transactions are for financial reinsurance purposes.

3. If there are concerns that reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another (Level 2 Annual Procedure #3), consider completing one or more of the following procedures:

   a. Obtain and review the underlying agreements that support the transaction(s) in question.

   b. Critically assess the substance of the transaction in terms of the following criteria:

      i. The transaction must be economic-based and at arm's length.

      ii. The transaction must result in the transfer of risk and represent a consummated or permanent act.

      iii. Any assets transferred to an affiliate must be transferred at fair value if an economic-based transaction.

      iv. In the case of a portfolio transfer involving an affiliate, the transaction may not be allowable under state law or may require prior regulatory approvals.

4. If there are concerns that reinsurance is being used for fronting purposes (Level 2 Annual Procedure #4), consider completing one or more of the following procedures:

   a. Determine whether the requirements of the Fronting Disclosure and Regulation Model Act have been met.

   b. Review the types of reinsurance being used and the specific products involved, and assess whether such reinsurance is being used for fronting purposes.

   c. Perform procedures to evaluate collectibility (see Level 3 Procedure #2).

5. If there are concerns that significant and/or unusual reinsurance intermediary agreements or reinsurance assumed agreements exist (Level 2 Annual Procedure #5), consider completing one or more of the following procedures:

   a. Obtain and review underlying documents relating to the use of the reinsurance intermediary or reinsurance assumed.

   b. Determine whether the agreement is at arm's length and has economic substance.

   c. Verify by direct contact or confirmation that funds withheld for payment are valid and adequately segregated for payment of losses.

   d. Determine whether the requirements of the Reinsurance Intermediary Model Act have been met.

   e. Determine whether the requirements of the Managing General Agents Model Act have been met.

6. If there are concerns as to significant or unusual reinsurance transactions (Level 2 Annual Procedure #6), briefly scan the individual reinsurers in Schedule S – Part 3 – Section 1 (Life and Annuities) and Schedule S – Part 3 – Section 2 (Accident and Health).

   a. Are there any significant new reinsurers generally known to engage in surplus relief transactions that may trigger concerns as to transfer of risk with respect to this specific insurer?

   b. Are there any specific situations noted, or overall trends, that involve significant shifts in the mix of reinsurers to lower quality, higher risk companies?

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Consider completing one or more of the following procedures:

c. Obtain and review significant bulk reinsurance and surplus relief agreements.

   i. Determine that transfer of risk criteria have been met.

   ii. 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 that the transaction has been properly "mirrored."

d. Obtain and review assumption reinsurance agreements.

   i. Were proper policyholder consents received before the assumption reinsurance transfer was consummated?

   ii. Determine whether the underlying motivation of the insurer to enter into such a transaction involves financial difficulties that warrant additional investigation.

e. Review any disclosures made by the insurer, in accordance with the Disclosure of Material Transactions Model Act, regarding material nonrenewals, cancellations, or revisions of ceded reinsurance agreements.

   i. Obtain and review supporting documentation of such material transactions.

   ii. Determine if, in the analyst's opinion, additional procedures are considered necessary.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding reinsurance based on the additional procedures performed in the Level 3 Procedures.

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

- ❑ Contract insurer seeking explanations or additional information
- ❑ Obtain the insurer's business plan
- ❑ Require additional interim reporting from the insurer
- ❑ Refer concerns to examination section for targeted examination
- ❑ Engage an independent actuary or other reinsurance expert to review specific reinsurance contracts
- ❑ Meet with the insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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IV. Level 3 Procedures – C. 7. Affiliated Transactions

1. If the insurer's corporate structure elevates concerns about affiliated transactions (Level 2 Annual Procedure #1), consider completing one or more of the following procedures:
   a. Obtain and review the financial statements of the parent holding company (available with Form B filing) in order to understand its debt and equity structure.
   b. Determine the level of debt service required by the holding company and gain an understanding of its primary sources of revenue.
   c. If the primary sources of revenue are dividends and fees from the insurer, evaluate these sources to determine their validity and reasonableness.
   d. Obtain and review SEC filings, if available.

2. If there are concerns that major transactions with affiliates are <u>not</u> economic based or that they are not in compliance with regulatory guidelines (Level 2 Annual Procedure #2), consider completing one or more of the following procedures:
   a. Verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.
   b. If the concern relates to the economic substance of the transaction, obtain and review supporting documents.
   c. If the concern relates to the fair value used to record the transaction:
      i. Obtain and review an appraisal of the asset transferred.
      ii. Consider consulting an independent appraiser.
   d. If the concern involves a Management Agreement or Service Contract:
      i. Determine that appropriate regulatory approvals were received and that the insurer is complying with the terms as approved.
      ii. Obtain and review the supporting contract.
      iii. Determine that the amounts involved are reasonable approximations of actual costs.
      iv. Determine that actual amounts paid are in agreement with the supporting contract.
      v. For any agreement based on a cost plus formula or percent of premiums formula, request justification from the insurer for amounts in excess of the actual cost of providing the service.
      vi. For those services being performed by/for an affiliate, and which are also provided by unrelated third-party vendors (i.e., data processing, actuarial, investment management), contact such vendors or review vendor pricing schedules in order to determine the reasonableness of the intercompany transfer pricing level.
      vii. Evaluate whether any portion of such fees is in substance dividends that should be evaluated in the context of dividend regulations.

3. If investments in affiliates are significant or if there are concerns whether investments in affiliates are properly valued in accordance with statutory accounting practices (Level 2 Annual Procedures #3 and #4), consider completing one or more of the following procedures:
   a. Review details of affiliated investments as reported in Schedules A, B, BA and D, and compare with prior years.

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b. Obtain an understanding of the primary business activity of the affiliate and determine that such an investment complies with regulatory requirements.

c. Review the components of investment income reflected on Exhibit of Net Investment Income and Exhibit of Capital Gains (Losses).

   i. Calculate the return on investment for current and prior years.

   ii. Review the components of investment income and determine whether the source is cash or merely an increase in accrued interest income.

   iii. If a substantial portion of investment income relates to an increase in the accrual, determine whether such revenue recognition is legitimate and reasonable.

   iv. Determine whether accrued interest on investments in affiliates have grown to a significant level.

d. Obtain and review the Audited Financial Statement and Annual Financial Statement of the affiliate, if available.

e. Determine the current ratings of the affiliate from the major rating agencies, if available.

f. Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.

g. Obtain and review the Statement of Actuarial Opinion of the affiliate, if available.

h. Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.

i. Using the Global Receivership Information Database (GRID) within I-Site, review the status of any relevant multi-state, single state or alien affiliated company departmental or jurisdictional supervised receivership (i.e., conservatorship, rehabilitation, or liquidation proceedings).

4. If there are concerns whether other affiliated transactions are legitimate and are properly accounted for (Level 2 Annual Procedure #5), consider completing one or more of the following procedures:

   a. If the concern relates to federal tax recoverables from a parent or affiliate:

      i. Obtain and review the financial statements of the parent or affiliate and evaluate any collectibility risk to the insurer.

      ii. Review tax sharing agreement and verify that terms of the tax sharing agreement are being followed.

      iii. Verify that the amount recoverable from the prior year-end has been paid.

   b. Assemble a list of all affiliates and other related parties.

      i. Summarize the financial impact of each transaction.

      ii. Identify any other unusual transactions and investigate for reasonableness.

      iii. Determine that any required regulatory approvals were obtained.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding affiliated transactions based on the additional procedures performed in the Level 3 Procedures.

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IV. Level 3 Procedures – C. 7. Affiliated Transactions

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

- ❑ Contact insurer seeking explanations or additional information
- ❑ Obtain the insurer's business plan
- ❑ Request consolidating holding company schedules
- ❑ Require additional interim reporting from the insurer
- ❑ Refer concerns to examination section for targeted examination
- ❑ Consult an independent appraiser to evaluate specific transactions involving significant transfers of assets
- ❑ Meet with the insurer's management
- ❑ Recommend that a cease and desist order and/or fines be issued for holding company violations that were detected during the review
- ❑ Obtain a corrective plan from the insurer
- ❑ Recommend that action be taken to reverse or modify contracts that are harmful to insurer
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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IV. Level 3 Procedures – C. 8. MGAs and TPAs

1. If there are concerns due to a significant amount of the insurer's direct premiums being written through Managing General Agents (MGAs) and Third Party Administrators (TPAs) (Level 2 Annual Procedure #1), consider performing one or more of the following procedures:

   a. Review Notes to Financial Statements Procedure #19 – Direct Premiums Written by Managing General Agents/Third Party Administrators (which lists individual MGAs and TPAs through which direct writings are greater than 5 percent of capital and surplus) to determine 1) which MGAs and TPAs are being utilized (and whether any of the MGAs or TPAs are affiliated with the insurer), 2) the types and amount of direct business written by the MGAs and TPAs, and 3) the types of authority granted to the MGAs and TPAs by the insurer.

   b. For the more significant MGAs and TPAs, request information from the insurer regarding commission rates and any other amounts paid to the MGAs and TPAs, review the information for reasonableness and compare the commission rates to those paid by the insurer to other agents.

   c. For the more significant MGAs and TPAs, request information from the insurer to determine whether the business produced by the MGA or TPA is ceded to a particular reinsurer and, if so, whether that reinsurance was arranged for by the MGA or TPA. If the MGA or TPA arranged for the reinsurance, determine whether the MGA or TPA is affiliated with the reinsurer and consider reviewing the reinsurance agreements to determine whether the terms are reasonable.

   d. Determine whether the MGAs utilized by the insurer are properly licensed and whether the TPAs utilized by the insurer hold valid certificates of authority. (In some states, an insurer may utilize an MGA who is not licensed if biographical questionnaires have been submitted for each individual owning more than 10 percent of the MGA. If this provision is applicable and the MGA is not licensed, verify that the required biographical questionnaires have been submitted.)

   e. Request copies of the contracts between the insurer and its more significant MGAs and review to determine that the contracts include the minimum required provisions per Section 4 of the NAIC Model Managing General Agents Act and/or the applicable sections of the Insurance Code.

   f. Request copies of the contracts between the insurer and its more significant TPAs and review to determine that the contracts include the minimum required provisions per Sections 2, 4, 6, 7 and 8 of the NAIC Model Third Party Administrator Statute and/or the applicable sections of the Insurance Code.

   g. For the more significant MGAs utilized by the insurer, request and review the following:

      i. The most recent Audited Financial Statement of the MGA.

      ii. If the MGA establishes loss reserves, the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA.

      iii. Documentation supporting the insurer's periodic (at least semi-annual) on-site review of the MGA's underwriting and claims processing operations.

   h. For the more significant TPAs utilized by the insurer, request and review the following:

      i. The most recent annual report of the TPA.

      ii. Documentation supporting the insurer's periodic (at least semi-annual) review of the operations of the TPA. (At least one of the semi-annual reviews is required to be an on-site audit of the operations of the TPA.)

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

   i. Compare the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether they are similar (i.e., contain the same commission rates).

   ii. Compare the insurer's loss and loss adjustment expense ratios on the business placed by the MGA or TPA with those of the other insurers utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the insurer may be receiving a disproportionate amount of "bad" business from the MGA or TPA.

Summary and Conclusion

Develop and document an overal summary and conclusion regarding the insurer's use of MGAs and TPAs based on the additional procedures performed in the Level 3 Procedures.

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

- ❑ Contact the insurer seeking explanations or additional information
- ❑ Obtain the insurer's business plan
- ❑ Require additional interim reporting from the insurer
- ❑ Refer concerns to the examination section for targeted examination
- ❑ Refer concerns regarding a particular MGA or TPA to the examination section for examination of the MGA or TPA
- ❑ Meet with the insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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IV. Level 3 Procedures – C. 9. Separate Accounts

1. If there are concerns that separate accounts assets may be creating a contingent liability to the general account of the insurer (Level 2 Annual Procedure #2), consider completing one or more of the following procedures:

   a. Contact the qualified actuary to discuss the nature and scope of the valuation procedures performed relating to guarantees included with separate accounts products.

   b. Review the insurer's separate accounts plan descriptions and/or policy forms to better understand the types of plans offered and the specific policy features and benefits, particularly minimum guarantees.

   c. Specifically, determine whether the insurer writes any modified guaranteed annuities, and if so, the overall materiality and potential negative impact on the insurer's general account.

   d. If material guarantees exist, or if non-insulated products exist, determine whether the assets associated with these products are being invested in accordance with statutory guidelines.

   e. Request that the field examination staff request a valuation listing by plan and issue year and test a sample of the individual policy reserves for accuracy.

   f. Review the results of the Cash Flow and Liquidity section of the Level 2 Annual Procedures. Determine whether any potential liquidity concerns of the general account could adversely impact the financial condition of the separate accounts.

   g. Determine whether growth in separate accounts appears to be financed through borrowings of the general account, and if so, whether any concerns exist regarding the terms of repayment or collateralization.

2. If there are concerns that the accounting for activity between the general account and the separate accounts is proper (Level 2 Annual Procedure #3), consider completing one or more of the following procedures.

   a. Obtain a copy of the insurer's Separate Accounts Annual Financial Statement and the general account Annual Financial Statement and:

      i. Verify that the separate accounts gain from operations is properly recorded in the capital and surplus account section of the general account Summary of Operations.

      ii Verify that all other premium and benefits activity is properly recorded on the net transfers to or (from) separate accounts line of the general account Summary of Operations.

   b. Review the separate accounts summary of operations and surplus account in order to identify potential misclassifications as to "above the line" and "below the line" classifications.

   c. Review the level of investment management fees charged to the separate accounts to determine that they are in the generally accepted range of 125 to 140 basis points on separate accounts assets.

3. Review the company's response to General Interrogatory Part 2 question #3.3. Develop and document an overall conclusion regarding the portion of capital and surplus funds of the company covered by assets in the Separate Accounts Financial Statement which is not currently distributable from the separate accounts to the general account for use by the general account.

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IV. Level 3 Procedures – C. 9. Separate Accounts

Summary and Conclusion

Develop and document an overall summary and conclusion regarding Separate Accounts based on the additional procedures performed in the Level 3 Procedures.

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

- ❑ Contact insurer seeking explanations or additional information
- ❑ Obtain the insurer's business plan
- ❑ Require additional interim reporting from the insurer
- ❑ Refer concerns to examination section for target examination
- ❑ Conduct additional asset adequacy analysis
- ❑ Meet with insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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IV.D. Fraternal Level 1 Annual Procedures

IV. D. Level 1 Annual Procedures for Fraternal Societies

Background Analysis

1. Review the analysis performed on the society for the prior year and prior quarters.
   a. Indicate the state's priority designation or any prioritization tool result as of the last review and start of the current review:

      State's Priority Designation _____
      IRIS System Results _____
      Analyst Team System Validated Level _____
      RBC Ratio _____

   b. Were there any issues or concerns noted in previous annual or quarterly analysis completed in the prior year? If "yes," discuss the issues or concerns, the follow-up conducted, and include any correspondence with the society, along with any conclusions.

   c. As the domestic regulator, review the Insurer Profile Summary, including the Supervisory Plan, if applicable, and document any areas of concern that impact the current analysis.

2. Review any inter-departmental communication, as well as communication with other state insurance departments and the society. Note any unusual items or areas that indicate further review or follow-up is necessary.

3. Review General Interrogatory #5.1 and #5.2. Has the society been a party to a merger or consolidation? If yes, review the list of the companies involved in the merger/consolidation, noting any observations. Also, ensure Form A or additional filings have been approved.

4. Review General Interrogatory #6.1 and #6.2. Has the society had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? If yes, review the reason(s) stated for the revocation or suspension, noting any observations.

5. Are there any changes in the state's statutes and/or regulations that could impact the society's financial reporting or position? If yes, to the extent information is available, has the society failed to comply with the state's statutes and regulations enacted during the period?

6. Review the most recent report from a nationally recognized rating agency. Also note the current financial strength and credit rating, and briefly discuss the explanation of the rating or any change in the rating.

7. Review any industry reports, news releases and emerging issues that have the potential to negatively impact the society.

8. Review the most recent business plan and financial projections, if available from recent surveillance activity and if considered necessary based on the society's priority designation and financial condition.
   a. If significant changes in business plan or philosophy have occurred, assess the society's ability to attain the expectations of the business plan.

   b. Are actual results consistent with management's expectations?

Management Assessment

9. Review the Annual Financial Statement Jurat page (page 1).
   a. Did the society fail to properly execute and notarize the Jurat page?

   b. Has there been any change(s) in officers, directors or trustees since the previous Annual Financial Statement filing (indicated by a "#" after the name)? If yes, indicate the positions in which the

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changes have occurred. Review the Biographical Affidavit(s) for any new officers, directors, or trustees indicated above and note any areas of concern that would indicate further review is necessary.

- ☐ President
- ☐ Secretary
- ☐ Treasurer
- ☐ Vice Presidents (number: ____)
- ☐ Directors or Trustees (number: ____)
- ☐ Other

c. Assess any significant corporate governance changes and determine whether these changes appear to indicate a shift in management philosophy, or whether management has made any changes in business culture or business plan.

Balance Sheet Assessment

10. Review the Annual Financial Statement Assets (page 2) and Liabilities, Surplus and Other Funds (page 3).

a. Is surplus below the statutory minimum surplus required?

b. Is surplus less than 5 percent of total admitted assets excluding separate accounts?

c. Has surplus changed by greater than +/-20 percent from the prior year?

d. Is the RBC ratio (total adjusted capital divided by 50% of calculated risk-based capital amount shown in the Annual Financial Statement Five-Year Historical Data) less than or equal to 250 percent?

e. Has there been any change in surplus notes compared to the prior year-end? If yes, indicate the current and prior year-end balances and the amount of the change. Also comment on any notes issued, principal or interest paid, or any other changes that have been made and whether any necessary approvals were obtained.

f. Is the amount of any individual non-invested asset category greater than 10 percent of total admitted assets? If yes, indicate the asset category and amount.

g. Has any individual asset category, which is greater than 5 percent of total assets (excluding separate accounts), changed by greater than +/-20 percent from the prior year? If yes, indicate the asset category, current year-end balance and the percentage change from the prior year. The analyst should also consider shifts within individual asset categories, such as between investment-grade and non-investment-grade bonds, and between publicly traded and privately placed securities.

i. Is the amount of any individual liability category—other than aggregate reserves for life policies and contracts, aggregate reserves for accident and health policies and liability for deposit-type contracts—greater than 10 percent of total liabilities (excluding separate accounts)? If yes, indicate the liability category and amount.

j. Has any individual liability category, which is greater than 5 percent of total liabilities (excluding separate accounts), changed by greater than +/-20 percent from the prior year? If yes, indicate the liability category, current year-end balance and the percentage change from the prior year.

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IV. D. Level 1 Annual Procedures for Fraternal Societies

Operations Assessment

11. Review the Annual Financial Statement Summary of Operations (page 4).

    a. If the absolute value of net income (loss) exceeds 5 percent of surplus, has net income (loss) decreased by more than 20 percent or increased by more than 40 percent from the prior year?

    b. Has any individual income or expense category, for which the current or prior year balance exceeded 5 percent of surplus, changed by more than +/-20 percent from the prior year? If yes, indicate the income or expense category, current year-end balance, and the percentage change from the prior year.

    c. Has any individual surplus account category changed by more than +/-10 percent from prior year-end? If yes, indicate the capital and surplus category, current year-end balance change and the percent change from the prior year.

    d. Are net unrealized capital gains/(losses) more than 10 percent of prior year-end surplus?

12. Review the Annual Financial Statement of Cash Flow (page 5). Is net cash from operations negative?

13. Evaluate any material ceded reinsurance as reported in Schedule S – Part 3—Reinsurance Ceded. Review all General Interrogatories and Notes to Financials pertaining to reinsurance and note any areas of concern.

Investment Practices

14. Evaluate the society's investment management practices.

    a. Review General Interrogatory #14. Has the purchase or sale of any investments not been approved by the board of directors or a subordinate committee thereof?

    b. Review General Interrogatory #22.1 and #22.2. Were any securities owned, over which the society has exclusive control, not in the actual possession of the society, except as shown by the Schedule of Special Deposits?

    c. Review General Interrogatory #23.1 and #23.2. Were any assets owned by the society not exclusively under the control of the society? If yes, indicate the amount at December 31 of current year.

    d. Review General Interrogatory #19.1 and #19.2. Were any assets subject to a contractual obligation to transfer to another party without the liability for such obligation being reported? If yes, indicate the amount at December 31 of the current year.

15. Review the Annual Financial Statement Summary Investment Schedule (page SI01). Note any unusual items or areas that indicate further review is warranted.

16. Review the Supplemental Investment Risks Interrogatories. Note any unusual items that would indicate a non-diversified portfolio or inappropriate liquidity.

17. Review the Annual Financial Statement Schedule E, Part 3—Special Deposits. Is the book/adjusted carrying value of total special deposits greater than 10 percent of assets?

Review of Disclosures

18. Review the Annual Financial Statement Notes to Financial Statements (page 19).

    a. Have any notes required per the NAIC's *Annual Statement Instructions for Life and Health Insurance Companies* been omitted?

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b. Provide an explanation for any unusual or significant items noted.

19. Review the Annual Financial Statement General Interrogatories (page 21) and note any unusual responses.

Assessment of Latest Examination Report and Results

20. Review General Interrogatory #3 and determine if a financial examination report was released by the domiciliary state since the last review.

    a. As of what balance sheet date is/was the latest financial examination of the society?

    b. As of what balance sheet date is the latest financial examination report available from either the state of domicile or the society?

    c. As of what release date is the latest financial examination report available from either the state of domicile or the society?

    d. Have any financial statement adjustments within the latest financial examination report not been accounted for in a subsequent financial statement filed with the Department?

    e. Have any of the recommendations within the latest financial examination report not been complied with?

    If yes, or if follow-up was required from the review of the examination report in a previous analysis period, complete the following procedures.

    f. If the answers to 20.d or 20.e are yes, follow up with the society regarding the implementation of recommendations in the Financial Examination Report.

    g. Assess the current and future impact of any financial statement adjustments on the society's financial condition.

21. During the review of the latest state examination report, the results from that examination and communication with the examiner-in-charge (for domestic societies), did the analyst note any items or areas that indicate further review is warranted?

22. Follow up and document on any management letter comments that should be addressed in the current period, if applicable.

Assessment of Results from Prioritization & Analytical Tools

23. Review the society's IRIS ratio results.

    a. Indicate the number of ratio results that fall outside the usual range.

    b. Provide an explanation on each of the ratios that fall outside the usual range.

24. Review and understand the assigned Analyst Team System Validated Level.

25. Review the NAIC Annual Financial Profile Report, and provide an explanation for any unusual or significant fluctuations or trends noted.

26. Review any market conduct information, including information available from the state's market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee), and the NAIC market analysis tools and databases (MAP, ETS, MARS, RIRS, SAD, MITS, and Complaints). The

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analyst should note any unusual items that translate into financial risks or indicate that further review and/or additional communication is needed with the Department's market analysis staff.

Assessment of Supplemental Filings

27. During the review of the Statement of Actuarial Opinion, did the analyst note any unusual items or areas that indicate further review is warranted?

28. During the review of the Management's Discussion and Analysis, did the analyst note any unusual items or areas that indicate further review is warranted (April 1 filing)?

29. During the review of the Audited Financial Report, did the analyst note any unusual items or areas that indicate further review is warranted (June 1 filing)?

30. Review the most recent Annual Financial Statement of the society's holding company and its subsidiaries and holding company filings (such as Forms A, B, D, E—or Other Required Information—and Extraordinary Dividend/Distribution and SEC forms 10-K and 8-K) if available.

    a. During the review, did the analyst note any new or unusual items or areas of concern that may potentially impact the society?

    b. If other societies within the group exist, note any communication with the domestic state insurance departments for those affiliated societies.

Recommendation for Further Analysis

Based on the Level 1 procedures performed, do you recommend that the Level 2, 3 or Supplemental Annual Procedures or other procedures listed below be completed? If yes, refer to the procedures in the Life/A&H Level 2 and 3 listed below for possible additional procedures and indicate the sections that you recommend be completed:

A. Perform Level 2 and/or Level 3 Procedures:

All Sections
Investments
Life Reserves
Accident and Health Reserves
Annuity Reserves
Income Statement and Surplus
Risk-Based Capital
Cash Flow and Liquidity
Reinsurance
Affiliated Transactions
MGAs and TPAs
Separate Accounts

B. Perform Supplemental Procedures:

Annual Audited Financial Reports
Statement of Actuarial Opinion
Management's Discussion and Analysis

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Holding Company Analysis

Form A

Form B

Form D

Form E—or Other Required Information

Extraordinary Dividend/Distribution

C. Request and review the current business plan and financial projections.

i. If significant changes in the business plan or philosophy have occurred, assess the society's ability to attain these expectations.

ii. Determine if actual results are tracking with projection and note any significant variances and the reason(s).

Summary and Conclusion

After completion of any Level 2 or subordinate procedures, develop and document an overall summary and conclusion based on the findings. In developing a conclusion, the analyst should consider the above procedures, as well as any other factors that, in the analyst's judgment, are relevant to evaluating the society's overall financial condition. The summary and conclusion should include details regarding the society's strengths and weaknesses. In addition, update the Insurer Profile Summary, including the Supervisory Plan, if applicable, for the results of the analysis performed.

Do you recommend that the society be designated a priority as a result of the procedures performed? If yes, indicate the recommended priority designation and rationale.

Describe the rationale for these recommendations.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

Correspondence

The analyst should document any follow-up regarding the Level 1, 2, 3, and Supplemental Procedures.

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V. Supplemental Procedures

A. Audited Financial Report

B. Statement of Actuarial Opinion

C. Management's Discussion and Analysis

D. Holding Company Analysis

E. Form A

F. Form B

G. Form D

H. Form E or Other Required Information

I. Extraordinary Dividend/Distribution

V. Supplemental Procedures – A. Audited Financial Report

Audited Financial Report

1. Were the financial statements included in the Audited Financial Report prepared based on statutory accounting practices?

2. Were the financial statements included in the Audited Financial Report specific to the insurer rather than on a consolidated or combined basis?

3. If the financial statements included in the Audited Financial Report were prepared on a consolidated or combined basis, answer the following questions:
   a. Was this basis approved by the domiciliary commissioner upon application by the insurer due to a pooling or 100 percent reinsurance agreement with affiliates?
   b. Was a consolidating or combining worksheet included with the financial statements which:
      i. Shows amounts separately for each insurer (non-insurance operations may be shown on a combined or individual basis)?
      ii. Provides explanations for consolidating and eliminating entries?
      iii. Includes a reconciliation of any differences between the amounts shown for an individual insurer and the amounts per the insurer's Annual Financial Statement?

4. What type of opinion was issued by the CPA?
   - ❑ Unqualified
   - ❑ Unqualified with explanatory language added
   - ❑ Qualified
   - ❑ Adverse
   - ❑ Disclaimer of opinion

5. If the opinion was other than unqualified, comment on the reasons for the deviation.

6. Do total assets, net income and surplus per the Audited Financial Report, agree with the amounts per the insurer's Annual Financial Statement?

7. If total assets, net income and/or surplus do not agree with the amounts per the Annual Financial Statement, review the reconciliation of differences and comment on the differences and the reasons, based on the Notes to Financial Statements. Also consider the impact of the audit adjustments made by the independent CPA on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (e.g., complete additional Level 3 Procedures for items impacted by the audit adjustments, etc.) on the Annual Financial Statement information.

8. Review the Notes to Financial Statements and comment on items of significance, including, but not limited to investments, reserves, reinsurance, transactions with affiliates, contingent liabilities and the summary of ownership and relationships with affiliated companies. Also, consider the impact, if any, of the information in the Notes to Financial Statements on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (e.g., complete portions of the Level 3 Procedures, etc.) on the Annual Financial Statement information.

9. If affiliated transactions are significant, consider comparing information regarding affiliated relationships and affiliated transactions per the Audited Financial Report to information reported by the insurer in the

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Annual Financial Statement and in the various holding company filings and comment on any discrepancies noted.

Internal Controls

10. Review the report of significant deficiencies in the insurer's internal control structure prepared by the CPA, if applicable (the report is only prepared if the insurer is a SEC registrant or significant deficiencies are reported in the Audited Financial Report) and comment on the deficiencies noted and the improvements made or proposed by the insurer to correct those deficiencies.

CPA's Letter of Qualifications

This section of the Audited Financial Report Procedures should be completed whenever there has been a change in the independent CPA from the prior year and may be completed annually whether or not there has been a change in independent CPA.

11. Does the CPA's letter of qualifications include the following?

    a. A statement that the CPA is independent with respect to the insurer and conforms to the standards of the profession?

    b. Information regarding the background and experience, including the experience in audits of insurers, of the staff assigned to the audit and whether each is a certified public accountant?

    c. A statement that the CPA understands that the domiciliary commissioner will be relying on the Audited Financial Report, and the CPA's opinion thereon, in the monitoring and regulation of the financial position of the insurer?

    d. A statement that the auditor is properly licensed by an appropriate state licensing authority?

    e. A statement that the auditor is in compliance with the following qualifications, which are specified in NAIC *Annual Financial Statement Instruction*s for the Audited Financial Reports:

        i. The CPA is in good standing with the American Institute of Certified Public Accountants and with all states in which the CPA is licensed to practice, or, for a Canadian or British insurer, is a chartered accountant?

        ii. The CPA conforms to the standards of the profession?

        iii. The partner or other person responsible for rendering the Annual Audited Financial Report has not acted in that capacity for more than seven consecutive years, and following any such period of service, that person shall be disqualified from serving in that or a similar position for the same insurer for a period of two years?

        iv. The domiciliary commissioner has not ruled that the CPA is unqualified for purposes of expressing an opinion on the financial statements in the Annual Audited Financial Reports?

    f. A statement that the CPA agrees to:

        i. Make available for review by the domiciliary state insurance department examiners, at any reasonable place designated by the domiciliary commissioner, all workpapers prepared in the conduct of the audit and any communications between the CPA and the insurer related to the audit at any reasonable place designated by the domiciliary commissioner?

        ii. Retain the audit workpapers and communications until the domiciliary state insurance department has filed an examination report covering the period of the audit, but no longer than seven years from the date of the audit report?

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iii. Allow copies of pertinent audit workpapers to be made and retained by the domiciliary state insurance department examiners?

12. Comment on any deviations between the statements in the CPA's letter of qualifications and the required statements per the NAIC *Annual Financial Statement Instructions* for life/health insurers as summarized in step 1 above.

Change in CPA

13. Was the CPA who issued the opinion on the insurer's financial statements the same CPA who issued the opinion on the insurer's financial statements in the prior year?

14. If the CPA who issued the opinion on the insurer's financial statements this year is different from the CPA in the prior year:

    a. Was the domiciliary state insurance department notified of the change?

    b. Has a letter from the new CPA been filed with the domiciliary state insurance department which states that the CPA is aware of the provisions of the Insurance Code and the rules and regulations of the domiciliary state insurance department that relate to accounting and financial matters and which affirms that the CPA will express an opinion on the financial statements of the insurer in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that department, specifying such exceptions as the CPA may believe appropriate?

    c. Did the insurer file a letter with the domiciliary state insurance department stating whether, in the 24 months preceding the change in CPAs, there were any disagreements with the former CPA regarding accounting principles or practices, financial statement disclosure, or auditing scope or procedure which, if not resolved to the satisfaction of the former CPA, would have caused the CPA to make reference to the subject matter of the disagreement in connection with the CPA's opinion?

    d. With regard to the letter referred to in item 14.c., did the insurer also file a letter from the former CPA stating whether the CPA agrees with the statements regarding disagreements in the insurer's letter?

15. Comment on any disagreements noted in the letters from either the insurer or the former CPA.

Audit Committee

16. Effective January 1, 2010, every insurer is required to have designated an Audit Committee, a percentage of whose members should be independent from the insurer.

    a. Has the insurer established an Audit Committee?

    b. Does the Audit Committee membership meet independence requirements of the domicilary state insurance laws?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the Audited Financial Report. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which in the analyst's judgment, are relevant to evaluating the Audited Financial Report under the specific circumstances involved. In documenting the conclusion, the analyst should comment specifically on the reasons for anything but a standard unqualified opinion.

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V. Supplemental Procedures – A. Audited Financial Report

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

- ❑ Contact insurer seeking explanations or additional information from the insurer or the independent CPA
- ❑ Obtain the insurer's business plan
- ❑ Require additional interim reporting from the insurer
- ❑ Refer concerns to examination section for targeted examination
- ❑ Meet with insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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V. Supplemental Procedures – B. Statement of Actuarial Opinion

During 2001, the NAIC adopted revisions to the Actuarial Opinion and Memorandum Regulation (AOMR). The most significant revision to the AOMR was the requirement that **all** companies perform an asset adequacy analysis. This revision eliminates the current Section 7 opinion that was allowed for certain insurers. This AOMR revision impacts this Handbook because the Supplemental Procedures for the Statement of Actuarial Opinion currently has two different sets of procedures; one that can be used when an asset adequacy analysis opinion is required and another when the asset adequacy opinion is not required. In addition to the deletion of the Section 7 opinion, the revised AOMR includes an executive summary, which is referred to in Section B.8. below.

Because the full body of the NAIC did not adopt the changes to AOMR until the fall of 2001, many states have not yet adopted the changes. Therefore, no changes have been made to the following procedures as it pertains to the AOMR revisions to allow states to continue to use either set of procedures.

Statement of Actuarial Opinion not including an asset adequacy analysis (if applicable)

1. Do the reserve amounts included in the Statement of Actuarial Opinion agree with the amounts per the Annual Financial Statement?

2. Has the insurer provided a notification letter to the domiciliary state that includes the name, title (and in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the insurer as an appointed actuary, and does such notice state that the person meets the definition of a qualified actuary?

3. Does the Statement of Actuarial Opinion state that the insurer is exempt from submitting a Statement of Actuarial Opinion based on an asset adequacy analysis and document the reasons for this conclusion?

4. Does the Statement of Actuarial Opinion cover at least the following items and amounts: aggregate reserve for life policies and contracts (Exhibit 5), aggregate reserve for accident and health policies (Exhibit 6), aggregate reserve for deposit-type contracts and other liabilities without life or disabilities contingencies (Exhibit 7), or policy and contract claims-liability end of current year (Exhibit 8 part 1)?

5. If the appointed actuary has not examined the underlying records and has relied upon the listings and summaries of policies in-force prepared by the insurer or a third party, is there a certification letter attached to the Statement of Actuarial Opinion signed by the individual or firm who prepared such underlying data?

6. Does the Statement of Actuarial Opinion state that the reserves:

    a. Are computed in accordance with those presently accepted actuarial standards that specifically relate to the opinion required under this section?

    b. Are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions?

    c. Meet the requirements of the insurance law and regulations of the state of domicile and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed?

    d. Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the Annual Financial Statement of the preceding year-end with any exceptions as noted below?

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e. Include provision for all actuarial reserves and related statement items that ought to be established?

Statement of Actuarial Opinion Based On An Asset Adequacy Analysis (if applicable)

7. Do the reserve amounts included in the Statement of Actuarial Opinion agree with the amounts per the Annual Financial Statement?

8. Has the insurer provided a notification letter to the domiciliary state that includes the name, title (and in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the insurer as an appointed actuary, and does such notice state that the person meets the definition of a qualified actuary?

9. Does the Statement of Actuarial Opinion cover at least the following items and amounts: aggregate reserve for life policies and contracts (Exhibit 5); aggregate reserve for accident and health contracts (Exhibit 6); aggregate reserve for deposit-type contracts (Exhibit 7); and policy and contract claims - liability end of current year (Exhibit 8, part 1)?

10. Does the Statement of Actuarial Opinion include a table that indicates those reserves that have been analyzed for asset adequacy, including the method of analysis, and indicate that any additional actuarial reserves must be established?

11. Review Exhibits 5, 6 and 7. Were the additional actuarial reserves properly established as a result of the asset/liability analysis?

12. Does the Statement of Actuarial Opinion state that the reserves:

    a. Are calculated in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles?

    b. Are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions?

    c. Meet the requirements of the insurance law and regulation of the state of domicile and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed?

    d. Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the Annual Financial Statement of the preceding year-end (with any exceptions noted)?

    e. Include provisions for all actuarial reserves and related statement items that ought to be established?

    f. When considered in light of the assets held by the insurer, including the related investment earnings, are adequate to support the insurer's future policy obligations?

Actuarial Memorandum

13. Did the qualified actuary conduct an asset adequacy test on at least 95 percent of the insurer's total reserves?

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14. Based upon the judgment of the analyst and after reviewing the Statement of Actuarial Opinion and Regulatory Asset Adequacy Issues Summary, if available, should the actuarial memorandum be requested from the insurer? If no, skip to the summary.

15. Does the Statement of Actuarial Memorandum including an asset adequacy analysis include the following?

    a. For reserves:
        i. Product descriptions
        ii Source of liability in-force
        iii. Reserve method and basis
        iv. Investment reserves
        v. Reinsurance arrangements
        vi. Persistency of in-force business

    b. For assets:
        i. Portfolio descriptions
        ii. Investment and disinvestment assumptions
        iii. Source of asset data
        iv. Asset valuation bases

    c. For analysis basis:
        i. Methodology
        ii. Rationale for inclusion/exclusion of different blocks of business and how pertinent risks were analyzed
        iii. Rationale for degree of rigor in analyzing different blocks of business
        iv. Criteria for determining asset adequacy
        v. Effect of federal income taxes, reinsurance and other relevant factors such as dividends, commissions, etc

    d. Summary of results

    e. Conclusions

    f. A statement that the actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Actuarial Standards of Practice as promulgated by the Actuarial Standards Boards, which standards form the basis for the memorandum

    g. Method for aggregating reserves and assets

    h. Method for selecting and/or allocating assets supporting the Asset Valuation Reserve.

    i. Analysis of the effect of required interest rate scenarios.

Non-Guaranteed Elements Opinion (if applicable)

16. Has the insurer provided a notification letter to the domiciliary state that includes the name, title (and in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the insurer as an appointed actuary, and does such notice state that the person meets the definition of a qualified actuary?

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17. Does the Statement of Actuarial Opinion include the following sections?

    a. Determination procedure section that defines the insurer's policy in determining non-guaranteed elements, particularly the degree of discretion allowed by the insurer.

    b. Interrogatories section.

    c. Statement of Actuarial Opinion section that states that the non-guaranteed elements for individual life and annuities policies have been determined in accordance with generally accepted actuarial principles and practices.

18. Summarize any pertinent comments by the qualified actuary.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the Statement of Actuarial Opinion, and if applicable, the actuarial memorandum. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst's judgment, are relevant to evaluating the Statement of Actuarial Opinion and actuarial memorandum under the specific circumstances involved.

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

- ❑ Contact the insurer seeking explanations or additional information from the insurer or the qualified actuary
- ❑ Obtain the insurer's business plan
- ❑ Require additional interim reporting from the insurer
- ❑ Refer concerns to examination section for targeted examination
- ❑ Consult with the in-house actuary
- ❑ Engage an independent actuary to review insurer's reserves
- ❑ Meet with the insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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V. Supplemental Procedures – C. Management's Discussion and Analysis

1. Did the Management's Discussion and Analysis (MD&A) filed in accordance with the Annual Financial Statement Instructions include the following overall content?
   a. Discussion of short and long-term analysis of the business of the insurer.
   b. Discussion of the two-year period covered by the Annual Financial Statement including year-to-year comparisons.
   c. Reference to the Five-Year Historical Data Exhibit and other exhibits or schedules where trend information is relevant.
   d. Explanation of accounting policies applied, judgments made in their application and changes in assumptions or conditions that result in materially different reported results.
   e. Discussion of material events known to management that would cause reported financial information not to be necessarily indicative of future operating results or of future financial position.

2. Was the MD&A prepared on a non-consolidated basis? If no, does the domiciliary state permit audited consolidated financial statements, or does the insurer cede substantially all of its direct and assumed business to a pool?

3. Did the MD&A include a discussion regarding the insurer's results of operations?
   a. Describe any unusual or infrequent events, transactions, significant economic changes that materially impact income or other gains/losses in surplus, or any significant components of income.
   b. Describe any known trends or uncertainties that could have a material impact on premiums, income or surplus.
   c. Describe known changes in the relationship of expenses and premiums.
   d. Discuss the extent to which material increases in premiums are due to increases in prices or volume of existing products or new products being sold.

4. Did the MD&A include a discussion regarding prospective information?
   a. Discuss known trends or uncertainties that are reasonably likely to impact liquidity, capital resources and the mix and cost of such resources.
   b. Discuss known trends or uncertainties that are reasonably likely to impact premiums, net income and surplus.

5. Did the MD&A include disclosure of reasons for material changes to line items or discussion and quantification of the contribution of two or more factors to such material changes?

6. Did the MD&A include a discussion on liquidity, asset/liability matching and capital resources?
   a. Indicate those balance sheet, income statement, or cash flow items that the insurer believes may be indicators of its liquidity condition.
   b. Discuss the nature and extent of restrictions on the ability of subsidiaries to transfer funds to the insurer and the impact such restrictions may have on the ability of the insurer to meet cash obligations.

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c. Identify any known trends, demands, commitments, events, or uncertainties that are reasonably likely to result in material changes in the insurer's liquidity. If any are identified, describe the course of action taken by the insurer to remedy a decline in liquidity.

d. Describe internal and external sources of capital available to improve liquidity and any material unused sources of liquid assets.

e. Describe any material trends in the insurer's capital resources including any material changes in the mix or relative cost of such resources.

f. Discuss on cash flows from investing and financing.

g. Discuss off-balance sheet financing if liquidity is dependent on such arrangements.

h. Disclose circumstances that materially effect liquidity, such as market price changes, economic declines, defaults on guarantees, etc.

7. Did the MD&A include a discussion on those items that affect the volatility of loss reserves (property/casualty only)?

8. Did the MD&A include a discussion on off-balance sheet arrangements?

   a. Discuss off-balance sheet arrangements and transactions with limited purpose entities.

   b. Describe the extent of the insurer's reliance on off-balance sheet arrangements.

   c. Disclose uncertainties where contingencies inherent in the arrangements are reasonably likely to affect the continued availability of a material historical source of liquidity and finance.

9. Did the MD&A include a discussion on participation in high yield financings, highly leveraged transactions or non-investment grade loans and investments?

   a. Identify transactions or investments and the nature and extent of the insurer's involvement in such transactions or investments, if participation or involvement is reasonably likely to have a material effect on financial condition or results of operations.

   b. Describe additional risks to the insurer as well as associated fees and recognized losses.

   c. Describe the insurer's judgment as to the material effect, if any, on the financial condition of the insurer.

10. Did the MD&A include a discussion on preliminary merger/acquisition negotiations, where disclosure is otherwise required or has been made by or on behalf of the insurer?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding MD&A. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst's judgment, are relevant to evaluating MD&A under the specific circumstances involved.

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

- ❑ If the insurer's MD&A is not sufficient, request the insurer re-submit the MD&A with more disclosure.
- ❑ Obtain the insurer's business plan
- ❑ Require additional interim reporting from the insurer
- ❑ Refer concerns to examination section for targeted examination

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V. Supplemental Procedures – C. Management's Discussion and Analysis

- ❑ Consult with the in-house actuary
- ❑ Meet with the insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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V. Supplemental Procedures – D. Holding Company Analysis

Special Note: The following procedures may be completed in part or in total at the discretion of the analyst depending on the level of concern, the area in which the risk was identified, and the degree of interdependence within the holding company entities.

Identify and Understand the Holding Company Structure

1. Identify the organization structure (e.g., public, non-public, mutual, etc.).

2. Evaluate the insurer's statutory Schedule Y, Notes to Financial Statements, and the GAAP financial filings of the holding company. Identify and understand the following:
   - ❑ Ultimate controlling entity or person(s)
   - ❑ Intermediate holding companies
   - ❑ Insurance vs. non-insurance entities
   - ❑ Ownership structure

3. Review the insurer's General Interrogatories Part 1, #8.1 and #8.4 and identified other regulatory bodies, which have authority over the group (e.g., Federal Reserve, Office of the Comptroller of the Currency, Office of Thrift Supervision, etc.).

   Identify the following:
   - ❑ Controlling federal regulatory services agency
   - ❑ Any federally regulated action taken
   - ❑ Any communication between state and federal regulators that has been planned or initiated

4. Utilize the following financial filings to summarize the group's background:
   - ❑ SEC filings (if applicable)
   - ❑ Management's Discussion and Analysis
   - ❑ Statutory and GAAP Auditor's Report(s)
   - ❑ Statutory filings including combined filings and forms
   - ❑ Annual Report to Shareholders

5. Is the ultimate holding company a shell dedicated only to the insurance subsidiary's benefit? If so, identify the intermediate holding company to be analyzed.

6. Review the insurer's Jurat Page in the Annual Statutory Financial Statement of the domestic insurer and identify changes or trends of changes in officers and directors.

7. Review the insurer's Notes to Financial Statements, Interrogatories, and Holding Company Form B as well as recent examination reports. Identify and understand the following types of agreements the insurer has in place with the holding company and/or affiliates.
   - ❑ Management agreements
   - ❑ Third-party agreements
   - ❑ Managing general agent agreements
   - ❑ Investment management pools

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- Reinsurance agreements and pools
- Income tax pool

8. Describe the nature of the insurance subsidiaries interdependence on the holding company or affiliated entities for business operations or financial stability (e.g., employees, services provided, reinsurance and/or capital support in the near term).

9. Determine and describe the level of reputational risk that the holding company poses to the insurance subsidiaries.

10. Determine if income of the insurance subsidiaries is being used to finance holding company debt or other corporate initiatives.

11. Determine the level of holding company debt (e.g., corporate debt, borrowed money, and other types of debt) and its relative value to equity. If significant, summarize the following:
    - Type of debt
    - Terms of the debt covenants
    - Maturity schedules
    - Interest payment schedules
    - Ability to meet payments
    - Business purpose
    - Collateral

12. Determine the level of reliance on cash flows from subsidiaries to fund the holding company's interest and principal payments on the debt.

13. Have any subsidiaries of the 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 policyholders' surplus as well as the materiality of the insurance company dividends.
    b. Did the domiciliary Department of Insurance approve extraordinary dividends in order to support the holding company?

14. Understand and evaluate the method in which the group markets its products through the review of the legal entity's marketing plan.

15. Review the holding company and legal entity reports of the independent public accountant. Comment on the following:
    - Auditor's Opinion
    - Notes to Financial Statements
    - Management's Assessment on Internal Controls
    - Auditor's Assessment on Management's Assessment on Internal Controls
    - Material differences between statutory and GAAP opinions where relevant

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V. Supplemental Procedures – D. Holding Company Analysis

I-SITE Lead State Report and Interstate Coordination

16. Using the I-SITE Lead State Report, identify the lead state(s).

17. Identify a lead person or team of experts to create a contact list of key individuals within other interested states.

18. Establish a plan for communicating and coordinating with the lead state(s) if significant events, material concerns or perspective risks are identified.

19. Has your Department considered implementing the following methods of communication with other states, if significant events or material concerns are identified:
    - ❑ Establish a multi-state team of regulators
    - ❑ Establish a structure for obtaining updated information
    - ❑ Conference calls
    - ❑ Status e-mails
    - ❑ Disseminating relevant insurer documents and reports
    - ❑ Holding meetings with the insurer and relevant regulators

Evaluate the Financial Condition of the Holding Company Group

For the following financial assessment procedures, utilize the shareholders' report, combined financial statements, SEC filings, audited financial statements, media releases, confidential information from other regulatory bodies, and any other available sources.

Assets

20. Review the distribution of the invested assets in order to assess the overall asset quality and note any shift in the mix.

21. 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.

22. Review the distribution of the non-invested assets and assess the overall collectability risk.

23. Review the level of goodwill and intangible assets. Determine the level of goodwill and intangible assets relative to the value of equity. If significant, summarize the following:
    - ❑ Nature of intangible assets
    - ❑ Change or trend in goodwill
    - ❑ Source of goodwill
    - ❑ Impairment of goodwill

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V. Supplemental Procedures – D. Holding Company Analysis

Liabilities (also see questions 12 & 13 regarding holding company debt)

24. Assess overall reserves and loss reserve development and note any unusual trends.

25. Have loss reserves shown an increasing pattern while writings have remained flat? If yes, explain any unusual changes.

26. Review the holding company's commitments and contingent liabilities.
    a. Has the holding company been subject to substantial complaints, class action lawsuits or other litigation or investigations? If so, document the nature and outcome of those matters.
    b. Are any contingencies expected to have a material impact on the financial condition of the holding company? If so, document whether the holding company estimated the potential costs and established a reserve liability.

27. Review all other liabilities (including off-balance sheet risks) and assess any material risks.

Shareholders' Equity (also see question 14 regarding dividends)

28. Review the holding company's statement of shareholders' equity. Has equity decreased from the prior year or deteriorated over the past three years? If yes, describe the reason(s) for the decline.

29. 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.

30. If publicly traded, review the changes in the 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.

31. Assess the holding company's sources of capital and access to capital markets.

Operations

32. Review the revenue of the group.
    a. Identify and understand the lines of business and the types of non-insurance business.
    b. Has the holding company entered into any new lines of business or types of non-insurance business or discontinued any business?
    c. Has the volume of business increased or decreased significantly over the prior year? If so, explain the reason for the change.

33. Review the holding company's gross and net writings to surplus leverage. Are the ratios within an acceptable range?

34. If the holding company group places a significant amount of gross business with reinsurers, assess the following regarding reinsurance agreements:
    - ❑ Risk Transfer
    - ❑ Collateralization to Unauthorized Reinsurance
    - ❑ Recent Reinsurance Transactions
    - ❑ Credit Quality of the Reinsurer

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- Collectibility of Recoverables
- Level of Surplus Aid

Profitability

35. Review the holding company's Statement of Income.
    a. Did the holding company report material operating or net losses?
    b. Review the trend in net earnings. Have net earnings declined over the prior year or over the past five years?

36. Evaluate the earnings trend for insurance operations vs. non-insurance operations and document and determine the causes for weak and/or deteriorating performance by business segment.

37. Review investment income and realized capital gains and losses.
    a. Has net investment income increased or decreased significantly over the prior year? If so, explain the reason for the change.
    b. Document the amount of investment income that is attributed to dividends received from insurance subsidiaries.
    c. Document the annual investment yield. Has the yield decreased materially over the prior year? If so, explain the reason for the change.
    d. Review the components of investment income. Has investment income from any asset category changed significantly over the prior year? If so, explain the reason for the change.
    e. Did the holding company report material realized capital gains/losses? If so, identify the cause of the loss.

38. Review all other sources of revenue and note any material changes or weaknesses.

39. Review benefits and expenses.
    a. Have insurance policy losses increased or decreased substantially over the prior year? If so, explain the reason for the change.
    b. Have administrative and other expenses increased significantly over the prior year? If so, explain the reason for the change.
    c. Summarize the loss and expense ratios by line of business and review the trend.

40. Has the holding company reported any non-recurring revenues or expenses that materially inflate or reduce earnings? If so, describe the reason for the revenue or expense.

41. Did the holding company report income or losses from discontinued operations? If so, summarize the nature of those operations and evaluate the earnings from those operations.

Cash Flow

42. Examine Cash Flow.
    a. Has there been a negative trend in operating activities over the past five years?
    b. Has there been a negative trend in investing activities over the past five years?

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c. Has there been a negative trend in financing activities over the past five years?

43. Evaluate any downstream payments.

International

44. If applicable, develop an overall understanding of the relevant regulatory requirements of the domiciliary country as well as the appropriate supervisory authority.

45. If necessary, identify the appropriate channels of communication with the supervisory authority.

46. Ensure proper monetary conversion of financial data to U.S. currency.

Supplemental Forms

47. If any of the following forms have been filed and the analyst has concerns, consider completing the applicable checklist.

Analyst Recommendation	
❑	Form A (Acquisition of Control or Merger)
❑	Form B (Insurance Holding Company System)
❑	Form D (Prior Notice of a Transaction)
❑	Form E (Pre-Acquisition Notification) or Other Required Information
❑	Extraordinary Dividend/Distribution

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company analysis. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures which, in the analyst's judgment, are relevant to evaluating a holding company under the specific circumstances involved.

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
- ❑ Refer concerns to examination section for targeted examination
- ❑ Meet with the insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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V. Supplemental Procedures – E. Form A

Special Note: The following procedures do not supercede state regulation, but are merely additional guidance an analyst may consider useful.

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. The review of these transactions may vary as some states may have regulations that differ for Form A.

1. Review the NAIC's Form A database to determine whether or not the Form A is pending or has been approved, denied, or withdrawn in another state.

2. Perform a query of the Form A database on the name of the applicant, directors, executive officers or owners of 10 percent or more of the voting securities of the applicant to identify the nature of other filings made in other states by similar individuals.

3. Establish contacts with other states to discuss the status and/or disposition of the current and prior filings made with those states.

4. Does Form A provide a brief description of how control is to be acquired?

5. Does Form A contain the following information:
   - Name and address (legal residence for an individual or street address if not an individual) of the applicant
   - State the nature of the applicant's business operations for the past five years, if the applicant is not an individual
   - Describe the business to be performed by the applicant and its subsidiaries
   - Determine if the organization chart identifies and states the relationship of every member of the insurance holding company system, except for affiliates with total assets less than 0.5 percent of the total assets of the ultimate controlling person within the holding company system

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

7. Does 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?

8. If amounts will be borrowed, does 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? Although not specifically required, if amounts will be borrowed, are the sources of funds to be used to service the debt stated?

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

10. Does Form A describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate the insurer, to enter into material agreements (including affiliated agreements), to

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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?

11. Does Form A state the number of each class of shares of the insurer's voting securities that the applicant, its affiliates and any person plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was determined?

12. Does Form A state 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?

13. Does Form A give 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.

14. Does Form A 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 Form A?

15. Does Form A describe any recommendations to purchase any voting securities of the insurer made by the applicant, its affiliates or any person, or by anyone based upon interviews or the suggestion of the applicant, its affiliates or any person during the 12 calendar months preceding the filing of the Form A?

16. Does Form A 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?

17. Does Form A summarize the financial statements and exhibits attached to the filing?
    - ❑ Audited Financial Statements of persons identified in Form A
    - ❑ 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
    - ❑ Management's assessment of internal controls accompanied by an independent public accountant's report to the effect that the applicant maintained effective internal control

18. Does Form A 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, 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 Form A?

19. Does Form A contain the required signature and certification?

Assessment of the Change in Control

20. After the change of control, will the insurer be able to satisfy the requirements for the issuance of a license to write the classes of insurance for which it is presently licensed?

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V. Supplemental Procedures – E. Form A

21. 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 Form E been filed?

22. Is the financial condition of any acquiring person such that it might jeopardize the financial stability of the insurer, or prejudice the interest of the insurer's policyholders?

23. Will dividends from the insurer be required to support debt payments of the applicant or the applicant's subsidiaries?

24. Are the competence, experience, and integrity of those persons who would control the operation of the insurer such that it would not be in the interest of the insurer's policyholders and of the public to permit the acquisition of control?

25. After the change in control, will the insurer's policyholders' surplus be reasonable in relation to its outstanding liabilities and adequate for its financial needs?

26. Review financial projections for both 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 and are based on reasonable expectations.

27. 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 cash flows appear adequate to cover such obligations without relying heavily on cash flows from the insurer.

28. 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 arms-length, fair and reasonable to the insurer.

29. 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.)?

30. Has the application been publicized to all interested persons both inside and outside of the insurance department in accordance with the department's policy or applicable laws?

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

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

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form A. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating holding company Form A under the specific circumstances involved.

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

- ❑ Contact the insurer seeking explanations or additional information

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V. Supplemental Procedures – E. Form A

- ❑ Obtain the insurer's business plan
- ❑ Require additional interim reporting from the insurer
- ❑ Refer concerns to examination section for targeted examination
- ❑ Meet with the insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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V. Supplemental Procedures – F. Form B

Special Note: The following procedures do not supercede state regulation, but are merely additional guidance an analyst may consider useful.

Form B – Insurance Holding Company System Annual Registration Statement

1. Did the registration statement, filed in accordance with the NAIC Model Holding Company System Regulatory Act, include the following current information?
    a. 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.
    b. The identity and relationship of every member of the insurance holding company system, except affiliates with total assets equal to or less than 0.5 percent of the total assets of the ultimate controlling person within the holding company system.
    c. The following agreements in force and transactions currently outstanding or which have occurred during the last calendar year between the insurer and its affiliates:
        i. Loans, other investments, purchases, sales, or exchanges of securities of the affiliates by the insurer or vice versa, involving 0.5 percent or more of the registrant's admitted assets as of December 31 of the most recent prior year ended
        ii. Purchases, sales, or exchange of assets involving 0.5 percent or more of registrant's admitted assets as of December 31, of the most recent prior year ended
        iii. Transactions not in the ordinary course of business
        iv. 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 percent or more of registrant's admitted assets as of December 31 of the most recent prior year ended, other than insurance contracts entered into in the ordinary course of the insurer's business
        v. All reinsurance or management agreements, service contracts, consolidated tax allocation agreements, and cost-sharing arrangements
        vii. Dividends and other distributions to shareholders
    d. 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.
    e. 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.
    f. A summary outlining all items in the current registration statement representing changes from the prior registration statement (Form C).

2. If the response is yes to any of the questions in 1.c. - 1.e. above, did the insurer provide a description of the transaction or agreement, which would permit a proper evaluation by the Commissioner, 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.

3. Did each registered insurer properly report dividends and other distributions to shareholders in accordance with the following Model Holding Company System Regulatory Act requirements?
    a. Were all dividends and other distributions to shareholders reported within fifteen business days following the declaration thereof?
    b. Were any dividends and other distributions to shareholders considered extraordinary?

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c. If the answer to 3.b. above is yes, did the transaction receive proper regulatory approval?

4. Did any transaction, which occurred during the last calendar year involving the insurer and others in its holding company system, require prior regulatory approval?

a. Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments where the transactions equal or exceed:

i. With respect to non-life insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of policyholders' surplus as of December 31 of the most recent prior year ended

ii. With respect to life insurers, 3 percent of the insurer's admitted assets as of December 31 of the most recent prior year ended

b. 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:

i. With respect to non-life insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of policyholders' surplus as of December 31 of the most recent prior year ended

ii. With respect to life insurers, 3 percent of the insurer's admitted assets as of December 31 of the most recent prior year ended

c. Reinsurance agreements or modifications thereto, in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds 5 percent of the insurer's policyholders' surplus as of December 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.

d. All management agreements, service contracts, and cost-sharing arrangements.

e. Any material transactions, specified by regulation, which the Commissioner determines may adversely affect the interest of the insurer's policyholders.

f. If the answer to any of the questions in 4.a. - 4.e. above is yes, did the insurer receive proper prior regulatory approval?

5. Based upon a review of the registration statement, were any significant and/or unusual items noted, such as the following:

a. Persons holding 10 percent 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.

b. Biographical information about directors or officers, which may elevate concerns such as convictions of crimes.

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.

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V. Supplemental Procedures – F. Form B

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.

e. Unusual information included in the holding company financial statements, such as:

i. Heavy reliance on dividends from the insurer to fund any holding company debt service requirements

ii. Lenders of the holding company that are open depositories of the insurer

iii. Evidence of any financial problems that may potentially impact the insurer

6. Were there any inconsistencies between responses indicated in the Affiliated Transactions Level 2 Procedures and the response in this Form B analysis?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form B. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating holding company Form B under the specific circumstances involved.

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
- ❑ Refer concerns to examination section for targeted examination
- ❑ Meet with the insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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V. Supplemental Procedures – G. Form D

Special Note: The following procedures do not supercede state regulation, but are merely additional guidance an analyst may consider useful.

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.

1. If a material transaction has occurred, did the insurer file a Form D with their domestic state? (Section 5 of the NAIC Insurance Holding Company System Regulatory Act 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:
   - ❑ 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
   - ❑ 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

5. If the transaction involves consideration other than cash, does the 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 which 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?

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V. Supplemental Procedures – G. Form D

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 the 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, 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)

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

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- ❑ A brief description of the accounting basis to be used in calculating each party's costs under the agreement
- ❑ A description of when amounts are settled and a provision for interest in the event that settlements are not made timely

14. Review Form D for any significant and/or unusual items or inconsistencies. Determine if the transaction appears fair and reasonable in relation to the following:
    a. For reinsurance agreements, are the general terms, settlement provision and pricing consistent with those of non-affiliated agreements?
    b. For management, service or cost-sharing agreement are the 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*?
    f. Do unusual circumstances or concerns exist?

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

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form D. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures, which in the analyst's judgment are relevant to evaluating holding company Form D under the specific circumstances involved.

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
- ❑ Refer concerns to examination section for targeted examination
- ❑ Meet with the insurer's management
- ❑ Obtain a corrective plan from the insurer
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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V. Supplemental Procedures – H. Form E (or Other Required Information)

Special Note: The following procedures do not supersede state regulation, but are merely additional guidance an analyst 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 persons 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 persons affiliated with the persons 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 persons 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 persons identified in questions 1 and 2 currently benefit from in this state
   - ❑ Historical market and market share data for each person identified in questions 1 and 2 for the past five years
   - ❑ The sources of the above 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?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form E or other required information. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating holding company Form E or other required information under the specific circumstances involved.

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

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V. Supplemental Procedures – H. Form E (or Other Required Information)

- ❑ Require additional interim reporting from the insurer
- ❑ Meet with the insurer's management
- ❑ Other (explain)

Analyst _____ Date_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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V. Supplemental Procedures – I. Extraordinary Dividend/Distribution

Special Note: The following procedures do not supersede state regulation, but are merely additional guidance an analyst 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 Extraordinary Dividend/Distribution form. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the holding company Extraordinary Dividend/Distribution form under the specific circumstances involved.

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_____

Comments as a result of supervisory review.

Reviewer_____ Date_____

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VI. Quarterly Procedures

Level 1

A. Level 1 Quarterly Procedures

Level 2

B.1. Investments

B.2. Life Reserves

B.3. Accident and Health Reserves

B.4. Annuity Reserves

B.5. Income Statement and Surplus

B.6. Cash Flow and Liquidity

B.7. Reinsurance

B.8. Affiliated Transactions

B.9. MGAs and TPAs

B.10. Separate Accounts

Fraternal

C.1. Level 1 Quarterly Procedures

VI.A. Level 1 Quarterly Procedures

Background Analysis

1. Review the analysis performed on the insurer for the prior year and prior quarters.

   a. Indicate the state's priority designation or any prioritization tool result as of the last review and start of the current review:

   State's Priority Designation _____
   Scoring System Total _____
   IRIS System Results _____
   Analyst Team System Validated Level _____
   RBC Ratio and Trend Test _____

   b. Were there any issues or concerns noted in previous annual or quarterly analysis completed in the prior year? If "yes," discuss the issues or concerns, the follow-up conducted, and include any correspondence with the insurer, along with any conclusions.

   c. Have any of the following been received or reviewed since the last analysis? If yes, complete or review any Level 2 or Supplemental Procedures that relate to these items and comment on them here:

   - ❑ Financial Examination Report
   - ❑ Audited Financial Report
   - ❑ Statement of Actuarial Opinion
   - ❑ MD&A
   - ❑ Holding Company Filing(s)

   d. As the domestic regulator, review the Insurer Profile Summary, including the Supervisory Plan, if applicable, and document any areas of concern that impact the current analysis.

2. Review any inter-departmental communication, as well as communication with other state insurance departments and the insurer. Note any unusual items or areas that indicate further review or follow-up is necessary.

3. Review General Interrogatory # 4.1. Has the insurer been a party to a merger or consolidation? If yes, review the list of the companies involved in the merger/consolidation and note any observations. Also, ensure Form A or additional filings have been approved.

4. Review General Interrogatory # 7.1. Has the insurer had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? If yes, please review the reason(s) stated for the revocation or suspension, noting any observations.

5. Are there any changes in the state's statutes and/or regulations that could impact the insurer's financial position and reporting? If yes, to the extent information is available, has the insurer failed to comply with the state's statutes and regulations enacted during the period?

6. Review the most recent report from an Acceptable Rating Orgnization. Also note the current financial strength and credit rating and briefly discuss the explanation of the rating or any change in the rating.

7. Review any industry reports, news releases and emerging issues that have the potential to negatively impact the insurer.

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VI.A. Level 1 Quarterly Procedures

8. Review the most recent business plan and financial projections, if available from recent surveillance activity and if considered necessary based on the insurer's priority designation and financial condition.

   a. If significant changes in business plan or philosophy have occurred, assess the insurer's ability to attain the expectations of the business plan.

   b. Are actual results consistent with management's expectations?

Management Assessment

9. Review the Quarterly Financial Statement Jurat Page (page 1).

   a. Did the insurer fail to properly execute and notarize the Jurat Page?

   b. Has there been any change(s) in officers, directors or trustees since the previous Financial Statement (indicated by a "#" after the name)? If yes, indicate the positions in which the changes have occurred. Review the Biographical Affidavit(s) for any new officers, directors or trustees indicated above and note any areas of concern that would indicate further review is necessary.

      - ☐ President
      - ☐ Secretary
      - ☐ Treasurer
      - ☐ Vice Presidents (number: ____)
      - ☐ Directors or Trustees (number: ____)
      - ☐ Other

   c. Assess any significant corporate governance changes and determine whether these changes appear to indicate a shift in management philosophy, or whether management has made any changes in business culture or business plan.

Balance Sheet Assessment

10. Review the Quarterly Financial Statement Assets (page 2) and Liabilities, Surplus and Other Funds (page 3) and the Quarterly Financial Profile Report.

    a. Is capital and surplus below the statutory required minimum?

    b. Is capital and surplus less than 5 percent of total admitted assets, excluding separate accounts?

    c. Has capital and surplus changed by greater than +/-20 percent from the prior year-end? If yes, indicate the current quarter balance and the percentage change from the prior year-end.

    d. Has there been any change in surplus or capital notes during the quarter? If yes, comment on any notes issued, principal or interest paid, or any other changes that have been made. Also, comment on whether any necessary approvals were obtained.

    e. Is the amount of any individual asset category, other than cash and invested assets, greater than 10 percent of total admitted assets, excluding separate accounts? If yes, indicate the asset category and amount.

    f. Has any individual asset category, which exceeds 5 percent of total assets for either the current or prior year, changed by more than +/-20 percent from the prior year-end? If yes, indicate the asset category, current balance, and the percentage change from the prior year-end.

    g. Is the amount of any individual liability category, other than aggregate reserves for life policies and contracts, aggregate reserves for accident and health policies, deposit-type deposit contracts greater than 10 percent of total liabilities? If yes, indicate the liability category and amount.

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h. Has any individual liability category, which exceeds 5 percent of total liabilities for either the current or prior year, changed by more than +/-20 percent from the prior year-end? If yes, indicate the liability category, current balance, and the percentage change from the prior year-end.

Operations Assessment

11. Review the Quarterly Financial Statement, Statement of Operations (page 4) and the Quarterly Financial Profile Report.

    a. If the absolute value of net income (loss) exceeds 5 percent of capital and surplus, has net income (loss) decreased by more than 20 percent or increased by more than 40 percent from the prior year-to-date? If yes, indicate the current quarter balance and the percentage change from the prior year-to-date.

    b. Has any individual summary of operations category, whose balance exceeded 5 percent of capital and surplus for either the current year or prior year, changed by more than +/-20 percent from the prior year-to-date? If yes, indicate the line item, current balance, and the percentage change from the prior year-to-date.

    c. Has any individual direct premiums and deposit-type contract funds category changed by more than +/-20 percent from the prior year-to-date? If yes, indicate the premium category, current year-to-date balance, and the percentage change from the prior year-to-date.

    d. Are net unrealized capital gain/losses more than 10 percent of prior year-end capital and surplus?

Investment Practices

12. Review Schedule D – Part 1B, showing the acquisitions, dispositions and non-trading activity during the current period for bonds and preferred stocks by rating class.

    a. Has the percentage of (i) investment or (ii) non-investment grade bonds to total bonds at the end of the quarter changed by +/-10 percentage points or greater from the percentage owned at the beginning of the quarter?

    b. Has the percentage of (i) investment or (ii) non-investment grade preferred stock to total preferred stock at the end of the quarter changed by +/-10 percentage points or greater from the percentage owned at the beginning of the quarter?

Review of Disclosures

13. Review the Quarterly Statement Notes to Financials, General Interrogatories and Supplemental Schedules and note anything unusual.

Assessment of Results from Prioritization and Analytical Tools

14. Review the insurer's Quarterly Scoring System results.

    a. Indicate the insurer's total score.

    b. Provide an explanation on each individual ratio result that received a score of 50 points.

15. Review the Quarterly Financial Profile Report and provide an explanation for any unusual or significant fluctuations or trends.

16. Review any market conduct information including information available from the state's market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee), and the NAIC market analysis tools and databases (MAP, ETS, MARS, RIRS, SAD, MITS, and Complaints). The

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analyst should note any unusual items that translate into financial risks or indicate further review and/or additional communication is needed with the Department's market analysis staff.

Assessment of Latest Examination Report and Results

17. Review General Interrogatory #6, and determine if a financial examination report was released by the domicilary state since the last review.

    a. As of what balance sheet date is/was the latest financial examination of the insurer?

    b. As of what balance sheet date is the latest financial examination report available from either the state of domicile or the insurer?

    c. As of what release date is the latest financial examination report available from either the state of domicile or the insurer?

    d. Have any financial statement adjustments within the latest financial examination report not been accounted for in a subsequent financial statement filed with the Department?

    e. Have any of the recommendations within the latest financial examination report not been complied with?

    If yes, or if follow-up was required from the review of the examination report in a previous analysis period, complete the following procedures.

    f. If the answers to 17.d. or 17.e. are yes, follow up with the insurer regarding the implementation of recommendations in the Financial Examination Report.

    g. During the review of the latest state examination report, the results from that examination and communication with the examiner-in-charge (for domestic insurers), did the analyst note any items or areas that indicate further review is warranted?

    h. Follow up and document on any management letter comments that should be addressed in the current period, if applicable.

Recommendation for Further Analysis

Do you recommend that any of the Level 2, 3 or Supplemental Procedures or other procedures listed below be completed? If yes, indicate the sections that the analyst recommend be completed:

A. Perform Level 2 or Level 3 Procedures:

- ❑ All Sections
- ❑ Investments
- ❑ Life Reserves
- ❑ Accident and Health Reserves
- ❑ Annuity Reserves
- ❑ Income Statement and Surplus
- ❑ Cash Flow and Liquidity
- ❑ Reinsurance
- ❑ Affiliated Transactions
- ❑ MGAs and TPAs
- ❑ Separate Accounts

B. Perform Supplemental Procedures:

- ❑ Audited Annual Financial Statement
- ❑ Statement of Actuarial Opinion

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VI.A. Level 1 Quarterly Procedures

- ❑ Management's Discussion and Analysis
- ❑ Holding Company Analysis
- ❑ Form A
- ❑ Form B
- ❑ Form D
- ❑ Form E (or Other Required Information)
- ❑ Extraordinary Dividends/Distributions

C. Request and review the current business plan and financial projections.

i. If significant changes in the business plan or philosophy have occurred, assess the insurer's ability to attain these expectations.

ii. Determine if actual results are tracking with projection and note any significant variances and the reason(s).

Summary and Conclusion

After completion of any Level 2 or subordinate procedures, develop and document an overall summary and conclusion based on the findings. In developing a conclusion, the analyst should consider the above procedures, as well as any other factors that, in the analyst's judgment, are relevant to evaluating the insurer's overall financial condition. The summary and conclusion should include details regarding strengths and weaknesses. In addition, update the Insurer Profile Summary, including the Supervisory Plan, if applicable, for the results of the analysis performed.

Do you recommend that the insurer be designated a priority as a result of the procedures performed? If yes, indicate the recommended priority designation and rationale.

Describe the rationale for these recommendations.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

Correspondence

The analyst should document any follow-up regarding the Level 1, 2, 3 and Supplemental Procedures.

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VI. Level 2 Quarterly Procedures – B. 1. Investments

1. Determine whether the insurer's investment portfolio appears to be adequately diversified to avoid an undue concentration of investments by type.
   a. Are preferred stocks owned greater than 5 percent of total admitted assets (excluding separate accounts)?
   b. Are common stocks owned greater than 10 percent of total admitted assets (excluding separate accounts)?
   c. Are non-investment grade bonds owned greater than 3.5 percent of total admitted assets (excluding separate accounts)?
   d. Are mortgage loans owned greater than 20 percent of total admitted assets (excluding separate accounts)?
   e. Is real estate owned (less encumbrances), including home office real estate, greater than 10 percent of total admitted assets (excluding separate accounts)?
   f. Are other invested assets (Schedule BA) greater than 5 percent of total admitted assets (excluding separate accounts)?
   g. Are aggregate write-ins for invested assets greater than 5 percent of total admitted assets (excluding separate accounts)?
   h. Are investments in affiliates greater than 10 percent of total admitted assets (excluding separate accounts)?

2. Determine whether the insurer has significantly increased its holdings since the prior year-end in certain types of investments, which tend to be riskier and/or less liquid than publicly traded investment grade bonds and stocks, cash and short-term investments.
   a. If the ratio of investments in non-investment grade bonds to invested assets exceeds 3.5 percent, have such investments increased by greater than 15 percent over the prior year-end?
   b. If the ratio of investments in total real estate and mortgage loans to invested assets exceeds 10 percent, have such investments increased by greater than 15 percent over the prior year-end?
   c. If the ratio of investments in Schedule BA assets to invested assets exceeds 3.5 percent, have such assets increased by greater than 10 percent over the prior year-end?
   d. If the ratio of aggregate write-ins for invested assets to invested assets exceeds 3.5 percent, have such assets increased by greater than 20 percent over the prior year-end?
   e. If the ratio of affiliated investments to invested assets exceeds 3.5 percent, have such assets increased by greater than 20 percent over the prior year-end?

3. Determine whether there are concerns due to the level of investment in derivative instruments.
   a. Review Schedule DB, Parts A, B and C, Section 1. Is the total statement value greater than 5 percent of capital and surplus and AVR? If yes, list total statement value and percentage of capital and surplus and AVR for hedging, other and total derivative transactions.
   b. Review Schedule DB – Part A – Section 1 (Options, Caps, Floors, Collars, Swaps and Forwards Open as of Current Statement Date) and Schedule DB – Part B – Section 1 (Future Contracts Open as of Current Statement Date). If the ratio of potential exposure on futures contracts and options, caps and floors, collars, swaps and forwards to capital and surplus and AVR exceeds 3.5 percent, have such investments increased more than 10 percent over the prior year-end?

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c. Review Schedule DB – Part D – Section 1: Counterparty Exposure for Derivative Instruments Open as of Current Statement Date. If the ratio of potential exposure on counterparty exposure for derivative instruments to capital and surplus and AVR exceeds 3.5 percent, have such investments increased more than 10 percent over the prior year-end?

4. Determine whether all securities owned are under the control of the insurer and in the insurer's possession. Review General Interrogatory #11.1. Were any of the assets of the insurer loaned, placed under option agreement or otherwise made available for use by another person (excluding securities under securities lending agreements)?

5. Determine whether securities owned have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office.

   a. Review General Interrogatory for Investments Part 1, #17.1. Has the Company failed to follow the filing requirements of the *Purposes and Procedures Manual* of the SVO?

   b. If the answer to 5.a. is yes, document the exceptions listed in General Interrogatory Part 1, #17.2.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating the insurer's investments under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for investments be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B. 2. Life Reserves

1. If aggregate reserve for life policies and contracts exceeds 10 percent of capital and surplus, has such reserve changed by greater than +/-25 percent from the prior year-end?

2. Review the Mix of Assets section of the Quarterly Financial Profile Reports. Have there been any significant shifts (greater than +/-25 points) in any asset categories from the prior year-end.

3. Review, by line of business, the year-to-date direct premiums for the current and prior year in the Exhibit of Direct Premiums and Deposit-Type Contracts (Lines 1, 2, 4, 5, and 10). Have direct premiums for any line of business changed by greater than +/-25 percent from the prior year, same quarter?

Summary and Conclusions

Develop and document an overall summary and conclusion regarding life reserves. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating the insurer's life reserves under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for life reserves be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B. 3. Accident and Health Reserves

1. If aggregate reserve for A&H policies exceeds 10 percent of capital and surplus, has such reserve changed by greater than +/-10 percent from the prior year-end?

2. If A&H policy and contract claims exceed 10 percent of capital and surplus, have such policy and claims changed by greater than +/-10 percent from the prior year-end?

3. If disability benefits and benefits under A&H policies exceed 10 percent of capital and surplus, have such benefits changed by greater than +/-10 percent from the prior year, same quarter?

4. Is the ratio of aggregate reserves for A&H policies to capital and surplus greater than 300 percent?

5. Review, by line of business, the year-to-date direct premiums for the current and prior year in the Exhibit of Direct Premiums and Deposit-Type Contracts (lines 7, 8, 9, and 10). Have direct premiums for any line of business changed by greater than +/-25 percent from the prior year, same quarter?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding A&H reserves. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating A&H reserves under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for A&H reserves be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures - B. 4. Annuity & Deposit-Type Fund Reserve

1. Review the Quarterly Financial Statement Liabilities, Surplus, and Other Funds (page 3). If liability for deposit-type contracts exceed 5 percent of capital and surplus, have such contracts changed by greater than +/-15 percent from the prior year end?

2. Has the Summary of Operations item surrender benefits and other fund withdrawals changed by greater than +/-25 percent from the prior year, same quarter?

3. Review the Mix of Assets section of the Quarterly Financial Profile Reports. Have there been significant shifts (greater than +/-25 points) in any asset categories from the prior year-end?

4. Review, by line of business, the year-to-date direct premiums and deposit-type contract funds for the current and prior year in the Exhibit of Direct Premiums and Deposit-Type Contracts (lines 3, 6, 10 and 12). Have direct premiums for any line of business or deposit-type contract funds changed by greater than +/-25 percent from the prior year, same quarter?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding annuity reserves. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating the insurer's annuity reserves under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for annuity reserves be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B. 5. Income Statement and Surplus

1. Determine whether concerns exist regarding the insurer's income statement or operating performance.
   a. Has there been a year-to-date net loss?
   b. If the absolute value of the change in net income from the prior year-to-date exceeds 10 percent of capital and surplus, is the change less than -30 percent?
   c. Is the ratio of surrenders to premiums greater than 30 percent?
   d. Is the ratio of commissions and administrative expenses to premiums and deposits (Quarterly Financial Profile Reports) greater than 50 percent?
   e. If the absolute value of net realized capital gains or losses exceeds 3 percent of capital and surplus, is the ratio of net realized capital gains to net income greater than +/-25 percent?
   f. Review the Summary of Operations in the Quarterly Financial Statement.
      i. If aggregate write-ins for miscellaneous income exceed 3 percent of capital and surplus, is the ratio of aggregate write-ins for miscellaneous income to net income greater than +/-25 percent?
      ii. If aggregate write-ins for deductions exceed 3 percent of capital and surplus, is the ratio of aggregate write-ins for deductions to net income greater than +/-25 percent?

2. Determine whether concerns exist regarding changes in the volume of premiums and deposit-type contract funds or changes in the insurer's product mix.
   a. Is the ratio of change in net premiums and annuity considerations greater than +/-30 percent, from the prior year, same quarter?
   b. Review, by line of business, the year-to-date direct premiums and deposit-type funds for the current and prior year in the Exhibit of Direct Premiums and Deposit-Type Contracts. Have the direct premiums for any line of business changed by greater than +/-25 percent from the prior year, same quarter?

3. Determine whether the insurer may be excessively leveraged due to its volume of accident and health (A&H) business.
   a. Is the ratio of A&H premiums to net premiums and annuity considerations greater than 75 percent?
   b. If the response to a. above is yes, is the ratio of gross A&H premiums for the last four quarters to capital and surplus greater than 500 percent?
   c. If the response to a. above is yes, is the ratio of net A&H premiums for the last four quarters to capital and surplus greater than 300 percent?

4. Determine whether concerns exist regarding the amount of the insurer's capital and surplus.
   a. Has capital and surplus changed by greater than 50 percent or less than -10 percent from the prior year-end?
   b. Does the absolute value of the current year change exceed 3 percent of current year capital and surplus for any of the following items: 1) net unrealized capital gains/losses, 2) net unrealized foreign exchange capital gains/losses, 3) net deferred income tax, 4) nonadmitted assets, 5) the liability for unauthorized reinsurance, 6) reserve valuation basis, 7) AVR, 8) surplus notes, and/or 9) change in accounting principles?

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c. If the insurer issued capital or surplus notes during the quarter, is the sum of the capital and surplus notes issued during the quarter greater than 10 percent of the current quarter capital and surplus? If the answer is yes, then list the amount of any new capital or surplus notes issued during the quarter.

d. Did the insurer repay any principal and/or pay any interest on capital or surplus notes during the quarter?

e. Did the insurer pay dividends to stockholders during the quarter?

   i. If the answer to e. above is yes, was the amount of the stockholder dividend at a level that required prior regulatory approval or notification?

   ii. If the answer to e.i. above is yes, did the insurer fail to obtain proper prior regulatory approvals?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the insurer's income statement and surplus. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating the insurer's income statement and surplus under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for the income statement and surplus be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B. 6. Cash Flow and Liquidity

1. Determine whether concerns exist regarding the insurer's cash flow from operations. Review the Statements of Cash Flow for the current quarter and prior year, same quarter.
   a. Is net cash from operations negative?

      If yes, calculate and consider the ratios:

      i. Net cash from operations to premium income.

      ii. Net cash from operations to capital and surplus.

   b. Has net cash from operations, changed by greater than +/-10 percent of capital and surplus?

   c. Has net transfers to or from separate accounts, changed by greater than +/-10 percent from the prior quarter-to-date?

   d. Is net transfers to or from separate accounts, greater than 20 percent of capital and surplus?

   e. Has other cash provided (applied), changed by greater than +/-10 percent of capital and surplus?

   f. Is other cash provided (applied), greater than 10 percent of capital and surplus?

   g. Is other cash provided (applied), greater than +/-150 percent of net cash from operations?

   h. Have surrender benefits (from Summary of Operations), changed by greater than +/- 5 percent of capital and surplus?

2. Determine whether concerns exist regarding the insurer's overall level of liquidity.
   a. Is the Change in Liquid Assets from the prior year quarter-to-date or from the prior year-end less than negative 15 percent or greater than 80 percent?

   b. Are surrender benefits (from Summary of Operations) greater than 20 percent of capital and surplus?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding cash flow and liquidity. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating cash flow and liquidity under the specific circumstances involved.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B. 7. Reinsurance

1. Determine whether amounts recoverable from reinsurers are significant.
   a. Is the balance sheet asset, reinsurance ceded, greater than 10 percent of capital and surplus?
   b. Has the balance sheet asset, reinsurance ceded, changed by greater +/-25 percent from the prior year-end?

2. Determine whether the liability for reinsurance in unauthorized companies is significant. Review the Quarterly Financial Statement pages related to Liabilities, Surplus and Other Funds and Summary of Operations.
   a. Is there a balance sheet liability for reinsurance in unauthorized companies?
   b. Has the balance sheet liability reinsurance in unauthorized companies changed by greater than +/-10% from the prior quarter or +/-20 percent from the prior year-end?
   c. Has the Summary of Operations, capital and surplus account line item relating to the change in liability for reinsurance in unauthorized companies changed by greater than +/-10 percent from the prior quarter or +/-20 percent from the prior year-end?

3. Determine whether any unusual reinsurance transactions were completed during the quarter.
   a. Review Schedule S - Ceded Reinsurance. Were any new reinsurers added since the prior quarter?
   b. Did the insurer report, during the quarter, in accordance with the Disclosure of Material Transactions Model Act (General Interrogatory #1.1), any material nonrenewals, cancellations or revisions of ceded reinsurance agreements?
   c. If the answer to 3.b. is yes, did the insurer fail to make the appropriate filing of a Disclosure of Material Transactions with the State of Domicile Act (General Interrogatory #1.2)?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding reinsurance. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating reinsurance under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for reinsurance be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B. 8. Affiliated Transactions

1. Determine whether the insurer is a member of a holding company group and, if so, whether the corporate structure, or any changes in the corporate structure, elevate concerns about affiliated transactions.
   a. Was the insurer a member of an insurance Holding Company System as of the prior year-end?
   b. Has the Department directed the insurer to file a Holding Company registration statement?
   c. Did the insurer fail to file a registration statement in accordance with the Model Holding Company System Regulatory Act?
   d. Briefly scan Schedule Y, along with the General Interrogatories. Is there any information noted that contradicts the response to 1.a. above?

If the answers to 1.a. – 1.d. are no, do not proceed with the Affiliated Transactions procedures and skip to the next financial analysis topic.

   e. Review Notes to Financials. Did the insurer report a change in the insurer's capital structure?
   f. Review General Interrogatory #3. Have there been substantial changes in the organization chart?
   g. If the answer to 1.f. is yes, and the change involved ownership of the insurer or a transaction with an affiliate, did the insurer fail to receive proper regulatory approvals?
   h. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company?
   i. Does the insurer have an agency or brokerage subsidiary?
   j. Review General Interrogatory #5. Have there been changes to any management agreement in terms of the agreement or principals involved?

2. Determine whether major transactions with affiliates are economic-based and in compliance with regulatory guidelines.
   a. Review the Summary of Operations, capital and surplus account line item dividends to stockholders.
      i. Is the amount of the stockholder dividend at a level that required prior regulatory approval or notification?
      ii. If the answer to 2.a.i. is yes, did the insurer fail to obtain proper prior regulatory approvals?
   b. Review Schedule A - Part 2, Real Estate Acquired by Company During the Current Period, and Schedule BA - Part 1, Long-Term Invested Assets Acquired During the Current Period?
      i. Did any such acquisitions involve an affiliate, or other related party?
      ii. If the answer to 2.b.i. is yes, is the amount of the acquisition greater than 5 percent of capital and surplus?
      iii. If either answers to 2.b.i. and ii. is yes, is there any reason to believe the sale was recorded on a basis other than fair market value?
   c. Review Schedule A - Part 3, Real Estate Sold During the Current Period, and Schedule BA - Part 2, Long-Term Invested Assets Disposed of During the Current Period.
      i. Did any such dispositions involve an affiliate or other related party?
      ii. If the answer to 2.c.i. is yes, is the amount of the disposition greater than 5 percent of capital and surplus?

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iii. If either answers to 2.c.i. and ii. is yes, is there any reason to believe the sale was recorded on a basis other than fair market value?

3. Review General Interrogatory #14. Determine whether investments in affiliates are significant.
   a. Is the total of all investments in affiliates greater than 20 percent of capital and surplus?
   b. Has the total of all investments in affiliates changed by greater than +/-20 percent from the prior year-end?
   c. Has there been any change in any category of affiliated investments greater than +/-10 percent from the prior year-end?

4. Determine whether other affiliated transactions are legitimate and properly accounted for.
   a. If federal and foreign income tax recoverables exceed 3 percent of total assets (excluding separate accounts), have such recoverables changed by greater than +/-10 percent from the prior quarter or +/-20 percent from the prior year-end?
   b. Is the receivable from parent, subsidiaries and affiliates greater than 10 percent of capital and surplus?
   c. Has the receivable from parent, subsidiaries and affiliates changed by greater than +/-25 percent from the prior year-end?
   d. Is the payable to parent, subsidiaries and affiliates greater than 10 percent of capital and surplus?
   e. Has the payable to parent, subsidiaries and affiliates changed by greater than +/-25 percent from the prior year-end?
   f. Review Schedule E.
      i. Were any open depositories a parent, subsidiary or affiliate?
      ii. Based upon a review of the holding company financial statements, are there any holding company lenders that appear as open depositories of the insurer?

5. Are there any indications that significant transactions or unusual transactions involve an affiliate or other related party?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding affiliated transactions. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating affiliated transactions under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for affiliated transactions be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B. 9. MGAs and TPAs

1. Review General Interrogatory #5. Have there been any significant changes regarding the terms of any agreements with MGAs or TPAs?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding whether concerns exist due to the insurer's use of MGAs and TPAs. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating the insurer's use of MGAs and TPAs under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for MGAs and TPAs be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI. Level 2 Quarterly Procedures – B. 10. Separate Accounts

1. Determine whether the insurer maintains separate accounts. Review the Balance Sheet asset and liability items relating to separate accounts business. Are there balances in either of these categories?

   If the answer above is no, do not proceed with the Separate Accounts procedures and skip to the next financial analysis topic.

2. Have the Balance Sheet items assets from separate accounts or liabilities from separate accounts changed by greater than +/-10 percent from the prior year-end?

3. Review the Capital and Surplus Account Statement (page 4).
   a. Is the line item, other changes in surplus, in the Separate Accounts Statement greater than 5 percent of capital and surplus?
   b. Did the line item, other changes in surplus, in the Separate Accounts Statement change by greater than +/-10 percent from the prior year, same quarter?

4. Review the Summary of Operations (page 4).
   a. Did the line item, net transfers to or (from) separate accounts, change by greater than +/-20 percent from the prior year, same quarter?
   b. Did the insurer report a net loss in the line item, net gain from operations from separate accounts, whose absolute value is greater than 5 percent of general account capital and surplus?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding separate accounts. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures, which, in the analyst's judgment, are relevant to evaluating the insurer's separate accounts under the specific circumstances involved.

Do you recommend that one or more of the procedures in the Level 3 Procedures for separate accounts be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed? Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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VI.C. Level 1 Quarterly Procedures for Fraternal Societies

Background Analysis

1. Review the analysis performed on the society for the prior year and prior quarters.

   a. Indicate the state's priority designation or any prioritization tool result as of the last review and start of the current review:

   State's Priority Designation _____
   IRIS System Results _____
   Analyst Team System Validated Level _____
   RBC Ratio _____

   b. Were there any issues or concerns noted in previous annual or quarterly analysis completed in the prior year? If "yes," discuss the issues or concerns, the follow-up conducted, and include any correspondence with the society, along with any conclusions.

   c. Have any of the following been received or reviewed since the last analysis? If yes, complete or review any Level 2 or Supplemental Procedures that relate to these items and comment on them here:

   - ❑ Financial Examination Report
   - ❑ Audited Financial Report
   - ❑ Statement of Actuarial Opinion
   - ❑ MD&A
   - ❑ Holding Company Filing(s)

   d. As the domestic regulator, review the Insurer Profile Summary, including the Supervisory Plan, if applicable, and document any areas of concern that impact the current analysis.

2. Review any inter-departmental communication, as well as communication with other state insurance departments and the society. Note any unusual items or areas that indicate further review or follow-up is necessary.

3. Review General Interrogatory #4.1. Has the society been a party to a merger or consolidation? If yes, review the list of the companies involved in the merger/consolidation and note any observations. Also, ensure Form A or additional filings have been approved.

4. Review General Interrogatory #7.1. Has the society had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? If yes, please review the reason(s) stated for the revocation or suspension, noting any observations.

5. Are there any changes in the state's statutes and/or regulations that could impact the society's financial position and reporting? If yes, to the extent information is available, has the society failed to comply with the state's statutes and regulations enacted during the period?

6. Review the most recent report from a nationally recognized rating agency. Also note the current financial strength and credit rating and briefly discuss the explanation of the rating or any change in the rating.

7. Review any industry reports, news releases and emerging issues that have the potential to negatively impact the society.

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VI.C. Level 1 Quarterly Procedures for Fraternal Societies

8. Review the most recent business plan and financial projections, if available from recent surveillance activity and if considered necessary based on the society's priority designation and financial condition.

   a. If significant changes in business plan or philosophy have occurred, assess the society's ability to attain the expectations of the business plan.

   b. Are actual results consistent with management's expectations?

Management Assessment

9. Review the Quarterly Financial Statement Jurat Page (page 1).

   a. Did the society fail to properly execute and notarize the Jurat Page?

   b. Has there been any change(s) in officers, directors or trustees since the previous Financial Statement (indicated by a "#" after the name)? If yes, indicate the positions in which the changes have occurred. Review the Biographical Affidavit(s) for any new officers, directors or trustees indicated above and note any areas of concern that would indicate further review is necessary.

      - ☐ President
      - ☐ Secretary
      - ☐ Treasurer
      - ☐ Vice Presidents (number: ____)
      - ☐ Directors or Trustees (number: ____)
      - ☐ Other

   c. Assess any significant corporate governance changes and determine whether these changes appear to indicate a shift in management philosophy, or whether management has made any changes in business culture or business plan.

Balance Sheet Assessment

10. Review the Quarterly Financial Statement Assets (page 2) and Liabilities, Surplus and Other Funds (page 3) and the Quarterly Financial Profile Report.

    a. Is surplus below the statutory required minimum?

    b. Is surplus less than 5 percent of total admitted assets, excluding separate accounts?

    c. Has surplus changed by greater than +/-20 percent from the prior year-end? If yes, indicate the current quarter balance and the percentage change from the prior year-end.

    d. Has there been any change in surplus notes during the quarter? If yes, comment on any notes issued, principal or interest paid, or any other changes that have been made. Also, comment on whether any necessary approvals were obtained.

    e. Is the amount of any individual asset category, other than cash and invested assets, greater than 10 percent of total admitted assets, excluding separate accounts? If yes, indicate the asset category and amount.

    f. Has any individual asset category, which exceeds 5 percent of total assets for either the current or prior year, changed by more than +/-20 percent from the prior year-end? If yes, indicate the asset category, current balance, and the percentage change from the prior year-end.

    g. Is the amount of any individual liability category—other than aggregate reserves for life policies and contracts, aggregate reserves for accident and health policies, liability for deposit-type

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contracts—greater than 10 percent of total liabilities? If yes, indicate the liability category and amount.

h. Has any individual liability category, which exceeds 5 percent of total liabilities for either the current or prior year, changed by more than +/-20 percent from the prior year-end? If yes, indicate the liability category, current balance, and the percentage change from the prior year-end.

Operations Assessment

11. Review the Quarterly Financial Statement, Statement of Operations (page 4) and the Quarterly Financial Profile Report.

    a. If the absolute value of net income (loss) exceeds 5 percent of surplus, has net income (loss) decreased by more than 20 percent or increased by more than 40 percent from the prior year-to-date? If yes, indicate the current quarter balance and the percentage change from the prior year-to-date.

    b. Has any individual summary of operations category, whose balance exceeded 5 percent of surplus for either the current year or prior year, changed by more than +/-20 percent from the prior year-to-date? If yes, indicate the line item, current balance, and the percentage change from the prior year-to-date.

    c. Has any individual direct premiums and deposit-type contract funds category changed by more than +/-20 percent from the prior year-to-date? If yes, indicate the premium category, current year-to-date balance, and the percentage change from the prior year-to-date.

    d. Are net unrealized capital gain/losses more than 10 percent of prior year-end surplus?

Investment Practices

12. Review Schedule D – Part 1B, showing the acquisitions, dispositions and non-trading activity during the current period for bonds and preferred stocks by rating class.

    a. Has the percentage of (i) investment or (ii) non-investment-grade bonds to total bonds at the end of the quarter changed by +/-10 percentage points or greater from the percentage owned at the beginning of the quarter?

    b. Has the percentage of (i) investment or (ii) non-investment-grade preferred stock to total preferred stock at the end of the quarter changed by +/-10 percentage points or greater from the percentage owned at the beginning of the quarter?

Review of Disclosures

13. Review the Quarterly Statement Notes to Financials, General Interrogatories and Supplemental Schedules and note anything unusual.

Assessment of Results from Prioritization and Analytical Tools

14. Review the Quarterly Financial Profile Report and provide an explanation for any unusual or significant fluctuations or trends.

15. Review any market conduct information, including information available from the state's market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee), and the NAIC market analysis tools and databases (MAP, ETS, MARS, RIRS, SAD, MITS, and Complaints). The analyst should note any unusual items that translate into financial risks or indicate further review and/or additional communication is needed with the Department's market analysis staff.

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VI.C. Level 1 Quarterly Procedures for Fraternal Societies

Assessment of Latest Examination Report and Results

16. Review General Interrogatory #6, and determine if a financial examination report was released by the domicilary state since the last review.

    a. As of what balance sheet date is/was the latest financial examination of the society?

    b. As of what balance sheet date is the latest financial examination report available from either the state of domicile or the society?

    c. As of what release date is the latest financial examination report available from either the state of domicile or the society?

    d. Have any financial statement adjustments within the latest financial examination report not been accounted for in a subsequent financial statement filed with the Department?

    e. Have any of the recommendations within the latest financial examination report not been complied with?

    If yes, or if follow-up was required from the review of the examination report in a previous analysis period, complete the following procedures.

    f. If the answers to 16.d or 16.e are yes, follow up with the society regarding the implementation of recommendations in the Financial Examination Report.

    g. During the review of the latest state examination report, the results from that examination and communication with the examiner-in-charge (for domestic societies), did the analyst note any items or areas that indicate further review is warranted?

    h. Follow up and document on any management letter comments that should be addressed in the current period, if applicable.

Recommendation for Further Analysis

Do you recommend that any of the Level 2, 3 or Supplemental Procedures or other procedures listed below be completed? If yes, refer to the procedures in the Life/A&H Level 2 and 3 listed below for possible additional procedures and indicate the sections that the analyst recommend be completed:

A. Perform Level 2 or Level 3 Procedures:

- ❑ All Sections
- ❑ Investments
- ❑ Life Reserves
- ❑ Accident and Health Reserves
- ❑ Annuity Reserves
- ❑ Income Statement and Surplus
- ❑ Cash Flow and Liquidity
- ❑ Reinsurance
- ❑ Affiliated Transactions
- ❑ MGAs and TPAs
- ❑ Separate Accounts

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VI.C. Level 1 Quarterly Procedures for Fraternal Societies

B. Perform Supplemental Procedures:

- ❑ Audited Annual Financial Statement
- ❑ Statement of Actuarial Opinion
- ❑ Management's Discussion and Analysis
- ❑ Holding Company Analysis
- ❑ Form A
- ❑ Form B
- ❑ Form D
- ❑ Form E (or Other Required Information)
- ❑ Extraordinary Dividends/Distributions

C. Request and review the current business plan and financial projections.

i. If significant changes in the business plan or philosophy have occurred, assess the society's ability to attain these expectations.

ii. Determine if actual results are tracking with projection and note any significant variances and the reason(s).

Summary and Conclusion

After completion of any Level 2 or subordinate procedures, develop and document an overall summary and conclusion based on the findings. In developing a conclusion, the analyst should consider the above procedures, as well as any other factors that, in the analyst's judgment, are relevant to evaluating the society's overall financial condition. The summary and conclusion should include details regarding strengths and weaknesses. In addition, update the Insurer Profile Summary, including the Supervisory Plan, if applicable, for the results of the analysis performed.

Do you recommend that the society be designated a priority as a result of the procedures performed? If yes, indicate the recommended priority designation and rationale.

Describe the rationale for these recommendations.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

Correspondence

The analyst should document any follow-up regarding the Level 1, 2, 3 and Supplemental Procedures.

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VII. Guidance for Notes to Financial Statements

VII. Guidance for Notes to Financial Statements

Note 1 – Summary of Significant Accounting Policies

This Note is split into three primary sections. The first section (A) focuses on the insurer's accounting policies compared to the NAIC *Accounting Practices and Procedures Manual (AP&P Manual)* and represents a disclosure that is required as a result of SSAP 1, *Disclosure of Accounting Policies, Risks, & Uncertainties, and Other Disclosures* (SSAP 1). The second section (B) is also required by SSAP 1 and is focused on the insurer's compliance with the NAIC *Annual Statement Instructions* and the *AP&P Manual* and the insurer's use of estimates. The third section (C) is also required by SSAP 1 and is focused on disclosure of all accounting policies that materially affect the assets, liabilities, capital and surplus or results of operations. These sections each provide information that an analyst should use in evaluating the accounting procedures of the insurer.

The first section (A) of this Note is broken into two different parts. The first part of the first section addresses accounting policies that differ from the *AP&P Manual*. The second part of the first section addresses accounting policies not discussed in the *AP&P Manual*.

The analyst should use the information provided in the first part of the first section (A) of this Note to determine if an insurer's financial position would be different if all the accounting rules of the NAIC were followed. Not only does the disclosure require the insurer to indicate permitted practices that have been provided by the state of domicile (a disclosure which was previously required by the model audit rule), but it also requires that prescribed differences be disclosed. Prescribed differences represent differences in the accounting methods that the state requires for all of its companies and the accounting methods of the NAIC *AP&P Manual*. This disclosure primarily assists regulators in reviewing the financial statements of foreign (non-domestic) companies. 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 obtain an understanding of the differences if the insurer's capital and surplus is reduced by 5 percent or greater as a result of applying the NAIC methods. A difference of this magnitude indicates that the insurer's financial position may vary significantly from what is reported using the accounting rules that have been established by the state of domicile.

The analyst should use the information provided in the second part of the first section (A) of this Note to determine if the insurer has any unusual transaction(s) for which the NAIC has not developed any standard accounting rules. 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 analyst should review the insurer's disclosure to obtain an understanding of the transaction(s). 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. The concepts are discussed in the Preamble of the *AP&P Manual*. The analyst should determine if risk-based capital 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.

The second section (B) of this Note requires the insurer to disclose its compliance with the NAIC *Annual Statement Instructions*. The NAIC *Annual Statement Instructions* are required to be followed by most insurance departments; 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.

The analyst should use the information provided in the third section (C) of this Note to determine if the insurer has used any unusual accounting methods for its invested assets. 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 1 and Appendix 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

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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.

Note 2 – Accounting Changes and Corrrection of Errors

Section (A) focuses on general changes in accounting principles and/or corrections of errors and is required as a result of SSAP 3, *Accounting Changes and Corrections of Errors* (SSAP 3). Section (A) includes three parts that requires additional details regarding the accounting changes and correction of errors. The information provided in section (A) of this Note can be helpful in assessing the continuing operations of the insurer.

The analyst should use the information provided in section (A) of 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 percent 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 principle may highlight the exposure that an insurer has to a particular issue.

The analyst should also use the information provided in section (A) of this Note to understand any errors the insurer has corrected and determine the financial impact of the correction. In cases where the insurer's total capital and surplus decreased by 5 percent or greater, special attention should be given. SSAP 3 allows correction of errors to be reported as direct charges to surplus. SSAP 3 and SSAP 24, *Discontinued Operations and Extraordinary 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.

The analyst should also use the information provided in section (A) of this Note to understand any change in accounting estimates, which are also required by SSAP 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.

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.

Note 3 – Business Combinations and Goodwill

This Note has four primary sections. Part A focuses on statutory purchases and Part B focuses on statutory mergers. Part C focuses on assumption reinsurance but is substantially the same as part A. The last section, Part D, focuses on impairment losses.

For the first part of business combinations, the statutory purchase method is addressed in Part A, and is probably the most common. The accounting guidance for the statutory purchase method is discussed in SSAP 68, *Business Combinations and Goodwill* (SSAP 68). One of the most significant aspects of SSAP 68 provides that 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. Part A of this Note focuses on the goodwill and requires the insurer to disclose all of the pertintent 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

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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 68 provides specific guidance on determining if an impairment in the asset has occurred. Because the disclosure for assumption reinsurance (Part C) is substantially the same as this section, it is not discussed further.

The second type of business combination, the statutory merger is addressed in Part B of the Note. The accounting guidance for this type of business combination is also discussed in SSAP 68. The SSAP references SSAP 3, *Accounting Changes and Corrections of Errors*, 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 occured. Part B of this Note focuses on the transaction that occurred and requires the insurer to disclose all pertintent information related to the merger. This includes financial information on each of the companies before they 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.

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 the insurer has entered into. The analyst should use that information in those parts to determine if the value of any unamortized goodwill appears reasonable, but should also use the information in Part D 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 continue to determine if the value of the unamortized goodwill appears to be reasonable.

Note 4 – Discontinued Operations

This Note is split into five different sections which each require the insurer to report certain information on discontinued operations. The analyst should use the information provided in the Note to obtain a greater understanding of the operations that have been discontinued and determine the effect that the decision to discontinue could have on the current and future periods. It should be noted that SSAP 24, *Discontinued Operations and Extraordinary Operations* requires that an insurer report its results from discontinued operations consistent with its reporting of continuing operations (i.e., no separate line item presentation).

The first section requires an insurer to identify the segment of business that has been or will be discontinued. The second section requires an insurer to identify the date of disposal and the third section requires the insurer to identify the manner of disposal. All of this information should be used to obtain a greater understanding of the transaction. 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 may 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 may be needed to generate cash to support the other lines of business or may be needed in order to reduce the amount of future losses the company is exposed to. 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 use the information provided to gain a greater understanding of why the segment was discontinued. The analyst should consider if the disposal was approved by the domiciliary state and if a plan of run-off was also approved.

As noted above, although the run-off of certain lines of business can alleviate certain problems of an insurer, it may not always be in the best interests of all policyholders. The analyst should consider the type of business being discontinued and the geographic locations of the business to better understand the potential problems that could develop from the run-off. Generally, run-off of business with longer tails represents a greater risk to insurers and should be reviewed more closely. However, run-off of shorter tail business still represents a risk to insurers because, in some cases, the run-off can lead to greater utilization such as that which is experienced in accident and health business. In all cases, the analyst should understand the assumptions used and the work that was performed

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to assure that the assets will be sufficient to run-off outstanding losses, such as that performed by a consulting actuary. However, in some cases, where an independent review of the payout pattern was not performed, the insurer may have obtained an irrevocable guarantee from its parent. The insurer may have also arranged for a portfolio transfer of the business through a reinsurance arrangement.

The fourth section requires an insurer to describe the remaining assets and liabilities of the segment at the balance sheet date. The fifth section requires an insurer to quantify the effect on the financial statements including the balance sheet and the income statement. The analyst should use the information provided in these sections to better understand the potential impact on the insurer. By using this information, the analyst will be able to determine if the business being discontinued is significant in terms of premium volume and reserve levels. Using this information, the analyst may be able to determine if the results of the discontinued operations will be positive or negative. The analyst should not only consider the positive impact that the discontinued operations may have on the profitability of the insurer, but also the impact that the decision will have on cash flow and liquidity. In making this determination, the analyst should also understand how the insurer has accounted for the transaction. As noted above, SSAP 24 requires that discontinued operations be reported with an insurer's continuing operations. Additionally, the risk the insurer is exposed to under the discontinuance is of utmost importance. In determining the financial impact that the transaction will have on continuing operations, the analyst must still consider the risks the insurer is still exposed to after discontinuance.

Note 5 – Investments

This Note is split into seven primary sections. The first section (A) focuses on the accounting for mortgage loans including mezzanine real estate loans and the allowance for credit losses as required as a result of SSAP 37, *Mortgage Loans* (SSAP 37). The second section (B) focuses on the recording of the investment in loans that have been recognized as impaired as required by SSAP 36, *Troubled Debt Restructuring* (SSAP 36). The third section (C) focuses on 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 39, *Reverse Mortgages* (SSAP 39). The fourth section (D) focuses on determining prepayment assumptions for yield calculations and the risk exposure in Loan-backed securities as required by SSAP 43R, *Revised Loan-backed and Structured Securities* (SSAP 43R). The fifth section (E) focuses on the 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 91R, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities* (SSAP 91R). The sixth section (F) focuses on the 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 40, *Real Estate Investments* (SSAP 40). The seventh section (G) focuses on 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 93, *Accounting for Low Income Housing Tax Credit Property Investments* (SSAP 93). All seven sections of this Note include significant parts but each part of each section simply requires additional details. 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.

The information provided in the first section (A) of this Note can be helpful in quantifying the insurer's investment in mortgage loans, including mezzanine real estate loans, and assessing the impact of impaired loans. The analyst should use the information provided in this section to determine whether the insurer followed the guidelines as prescribed by SSAP 37 to record the carrying value of the loan and what allowances for credit losses on impaired loans has been made by the insurer.

The analyst should pay particular attention to the amount of mortgage loans deemed to be impaired. Under SSAP 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 including the total investment in impaired loans at the end of each period and the allowance for credit losses. The insurer should

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have also disclosed the amount of investment in impaired mortgage loans for which there is no related allowance for credit losses.

The insurer should have also 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.

The analyst should also 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.

The information provided in the second section (B) of this Note can be helpful in quantifying the insurer's investment in loans determined to be impaired. The analyst should use the information provided in this section to determine whether the insurer has recorded the investment in loans recognized as impaired as prescribed by SSAP 36.

The analyst should consider the information disclosed in this section to evaluate the insurer's investment in loans impaired and the terms agreed upon for debt restructuring. The analyst should note 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 though the value received is less than the amount of the debt, if the insurer concludes that can maximize recovery of the loan.

The analyst should review the information provided in the third section (C) to determine whether the insurer followed the guidelines as prescribed by SSAP 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 note 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 set up 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.

The analyst should consider the information provided in the fourth section (D) to gain an understanding of the insurer's assumptions in determining prepayment of loan-backed securities. The information should help the analyst determine how closely the insurer followed the principles of valuation and prepayment assumptions as prescribed by SSAP 43R. As described in SSAP 43R paragraphs 48f, 48g and 48h, insurers are also required to disclose certain aggregate information about securities with recognized other-than-temporary impairments and impaired securities (fair value is less than cost or amortized cost) for with 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

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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 prepayment assumptions and cash flows and makes 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.

The analyst should use the information provided in the fifth 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 91R, 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 note 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. Per SSAP 91R, if the insurer has accepted collateral that is permitted by contract or custom to sell or repledge, regardless of whether the transaction is "on-balance sheet" or "off-balance sheet", the insurer should disclose certain information 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 aggregate fair value of all reinvested collateral. 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.

The information provided in the sixth section (F) of Note 5 can be helpful in quantifying the insurer's investment in real estate determined to be impaired. The analyst should use the information provided in this section to determine whether the insurer has recorded the investment in real estate recognized as impaired as prescribed by SSAP 40. Additionally, 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 40.

The analyst should use the information provided in the seventh section (G) of this Note to gain an understanding an insurer's investment in LIHTC properties. The insurer is required by SSAP 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 percent of total admitted assets. In addition, the insurer is required to disclose any recognized impairments and the nature of any write-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 to identify the extent of the insurer's exposure and any issues regarding impairment write-downs or reclassifications.

The analyst should consider the information disclosed in this section to evaluate the insurer's investment in real estate impaired. 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 and the planned expenditures and recorded obligations for improvements.

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VII. Guidance for Notes to Financial Statements

Note 6 – Joint Ventures, Partnerships and Limited Liability Companies

This Note focuses on investments in joint ventures, partnerships and limited liability companies and is split into two primary sections. The first section (A) requires the insurer to disclose various information about investments in joint ventures, partnerships, and limited liability companies that exceed 10 percent of the admitted assets of the insurer. The second section (B) requires the insurer to disclose specific information on the above types of investments that have become impaired.

The accounting guidance for the above types of investments is addressed in SSAP 48, *Joint Ventures, Partnerships and Limited Liability Companies* (SSAP 48). SSAP 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 48 defines a general partnership as an association in which each partner has unlimited liability and a limited liability company as a hybrid organization which falls between a corporation and a partnership whereby the owners have limited their individual 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 of these types of investments that are held by the insurer, 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 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.

Note 7 – Investment Income

This Note is split into two primary sections. The first section (A) focuses on the insurer's basis for nonadmitting due and accrued investment income as required as a result of SSAP 34, *Investment Income Due and Accrued* (SSAP 34) and SSAP 99, *Accounting for Certain Securities Subsequent to an Other-Than-Temporary Impairment* (SSAP 99). The second section (B) discloses the amount the insurer nonadmits upon determining collectibility of due and accrued investment income. The information provided in both sections is helpful to the analyst in reviewing the financial statements and related exhibits and schedules for real estate, mortgage loans and long term bonds.

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 defines investment income due as investment income earned and legally due to be paid to the insurer as a 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 4, *Assets and Nonadmitted* Assets (SSAP 4) to obtain an understanding of the distinction between an asset that has a probable future economic benefit versus an asset that is unavailable to meet policyholder obligations due to encumbrances or third party interests. The nonadmitted asset should not be included on the balance sheet as well as the balance for investment income due and accrued.

To the extent the nonadmitted investment income is material, the analyst should question the collectibility of the remaining investment income due. The analyst should review SSAP 99 and SSAP 5, *Liabilities, Contingencies*

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and Impairments of Assets (SSAP 5) to obtain an understanding of the principle of asset impairment and the collection of investment income. The analyst should also review SSAP 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 uncollectible and should be written off and charged against investment income. Interest can be accrued on mortgage loans in default if interest is deemed collectible. But if interest is deemed uncollectible, 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 which has been determined to be collectible, all accrued interest should be reported as a nonadmitted asset.

Note 8 – Derivative Instruments

This Note contains separate information and accounting requirements based on the date of the derivative instrument transaction. For those derivative transactions entered into, or modified on or after Jan. 1, 2003, SSAP 86, *Accounting for Derivative Instruments and Hedging Activities* (SSAP 86), will provide guidance for this Note. For derivative transactions prior to Jan. 1, 2003, SSAP 31, *Derivative Instruments* (SSAP 31), will apply. Alternatively, an insurer may choose to apply SSAP 86 to all derivatives to which the insurer is a party as of Jan. 1, 2003. In either case, the insurer is to disclose the transition approach that is being used.

Disclosure Guidance for Derivative Transactions Occurring Prior to Jan. 1, 2003

This Note contains four sections. The first section (A) focuses on 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 31. The discussion provided in the first section (A) of this Note can be helpful in determining the insurer's risk exposure associated with its derivative investments. The second section (B) focuses on the insurer's objectives for holding or issuing derivative financial instruments and is also required under SSAP 31. The information provided in the second section (B) of this Note is useful in understanding the insurer's investment stategy in regards to its use of deriviative instuments. The third section (C) focuses on how each category of derivative instrument is reported in the financial statements and is also required by SSAP 31. The information provided in the third section (C) is helpful to the analyst in reviewing the financial statements and more specifically, the related schedules for derivatives and exhibits for investment income from derivatives and gains & losses on derivatives. The fourth section (D) focuses on the unrealized gains and losses resulting from derivatives that were excluded from the assessment of hedge effectiveness. The information provided in the fourth section (D) assists the analyst in evaluating the portion of the unrealized gain or loss on derivatives that were excluded from the assessment of hedge effectiveness. The fifth section (E) focuses on the unrealized gains and losses resulting from derivatives that no longer qualify for hedge accounting. The information provided in the fifth section (E) assists the analyst in evaluating the portion of the unrealized gain or loss on derivatives that no longer qualify for hedge accounting. The sixth section (F) focuses on the use of cash flow hedges in transaction forecasting.

Derivative instruments are often complex and involve substantial risk of loss. The analyst should use the discussion provided in the first 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.

The analyst should use the information provided in the second 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 31 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 or liabilities or future cash flows for which the derivative transactions were entered into or issued to hedge against. See the Investments – Primer on Derivatives section for further discussion of derivative instruments.

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The analyst should consider the information disclosed in the third section (C) in conjunction with information provided 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 & losses. Accounting procedures for derivatives vary widely depending on the nature of the derivative. SSAP 31 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 percent of net investment income or if the insurer is experiencing capital losses on derivative instruments of more than 10 percent of capital and surplus and AVR. In cases where the insurer's total derivative instruments represent more than 10 percent of capital and surplus and AVR, special attention should also be given to this Note. See the Investments Level 2 Annual Procedures, question 14 for specific guidance in evaluating the materiality of an insurer's risk to derivatives.

The analyst should consider the information disclosed in the fourth section (D) 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. 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.

Disclosure Guidance for Derivative Transactions Occurring Jan. 1, 2003

This Note contains six sections. The first section (A) focuses on 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 86. The discussion provided in the first section (A) of this Note can be helpful in determining the insurer's risk exposure associated with its derivative investments. The second section (B) focuses on the insurer's objectives for holding or issuing derivative instruments and is also required under SSAP 86. The information provided in the second section (B) of this Note is useful in understanding the insurer's investment strategy in regards to its use of derivative instruments. The third section (C) focuses on how each category of derivative is reported in the financial statements and is also required by SSAP 86. The information provided in the third section (C) is helpful to the analyst in reviewing the financial statements and more specifically, the related schedules for derivatives and exhibits for investment income from derivatives and gains & losses on derivatives. The information provided in the fourth (D) and fifth (E) sections assist the analyst in evaluating the portion of the unrealized gain or loss on derivatives that represents derivatives excluded from the assessment of hedge effectiveness or no longer qualifying for hedge accounting. The information in the sixth section (F) provides details about derivatives accounted for as cash flow hedges of a forecasted transaction.

Derivative instruments are often complex and involve substantial risk of loss. The analyst should use the discussion provided in the first 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.

The analyst should use the information provided in the second 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 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 or liabilities or future cash flows for which the derivative transactions were entered into or issued to hedge against. See section III. B.1A Investments – Primer on Derivatives for further discussion of derivative instruments.

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The analyst should consider the information disclosed in the third section (C) in conjunction with information provided 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 & losses. Accounting procedures for derivatives vary widely depending on the nature of the derivative. SSAP 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 percent of net investment income or if the insurer is experiencing capital losses on derivative instruments of more than 10 percent of capital and surplus. In cases where the insurer's total derivative instruments represent more than 10 percent of capital and surplus, special attention should also be given to this Note. See the Investments Level 2 Annual Procedures, question 9 for specific guidance in evaluating the materiality of an insurer's risk to derivatives.

The analyst should consider the information disclosed in the fourth section (D) 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. 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.

The analyst should consider the information disclosed in the fifth section (E) 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.

The analyst should consider the information disclosed in the sixth section (F) 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 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.

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 and liabilities 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 10R, *Income Taxes-Revised, A Temporary Replacement of SSAP 10*, (SSAP 10R) simply requires the recognition of the tax consequences of that transaction or event in the financial statements. Note that SSAP 10R is only effective for annual periods ending December 31, 2009 and interim and annual periods of 2010.

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Deferred tax liabilities (DTLs) represent temporary differences that will result in future taxable amounts. Deferred tax assets (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 may not understand what is meant by the term temporary differences. The easiest way to understand the concept of a temporary difference is to review an example of one.

One of the most common types of temporary differences for life insurers is deferred acquisition expenses. SSAP 71, *Policy Acquisition Costs and Commissions* (SSAP 71), 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 IRS requires an insurer to set up what is known as a Proxy DAC asset.

The Proxy DAC asset that is set up by insurers for tax purposes is based upon a percentage of net premiums from specified insurance contracts (i.e., life, annuity and accident and health), 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 a 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.

Example:
Insurer XYZ incurred $10.0 million of policy acquisition expenses to establish ordinary life policies in year 2002, which brought in $100.0 million of premium income in that same year. For statutory purposes, all of these costs are expensed in 2001 since the expenses have been incurred. As a result, the insurer's book income is reduced by the entire amount in 2002. For tax purposes, the insurer establishes a Proxy DAC asset of approximately $7.1 million ($100.0 million premium income multiplied by 7.07 percent-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 2002, the insurer will only be allowed to amortize $355,000, since 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. The $0 recorded for statutory purposes 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. The $6.7 million recorded for tax purposes 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 percent), since 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 10R 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.

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Other Common Temporary Differences

Life 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 26; *Bonds excluding Loan-Backed and Structured Securities* (SSAP 26) requires insurers to accrue any market discount into income over the life of the bond. For example, if a bond is purchased for $900,000 with a par value of $1.0 million, the $100,000 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, $900,000 in this case. However, for tax purposes, companies generally do not amortize this market discount into income, and instead, are taxed on the gain ($100,000 ($1.0 million for consideration received when the bond matures - $900,000 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 since they hold large amounts of bonds.

Unrealized Gains/Losses-This temporary difference is similar to that which exists for accrued market discount and will result in a DTL if an insurer has recorded a significant amount of unrealized gains or a DTA if an insurer has recorded a significant amount of unrealized losses. 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 paragraph 14 of SSAP 10R 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 10R 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 *Statement of Financial Accounting Standards No. 96*, which used an income statement approach. The balance sheet approach is simpler than the income statement approach because it doesn't 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 2010 to perform this calculation. However, SSAP 10R does use some conservatism that requires the insurer to determine what will reverse in the next year.

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Limitations

The SSAP limits the amount of net DTAs that an insurer can carry to 10 percent and if the insurer meets certain criteria in paragraph 10 of SSAP 10R, it limits the DTA to 15 percent of capital and surplus. Additionally, the SSAP further limits the amount of DTAs that an insurer can hold to the amount of DTAs that will reverse within a year, three years, or during a timeframe corresponding with IRS tax loss carryback provisions. This limitation is consistent with the overall definition of an admitted asset. See SSAP 10R for 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 & 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.

Disclosure

The disclosure requirements of SSAP 10R are rather extensive, and are broken down into six parts. The first section (A) of this Note requires that the insurer disclose the financial components (assets, liabilities and surplus impact) of the deferred taxes. The second section (B) of this Note requires that the insurer disclose any DTLs that are not required to be reported as a liability in connection with paragraph 31 of FASB 109. The third section (C) of this Note requires the insurer to disclose the significant components of its current income taxes incurred. The fourth section (D) of this Note requires an insurer to disclose the types and amount of temporary differences that affect the insurer's effective tax rate. The fifth section (E) of this Note requires the insurer to disclose certain information on operating loss and tax credit carry forwards. The sixth section (F) of this Note requires the insurer to disclose certain information on consolidated tax returns if applicable.

The analyst should use the information required in the first section (A) of this Note to determine the overall impact that SSAP 10R has had on the financial position of the insurer. The first section requires the insurer to report its gross, adjusted gross, admitted and nonadmitted DTAs by tax character, total DTLs by tax character, total nonadmitted DTAs and overall surplus impact. SSAP 10R also requires the disclosure of certain information resulting from the application of SSAP 10R 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 total adjusted capital in the RBC calculation; and the increased amount of DTAs, admitted assets and surplus. 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. Despite these limitations, the number of insurers that may report an increase in capital and surplus as a result of this statement may outnumber the number of insurers that report a decrease. Because a 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 analyst should use the information required in the second 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" (See the Internal Revenue Code for further discussion) account.

The analyst should use the information required in the third section (C) of this Note to better understand the components of an insurer's total income taxes incurred. This section provides the analysts 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

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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 10R prohibits the use of anticipated tax rates in its application.

The analyst should use the information required in the fourth 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 upon the corporate tax rate) with the actual incurred tax expense. This disclosure also requires the insurer to disclose 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.

The analyst should use the information required in the fifth 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 carryforward, the analyst should consider if the insurer will be able to utilize the amount within one year.

The analyst should use the information required in the sixth section (F) of this Note to determine if the insurer has appropriately applied the principles of SSAP 10R to its financial statements regardless of a consolidated tax return being prepared. SSAP 10R allows the allocation of taxes between affiliated entities that file a consolidated tax return but the basic requirements of SSAP 10R 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.

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 10R.

The analyst should also determine if the insurer has appropriately limited the DTA to 10 percent of capital and surplus. Under SSAP 10R, if the insurer is subject to RBC requirements and meets the requirements outlined in SSAP 10R paragraph 10, the insurer may elect to admit a higher amount of adjusted gross DTAs up to a limit of 15 percent of capital and surplus. It should be noted that the 10 percent limitation requirement within SSAP 10R actually includes some additional calculations that make the limitation even more conservative.

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 CPA firm to perform this calculation. The insurers' reliance on a CPA firm to perform this work on an annual basis may 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 upon changes in the insurer's reserves and invested assets.

Note 10 – Information Concerning Parent, Subsidiaries and Affiliates

As discussed in SSAP 25 *Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties* (SSAP 25), related party transactions are subject to abuse because reporting entities may be induced to enter transactions that may not reflect economic realities or may not be fair and reasonable to the insurer or its policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny. Because of this, the purpose of this Note is to provide detailed information regarding all types of affiliates and affiliated transactions. It is broken up into eleven different sections, which provide specific information on an insurer's affiliated relationships or transactions. The accounting guidance for affiliates is addressed in SSAP 25. SSAP 25 defines an affiliate as an entity that is within the holding company system or a

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party that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity.

The analyst should use the information in this Note to gain an understanding of the effects of the related party transactions on the financial statement and determine whether concerns exist regarding affiliated transactions. The analyst should evaluate amounts owed by a related party to determine if there may be a significant collectibility 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, which 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's important to evaluate the effect of any guarantees or affiliated undertakings 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.

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. 10K filing), to understand the amount of debt 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.

It's 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.

In cases where the insurer and other enterprises are under common ownership or control relationships exist, the analyst should evaluate the risk that the operating results or financial position of the insurer may pose. The risks may be significantly different than those that would have existed if the enterprises were autonomous. Unusual agreements or affiliated transactions 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.

Note 11 – Debt

This note contains two sections. The first section (A) requires disclosure of information related to all other debt, including capital notes. The accounting guidance is provided by SSAP 15, *Debt and Holding Company*

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Obligations (SSAP 15). SSAP 15 requires a full description of the type of borrowing; amounts; interest rates; collateral; interest paid; and debt terms, covenants, and any violations. The section (B) requires disclosure of information related to agreements with the Federal Home Loan Bank (FHLB).

For the first section (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 percent of capital and surplus, special attention should be given. For all debt, the analyst will want to verify 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 of the insurer for additional funding. Another important area to review is repayment conditions, restrictions, or covenants. In particular, the analyst needs to be aware if there are any violations of the covenants or restrictions and possible ramification (i.e., 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.

For the second section (B) the analyst should review for 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 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 Benefit Plans

This Note contains five sections. The first section (A) requires the insurer to disclose details of employer sponsored defined benefit plans and is required by SSAP 89, *Accounting for Pensions, A Replacement of SSAP No. 8*, SSAP 11 – *Postemployment Benefits and Compensated Absences* (SSAP 11) and SSAP 14 - *Postretirement Benefits Other Than Pensions* (SSAP 14). The second section (B) focuses on the details of defined contribution plans and other postretirement benefit plans and is required by SSAP 89 and SSAP 14. The third section (C) focuses on multi-employer plans and is required by SSAP 89 and SSAP 14. The fourth section (D) discusses parent or holding company sponsored plans and is required by SSAP 89, SSAP 11 & SSAP 14. The fifth section (E) discusses postemployment benefits and compensated absences that do not meet the conditions for accrual as a liability and is required by SSAP 11.

The first section (A) of this Note provides significant disclosure regarding the insurer's employer sponsored defined benefit plans. As discussed in SSAP 89, 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.

As defined in SSAP 89, a defined contribution plan defines the amount of the employer's contributions to the plan and its allocation to plan participants. Less disclosure is required for this type of pension plan. In section two (B), the insurer is required to disclose the cost recognized for the defined contribution plan separately from the amount of cost recognized for defined benefit plans. Also, they must disclose a description of significant changes to the plan. The analyst should evaluate the plan disclosures to determine the impact to the financial statements.

The third section (C) of this Note focuses on multi-employer plans. It is very similar to section two (B) in regards to the type of disclosure required. As with defined benefit and defined contribution plans, the analyst should

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evaluate the impact of costs and changes in liabilities for multi-employer plans on the operations and balance sheet of the insurer.

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 provided in the fourth section (D) of this Note 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.

As defined in SSAP 11, post employment 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 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 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 in section five (E) to determine if there is concern regarding a potential impact to the financial statements.

Note 13 – Capital & Surplus, Shareholder's Dividend Restrictions & Quasi Reorganizations

This Note is split into twelve separate sections and covers several key areas of an insurer's overall capitalization. The first area is capital and surplus and includes items 1-10. This area has questions regarding the capital structure of the insurer. The analyst should be familiar with the overall holding company structure of the insurer before reviewing and analyzing the information included in this Note. However, 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 section of this Note provides the number of shares of capital stock authorized, issued and outstanding as of the statement date. Sections two through nine of this Note disclose restrictions on dividends and surplus, along with other information on the company's capital and surplus. These sections 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 approved by the Department.

The second area of this Note requires the insurer to disclose certain information on surplus notes. The analyst should use the information required in this second area of the Note to obtain a greater understanding of the insurer's surplus note obligations. Using the information required, the analyst should be able to determine if the insurer has issued any surplus notes recently. Insurers must have prior 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. Other areas the analyst should review and consider when there are any new surplus notes include: verifying the proper accounting for the notes and any associated interest, the payment schedule for repayment and if the insurer will be able to meet this schedule, the type and quality of assets received in the transaction, and if the notes were issued to a parent or affiliates. If the notes were issued to an affiliate the analyst should consider reviewing the affiliate's financial statements to verify the notes are appropriately reported by the other entity.

The third and final area covered in this Note is quasi-reorganization. The analyst should use the information required in this third area of the Note to obtain an understanding of any quasi-reorganizations that may have occurred during the most recent period. 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

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disclosures and accounting for this transaction (See SSAP 72, *Surplus and Quasi-reorganizations* for further discussion).

Note 14 – Contingencies

This Note is split into four sections: contingent commitments, assessments, gain contingencies, and all other contingencies. The accounting guidance for contingencies is addressed in SSAP 5 and for specific items in SSAP 35, *Guaranty Fund and Other Assessments* (SSAP 35), SSAP 97, *Investments in Subsidiary, Controlled and Affiliated Entities, A Replacement of SSAP No. 88,* and SSAP 48.

Contingencies are defined in SSAP 5 as an existing condition, situation or set of circumstances involving uncertainty as to a possible loss or gain to an enterprise that will ultimately be resolved when one or more future event(s) occur or fail to occur.

As discussed in SSAP 5, 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.

It's important for the analyst to ensure the company has reported all contingent commitments to an SCA, joint venture, partnership, or limited liability company (SSAPs 97 & 48). The note requires detailed disclosure of guarantees on indebtedness of others, for example a guarantee on the indebtedness of a subsidiary.

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 35 for specific statutory reporting guidance and required disclosure in this Note.

Per SSAP 5, gain contingencies are not to be recognized in a reporting 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 un-issued 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.

Note 15 – Leases

This Note is split into two primary sections. The first section (A) focuses on the disclosure of items related to lessee arrangements. The second section (B) focuses on the disclosure of items related to lessor business activities. Both sections of this Note include 2 or 3 parts, but each part of each section simply requires additional details regarding the breakdown and disclosure of the lessee or lessor's arrangements.

The accounting guidance for leases is in SSAP 22*, Leases* (SSAP 22). A lease is defined by SSAP 22 as an agreement conveying the right to use property, plant, or equipment usually for a stated period of time. Under SSAP 22, 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 NAIC *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.

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Per SSAP 22, 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 22, 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-leaser's note, if any, increase the seller-lessees deposit account.

Leaseback transactions occur for several reasons. Under a normal leaseback transaction, the insurer's appropriate asset and associated debt is 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 gain a better understanding of how the transaction impacts the financial statements.

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 22, operating leases for lessor's 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 in the balance sheet and income statement. Lessor's that complete this section may rely on leasing for revenue, net income, and assets. The analyst should note property-type asset concentrations and examine the lessor's current and future profitability reliance on its rental income.

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 non-recourse debt. Thus, investment in leveraged leases includes rental receivables net of that portion of the rental applicable to principal and interest on the non-recourse 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. Additionally, the analyst should examine the components of net investment in leveraged assets to judge the accuracy of the amount.

Note 16 – Information About Financial Instruments With Off-Balance Sheet Risk And Financial Instruments With Concentrations of Credit Risk

This Note contains four parts, each of which is required by SSAP 27 – *Disclosure of Information about Financial Instruments with Off-Balance-Sheet Risk, Financial Instruments with Concentrations of Credit Risk and Disclosures about Fair Value of Financial Instruments* (SSAP 27). The first part (1) summarizes the face amount of financial instruments with off-balance sheet risk by class of financial instrument. The second part (2) discusses the credit risk, market risk, cash requirements of the instrument and the accounting policies related to the instrument. The third part (3) discloses the amount of accounting loss the entity would incur in a situation where there was non-performance of the contract terms of the financial instrument and the related collateral or other security supporting the financial instrument. The fourth 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.

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SSAP 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 in the balance sheet because they fail to meet some of the criterion for recognition as an asset or liability as defined in SSAP 4 and SSAP 5; 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 to Financial Statements.

In the first part 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. The analyst should use the second part of this Note 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.

The analyst should use the third part 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. The fourth part of this Note 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 their evaluation of the risks associated with their collateral.

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

This Note is split into three primary sections. The first section (A) focuses on the transfer of receivables reported as sales and represents a new disclosure that is required as a result of SSAP 42, *Sale of Premium Receivables*. The second section (B) focuses on the transfer and servicing of other financial assets and represents a new disclosure that is required as a result of SSAP 91R, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities* (SSAP 91R). The third section (C) is also required by SSAP 91R, but pertains only to wash sales. The third section, unlike most of the notes, is actually required to be included in the Quarterly Financial Statement if applicable.

The first section (A) of this Note 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 the information required in the first section (A) to determine the overall impact that the sale of the insurer's premium receivables may 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 27.

The second section (B) of this Note is broken up into six different areas. The first part of the second section (B) of this Note requires an insurer to disclose certain information regarding the valuation of certain assets transferred. The analyst should use the information required in this part of the Note to evaluate the reasonableness of the information recorded by the insurer. The second part of the second section (B) of this Note requires an insurer to disclose information on loaned securities, including the amount, as well as the Company's policy for requiring

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collateral and the type of collateral held. The analyst should use the information required in this part of the Note to help understand the types of investing and financing contracts the insurer uses to maximize profits and liquidity. The third part of the second section (B) of this Note requires an insurer to disclose certain information regarding servicing assets and liabilities recorded in the financial statements. The analyst should use the information required in this part of the Note to help understand the materiality of the servicing process in relation to the insurance operations. The analyst should also use the information required in this part of the Note, as well as other economic events to evaluate if certain circumstances have occurred within the insurer, or the marketplace, that indicate that a liability should be recorded. The fourth part of the second section (B) of this Note requires an insurer to disclose certain information regarding securitized financial assets in which the transfer is accounted for as a sale. The analyst should use the information required in this part of the Note to understand the insurer's accounting policies for initially measuring the interests interests that continue to be held by the transferor, if any, and the methodology used in determining the fair value of the underlying assets and of the interest in the securitization. The fifth part of the second section (B) of this Note requires an insurer to disclose certain information regarding the subsequent measurement of interests and fair market valuation. 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 the information required in this part of the Note to evaluate the possible impact of adverse outcomes highlighted in the sensitivity analysis or stress test. The sixth part of the second section (B) of this Note requires an insurer to disclose any transfers of receivables with recourse.

The third section (C) of this Note requires an insurer to disclose certain information regarding its use of "wash sales" as defined in SSAP 91R. The analyst should use the information required in this part of the Note to help understand the purpose and types of various financial contracts the insurer uses.

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

This Note is split into three primary sections. The first section focuses on the profitability of uninsured and partially insured A&H plans under Administrative Services Only (ASO) contracts. The second section focuses on the profitability of uninsured and partially insured A&H plans for the reporting entities of Administrative Service Contract (ASC) plans. The third section focuses on the profitability of Medicare or similarly structured cost based reimbursement contracts. All three sections of this Note of the NAIC *Annual Statement Instructions* include 4 or 5 parts, but each part of each section simply requires additional details regarding the break down of the uninsured or partially insured plan's expenses, fee income, and gain or loss.

The accounting guidance for health entities that operate uninsured plans and partially insured plans is in SSAP 47, *Uninsured Plans* (SSAP 47). An uninsured A&H plan may be either an ASO plan or an ASC plan. 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 may not be reimbursable and revenues may be adjusted based on subsequent challenges of costs included in filed cost reports,

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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.

This Note should also be used by the analyst to perform a more comparable analysis of general insurance expenses from one year to the next since the reimbursement on these types of plans are netted against an insurer's general expenses.

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 percent of surplus. This Note is required by SSAP 53, *Property Casualty Contracts-Premiums* (SSAP 53) and SSAP 54, *Individual and Group Accident and Health Contracts* (SSAP 54). 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. MGAs and TPAs are used by insurers to increase the volume of business written or to facilitate entry into new lines of business or geographical locations [See Section III.B.10 –for a detailed explanation of MGAs, TPAs and IPAs].

The analyst should use the information in this Note to determine 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's 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 may indicate that the insurer has contracted new MGAs and TPAs or is increasing overall production to improve cash flow.

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 (i.e., 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 produces. It's 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.

Note 20 – Other Items

This Note is split into seven primary sections. Each of the sections are individually unique and is required by various SSAPs, INTs and other sources. Some of the items are included in this Note on a temporary basis. Because of these reasons, the guidance on this Note is limited to an identification of the items and does not include a discussion of how to use the data.

The first section (A) focuses on extraordinary items and is required by SSAP 24, *Discontinued Operations and Extraordinary Items* (SSAP 24). The second section (B) focuses on troubled debt restructuring for debtors and is required by SSAP 36. The third section (C) focuses on disclosures on other miscellaneous amounts not recorded in the financial statements that represent assets pledged to others as collateral in accordance with SSAP 1,

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Disclosure of Accounting Policies, Risks and Uncertainties, and Other Disclosures. The fourth section (D) focuses on the disclosure requirements of reasonable possibly uncollectibile for assets and is required by SSAP 6, *Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers* (SSAP 6), SSAP 47, *Uninsured Plans* (SSAP 47), or SSAP 66, *Retrospectively Rated Contracts* (SSAP 66). The fifth section (E) focuses on disclosures for business interruption insurance recoveries including information related to the nature and aggregate amount of losses and recoveries recognized due to business interruption. The sixth section (F) focuses on disclosure of state transferable tax credits. The seventh section (G) focuses on the disclosure requirements of subprime mortgage related risk exposure and related risk management practices. The analyst may need to reference the *AP&P Manual* for further guidance on each particular section.

The first section (A) requires an insurer to disclose the nature of any extraordinary items. Under SSAP 24, an insurer is required to account for an extraordinary item using the same lines that are used to report continuing operations. The disclosure in section (A) of this Note allows the analyst to understand the impact that the extraordinary item has 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.

The second section (B) requires an insurer to disclose specifics regarding any troubled debt restructuring occuring within the past year, including a description of the terms and the gain or loss recorded on the restructure. The analyst should use the information in this Note 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 health entity for detailed information on other mortage loans to determine if similar events are likely to occur on other loans.

The third section (C) requires an insurer to disclose various items that do not meet the definition of an asset, a liability, revenue or expense as defined within the Accounting Practices and Procedures Manual (AP&P Manual), but are relevant to the overall financial position of an insurer. Such items include segregated funds held for others, assets pledged to others as collateral, forward commitments, or events that are unusual or infrequent, but not both. 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.

The fourth section (D) requires an insurer to disclosure the nature of any portion of an asset that is reasonably possible to be uncollectible. This disclosure is required by specific statements within the AP&P Manual but applies generally to all assets that have become impaired but do not meet the requirements of a loss contingency or impairment of an asset according to SSAP 5. Under SSAP 5, a loss contingency or impairment of an asset is only required to be recorded if the event is probable and the amount of the loss can be reasonably estimated. The SSAP defines probable, as well as reasonably possible, and remote. The loss contingency or impairment of an asset is not required to be recorded when the event is reasonably possible or when it is remote, however disclosure is required if the event is reasonably possible. 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.

The fifth section (E) requires the insurer to disclose information related to business interruption insurance recoveries received during the period. This information includes the nature of the event resulting in losses, the aggregate amount of the recoveries and the line items on the statement of operations in which those recoveries are classified and includes amounts defined as extraordinary items. The analyst review this information to determine if these recoveries have had a material impact of the operations of the insurer.

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The sixth section (F) 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: the carrying value of transferable state tax credits gross of any related state tax liabilities and total unused transferable state tax credits by state and in total, the method of estimating utilization of remaining transferable state tax credits or other projected recovery of the current carrying value, and the impairment amount recognized by the reporting period, if any. To the degree the amount of the transferable tax credits is material to the insurer, the analyst should perform a more indepth review.

The seventh section (G) requires the insurer to disclose informtion 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.

Note 21 – Events Subsequent

Subsequent events are required to be disclosed in the financial statements and/or notes as a result of SSAP 9, *Subsequent Events* (SSAP 9). 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, that have a material effect on the financial statements and therefore, require adjustment and/or disclosure in the statements. This Note is split into two primary parts. The first section (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 subsequent events 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. The second section (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 subsequent events provide relevant information needed to evaluate the information in the financial statements. Type II events are only disclosed in the Notes to Financial Statements.

The analyst should use the information disclosed in Type I of this Note to determine what impact subsequent events had to the financial statements for the current period. SSAP 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 since 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 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.

The analyst should use the information disclosed in Type II of this Note to assess and quantify the impact that 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.

Note 22 – Reinsurance

This Note is split into three primary sections. The first section (A) represents various information that the insurer must report. The second section (B) requires the insurer to report the same information on uncollectible

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reinsurance as the property/casualty insurers are required to report. The third section (C) requires the insurer to report certain information on commutation of reinsurance. The analyst should use all of the information provided in this Note to 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 of the standards. Therefore, an assessment of the financial stability of the reinsurer is extremely important task of the analyst. To assist in accomplishing this, the analyst may consult the following: the financial statements of the reinsurer, Analyst Team designations, regulatory and governmental filings (SEC and insurance department's Form B), rating agency reports (A.M. Best etc.), financial reports on the insurance industry, and other financial sources.

Under the AP&P Manual, SSAP 61*, Life, Deposit-Type and Accident and Health Reinsurance* (SSAP 61), Uncollectible Reinsurance, "The ceding and assuming companies must determine if reinsurance recoverables are collectible. If it is probable that reinsurance recoverables on paid or unpaid claims or benefit payments will be uncollectible, consistent with SSAP 5, *Liabilities, Contingencies, and Impairments of Assets*, these amounts shall be written off through a charge to the Statement of Operations utilizing the same accounts which established the reinsurance recoverables."

In addition to using all of the information in this Note to obtain a greater understanding of the insurer's reinsurance program, the analyst should also consider using specific sections of the Note as follows:

The analyst should use the information provided in the second section (B) of this Note to determine if any uncollectible 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.

The analyst should use the information provided in the third section (C) of this Note 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.

Note 23 – Retrospectively Rated Contracts & Contracts Subject to Redetermination

This Note requires the insurer to disclose general information regarding its premium volume under retrospectively written contracts. The accounting guidance for retrospectively rated contracts is addressed in SSAP 66, *Retrospectively Rated Contracts* (SSAP 66). SSAP 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 may 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 some time 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.

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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 analyst should review the Note to determine that the reported amount is recorded in compliance with necessary statutory guidance.

Note 24 – Change in Incurred Losses and Loss Adjustment Expenses

This Note requires an insurer to report any reasons for changes in the provision for incurred loss and loss adjustment expenses 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. Since 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 larger issue as 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 5-10 percent 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 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, so the analyst should review Exhibit 3 to identify the change in the provision for incurred losses and LAE and consider the level of comment merited under this Note.

If the 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 address supplemental procedures for Unpaid Losses and Loss Adjustment Expense.

Note 25 – Intercompany Pooling Arrangements

This Note requires an insurer to report certain information on reinsurance pooling arrangements with affiliated insurers. The analyst should use the information required in this Note to obtain a greater understanding of the insurer's pooling agreements. 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 where 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.

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Note 26 – 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. The accounting guidance for structured settlements is addressed in SSAP 65, *Property and Casualty Contracts* (SSAP 65). SSAP 65 discusses structured settlements but they 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 claimant. They come through "arms 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.

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 may continue for years. The victim would end up focusing on adapting to a new lifestyle that oftentimes involved unforeseen financial obligations. Today, structured settlements are flexible and can be designed for virtually 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 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's 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 have been disclosed since there is some exposure under these types of settlements. The name, state of domicile and location of the insurance company and the aggregate statement value of annuities due from life insurers should have been disclosed. A quick check on the financial rating of the life insurer may provide the analyst with some assurance that the insurer has the ability to meet its payments

Note 27 – Health Care Receivables

This Note is divided into two primary sections. The first section (A) requires disclosure on pharmaceutical rebate receivables. The second section (B) requires the insurer to disclose 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 84 *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP 84). Exhibit C – Implementation Guide, of SSAP 84 provides additional accounting guidance for the practical application of SSAP 84.

Section (A) – Pharmaceutical Rebate Receivables:

As stated in SSAP 84, pharmaceutical rebates are arrangements between pharmaceutical companies and insurers in which the insurer receives rebates based upon the drug utilization of its subscribers. These rebates are recorded as receivables by the insurer and include both billed amounts and estimated amounts. Estimates are calculated using a variety of methods. The first section (A) of the Note should address the method used by the reporting entity to estimate pharmaceutical rebate receivables. As stated in Exhibit C of SSAP 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

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the factors that can impact the amount of the receivable, material differences may exist between the estimated receivable and the actual receivable.

The first section (A) of the Note also contains a table, 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 following example.

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
12/31/2004	$150 (A)				
9/30/2004	130 (B)	$133 (C)	$62 (D)		
6/30/2004	142	143	138	$5	
3/31/2004	157	152	150	1	$1
12/31/2003	125	132	129	3	0
9/30/2003	123	129	125	1	0
6/30/2003	112	120	110	4	6
3/31/2003	110	118	118	0	0
12/31/2002	68	75	69	5	3
9/30/2002	60	59	58	1	0
6/30/2002	57	60	49	8	1
3/31/2002	45	50	48	1	1

This example assumes a financial statement date of 12/31/2004 and further assumes full implementation of SSAP 84 retroactive to 1/1/2002, with no transition. Exhibit C of SSAP 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 2004.

B. The $130 represents the company's best estimate of rebates to be received on drugs filled in the third quarter of 2004.

C. $133 is the actual amount of rebates determined for the third quarter of 2004, i.e. the amount billed to the pharmaceutical company or confirmed to the Pharmacy Benefit Manager. This amount was billed by 11/30/2004. 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 11/30/2004, the $62 represents the actual rebates received by the company during December 2004. In subsequent disclosures, the company would "update" this to include amounts received in January and February of 2005.

The admitted asset balance for pharmacy rebates at 12/31/2004 would equal $150 + 133 – 62 = 221. (A+C-D)

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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 3/31/2004 (1st quarter of 2004) line, actual rebates would have to be billed by May 31, so the column entitled "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).

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 their 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 their estimated receivable.

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 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 are not explained in the Note.

The Note was also designed to provide information on collectability. If, in accordance with SSAP 5, it is probable the balance of a receivable is uncollectible, any uncollectible 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 may 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 uncollectible.

Section (B) – Risk Sharing Receivables:

SSAP 84 defines risk-sharing agreements as contracts between insurers and providers with a risk-sharing element based upon utilization. These agreements can result in receivables due from providers if the actual utilization differs from the estimates. The second 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 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 may 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

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determined after the annual period, risk sharing receivables not yet invoiced, and amounts collected from providers as payments.

Exhibit B of SSAP 84 provides an illustration of the disclosure and an explanation of the amounts in the table. Exhibit C, Question #17 of SSAP 84 provides an 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 entitled "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.

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 may 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 collectibility of risk sharing receivables and certain receivables should be written off if they are deemed to be uncollectible. Risk sharing receivables from affiliated entities are included in this footnote and are reported as Health Care Receivables.

Note 28 – Participating Policies

This Note requires the insurer to disclose information on participating contracts. The Note for participating policies is required by SSAP 51, *Life Contracts* (SSAP 51) and SSAP 54, *Individual and Group Accident and Health Contracts* (SSAP 54).

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 policyholder dividends, the amount 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 29 – Premium Deficiency Reserves

This Note requires the insurer to disclose information on premium deficiency reserves. The Note for premium deficiency reserves is required by SSAP 53 and SSAP 54.

Premium deficiency reserves are established when anticipated losses, LAEs, 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 disclosure requires the insurer to provide the amount of that reserve and disclose if 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.

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Note 30 – 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. C.2. – Statement of Actuarial Opinion Analysts Reference Guide 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 Level 2 Annual Procedures for Life Reserves and Life Reserves Analysts Reference Guide, 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 – *Life Contracts* (SSAP 51) and SSAP 52 - *Deposit-Type Contracts* (SSAP 52). 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 A-825 discusses the Commissioners' Annuity Reserve Valuation Method (CARVM).
- Appendix C contains actuarial guidelines.

Disclosure of reserve practices required by SSAPs 51 and 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.

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.

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 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.

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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.

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.

Note 31 – Analysis of Annuity Actuarial Reserves and Deposit Type Liabilities by Withdrawal Characteristics

This Note is split into seven primary component (A-G) sections, however, for all practical purposes, there are three parts to the Note. Part 1 of 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 (Part 1 includes components A-E). Part 2 of this Note is a reconciliation of total annuity actuarial reserves and deposit fund liabilities (Part 2 represents component F). Part 3 of this Note discloses information on Federal Home Loan Bank (FHLB) agreements (funding agreements). 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. 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.

As noted above, Part 1 of this Note provides information on the withdrawal characteristics of annuities and deposit-type funds. This information is primarily helpful in identifying an insurer's interest-rate risk and its liquidity risk. The analyst should therefore use the information provided in Part 1 to assist in identifying these risks.

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 Risk-Based Capital formula uses essentially the same categories as this Note to determine interest rate risk on annuity and deposit-type ("ADF") reserves. For Risk-Based Capital 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 percent 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 Risk-Based Capital 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. 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 categories.)

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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 guaranteed interest contracts, 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 7 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.

Note 32- Premium and Annuity Considerations Deferred and Uncollected

This Note has one primary section. The section 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 two parts: uncollected and deferred premiums and annuity considerations, for each line of business listed above, on a gross basis (part 1) and net of loading (part 2).

The reporting of deferred and uncollected premium and annuity considerations are addressed in SSAP 51. Per SSAP 51, uncollected premiums are gross premiums that are due and unpaid as of the reporting date, net of loading. Per SSAP 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.

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.

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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.

Note 33 – Separate Accounts

There are two primary sections to this Note. The first section (A) focuses on the 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 56*, Separate Accounts* (SSAP 56). The second section (B) provides 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 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 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 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.

Part A of this Note 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 section of the Note 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. 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 percent, with rates greater than 4 percent, 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

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usually hedged. Non-indexed separate accounts with interest guarantees in excess of a year that do not exceed 4 percent 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 percent 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 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.

In Part B, 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.

Note 34 – Loss/Claim Adjustment Expenses

There are four primary sections to this Note. The first Section (A) discloses the balance of liabilities for unpaid loss/claim adjustment expenses. The second Section (B) discloses incurred loss/claim adjustment expenses. The third Section (C) discloses the payment of loss/claim adjustment expenses and the fourth Section (D) estimates the average salvage and subrogation. Life and annuity contracts are not subject to this disclosure requirement.

The reporting of claim liabilities and claims adjustment expenses are addressed in SSAP 55, *Unpaid Claims, Losses and Loss Adjustment Expenses* (SSAP 55) and SSAP 85, *Claims Adjustment Expenses, Amendments to SSAP 55 – Unpaid Claims, Losses and Loss Adjustment Expenses* (SSAP 85). SSAP 85 addresses claim adjustment expenses on accident and health 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 accident and health 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 85.

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 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.

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 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.

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VIII. Specialized Health Insurance Topics

VIII. Specialized Health Insurance Topics

The purpose of health insurance is to protect the insured against economic losses resulting from accident and/or sickness. There are many different types of health coverage provided by insurers and other organizations on either an individual or group basis including: medical (hospital, surgical, drug and major medical); dental; vision; managed care or prepaid health plans; medicare supplement; long-term care; short-term and long-term disability; and credit disability policies.

Health care coverage is provided by a variety of different types of organizations including health maintenance organizations (HMOs); hospital, medical and dental service or indemnity corporations (HMDIs); limited health service organizations (LHSOs); multiple employer welfare arrangements (MEWAs); self-funded employer plans; traditional life/health and property/casualty insurers; and fraternal benefit societies.

One significant concern of regulators regarding health care coverage is whether the entity holding the insurance risk is legally able to do so. For example, there have been many problems with unauthorized self-funded MEWAs in the past. Federal Employee Retirement Income Security Act (ERISA) provisions relating to MEWAs are complex and confusing, and this confusion has led to the operation of unauthorized self-funded MEWAs under false claims of ERISA preemption. These entities are often able to operate for long periods of time without any supervision or oversight until financial troubles leave numerous unpaid claims and cause participants to complain to state regulators.

To further complicate matters, many health care products being sold today include a preferred provider organization (PPO) option. A PPO contracts with a group of health care providers to provide health care services to covered members for a negotiated fee for services performed. Although covered members are not required to obtain health care services from PPO providers, the coinsurance percentages are higher for health care services provided by PPO providers. In most states, the PPO is not itself the insuring entity. Rather, the PPO "rents" its provider network by contracting with insurers and/or self-funded employers so that the PPO providers are an integral part of the health care product being issued. In fact, like some third party administrator (TPA) arrangements, sometimes the PPO is so fully integrated into the product that it appears as if the PPO itself is providing the health insurance even though it is not.

The NAIC's *Annual Statement Blanks*, *Annual Statement Instructions* and, *Accounting Practices and Procedures Manual* were developed for health entities that provide health care coverage. In addition, in some states, certain types of organizations providing health care coverage are regulated by a state agency other than the state insurance department.

The NAIC has developed the Health Edition of the Financial Analysis Handbook to be used by all state insurance departments for all entities providing health care coverage. For the most part, the financial analyst's concerns regarding the solvency of an organization providing health care coverage are the same as for a traditional life/health or property/casualty insurer: investments; reinsurance; adequacy of surplus; adequacy of premium rates; adequacy of policy and claim reserves; and, for insurers providing disability or long-term care coverage, asset-liability matching. Accordingly, many of the procedures in the NAIC's Life/Health and/or Property/Casualty *Financial Analysis Handbooks* are also applicable to the other types of health insurance organizations and the financial analyst should consider incorporating those procedures which are applicable into the analysis of HMOs, HMDIs and LHSOs that are licensed as life companies and that file the Life/Health Annual Financial Statement. The Health *Financial Analysis Handbook* is available for analysis of health entities that file the Health Annual Statement Blank.

The remainder of this chapter is devoted to a brief discussion of some of the special types of issues and concerns associated with the analysis of entities providing health care coverage.

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VIII. Specialized Health Insurance Topics

Blue Cross and Blue Shield Plans

A large percentage of health insurance in the United States is sold by Blue Cross and Blue Shield plans (the Blues). The Blues are individual corporations which are primarily single-state insurers that are members of the National Blue Cross and Blue Shield Association. It is difficult for financial analysts in the state insurance departments to perform any comparative analysis of the various Blues plans because of a lack of consistency in corporate structure and financial reporting. In many states, the Blues are HMDIs, although in some states they are life/health insurers and in still other states they are property/casualty insurers.

Risk-Based Capital

The NAIC's former Health Organizations Risk-Based Capital Working Group developed a formula specific to health insurers. The development of Risk-Based Capital (RBC) for health organizations was difficult because of the variety of products which are considered to be health coverage and the variety of regulatory structures and laws governing entities providing health care coverage. A common health blank is now filed by health organizations which previously filed different blanks.

Managed Care

Managed care represents an organized system for delivering cost-effective health care that incorporates benefit design features, financial incentives for providers and controls on utilization. Managed care attempts to reduce the overall expense of health care by doing such things as contractually setting prices through negotiated fee schedules with health care providers and providing risk sharing mechanisms with health care providers through the use of withholds, or capitation fees or bonus incentive payments.

Under a withhold arrangement, a portion of the health care provider's negotiated fee is not paid to the provider at the time the service is rendered but is instead held at risk. The withhold is then paid to the provider at the end of the period only if the aggregate cost of health care provided to a group of covered persons is at or below a target level. Under a capitation fee arrangement, a health care provider is paid in advance a fixed amount for each person to be served for the period, regardless of the actual number or nature of services provided to each person. Under a bonus incentive payment arrangement, health care providers are reimbursed according to discounted fee-for-service rates, fee schedules, capitations or negotiated per-diem amounts. A bonus payment is made at the end of an accounting period if specific utilization targets are met. In addition, staff model HMOs have been able to restructure the cost basis of health care by hiring doctors and paying them salaries rather than paying them on a fee-for-service basis.

Managed care can have a significant impact on the degree of predictability of health care costs. Although there is still risk due to the potential mismatch between the pricing period and the health care provider contracting period, the ability to negotiate arrangements with providers provides improved control and predictability over health care costs.

Similar to the Blues, it is difficult for financial analysts to perform comparative analysis of HMOs because of differing corporate structures. There are basically four types of HMOs: independent physician association (IPA), staff, group, and network models. Under the IPA model, the HMO provides health care through contracts with otherwise independent physicians operating out of their separate offices. Under the staff model, the HMO has a group of physicians on staff who are paid a specific salary and contracts for specialty care and inpatient services. Under the group model, the HMO contracts with a sponsoring clinic to provide primary and specialist services. Under the network model, the HMO provides health care through contracts with clinics and otherwise independent physicians operating out of their separate offices. Other managed care structures are emerging such as physician hospital organizations (PHO). These organizations consist of clinic, inpatient and outpatient facilities and are paid a capitation fee by HMOs to provide an integrated array of health care services.

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VIII. Specialized Health Insurance Topics

Uninsured and Partially Insured Health Plans

Some health insurance organizations act as administrators of health plans under which the plan retains all of the risk of claims. Such health plans are commonly referred to as "administrative services only" (ASO) plans and are described as uninsured plans because there is no risk to the health insurance organization due to claims under the health plan. Under an ASO agreement, the health insurance organization contracts with a self-insured group employer or other self-insured plan to provide administrative services to the self-insured plan which may include the following: actuarial, benefit plan design, claims processing, data capture and analysis, financial consulting, reporting, etc., in exchange for an administrative fee.

In addition to plans under which there is no risk to the health insurance organization, partially insured plans, which include "cost plus/stop loss" and "minimum premium" arrangements, are also offered by some health insurance organizations. Under a cost plus/stop loss arrangement, the plan is charged the amount of claims paid by the health insurance organization plus an administrative fee which is designed to cover the organization's expenses and provide a profit. However, the health insurance organization provides stop loss insurance coverage above certain loss limits in accordance with the contract with the plan. Under a minimum premium arrangement, the plan self-funds a fixed percentage of the estimated monthly claims for the plan and the health insurance organization insures the excess. The health insurance organization receives an administrative fee from the employer as well as a premium to cover the excess insured by the organization.

Amounts associated with administration fees pertaining to uninsured plans or to the uninsured portion of partially insured plans should not be reported as premium income by the health insurance organization. Rather, according to the SSAP No. 47, *Uninsured Plans*, these amounts should be deducted from general insurance expenses so that general insurance expenses are reported net of administration fees received pertaining to uninsured plans or to the uninsured portion of partially insured plans.

Rate Stabilization Reserve

Many health insurance organizations establish funding arrangements intended to avoid large fluctuations in premium levels by maintaining a special reserve, which may be legally claimed by a covered group, that is held by the health insurance organization and available to cover fluctuations in claim experience. These funds are accounted for separately for each group. Because these funds are held to moderate future rate fluctuations as a result of fluctuations in claim experience, they serve to stabilize the health insurance organization's financial results. A credit is allowed for rate stabilization reserves in the life RBC calculation.

Health Care Delivery Assets

The primary assets of staff model HMOs are real estate and equipment used in the delivery of health care. For these HMOs, real estate and equipment are not being held as traditional investments. Instead, the assets are held to allow the HMO to be able to provide the health care services stipulated in its contracts with its members. If traditional investment laws regarding limitations and valuation were applied to these assets, most would be considered nonadmitted assets. However, the HMOs argue that these assets represent physical plant rather than investments and, therefore, should not be subject to the traditional investment laws. Admissibility and valuation of real estate and equipment used by HMOs in the delivery of health care currently varies from state to state but are admitted assets under SSAP No. 73, *Health Care Delivery Assets*.

General Regulatory Factors

The regulatory environment faced by an entity providing health care coverage affects the risks it takes. Regulation varies from state to state. An example of this is rate regulation. In some states, the insurance department does not have the authority to approve rates whereas in other states, the insurance department reviews rate filings and has the ability to hold public hearings and ultimately approve a rate different from that proposed by the health insurance organization. In addition, federal actions, such as ERISA exemptions, the HMO Act and

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Medicare/Medicaid cost shifting, have significantly altered the financial arrangements and risk characteristics of health insurance in the past several years.

Summary

The myriad of types of health coverage, the variety of types of organizations which provide health coverage, and the diversity and current state of flux of state laws regulating these types of organizations make it more difficult to analyze entities providing health care coverage. However, for the most part, the financial analyst's concerns regarding the solvency of an organization providing health care coverage are the same as for a traditional life/health or property/casualty insurer: investments, reinsurance, adequacy of surplus, adequacy of premium rates, adequacy of policy and claim reserves, and asset-liability matching.

Analyst's should utilize the Health *Finanical Analysis Handbook* for additional discussion on issues and concerns regarding entities providing health care coverage.

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NAIC Financial Analysis Solvency Tools

Financial Analysis Handbook

Property/Casualty Edition

2009 Annual/2010 Quarterly

The NAIC is the authoritative source for insurance industry information. Our expert solutions support the efforts of regulators, insurers and researchers by providing detailed and comprehensive insurance information. The NAIC offers a wide range of publications in the following categories:

Accounting & Reporting
Accountants, members of the insurance industry and educators will find relevant information about statutory accounting practices and procedures.

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Securities Valuation Office
Provides insurers with portfolio values and procedures for complying with NAIC reporting requirements.

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Accountants, members of the insurance industry and educators will find relevant information on a variety of insurance topics.

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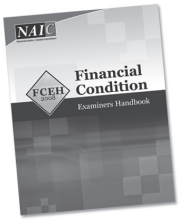
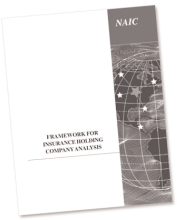
Companion Products

The following companion products provide additional information on the same or similar subject matter. Many customers who purchase the ***Financial Analysis Handbook*** also purchase one or more of the following products:



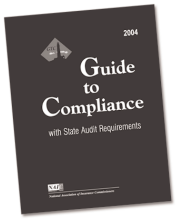
Financial Condition Examiners Handbook

This handbook provides a guide to assist state insurance departments in establishing an effective examination system. It provides an overview of the entire examination process and then offers specific instructions and suggestions for carrying out each individual phase of examination. Updated annually.



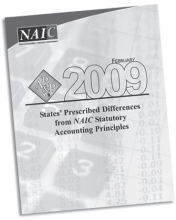
Framework for Insurance Holding Company Analysis

The Framework for Insurance Holding Company Analysis was created to document the best practices of states' efforts in analyzing holding companies and their insurance subsidiaries and in sharing information and coordinating regulatory action. The overall purpose of the Framework is to provide state insurance regulators with the tools and guidance necessary to gain an overall understanding of the holding company structure and the impact its management, business practices and financial condition has on its insurance subsidiaries. Copyright 2002.



Guide to Compliance with State Audit Requirements - As of 2004

This publication is a tool to assist insurers, CPAs and other interested parties in complying with the various state filing mandates for annual audited financial reports and related correspondence. It highlights differences in the states' requirements from the NAIC Model Audit Rule Requiring Audited Financial Statements and provides documentation of each state's rules and regulations. This guide also includes a copy of the AICPA's Statement Position 95-4, "Letters to State Insurance Regulators to Comply with the NAIC Model Audit Rule," as well as examples of various required letters and forms. This guide is also available on CD-ROM, providing instantaneous search capabilities powered by NextPage. Copyright 2004.



States' Prescribed Differences from NAIC Statutory Accounting Principles

The Accounting Practices and Procedures Manual presents a comprehensive basis of accounting that should be followed if not in conflict with state statutes and/or regulations. Should the domiciliary state set forth accounting guidance that differs from the AP&P Manual, disclosures of such must be made. This publication provides information regarding each state's prescribed differences from NAIC statutory accounting principles, including a citation to the respective state statute and/or regulation. Updated annually.

How to Order

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International orders must be prepaid, including shipping charges. Please contact an NAIC Customer Service Representative, Monday - Friday, 8:30 am - 5 pm CST.

National Association of Insurance Commissioners

Date: **January 2, 2010**

To: **Users of the NAIC's Financial Analysis Handbook—Property/Casualty Edition**

From: **NAIC Staff**

This edition of the NAIC *Financial Analysis Handbook* is to be used in conjunction with the 2009 Annual and 2010 Quarterly Financial Statements. The following summarizes the most significant changes since the prior edition:

Level 1 – Analyst Reference Guide and Procedures

Non-Routine Analysis

A new section was added to the Analyst Reference Guide that discusses non-routine analysis related to events or situations that fall outside the normal course of business and may have a material impact on the overall financial condition of an insurer. The discussion includes several examples of the types of non-routine analysis that may be performed.

New Procedures

A procedure was added to address RBC Trend Test failure and a procedure was added within "Assessment of Supplemental Filings" to address communication with the domestic states of affiliated insurers within a group.

Audited Financial Report – Analyst Reference Guide and Supplemental Procedures

Audit Committee

A procedure was added to address whether an insurer has established an audit committee.

Model Audit Rule

Due to the anticipated revisions to the Model Audit Rule effective January 1, 2010, three sections were added to the Analyst Reference Guide to address auditor independence, corporate responsibility, and internal control over financial reporting.

Captives and/or Insurers Filing on a U.S. GAAP Basis – Analyst Reference Guide and Supplemental Procedures

A brief discussion on the GAAP reporting of deferred acquisition costs was added to the Analyst Reference Guide. Also, a procedure was added to assess the potential impact of LOCs, GAAP/SAP investment differences, and/or deferred acquisition costs on the Total Adjusted Capital component of the RBC calculation. A supporting exhibit was also added at the end of the procedures.

If you have questions regarding the *Financial Analysis Handbook Property/Casualty Edition*, contact Andy Daleo, Property/Casualty Financial Analysis Manager at 816-783-8141 or via email at adaleo@naic.org.

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EXAMINATION OVERSIGHT (E) TASK FORCE
FINANCIAL ANALYSIS HANDBOOK WORKING GROUP

SUBMIT TO
NAIC - KC
By June 1, 2010

Financial Analysis Handbook Proposed Revision Form

INSTRUCTIONS	FOR NAIC USE ONLY
1. Complete this form for EACH Handbook proposal. Under "Identification of Item(s) to be Changed", include Section & Page number, Line or Item Identifier. 2. All attachments should be presented in a format wherein new language is underscored and deletions struck through. 3. Please consider whether this revision proposal issue is also addressed elsewhere in the Handbook. 4. All submission forms and attachments must be typed originals. 5. CAUTION: before completing this form, please read additional instructions on reverse side of this form.	DISPOSITION [ ] ADOPTED [ ] REJECTED [ ] DEFERRED [ ] OTHER (SPECIFY) _____
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HANDBOOK SECTIONS TO WHICH PROPOSAL APPLIES

[ ] LIFE/HEALTH [ ] PROPERTY & CASUALTY [ ] HEALTH

[ ] Introductory Chapters
[ ] Financial Analysis Framework
[ ] Analysts Reference Guide
[ ] Specialized Topics
[ ] Quarterly Procedures

[ ] Level 1 Annual Procedures
[ ] Level 2 Annual Procedures
[ ] Level 3 Annual Procedures
[ ] Other (Specify)

[ ] Audited Reports Supplemental Procedures
[ ] Actuarial Opinion Supplemental Procedures
[ ] M D & A Supplemental Procedures
[ ] Holding Company Supplemental Procedures

IDENTIFICATION OF ITEM(S) TO BE CHANGED

REASON OR JUSTIFICATION FOR CHANGE **
(STATE, IN SPECIFIC TERMS, THE BENEFIT TO BE DERIVED FROM THIS PROPOSAL)

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Additional Instructions and Information

The Financial Analysis Handbook Working Group meets via conference call throughout the year to consider proposed changes to the Financial Analysis Handbook (FAH). Suggestions to the FAH should be submitted by **June 1, 2010**. They will be reviewed by the Working Group and considered for adoption and implementation in the next FAH edition. Send proposals to:

National Association of Insurance Commissioners
Insurance Analysis & Information Services Department
2301 McGee Street, Suite 800
Kansas City, MO 64108-260

For questions call the Insurance Analysis & Information Services Department at (816) 842-3600.

Any member of a State Insurance Department is welcome to submit a Proposed Revision Form. The forms will be regarded as submitted on behalf of insurance departments rather than individuals.

Proposed Procedure Revisions

During the Working Group's review, changes proposed via this form will be considered along with an analysis conducted by the NAIC Financial Regulatory Services Division of the effectiveness of procedures. This analysis encompasses the effectiveness of ratio limits as well as the language of procedures. Additionally, the general usefulness of procedures are considered. Specific proposals from states relative to procedures are welcome and should include detailed analysis.

Proposed Revisions for Annual Statement Changes

The Insurance Analysis & Information Services Department also studies adopted changes to the Health Annual Statements and provides revision proposals to the Working Group. The Insurance Analysis & Information Services Department automatically makes changes to the FAH for minor changes, such as for page and line numbers. Specific proposals are welcome. Additionally, please alert the Insurance Analysis & Information Services Department to any overlooked minor annual statement changes.

Proposed Software Revisions

The Life/Health, Property/Casualty and Health Handbooks are automated on I-Site. The FAH is intended to be a dynamic tool. The Working Group is interested in feedback on both analytical and software features. Please contact the NAIC Help Desk at (816) 842-3600 before submitting a form. Many enhancements have been proposed which could not be implemented. Also, some proposals may relate to existing features that the Help Desk may be able to explain.

**** This section must be completed on all forms.**

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Preface

The NAIC consists of insurance regulatory officials from the 50 states, the District of Columbia, and several U.S. territories. One of the primary objectives of an insurance regulator is to identify, as early as possible, insurance companies that may be financially troubled so that corrective action can be taken to protect policyholders, claimants, and creditors from financial loss.

The *Financial Analysis Handbook* (*Handbook*) was developed and released by the Financial Analysis Handbook Working Group (FAHWG) of the Examination Oversight (E) Task Force with the assistance of outside consultants in 1997. The purpose of the *Handbook* is to provide a means for insurance departments to more accurately identify companies experiencing financial problems or that pose the greatest potential for developing financial problems. In addition, the *Handbook* provides guidance for the insurance departments to define and evaluate particular areas of concern in troubled companies. The overall goal of the *Handbook* is to enable regulators to identify financially troubled insurers earlier, evaluate and understand their problems better, and develop appropriate corrective action plans sooner, thus, potentially decreasing the frequency and severity of insurance company insolvencies.

The information in the *Handbook* is intended to provide concepts and approaches that will enable regulators to perform more effective and efficient analysis of insurance companies. It does not include state specific information or regulations, and does not establish guidelines that insurance companies and departments must follow. Parameters or benchmarks utilized are not regulatory requirements to be complied with by insurance companies. The accreditation standards indicate that the analyst should utilize procedures developed by their department or procedures within the *Handbook*.

NOTE: Please note that all references throughout this *Handbook* to the risk-focused surveillance approach, Insurer Profile Summary, and Supervisory Plan apply only to states that have adopted and implemented the risk-focused surveillance approach. The ownership and responsibility for updates to the Insurer Profile Summary may vary from state to state between the analysis and examination departments.

The *Handbook* contains the following:

Introductory Chapters
These chapters provide a general overview for the analyst concerning regulatory organization, communication, and prioritization.

Financial Analysis Framework
The framework discusses resources the analyst should utilize throughout the review process. In addition, the steps of the review process are presented.

Analyst Reference Guide and Procedures
The Analyst Reference Guide should be utilized with the Level 1, 2, 3, and Supplemental Procedures for both annual and quarterly periods. The Analyst Reference Guide provides discussion on the procedures that could be performed during an analysis of an insurer. There are three procedural levels within the *Handbook*. In Level 1, the analyst performs an overall review of the insurer. If there is any area of concern, additional procedures from Level 2 should be completed. Level 2 Procedures focus on specific financial areas that assist the analyst in conducting a thorough financial analysis. If continued concerns exist after completion of any Level 2 Procedures, Level 3 Procedures should be completed. Level 3 Procedures are

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intended to address qualitative issues of an insurer. The Supplemental Procedures assist the analyst in reviewing additional filings from the insurer such as its Audited Financial Report, Statement of Actuarial Opinion, Management's Discussion and Analysis, and Holding Company Analysis. There are also quarterly Level 1 and 2 Procedures.

Guidance for Notes to Financial Statements

The guidance provides guidelines to assist the analyst in further understanding the reporting requirements of an insurer.

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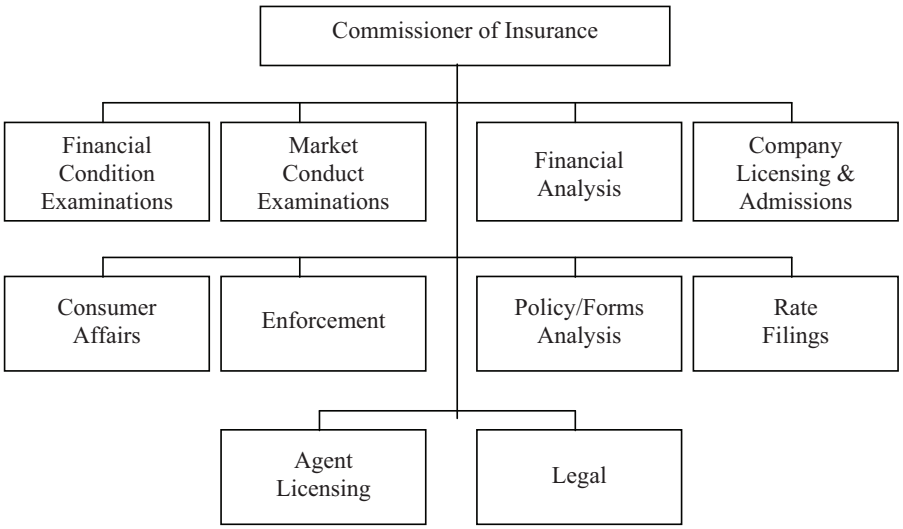
Organization Chart

The organizational structure of a state insurance department varies by state. However, there are several basic functions that are performed by all departments. It is important for the analyst to understand the purpose of each function and the information obtained that may assist in the financial monitoring and solvency surveillance process. The chart below depicts typical state insurance department functions rather than a typical organizational structure, due to the variances in organizational structure.

Chart of State Insurance Department Functional Units



In many states, more than one of the above functions may be performed or supervised by the same individuals. For example, the financial analysts may also perform financial examinations and financial examiners may also perform market conduct examinations. Additionally, some insurance departments rely on the Attorney General's office for legal assistance rather than having separate department counsel.

Financial Condition Examinations

The insurance code in most states allows the state insurance department to examine insurers as often as the commissioner deems appropriate and requires that each insurer be examined at least once every three to five years (as determined by each state). Financial condition examinations performed by the state insurance departments include full-scope periodic examinations and limited-scope or targeted examinations, which focus on specific accounts and/or issues. The results of a financial condition examination are documented in an examination report that assesses the financial condition of the insurer and sets forth findings of fact (together with citations of pertinent laws, regulations, and rules) with regard to any material adverse findings disclosed by the examination. Examination reports may also include corrective actions required to be taken by the insurer and/or recommendations for improvements. Through the risk-focused surveillance approach, the department gains knowledge about all aspects of the insurer, including its corporate governance, risk management practices, and key business activities, which can be useful to solvency analysis.

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Market Conduct Examinations

The market conduct examination focuses on such areas as sales, advertising, rating, and the handling of claims. Market conduct examinations evaluate an insurer's business practices and its compliance with statutes and regulations relating to dealings with policyholders and claimants. The results of a market conduct examination are documented in an examination report, which summarizes examination findings so that the insurer's performance can be assessed. The report may also recommend a corrective action to deal with significant problem areas. Because financial conditions and market conduct problems are often interrelated, the examinations are frequently conducted simultaneously.

Financial Analysis

Financial analysis provides an in-house desk audit of the Annual Financial Statement and all other supplemental filings made by an insurer. The analyst should refer to other available information as well, including information on the NAIC Financial Data Repository, in order to monitor the insurer's statutory compliance and solvency on an ongoing basis in coordination with the periodic on-site field examination process. As part of the risk-focused surveillance approach, the financial analysis unit responsibilities can include monitoring the state's domestic insurers, providing updates to the Insurer's Profile Summary, if applicable (see chapter III.A), providing input for the department's priority score and supervisory plan, and providing department management with timely knowledge of significant events and performing the prospective risk analysis. Refer to Chapter III.A Analyst Reference Guide for Level 1 Analysis for further discussion on prospective risk. As part of the analysis process and the review of the examination report and findings, the analyst should incorporate into his/her analysis information gained about the corporate governance and risk management processes of the insurer. If desired, regulators can request the Insurer's Profile Summary, if applicable, for non-domestic insurers from the domestic or lead state.

As a result of concerns identified during the financial analysis process, the insurance department may take a variety of actions, including but not limited to contacting the insurer seeking explanations or additional information, obtaining the insurer's business plan, requiring additional interim reporting from the insurer, calling for a targeted or limited-scope financial condition examination, engaging an independent expert to assist in determining whether a problem exists, meeting with the insurer's management, obtaining a corrective plan from the insurer, and/or restricting, suspending, or revoking an insurer's Certificate of Authority.

Company Licensing and Admissions

An insurer that chooses to obtain a Certificate of Authority to write business in a state must generally complete an application indicating the line(s) of business it plans to write. In addition, the insurer must submit an application along with other information, including the most recent Annual Financial Statement, Audited Financial Report, Actuarial Opinion, etc., to support its financial condition. Also, insurance departments frequently request information supporting the insurer's experience and expertise in writing the line(s) of business requested, background information regarding the insurer's management and board of directors, a business plan, and a multi-year pro-forma financial projection. After reviewing this information and any other information obtained, the insurance department makes a determination on whether to issue a Certificate of Authority.

The Alert Working Group developed the Uniform Certificate of Authority Application, also known as the UCAA or Uniform Application. The Alert Working Group was dissolved, and the National Treatment and Coordination Working Group currently maintains and updates the UCAA application. The UCAA process is designed to allow insurers to file copies of the same application for admission in numerous states. Each state that accepts the UCAA is designated as a uniform state. While each uniform state still performs its own independent review of each application, the need to file different applications in different formats has

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been eliminated. The Uniform Application is available to any insurer in good standing with their domiciliary state, regardless of size. Currently, all 50 states and the District of Columbia are uniform.

Consumer Affairs

Consumer Affairs is responsible for developing and distributing information regarding insurance products and the insurance industry to consumers. Consumer Affairs is also responsible for addressing complaints filed with the insurance department by policyholders and claimants against insurers and agents. Detailed statistics regarding complaints, both in number and type of complaint, and their resolutions may be maintained as a part of this function. Complaints are recorded on the Complaints Database System if filed with the NAIC.

Enforcement

Punitive actions taken against companies, agents, and other licensees found to be in violation of the insurance code are handled by the enforcement function. This function issues orders and levies fines and other penalties based on the results of investigations performed by other functions within the insurance department. Detailed records are maintained by the department on all regulatory actions taken against companies, agents, and other licensees. In addition, regulatory actions are also recorded in the Regulatory Information Retrieval System (RIRS) database if filed with the NAIC.

Policy/Forms Analysis

Every state requires an insurer to file policy forms for most lines of business for review and/or approval prior to selling the policies. The primary purpose of this review is to determine statutory compliance regarding policy provisions and benefits.

Rate Filings

Information regarding premium rates, including actuarial rate development assumptions, is generally required to be filed with the insurance department for certain lines of business. Some states are “file and use” states, which allow insurers to begin selling policies at the rates filed as soon as the filing is made. In other states, rates must be approved by the insurance department prior to use by the insurer. Rate filings, including the actuarial assumptions, are reviewed for reasonableness and statutory compliance as a part of this function.

Agent Licensing

Agents must be licensed by the insurance department in order to write business in the state. The agent licensing function administers tests for agents, reviews new and renewal applications from agents, and performs background checks on the agents. In addition, many states have continuing education requirements for agents, and agent licensing monitors compliance with these requirements. Detailed records of licensed agents are maintained by agent licensing, including information regarding the insurers for which the agents produce business.

Legal

Legal is generally involved in the review of proposed changes of control of insurers and other holding company transactions and frequently supports the other functions. Legal may also draft statutes and regulations to assist the insurance department in regulating insurers, agents, and other licensees; hold administrative hearings between the commissioner and insurers, agents, and other licensees; and represent the department in judicial and other proceedings.

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Communication

Communication with other divisions or areas within the department (intra-departmental communication) on a timely basis is an important element of effective solvency surveillance and is essential to the coordination of results of the risk-focused surveillance approach. Upon identifying a problem or concern during the financial analysis process, the financial analyst should communicate this information to other divisions within the department. In addition, other divisions within the department should communicate certain information to the financial analyst so that the analyst has all of the relevant information available regarding the insurer being analyzed. (Refer to the Insurer Profile Summary in the *NAIC Financial Condition Examiners Handbook*.)

Communication From the Financial Analyst to Other Divisions or Areas

The analyst may identify concerns as a result of the financial analysis process that, when communicated to the financial condition examinations division, may lead to a targeted or limited scope financial condition examination. In addition, since the analysis process and risk-focused examinations are interactive processes, the analyst should be familiar with the insurer's current financial condition, including any changes in its operations since the last periodic financial condition examination. Analysts should actively communicate findings from the analysis process to examiners, as this type of communication is beneficial to the financial condition examination staff during the planning of risk-focused examinations and any follow-up. An example of the type of communication may include significant financial variances found in the insurer's business plan projections. Another example may include a material turnover of high-level management positions. Statutory violations identified as a part of the analysis process should be communicated to the enforcement division for the issuance of appropriate penalties and/or corrective orders against the insurer. Additionally, solvency related concerns, when communicated to the legal division, may result in the restriction, suspension, or revocation of an insurer's Certificate of Authority.

Communication From Other Divisions or Areas to the Financial Analyst

In addition to intra-department communication, which originates within the financial analysis division, it is equally important that the department's procedures be designed to ensure relevant information and data received by the other divisions within the department be directed to the financial analysis division. The following are some examples of information or data that may be received by other divisions within the department, including an indication of the functional unit that would likely have received the information or data, which should be directed to the financial analysis division for consideration as a part of the financial analysis process:

1. Financial condition examination reports that include significant adjustments to the financial information reported to the department, corrective actions required to be taken by the insurer, and/or recommendations for improvements based on examination results. Communication from financial examination staff may also include significant current events, company conditions and issues, industry conditions impacting the insurer, and other financial concerns such as changes in profitability trends, deterioration in asset quality, liquidity or capital adequacy, or changes in investment strategies or reinsurance. Moreover, the risk-focused examination may provide information about the insurer's prospective risks and the effectiveness of the insurer's risk management processes.

2. Market conduct examination reports containing corrective actions required to be taken by the insurer as a result of violations in sales, advertising, ratings, and/or claims practices, which might be an indication of financial problems or lead to the risk of financial losses through class action suits or regulatory fines (market conduct examinations).

3. Any relevant information obtained in planning the financial examination stage.

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4. An increase in the number or type of complaints filed by policyholders, claimants, employees, agents, or third parties that could indicate liquidity or internal control problems (consumer affairs).

5. Corrective orders and other regulatory actions taken against an insurer and fines and penalties levied (enforcement).

6. New policy form filings or expansion into new lines of business, including high-risk and long-tail lines of business, which might imply planned rapid growth to obtain premiums in order to improve liquidity or cover prior losses (policy/forms analysis).

7. Requests for significant premium rate increases, which might be an indication of insufficient rates to cover losses and expenses in the past (rate filings).

8. An increase in the licensing of agents, including managing general agents or third party administrators, which could indicate planned rapid expansion or relaxed underwriting standards (agent licensing).

9. The use of managing general agents or third party administrators, which might be an indication that the insurer is not in control of its operations (agent licensing).

10. Information that management personnel of an insurer, including officers, directors, or any other persons who directly or indirectly control the operations of the insurer, fail to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such a position (legal).

11. The unexpected resignation of an insurer's officer(s), director(s), or other key management personnel, which might indicate internal turmoil or dissatisfaction with the insurer's goals or operating practices (legal).

Intra-Department Communication System

Intra-department communication in most state insurance departments is primarily informal due to the size of the department and the location of personnel. The commissioner may hold periodic meetings with the division heads to discuss current developments and concerns in each division. In some states, division heads prepare monthly activity reports highlighting current developments that are circulated to the other divisions within the department. Departments should have a formal structured mechanism to assure appropriate ongoing intra-department communication. Adequate controls should be implemented to assure that recommendations, decisions, actions, and results are effectively communicated and documented. Among the key objectives of a department's intra-department communication system are the following:

1. Key insurance department officials should possess all relevant information to permit decisions to be made on a timely basis.

2. The department should assure that all levels of staff have the appropriate knowledge, information, and feedback to effectively perform their assigned functions.

3. Managers within various functional units or divisions should be responsible for the proper internal communications and documentation of decisions and actions taken under their authority.

4. The department should establish procedures to assure that orders and directives are effectively communicated to the appropriate staff and that the staff observes such orders and directives.

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The operations of an insurance company often are not limited to one jurisdiction. Therefore, state insurance departments need to coordinate their regulatory efforts with those of other state insurance departments where their insurers do business. The *Troubled Insurance Company Handbook* states that opportunities to coordinate efforts should be sought throughout the entire process, from the monitoring and surveillance of insurers through regulatory actions regarding identified troubled insurers. Coordinated activities may take various forms, including establishment and maintenance of procedures to communicate information regarding troubled insurers with other state insurance departments, participation on joint examinations of insurers, assignment of specific regulatory tasks to different state insurance departments in order to achieve efficiency and effectiveness in regulatory efforts and to share personnel resources and expertise, and establishment of task forces consisting of personnel from various state insurance departments to carry out coordinated actions. Coordination of actions may also be useful to avoid duplication of individual state insurance department actions that may be counterproductive.

The NAIC Policy Statement on Financial Regulation Standards indicates that a state insurance department should generally follow and observe the procedures set forth in the *Troubled Insurance Company Handbook*. The *Troubled Insurance Company Handbook* provides guidance regarding communication with other state insurance departments about domestic insurers identified as troubled. Specifically, the standards state:

> State statute should allow for the sharing of otherwise confidential information, administrative or judicial orders, or other actions with other state regulatory officials providing that those officials are required, under their law, to maintain its confidentiality. The department should have a documented policy to cooperate and share information with respect to domestic insurers with other state regulators directly and also indirectly through committees established by the NAIC, which may be reviewing and coordinating regulatory oversight and activities. This policy should also include cooperation and sharing of information with respect to domestic insurers subject to delinquency proceedings.

The department should establish and implement procedures to ensure that regulatory actions are reported to the Regulatory Information Retrieval System (RIRS), investigative information is reported to the Special Activities Database (SAD), summary information on consumer complaints is reported to the Complaints Database System (CDS), and that the status of regulatory actions is reported to the Global Receivership Information Database (GRID). These databases are discussed in more detail in Chapter 1 Introduction—NAIC Information of this *Handbook*.

Effective interdepartmental action requires timely and effective communication among the various state insurance departments. Insurance departments should develop methods of multilateral communication in order to coordinate the prompt sharing of pertinent information regarding troubled insurers that may impact other jurisdictions. Open lines of communication may provide additional information to a department to assist in its surveillance, as well as, provide information to other state insurance departments. Such communications should be established to foster cooperation among the various state insurance departments, so that each department works toward the satisfactory resolution of all troubled insurer situations, regardless of the insurer's domicile, license, or operating status. Communications to other state insurance departments regarding troubled insurers should be made in an atmosphere of appropriate confidentiality. Knowledge by outsiders of actual or contemplated regulatory activities may cause undue negative consequences to the insurer, e.g., cancellation of policies or unavailability of reinsurance coverage, which may diminish the insurer's ability to receive assistance or to remain solvent.

The *Troubled Insurance Company Handbook* indicates that the effects on policyholders in all jurisdictions that may result from the actions of a department should be considered. The department,

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however, should consider any adverse consequences that could possibly result from making certain information known to other state insurance departments. Those possible disadvantages may be outweighed by the advantages gained from sharing information and working with the other state insurance departments.

An insurance department may go beyond routine communications to allow other departments to participate in decision-making activities related to an insurer that operates in more than one jurisdiction. Any such joint action depends on the nature of the decisions to be made and the relative impact on a particular jurisdiction. However, cooperation of this nature can significantly improve communications between departments, and the resulting increased knowledge of the insurer's condition and circumstances can lead to more effective regulatory action.

The NAIC and its various committees, task forces, and working groups may also provide a means for facilitating coordination and communication among the various departments. For example, the NAIC Examination Oversight (E) Task Force can participate in coordinating the efforts of various departments in a troubled insurer situation. An association examination of an insurance company may be requested through the NAIC, as described in the *Financial Condition Examiners Handbook*. The Financial Analysis (E) Working Group functions as a peer review; they identify insurance companies of national significance that are or may be financially troubled and determine whether appropriate regulatory action is being taken. The NAIC may also assist in organizing and facilitating other cooperative regulatory efforts, such as the formation of working groups to address specific troubled insurance company situations.

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There is a considerable amount of information available to assist the analyst in analyzing insurance companies. The NAIC maintains financial databases developed from the insurer filings and state insurance department actions, all of which are described in more detail in the next chapter. In addition to the NAIC information, there are a number of external sources of information available from the major rating agencies and industry analysts. The analyst should refer to these sources of information in order to increase his or her knowledge of the insurer's financial position and to corroborate the financial information filed by the insurer with the NAIC and state insurance departments. These sources of information are all available through direct purchase or subscription order from the rating agencies and/or industry analysts. Following is a discussion of the major sources of external information available.

Rating Agencies

There are five major rating agencies that review insurance companies. Each has its own unique methodology for assigning ratings. The rating agencies also produce other types of financial information that may be helpful to the analyst. The following paragraphs briefly describe each of the major rating agencies and the types of financial information available.

1. *A.M. Best*—The A.M. Best Company (Best) has been rating property/casualty insurance companies since 1900. The objective of Best's rating system is to evaluate the factors affecting the overall performance of an insurance company and to provide its opinion as to the company's relative financial strength and ability to meet its contractual obligations. Best conducts an extensive quantitative and qualitative evaluation of rated insurers based on various sources of information and knowledge of the company accumulated over a period of time. This knowledge is acquired through frequent contacts with company officials, as well as statutory financial statements, special questionnaires, and a variety of other sources. To obtain an A.M. Best rating, a newly rated insurer should have a credible business plan, experienced management, financial sponsorship/support, submit requested financial information, and pay a fee. The ratings are available through Best's Key Rating Guide and Best's Ratings Online. Best also publishes Aggregates and Averages, Company Reports, a Rating and Statistical Guide, as well as many other publications, directories, reports, and periodicals.

2. *Fitch*—Fitch Ratings was founded as the Fitch Publishing Company on Dec. 24, 1913. The Company began as publisher of financial statistics and soon became the recognized leader in providing critical financial statistics to the investment community. In 1924, Fitch introduced the "AAA" to "D" ratings scale along with in-depth analysis completed by a staff of investment experts. Fitch's rating evaluations are qualitative and quantitative and provide two basic types of ratings—insurer financial strength ratings and issuer and fixed income security ratings. The ratings are obtained via an in-depth industry review and insurer specific operational, organizational, management, and financial reviews. The ratings are available through Fitch's National Ratings List and Fitch Ratings Online.

3. *Moody's Investors Service*—Moody's Investors Service was founded in 1900. Moody's ratings of debt securities include taxable bonds, structured financings, and municipal bonds in the U.S. tax-exempt market. In addition, Moody's rates U.S. Treasury debt, deposits of banking groups, trillions of dollars of credit risk exposure in derivative markets, and insurance claims. In the insurance sector, Moody's has been rating the debt securities of insurance companies since the mid-1970s. Moody's began assigning insurer financial strength ratings in 1986. Moody's financial strength ratings reflect its opinion as to an insurer's ability to discharge senior policyholder obligations and claims. It seeks to measure credit risk, e.g., the risk that an insurer will fail to honor its senior policyholder claims in full and on a timely basis. Moody's financial strength ratings are based on qualitative analysis. Moody's disseminates its ratings through various publications and publishes credit opinions on a semi-annual basis with in-depth analysis,

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industry outlooks, and a statistical handbook published on an annual basis. Moody's also publishes insurer financial strength ratings lists and insurance industry debt lists monthly.

4. *Standard and Poor's*—Standard and Poor's (S&P) has been rating bonds since 1923 and insurance companies' claims-paying ability since 1983. S&P's insurer rating activity draws from its expertise and procedures in rating debt issues and utilizes a similar classification framework, but is conducted by professional analysts whose background, experience, and/or training is focused on the insurance industry. S&P sees its role as providing risk assessment of insurers to insurance buyers rather than serving as an adviser to insurers to assist them in improving their financial condition and rating. S&P's claims-paying ability rating is an assessment of an operating insurance company's financial capacity to meet its policyholder obligations in accordance with their terms. Claims-paying ability ratings are based on a comprehensive quantitative and qualitative financial analysis using various sources of information, including extensive interviews with company management, detailed financial data and projections, market share information, details of their investment portfolio, reinsurance program, and organizational structure. S&P insurance ratings are available on Credit Analysis Reference Disk (CARD). The disk is updated twice a month and provides a complete database of global insurance information on CD. Each disk includes interactive and public information, financial strength ratings, and debt ratings. The disk also includes pool affiliations, NAIC codes, key statistics, and full analyses of insurers worldwide.

5. *TheStreet.com Ratings*, formerly Weiss Research—TheStreet.com Ratings acquired the ratings business from Weiss Ratings, Inc. in August 2006. Martin D. Weiss, founder of Weiss Research, has been publishing newsletters about money markets, interest rates, bank safety, and economic forecasting since 1971. In 1989, Weiss began publishing "safety ratings" of life, health, and annuity insurers. Weiss' methodology and rating scale has generated some controversy within the industry. Weiss' safety rating indicates its opinion regarding an insurer's ability to meet its commitments to its policyholders under current economic conditions. An insurer's rating is determined based on a detailed analysis of numerous factors that are synthesized into a series of indexes such as capitalization, reserve adequacy, profitability, liquidity, and stability. The data for the analysis is obtained from statutory statements filed with the NAIC. TheStreet.com Ratings will continue to be called "Weiss Ratings" and emphasizes that it bases its analysis exclusively on objective, quantifiable information and other financial information provided by the insurers. Unlike other rating agencies, the Weiss Ratings product line does not accept compensation from the companies it rates nor does it allow the rated companies to influence the rating. Weiss supports its insurer rating activities through the sale of its rating information to the public.

Industry Analysts

In addition to the rating agencies, many of the investment houses and stock research firms do considerable research on the insurance industry. The following paragraphs briefly describe several sources.

1. *Investment Houses*—The major Wall Street firms dedicate considerable resources toward researching insurance industry issues. In general, much of this research is oriented towards emerging issues facing the industry. Specific insurance company research is also available but is generally limited to companies with publicly traded debt or equity securities.

2. *Ward's Results*—Annually, Ward Financial Group publishes a financial reference series entitled *Ward's Results*, available in separate life/health and property/casualty editions. The books include financial benchmarks for U.S. domiciled insurers, including unique peer group benchmarks. Each company is grouped into peer groups that consider the insurer's product mix, premium volume,

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and geographic mix of business. In addition to peer group benchmarks, the books also include top performing stock company and mutual company benchmarks.

Securities and Exchange Commission (SEC) Filings

Insurers that offer debt or equity securities to the public must register with the Securities and Exchange Commission (SEC) and fulfill various reporting requirements. Where applicable, the various SEC filings provide significant background information about the insurer and can assist the analyst in corroborating the information filed by the insurer with the NAIC or state insurance departments. Most of the SEC filings are also available on CD-ROM. While the SEC filing requirements are quite comprehensive, the following summarizes three of the SEC filing forms that may be of particular interest to the analyst.

1. *Form 10-K* is used to fulfill the SEC's annual reporting requirements. The 10-K must be filed with the SEC within 90 days after year-end. Information incorporated into the 10-K includes:
   - Business
   - Properties
   - Legal proceedings
   - Submission of matters to a vote of security holders
   - Market for registrant's common equity and related stockholder matters
   - Selected financial data
   - Management's Discussion and Analysis of financial condition and results of operations
   - Quantitative and qualitative disclosures about market risk
   - Financial statements and supplemental data
   - Changes in and disagreements with accountants on accounting and financial disclosure
   - Controls and procedures
   - Directors and executive officers of the registrant
   - Executive compensation
   - Security ownership of certain beneficial owners and management
   - Certain relationships and related transactions
   - Exhibits and financial statement schedules
2. *Form 10-Q* is used to fulfill the SEC's quarterly reporting requirements. The 10-Q must be filed with the SEC within 45 days after the end of each of the first three quarters and must include a condensed income statement, a condensed balance sheet, and an abbreviated statement of cash flow.
3. *Form 8-K* is used to report material events or corporate changes that have not yet been reported. The 8-K is required after any of the following events occur:
   - Change in control
   - Major acquisition or disposition of assets (for certain acquisitions and dispositions, historical and pro forma financial statements are required)
   - Bankruptcy or receivership
   - Change of independent accountant
   - Other events
   - Resignation of registrant's directors
   - Change in fiscal year

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Other External Sources

In addition to the specific sources referenced above, other resources that provide updates about the industry and specific insurers include:

- *Business Insurance*
- *BestWeek*
- *Best Review*
- *National Underwriter*
- *The Wall Street Journal*
- Bloomberg Financial
- Factiva
- Individual company Web sites

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In addition to the external information discussed in the previous chapter, there is a considerable amount of information available from the NAIC to assist the analyst in analyzing insurance companies. Most insurers are required to file Annual and Quarterly Financial Statements with the NAIC. Much of the information available from the NAIC is based on data included in these filings, which is made available on the Financial Data Repository. In addition, other NAIC databases contain information input by the various state insurance departments regarding regulatory actions taken against insurers, regulatory concerns about insurers or individuals, and consumer complaints filed against insurers. Following is a discussion of the more significant information available to the analyst from the NAIC.

Financial Analysis Solvency Tools (FAST)

FAST is a collection of analytical tools within the Insurance Regulatory Information System (IRIS) designed to provide state insurance departments with an integrated approach to screening and analyzing the financial condition of insurance companies. In addition, FAST assists state insurance departments in allocating resources to those insurers in greatest need of regulatory attention targeting those specific aspects of an insurer's financial position that could put the insurer at risk of future insolvency.

Scoring System

The Scoring System consists of a series of ratios, calculated annually and quarterly, for which an insurer scores a given number of points based on certain parameters set for each ratio. There are 22 annual scoring ratios and 13 quarterly ratios calculated for property/casualty insurers. These ratios focus on an insurer's financial position, results of operations, cash flow and liquidity, and leverage. Insurers with the highest scores would generally be considered a higher risk of potential insolvency. The Scoring System is designed so that an analyst can screen insurers on a total score basis or analyze each ratio result separately. Annually, the NAIC Insurance Analysis & Information Services Department, under the direction of the Financial Analysis Research and Development (E) Working Group, ensures that the Scoring System ratios are current and continue to be relevant to solvency monitoring, and that scoring parameters remain appropriate.

Financial Profile Reports

Financial Profile Reports are generated from an insurer's Annual and Quarterly Financial Statements data. The Financial Profile Report can be generated to provide either a condensed quarterly or five-year summary of an insurer's financial position or an in-depth five-year analysis of all aspects of an insurer's operations. The Financial Profile Report can assist the analyst in identifying unusual fluctuations, trends, or changes in the mix of an insurer's assets, liabilities, capital and surplus, and operations.

IRIS Ratio Application

The NAIC IRIS ratio application is a tool that assists in identifying those insurers that merit highest priority in the allocation of the state insurance department's resources, thus directing those resources to the best possible use.

The IRIS ratio application uses key financial data from the Annual Financial Statement to calculate ratio results. There are 13 IRIS ratios calculated for property/casualty insurers. The calculated results for each insurer are compared to the usual range of results for each ratio. Falling outside the usual range is not considered a failing result. For example, an increase in surplus or premiums that is larger than usual is not necessarily a problem. Furthermore, in some years it may not be unusual for financially stable insurers to have several ratios with results outside the usual range.

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IRIS ratio results are dependent on the accuracy of the Annual Financial Statement filed by insurers. The ratios cannot identify a misstatement of financial condition or the application of improper accounting practices or procedures. In fact, the NAIC warns state insurance departments not to rely on IRIS ratios as the only form of financial surveillance of insurers. IRIS ratios should be used in conjunction with the other NAIC solvency tools.

Analyst Team System

The Analyst Team reviews the Annual Financial Statement and ratio results of insurers meeting certain criteria (including four or more IRIS ratio results falling outside the usual range as determined by the NAIC). The Analyst Team consists of experienced examiners and analysts from several of the state insurance departments representing all zones of the NAIC. The Analyst Team reviews selected companies, validates automated level designations, and provides brief synopses of their validation findings or provides comments explaining factors that affect the company's overall financial condition. Companies are selected for validation based upon scores, ratios, and overall financial condition based on criteria established by the NAIC Examination Oversight (E) Task Force.

Examination Jumpstart

Examination Jumpstart, which is available through I-SITE, was developed by the NAIC to assist examiners in performing financial condition examinations. Using Examination Jumpstart, numerous reports can be generated pertaining to an insurer's reinsurance program and investment portfolio based on the information included in the NAIC database from the insurer's Annual Financial Statement. Although Examination Jumpstart was developed to assist examiners in performing financial condition examinations, many of the applications may be of interest to the financial analyst as well. Following is a brief discussion of some of the Examination Jumpstart reports available that may assist the financial analyst in the analysis process.

1. Reinsurance, Matching Assumed & Ceded—Verifies reinsurance ceded for an insurer by comparing reserves and premiums ceded per the reinsurance schedules of the insurer being analyzed with reserves and premiums assumed per the assuming insurers' reinsurance schedules.

2. CUSIP Exception Report—Matches the insurer's Schedule D with the SVO Master File and produces an exception report of all securities with CUSIP numbers not listed on the SVO Master File.

3. Designation Exception Report—Matches the insurer's Schedule D with the SVO Master File and produces an exception report of all securities with SVO designations different from those listed on the SVO Master File.

4. Market Value Exception Report—Matches the insurer's Schedule D with the SVO Master File and produces an exception report of all securities with market values different from those listed on the SVO Master File.

5. Material Holdings Report—Produces a listing of all securities owned, by issuer, where the market value of all securities of an individual issuer owned by the insurer is greater than a specified percentage of the insurer's prior year admitted assets or capital and surplus.

6. Specified Designation Report—Produces a listing of all securities owned by an insurer whose designations match a specified designation.

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Loss Reserves

Loss reserve analysis for a specific line of business can be performed for property/casualty insurers via I-SITE. The following is a brief discussion of some of the loss reserve reports.

1. Loss Reserve Data Triangles—Formats Schedule P, Parts 2, 3, and 6 data into a triangle that is traditionally used to analyze loss data.

2. Loss Reserve Development Factors—Creates age-to-age development factors in a triangle format for various projection methods.

3. Loss Ratios—Computes loss ratios based on premium and loss information by line of business in a triangle format.

4. Loss Projections—Creates a loss projection report by line of business using case reserves or paid numbers using various projection methods.

Regulatory Information Retrieval System (RIRS)

RIRS is a computerized database that contains information regarding formal administrative and regulatory actions taken against insurers and insurance agents. Information on RIRS includes the insurer or insurance agent against which formal administrative or regulatory action was taken, the date of the action, the state taking the action, the reason for the action, the disposition, and the amount of monetary penalty levied. RIRS relies on input from state insurance departments of all final actions taken and is available online to all state insurance departments.

Special Activities Database (SAD)

SAD is a confidential computerized database that tracks insurers, individuals, and entities that have been the subject of state insurance department inquiry. SAD is designed to flag entities or individuals of insurance regulatory concern and to provide regulatory contacts for obtaining more detailed information that can be considered in a more critical and subjective fashion. SAD will not provide all of the particulars regarding events, dates, or related issues. These particulars should be fully investigated before any further regulatory action is contemplated.

Complaints Database System (CDS)

CDS is a computerized database that contains information regarding consumer complaints filed against a firm or individuals in the insurance industry. CDS provides state insurance departments with the ability to evaluate an insurer's comparative performance in the marketplace. CDS generates consumer complaint activity trends by month and year and complaint counts by reason, e.g., claim payment delays.

Global Receivership Information Database

The I-SITE application Global Receivership Information Database (GRID) allows the regulator to review the status of a receivership (e.g., conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post receivership data, creditor class/claim data, legal data, financial data, and reporting data.

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Accounting Guidance

Statutory Accounting Principles (SAP) are those accounting principles or practices that are prescribed or permitted by the insurer's domiciliary state insurance department. SAP is prescribed in the insurance statutes, regulations, administrative rules of the various states, and in the *Accounting Practices and Procedures Manual* (*AP&P Manual*), the *Annual Statement Instructions*, the *Financial Condition Examiners Handbook*, the *Purposes and Procedures of the Securities Valuation Office Manual*, and NAIC subcommittee and task force minutes. In addition, certain accounting practices are explicitly or implicitly permitted by various state insurance departments on an issue-by-issue and/or company-by-company basis.

Financial statements filed with state insurance departments are prepared on a SAP basis. Since the primary concerns of insurance regulators are the protection of the policyholders and the solvency of each insurer, SAP places emphasis on the adequacy of statutory capital and surplus. Adequate capital and surplus provides protection against adverse operating results and also permits an insurer to expand its business. In addition, SAP emphasizes the balance sheet rather than the income statement. Statutory accounting is primarily directed toward the determination of an insurer's financial condition and its ability to satisfy its obligations to policyholders and creditors as of a certain date.

As stated in the preamble to the *AP&P Manual*, SAP is based on the concepts of conservatism, consistency, and recognition. All of these concepts are discussed in more detail below.

> *Conservatism*—Financial reporting by insurers requires the use of substantial judgments and estimates by management. Such estimates may vary from the actual amounts for various reasons. To the extent that factors or events result in adverse variation from management's accounting estimates, the ability to meet policyholder obligations may be lessened. In order to provide a margin of protection for policyholders, the concept of conservatism should be followed when developing estimates as well as establishing accounting principles for statutory reporting.
>
> Conservative valuation procedures provide protection to policyholders against adverse fluctuations in financial condition or operating results. Statutory accounting should be reasonably conservative over the span of economic cycles and in recognition of the primary responsibility to regulate for financial solvency. Valuation procedures should, to the extent possible, prevent sharp fluctuations in surplus.
>
> *Consistency*—The regulators' need for meaningful, comparable financial information to determine an insurer's financial condition requires consistency in the development and application of SAP. Because the marketplace, the economic and business environment, and insurance industry products and practices are constantly changing, regulatory concerns are also changing. An effective statutory accounting model must be responsive to these changes and address emerging accounting issues. Precedent or historically accepted practice alone should not be sufficient justification for continuing to follow a particular accounting principle or practice that may not coincide with the objectives of regulators.
>
> *Recognition*—The principal focus of solvency measurement is determination of financial condition through analysis of the balance sheet. However, protection of the policyholders can only be maintained through continued monitoring of the financial condition of the insurer. Operating performance is another indicator of an insurer's ability to maintain itself as a going concern. Accordingly, the income statement is a secondary focus of statutory accounting and should not be diminished in importance to the extent contemplated by a liquidation basis of accounting.

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The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than for fulfilling policyholder obligations, or those assets that may be unavailable due to encumbrances or other third party interests should not be recognized on the balance sheet but rather should be charged against policyholders' surplus when acquired or when availability otherwise becomes questionable.

Liabilities require recognition as they are incurred. Certain statutorily mandated liabilities may also be required to arrive at conservative estimates of liabilities and probable loss contingencies (e.g., interest maintenance reserves, asset valuation reserves, and others).

Revenue should be recognized only as the earnings process of the underlying underwriting or investment business is completed. Accounting treatments that tend to defer expense recognition do not generally represent acceptable SAP treatment.

SAP income reflects the extent that changes have occurred in SAP assets and liabilities for current period transactions, except changes in capital resulting from receipts or distributions to owners. SAP income also excludes certain other direct charges to surplus that are not directly attributable to the earnings process (e.g., changes in non-admitted assets).

Although the insurers' Annual and Quarterly Financial Statements and Audited Financial Reports filed with the state insurance departments are prepared on a statutory basis, financial analysts also review Holding Company Form B filings and SEC filings that may include financial statements prepared based on Generally Accepted Accounting Principles (GAAP). Therefore, the analyst must also have a general understanding of GAAP.

Though most non-publicly traded insurers are not required to produce financial statements on a GAAP basis, many do for internal purposes. Therefore, the analyst should consider requesting and analyzing GAAP financial statements in addition to SAP financial statements. Comparing financial results based on SAP to those based on GAAP for an insurer can provide meaningful information to the analyst regarding the insurer's financial status.

There are two main conceptual differences between SAP and GAAP. First, SAP stresses measurement of the ability to pay claims in the future, whereas GAAP stresses measurement of emerging earnings of a business from period to period, e.g., matching revenue to expenses.

The following is a discussion of the more significant specific differences between SAP and GAAP for a property/casualty insurance company:

Acquisition costs—Under Statement of Statutory Accounting Principles (SSAP) No. 71*, Policy Acquisition Costs and Commissions*, all acquisition costs, such as commissions and other costs incurred in acquiring and renewing business, are expensed as they are incurred. Under GAAP, those acquisition costs that are primarily related to and vary with the volume of premium income are capitalized as an asset and are then amortized by periodic charges to earnings over the terms of the related policies.

Valuation of bonds and redeemable preferred stocks—Under SSAP No. 26, *Bonds, excluding Loan-Backed and Structured Securities* and SSAP No. 32, *Investments in Preferred Stoc*k *(including investments in perferred stock of subsidiary, controlled, or affiliated entities)*, bonds and redeemable preferred stocks are carried at amortized cost only if the insurer has the ability and intent to hold the securities to maturity and there are no (other than temporary) declines in fair value. Otherwise, they are carried at market.

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Nonadmitted assets—Under SSAP No. 4*, Assets and Nonadmitted Assets* as superseded by SSAP No. 87, assets having economic value, other than those that can be used to fulfill policyholder obligations or other third party interests, should not be recognized on the balance sheet and are, therefore, considered nonadmitted. SSAP No. 4 defines nonadmitted assets as an asset that is accorded limited or no value in statutory reporting, and is one that is either specifically identified within the *AP&P Manual* as a nonadmitted asset or not specifically identified as an admitted asset within the *AP&P Manual.* SSAP No. 20, *Nonadmitted Assets*, specifically identifies the following as nonadmitted assets: deposits in suspended depositories; bills receivable not for premium and loans unsecured or secured by assets that do not qualify as investments; loans on personal security, cash advances to, or in the hands of, officers or agents and travel advances; all non-bankable checks (e.g., non-sufficient funds); trade names and other intangible assets; automobiles, airplanes, and other vehicles; furniture, fixtures, and equipment; and company's stock as collateral for loan.

Deferred income taxes—Under SSAP No. 10, *Income Taxes*, deferred income tax assets are limited under admissibility test and amounts over the criterion are nonadmitted. Under GAAP, a valuation allowance is used to reduce the asset to what can be realized. Also, under SSAP No. 10, changes in deferred tax assets and deferred tax liabilities are reported as a separate line in the surplus section. Under GAAP, changes in DTAs and DTLs are recognized in earnings.

Goodwill—Under SSAP No. 68, *Business Combinations and Goodwill* as superceded by SSAP No. 97, *Investments in Subsidiary, Controlled and Affiliated Entites, A Replacement of SSAP No. 88* goodwill represents the difference between the cost of acquiring the entity and the reporting entity's share of the book value of the acquired entity. Under GAAP, goodwill represents the difference between cost of acquiring the entity and the fair value of the assets less liabilities acquired.

Reinsurance in unauthorized companies—Under SSAP No. 62, *Property and Casualty Reinsuranc*e, reserves are required for the excess of unearned premiums and losses recoverable over funds held on business reinsured with companies not authorized to do business in the insurer's state of domicile. Under GAAP, reinsurance recoverables are allowed regardless of whether the reinsurer is authorized, subject to tests of recoverability.

Surplus notes—Under SSAP No. 41, *Surplus Notes*, surplus notes meeting certain requirements are considered as policyholders' surplus. Under GAAP, surplus notes are considered to be debt.

The following addresses reporting for risk retention groups (RRGs):

State regulators utilize financial analysis tools and RBC standards to evaluate the financial condition of insurance companies. The benchmarks for these tools are based on SAP. Since most states do not require RRGs to follow the same accounting principles when preparing their financial reports, the results may not be as meaningful or reliable and even misrepresented because the tools are being compared to financial data reported under GAAP, modified SAP, and modified GAAP. Additionally, most RRGs formed as captives are not required to comply with the NAIC's RBC requirements or the insurance holding company statutes, which can affect the traditional methods used to assess the financial condition of an insurer.

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The NAIC Policy Statement on Financial Regulation Standards indicates that a state insurance department's financial analysis process should be priority-based to ensure that potential problem insurers are reviewed promptly and that the prioritization scheme should utilize the IRIS and/or a state insurance department's own system.

To facilitate the financial analysis process, state insurance departments should establish a system to prioritize or classify insurance companies according to each insurer's relative stability and the perceived need for analysis. This prioritization system may be either formal, including the assignment of priority designations, or informal in nature. States with a small number of domestic insurers may consider all of their domestic insurers to be priority companies. However, states with a larger number of domestic insurers generally have more formal prioritization systems. In these states, prioritization is necessary because a state insurance department's financial analysts are not able to thoroughly analyze the financial condition of all insurers immediately upon receipt of the Annual and Quarterly Financial Statements and the supplemental filings.

An insurer's Analyst Team Validated Level should be reconsidered as the result of each review performed to determine whether the designation is still appropriate. However, changes in Analyst Team levels should only be made after approval by senior insurance department personnel.

Although prioritization is, to a large extent, subjective, a state insurance department should establish guidelines to assist in the consistent assignment of priority designations to its insurers. Factors that should be given consideration in the state insurance department's prioritization system include, but are not limited to, the following:

- Results of the prior-year analysis (including the analysis of the Annual Financial Statement, Quarterly Financial Statements, and the various supplemental filings)
- Whether the insurer was an ATS-validated Level A or B in the prior year and in the NAIC Analyst Team Report
- Adequacy of the insurer's capital and surplus
- Significant changes in the insurer's capital and surplus
- Negative trends in income and/or cash flow
- IRIS ratio results and the NAIC Analyst Team Report
- Scoring System results
- Changes in the insurer's management or board of directors
- Results of the *Financial Analysis Handbook*, Level 1 Annual Procedures
- Analysis performed by the NAIC Financial Analysis (E) Working Group
- Examination reports issued (financial condition and market conduct)
- Information from other divisions or areas of the insurance department
- Independent organization ratings and reports

As a general rule, financial statements and other materials pertaining to those insurers that are deemed a high priority should be reviewed before those materials pertaining to lower priority insurers. In addition, the review of high priority insurers might be more in-depth than the review of lower priority insurers.

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II. Financial Analysis Framework

Overview of the Financial Analysis Process

Financial analysis is an on-going process that can be divided into annual cycles, which includes the analysis of the Annual Financial Statement, Quarterly Financial Statements, and the various supplemental filings, such as the Statement of Actuarial Opinion & Actuarial Opinion Summary, MD&A, Audited Financial Report, and Holding Company filings. The financial analysis process, which has been developed and included in the *Handbook*, is designed to assist the analyst in reviewing and analyzing insurers throughout the annual cycle in a logical manner, focusing on areas of concern pertaining to the particular insurers being analyzed. The end result of this process is a financial analysis of each insurer specifically tailored to the concerns of that insurer as a result of its unique investments, underwriting, reserving, and operations. Some of the financial analysis procedures are to be completed for all domestic insurers, while other procedures will only be completed if concerns are noted.

Procedure Description	Complete for all domestics	Complete if further concern
Level 1 Annual Procedures, Annual Financial Statement, Scoring System, Financial Profile Report, IRIS Ratios	√	
Level 2 Annual Procedures	*	√
Level 3 Annual Procedures		√
Supplemental Procedures:		
Audited Financial Reports	**	√
Statement of Actuarial Opinion & Actuarial Opinion Summary	**	√
Management's Discussion & Analysis (MD&A)	**	√
Holding Company Analysis		√
Forms A, B**, D, E, and Extraordinary Dividend/Distribution		√
Captives and/or Insurers Filing on a U.S. GAAP Basis		√
Quarterly Procedures, Quarterly Financial Statement, Scoring System, Quarterly Financial Profile Report	√	

* Based on the characteristics of a state's domestic industry, the state insurance department determines when and to what extent the Level 2 Procedures for annual and quarterly, or any similar analyses designed to meet the same objectives, should be performed for areas that are significant to the insurer.

** The completion of the Supplemental Procedures or similar analysis is recommended for all multi-state insurers.

The following provides an overview of the *Handbook's* analysis process for an annual cycle, which focuses on the various documents filed with the insurance department by an insurer. The annual cycle is also presented in flowchart format at the end of this section.

NOTE: All references made throughout this *Handbook* to the risk-focused surveillance approach, Insurer Profile Summary, and Supervisory Plan are applicable only to states that have adopted and implemented the risk-focused surveillance approach. The ownership and responsibility for updates to the Insurer Profile Summary may vary from state to state between the analysis and examination departments.

Annual Financial Statement

An insurer is required to file an Annual Financial Statement with its state of domicile, the NAIC, and all jurisdictions in which the insurer is authorized to transact business by March 1 of each year for the 12 months ended December 31 of the previous year. The Annual Financial Statement information is loaded onto the NAIC database, at which time the Annual Scoring System and IRIS ratios are calculated and the

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NAIC Annual Financial Profile Report and *Handbook* results are generated. All of this information is available to the state insurance departments via I-SITE.

The analysis of the Annual and Quarterly Financial Statements have been divided into three levels. Level 1 Procedures are to be performed for all domestic insurers. Level 2 and Level 3 Procedures may be completed as a result of concerns identified by Level 1 Procedures at the state department's discretion, based on the materiality of the concerns noted and their prior knowledge of the insurer. At any level of analysis, the department may determine that there is no further concern or may proceed directly to regulatory action. Following is a detailed discussion of each level of Annual Financial Statement Analysis.

Level 1 Annual Analysis

The Level 1 Procedures consist of an overall analysis of the insurer and its operations. As part of the Level 1 Procedures, the analyst should review the NAIC's I-SITE Analyst Team System Report, Annual Scoring System Report, IRIS ratios, and the information included in the NAIC Annual Financial Profile Report for the insurer. In addition, the analyst should perform the procedures included in Level 1 or any similar analysis designed to meet the same objectives. Procedures included in Level 1 require the analyst to review the analysis performed during the prior year and to perform an overall review of the Annual Financial Statement, including a review of the General Interrogatories and Notes to Financial Statements. Other reports to be reviewed are the Audited Financial Report, Statement of Actuarial Opinion, MD&A, Holding Company filings, and examination report and findings when they are filed.

The analyst should ensure that those insurers identified as having significant concerns as a result of the Level 1 Procedures or any other levels, will be analyzed on a priority basis for their future filings. The analyst should consider utilizing these prioritization tools: Analyst Team System Report, the Annual Scoring System Report, the Risk-Based Capital (RBC) Report, and IRIS ratios.

There are five elements of the risk-focused surveillance cycle:

1) Risk-Focused Examination—addresses the need to identify key functional activities, risks, controls, and establish procedures and conduct an examination.
2) Off-Site Focused Financial Analysis—includes the use of all financial tools, such as ratio analysis.
3) Internal/External Changes—reviews any overall modifications to the insurer, such as corporate structure or management changes.
4) Priority System—used to establish a priority of insurer reviews.
5) Supervisory Plan—addresses the overall oversight of the insurer.

As part of the risk-focused surveillance approach, the analyst should work with the examination staff to assess the quality and reliability of corporate governance in order to identify, assess and manage the risk environment facing the insurer. This assessment will assist in identifying current or prospective solvency risk areas. Refer to Chapter III.A. Analyst Reference Guide for Level 1 Analysis for further discussion on prospective risk. By understanding the corporate governance structure and assessing the "tone at the top," the analyst will 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. To assist in this assessment, analysts may utilize:

1) Board and audit committee minutes.
2) List of critical management and operating committees, their members and meeting frequencies.
3) Examination findings related to the insurer's risk assessment and risk management activities.
4) Sarbanes-Oxley filings and similar filings through the NAIC Model Audit Rule, as applicable.

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At the conclusion of the Level 1 Procedures, the analyst must determine whether to proceed to the Level 2 Procedures. This determination should be approved in accordance with the state departmental procedures. State insurance departments can make this decision in a variety of ways. For example, in some states, Level 2 Procedures may be completed for all domestic insurers. Other states may require certain portions (e.g., investments, reserves, or reinsurance) of the Level 2 Procedures to be completed for all domestic insurers. Still other states may require Level 2 Procedures to be completed only for those domestic insurers that meet certain criteria established by the state insurance department. The department could also determine that additional procedures found in Level 3 be completed per regulatory action or required by state insurance law, regulation, or department policy. Alternatively, the analysis may be concluded with only the completion of the Level 1 Procedures. At the completion of the analysis process, including any Level 1, 2, 3, or Supplemental Procedures, the analyst should update the Insurer's Profile Summary, if applicable (see Chapter III.A.).

Level 2 Annual Analysis

Because of the importance of financial analysis in the department's overall financial regulation and solvency surveillance process, the NAIC recommends that consideration be given to performing some portion of the Level 2 Procedures for multi-state domestic insurers. The NAIC believes that Level 2 Procedures (or applicable sections) should be performed for multi-state domestic insurers that have unresolved concerns that were identified as a result of prior analysis. Other factors, such as the insurer's past regulatory history, accuracy of filing, age of insurer, stability of business plan, and knowledge of company's operations, may affect the extent to which sections within Level 2 Procedures are considered necessary.

The Level 2 Procedures have been designed to identify potential areas of concern regarding the financial position and operations of the insurer, primarily through the use of ratio and trend analysis. The Level 2 Procedures are divided into sections that focus on key areas (e.g., investments, reserves, reinsurance, income statement, etc.) and utilize information available from the Annual Financial Statement filed by the insurer. Each section includes one or more procedures that concentrate on a particular issue of possible concern. In addition, each procedure includes one or more questions designed to assist the analyst in determining whether or not there is a concern regarding a particular issue that would require additional analysis in that area. If the analyst has questions regarding procedures included in any of the sections of the Level 2 Procedures, reference should be made to the Analysts Reference Guide for further guidance.

At the end of each section of the Level 2 Procedures, the analyst is asked to develop and document an overall summary and conclusion, determine whether one or more procedures within Level 3 should be completed, and describe the rationale for this recommendation. It may be appropriate that the information be reviewed and approved prior to the analyst completing any of the procedures in Level 3. In addition, at the conclusion of an analysis, a management report that summarizes the results of the analysis performed, including the priority level assigned to each insurer, should be prepared and distributed to senior insurance department personnel.

Level 3 Annual Analysis

For concerns identified as a result of the completion of the Level 2 Procedures, Level 3 Procedures should be performed. The suggested procedures for the analyst to consider within Level 3 are keyed to specific concerns identified as a result of the completion of Level 1 and 2 Procedures and are designed to assist the analyst in focusing on those areas. If the analyst has questions regarding procedures included in Level 3, reference should be made to the Analysts Reference Guide for further guidance.

Some of the procedures in Level 3 require the analyst to obtain additional information from the insurer that is not available from the Annual Financial Statement. Therefore, it is important that the procedures

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the analyst proposes to complete be discussed with and approved by the analyst's supervisor beforehand. At this time, consideration of more substantive regulatory action may be warranted for a more efficient utilization of department resources.

At the end of each section of the Level 3 Procedures, the analyst is asked to develop and document an overall summary and conclusion and indicate any recommendations for further action based on the procedures performed. Recommendations for further action might include contacting the insurer for explanations or additional information, obtaining the insurer's business plan, requiring additional interim reporting from the insurer, referring concerns to the examination section for a targeted examination, engaging an independent expert to assist in determining whether a problem exists, meeting with the insurer's management, obtaining a corrective plan from the insurer, etc. At the conclusion of the Level 3 Procedures, a management report should be prepared and distributed to senior state insurance department personnel. As discussed above, the management report should summarize the results of the analysis performed, any recommendations for further action, and any adjustment to the priority level of the insurer.

It is important for the analyst's supervisor to be actively involved in each level of the financial analysis performed. It is also important that the review and supervision be performed on a timely basis.

Quarterly Financial Statements

An insurer is required to file Quarterly Financial Statements for the first, second, and third quarters with the state of domicile, the NAIC, and in most instances, all states in which the insurer is authorized to do business by May 15, Aug. 15, and Nov. 15, respectively. The Quarterly Financial Statement is loaded onto the NAIC database, at which time the Quarterly Scoring System ratios are calculated and the Quarterly Financial Profile Report is generated. This information is available to the state departments via I-SITE.

The Level 1 Quarterly Procedures are to be completed for all domestic insurers. As part of the Quarterly Financial Statement review, the analyst should also review all levels of procedures completed for annual and any prior quarterly procedures that were previously completed. In addition, the analyst should review the Quarterly Financial Profile Report, Quarterly Scoring System Report, and the Quarterly Financial Statement. The Level 1 Quarterly Procedures are designed to identify potential areas of concern regarding the financial position and operations of the insurer, primarily through the use of ratio and trend analysis, and to indicate significant fluctuations from the prior quarter, prior quarter-to-date, or prior year-end. The analyst will make the same determinations as for the annual review process, whether to proceed with additional analysis or other procedures.

The Level 2 Quarterly Procedures are divided into sections, each focusing on a key area for a more in-depth review (similar to the Level 2 Annual Procedures), and utilize information available from the Quarterly Financial Statements filed by the insurer. Each section includes one or more procedures designed to assist the analyst in determining whether there is a concern in a particular area that would require more in-depth analysis, and a determination similar to those required in the annual procedures. If the analyst has questions regarding procedures included in any of the sections for the quarterly procedures, reference should be made to the Analysts Reference Guide for further guidance.

As part of the risk-focused surveillance approach, the analyst should work with the examination staff to assess the quality and reliability or corporate governance as discussed in the Annual Financial Statement section above.

At the end of each section of the Level 2 Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the procedures performed, recommend whether one or more

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procedures within Level 3 be completed (if not completed during the analysis of the Annual Financial Statement), and describe the rationale for the recommendation or recommend other substantive regulatory action. The analyst should also document any correspondence or follow-up with the insurer. This information should be reviewed and approved by the analyst's supervisor prior to the analyst completing any of the procedures within Level 3. In addition, at the conclusion of an analysis, a management report that summarizes the results of the analysis performed, including the priority level assigned to each insurer, should be prepared and distributed to senior department personnel.

Audited Financial Report

Virtually all insurers are required to file, as a supplement to the Annual Financial Statement, an Audited Statutory Financial Report completed by an independent auditor, the auditor's letter of qualifications, and, if applicable, a report of significant deficiencies in the insurer's internal control structure with the state of domicile, the NAIC, and all states in which the insurer is authorized to do business by June 1 of each year as of the 12 months ended December 31 of the previous year.

The Audited Financial Report Supplemental Procedures are to be completed for all domestic insurers if Level 1 Procedures indicated further review was necessary. The Supplemental Procedures for the Audited Financial Report are designed to assist the analyst in reviewing the audited financial statements, auditor's letter of qualifications, and other reports filed to determine that they meet the requirements of the *Annual Statement Instructions*; that amounts per the audited financial statements agree with the Annual Financial Statement filed with the state insurance department; and to identify significant information and explanatory language included in the auditor's opinion or the Notes to the Audited Financial Statements.

At the end of the Audited Financial Report Supplemental Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the information in the Audited Financial Report and to indicate recommendations for further action, if any, based on the procedures performed. Recommendations for further action might include contacting the insurer for explanations or additional information from either the insurer or the independent CPA, obtaining the insurer's business plan, requiring additional interim reporting, referring concerns to the examination section for a targeted examination, meeting with the insurer's management, or obtaining a corrective plan.

Statement of Actuarial Opinion & Actuarial Opinion Summary

Virtually all insurers are required to file a supplement to the Annual Financial Statement—a Statement of Actuarial Opinion—with the state of domicile, the NAIC, and all states in which the insurer is authorized to transact business by March 1 of each year covering the reserves as of December 31 of the previous year. A qualified actuary must complete the Statement of Actuarial Opinion.

The Statement of Actuarial Opinion review is to be completed for all domestic insurers as part of the Level 1 Procedures and, if indicated, the analyst should complete the Statement of Actuarial Opinion Supplemental Procedures. If the Level 1 Procedures indicate further analysis is necessary, the analyst could review the reserves and reinsurance sections of the Level 2 and 3 Procedures. The Statement of Actuarial Opinion & Actuarial Opinion Summary Supplemental Procedures have been designed to assist the analyst in reviewing the Statement of Actuarial Opinion to determine that it meets the requirements of the *Annual Statement Instructions*, that reserve amounts per the Actuarial Opinion agree with the reserve amounts per the Annual Financial Statement filed with the state insurance department, and to identify significant information and explanatory language regarding the insurer that has been emphasized by the qualified actuary. The Procedures with regard to the Actuarial Opinion Summary assist the analyst in reviewing reserve practices.

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At the end of the Statement of Actuarial Opinion & Actuarial Opinion Summary Supplemental Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the information in the Statement of Actuarial Opinion & Actuarial Opinion Summary and to indicate any recommendations for further action based on the procedures performed. Recommendations for further action might include contacting the insurer for explanations or additional information, obtaining the insurer's business plan, requiring additional interim reporting from the insurer, referring concerns to the examination section for a targeted examination, consulting with an in-house actuary, engaging an independent actuary to assist in determining whether a problem exists, meeting with the insurer's management, or obtaining a corrective plan from the insurer.

Management's Discussion and Analysis (MD&A)

An insurer is required to file as a supplement to the Annual Financial Statement an MD&A with the state of domicile, the NAIC, and all states in which the insurer is authorized to do business by April 1 of each year. The purpose of this narrative document is to assist the analyst in understanding the insurer's financial condition, change in financial condition, liquidity, loss reserves, prospective information, off-balance sheet arrangements, participation in high yield financings, highly leveraged transactions or non-investment grade loans and investments, and preliminary merger/acquisition negotiations.

The MD&A Supplemental Procedures may be completed for all domestic insurers if the Level 1 Procedures indicated further review is necessary. The analyst should review the Annual Procedures completed, and complete the MD&A Supplemental Procedures. The MD&A review should be completed at the time of the Annual Financial Statement review if at all possible. The MD&A Supplemental Procedures are designed to assist the analyst in reviewing the MD&A to determine that the information included meets the requirements of the *Annual Statement Instructions* and to identify concerns as a result of the information provided.

Upon completion of the MD&A Supplemental Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the information in the MD&A and to indicate any recommendations for further action based on the procedures performed. Recommendations for further action might include contacting the insurer for explanations or additional information, obtaining the insurer's business plan, requiring additional interim reporting, referring concerns to the examination section for a targeted examination, meeting with the insurer's management, or obtaining a corrective plan from the insurer.

Flow Charts

The following flow charts illustrate the annual cycle of the financial analysis process. The flow charts generally indicate that a "Yes" response results in further analysis. However, if an insurer's RBC is below 200 percent, a state department may determine it is necessary to take the required legal action immediately prior to any further analysis.

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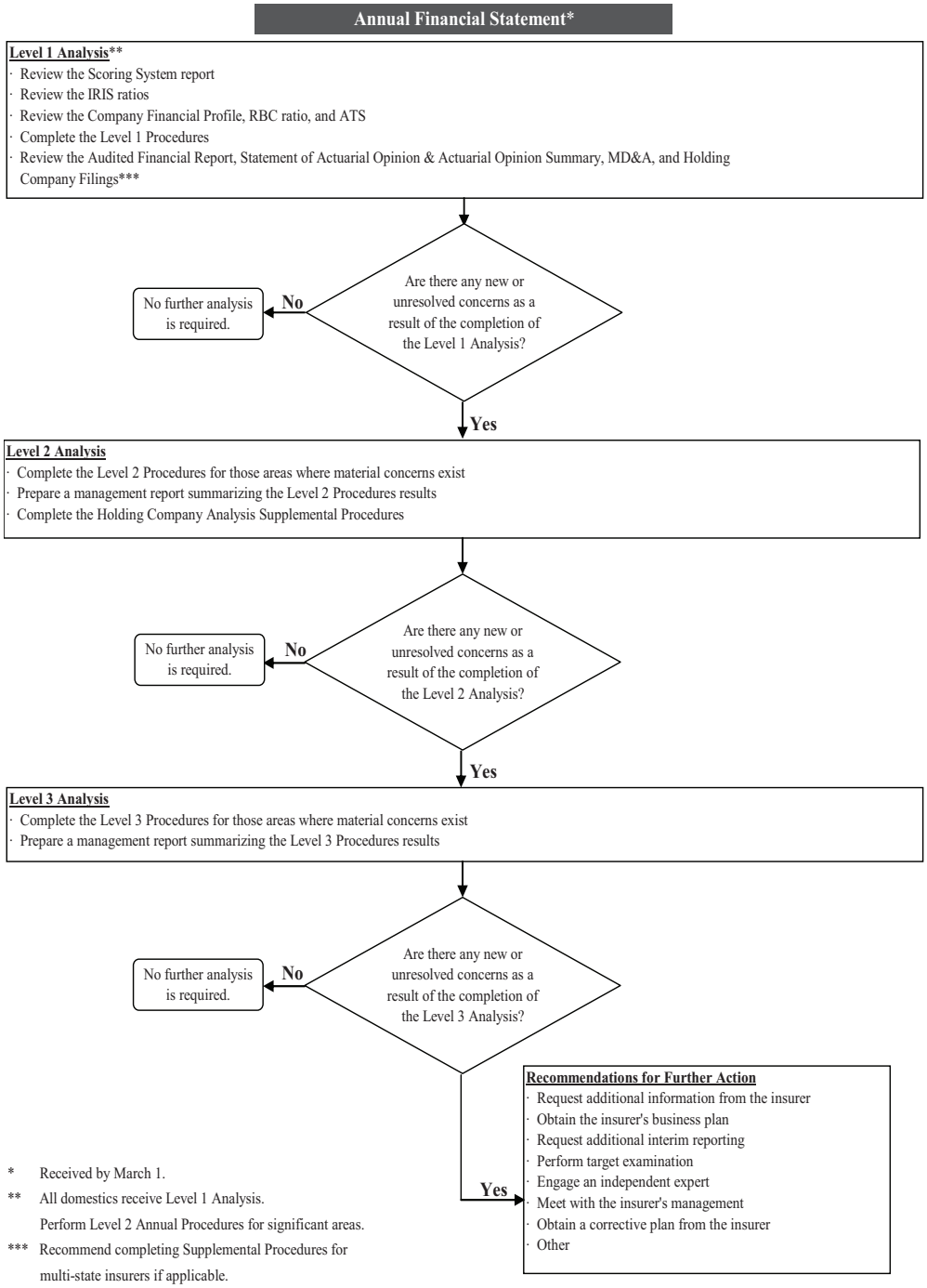

* Received by March 1.

** All domestics receive Level 1 Analysis.
Perform Level 2 Annual Procedures for significant areas.

*** Recommend completing Supplemental Procedures for multi-state insurers if applicable.

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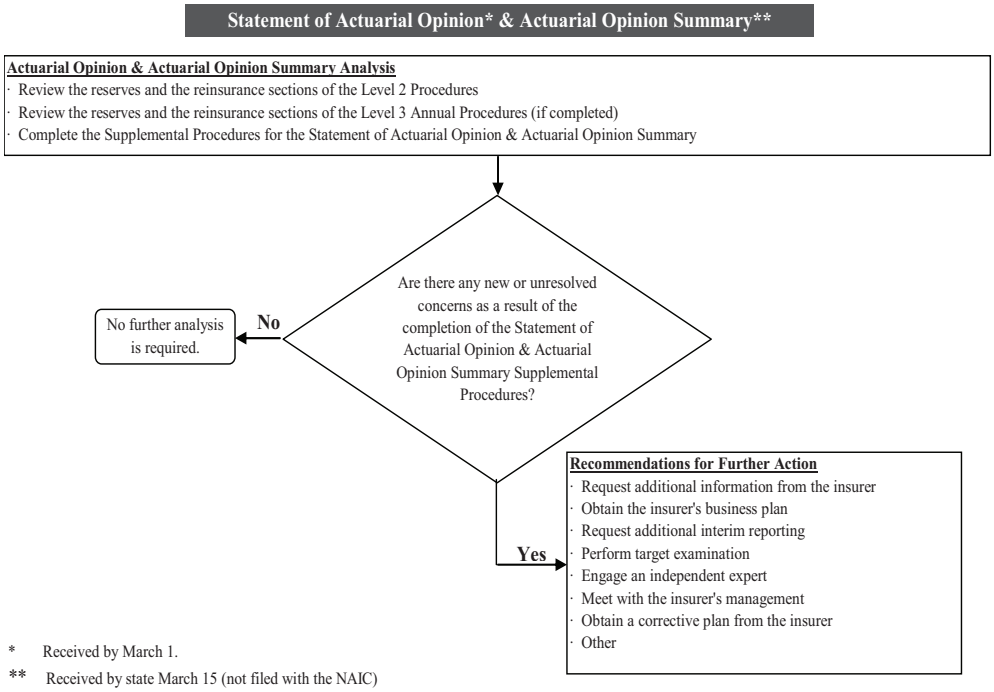

* Received by March 1.

** Received by state March 15 (not filed with the NAIC)

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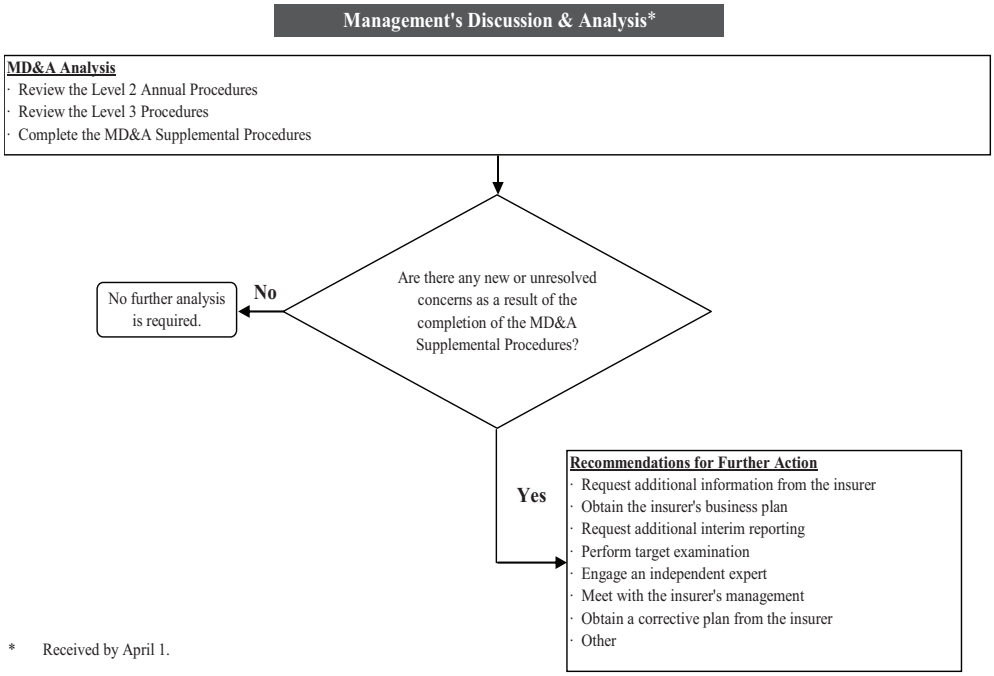

* Received by April 1.

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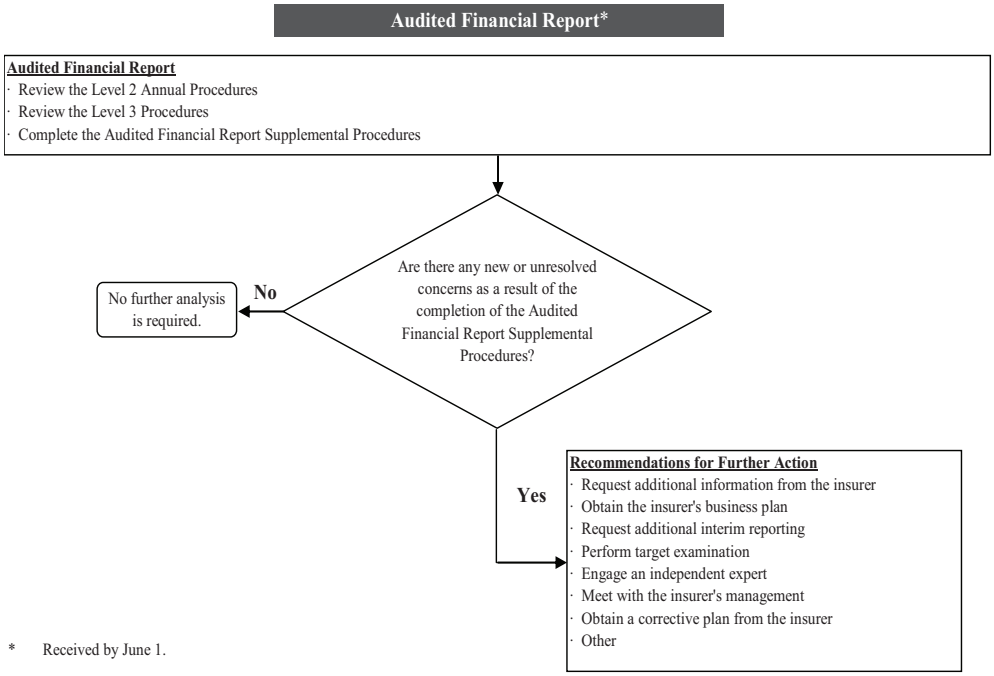

* Received by June 1.

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Other Financial Procedures

The Holding Company Analysis Supplemental Procedures review may be completed for domestic insurers if Level 1 Procedures indicated further holding company analysis was necessary. The Holding Company Analysis Supplemental Procedures encompass the following analysis areas:

- Understanding the holding company structure
- Lead state and interstate communication
- Financial condition of the holding company

Depending on the level of concern, the Holding Company Analysis Supplemental Procedures may need to be completed in part or in total.

The following checklists are included within the Holding Company Analysis Supplemental Procedures:

Form A, B, D, E 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
The Form A review is to be completed for all acquisitions, mergers, or changes in control. Form A is filed with the domestic state of each insurer in the group. The analyst should review the transaction and all applicable documents and complete the Form A Procedures, when necessary.

Form B
The Form B review is to be completed for all insurers that are members of a holding company system if Level 1 analysis indicated further procedures were necessary. The analyst should review the affiliated transactions section of the Level 2 and Level 3 Annual Procedures, if completed, and complete the Form B Procedures. The Form B Procedures are designed to assist the analyst in reviewing Form B to determine that the appropriate information has been filed and whether concerns exist regarding the financial position of the ultimate controlling person or any of the affiliated transactions or agreements.

Form D
The Form D review is to be completed for all prior notices of material transactions. Form D must be filed with the domestic state. The analyst should review the transaction and all applicable documents and complete the Form D Procedures, when necessary.

Form E or Other Required Information on Competitive Impact
The Form E or other review of competitive impact is to be completed for all pre-acquisition notifications regarding the potential competitive impact of a proposed merger or acquisition by a non-domiciliary insurer doing business in the state or by a domestic insurer. Form E or other required information must be filed with the domestic state. The insurer may also be required to file documents with the Federal Trade Commission under the Hart-Scott-Rodino Act. The analyst should review the transaction and all applicable documents and complete the Form E Procedures, when necessary.

Extraordinary Dividends/Distributions
The extraordinary dividend review is to be completed for any domestic insurers planning to pay any extraordinary dividend or make any other extraordinary distribution to its shareholders. Such dividends and distributions must receive proper prior regulatory approval. The analyst should review the transaction and all applicable documents and complete the Extraordinary Dividends Procedures, when necessary.

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At the end of the Holding Company Analysis Supplemental Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the information reviewed and to indicate any recommendations for further action based on the procedures performed. Recommendations for further action might include contacting the insurer for explanations or additional information, obtaining the insurer's business plan, requiring additional interim reporting, referring concerns to the examination section for a targeted examination, meeting with the insurer's management, or obtaining a corrective plan from the insurer.

Captives and/or Insurers Filing on a U.S. GAAP Basis

These Procedures are designed for insurers filing on a U.S. GAAP (or modified GAAP) basis, after the completion of the traditional Level 1 Procedures. The Procedures provide guidance on the review of a GAAP filer on a statutory blank and address the following areas:

- Management Assessment
- Balance Sheet Assessment
- Operations Assessment
- Investment Practices
- Review of Disclosures
- Assessment of results from prioritization and analytical tools

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III. Analyst Reference Guide

A. Level 1

Financial Analyst Role

During the risk-focused surveillance approach, the financial analyst role is to provide continuous off-site monitoring of an insurer's financial condition, monitor internal/external changes relating to all aspects of the insurer, maintain a prioritization system, and work with the examination staff to develop an ongoing Supervisory Plan as well as update the Insurer Profile Summary, if applicable.

Overview of Level 1

The objective of Level 1 is to perform a sufficient level of analysis on all domestic insurers in order to derive an overall assessment that highlights areas where a more detailed analysis, as found in Level 2, may be necessary. As part of Level 1, the analyst will review the insurer's Annual Scoring Report, IRIS ratios, Analyst Team Validated Level, RBC result, and the information included in the Financial Profile Report. The procedures for Level 1 require the analyst to review past analysis of the insurer, and to perform a general review of the current year's Annual Financial Statement along with an assessment of supplemental filings, including the Audited Financial Report, Statement of Actuarial Opinion & Actuarial Summary Report, MD&A, and the various holding company filings, e.g., 10-K, Form A, etc.

The analyst should have a firm understanding of the following risk classifications:

- **Credit—**Amounts actually collected or collectible are less than those contractually due.
- **Market—**Movement in market rates or prices, such as interest rates, foreign exchanges rates or equity prices adversely affect the reported and/or market value of investments.
- **Pricing/Underwriting—**Pricing and underwriting practices are inadequate to provide for risks assumed.
- **Reserving—**Actual losses or other contractual payments reflected in reported reserves or other liabilities will be greater than estimated.
- **Liquidity—**Inability to meet contractual obligations as they become due because of an inability to liquidate assets or obtain adequate funding without incurring unacceptable losses.
- **Operational—**Operational problems such as inadequate information systems, breaches in internal controls, fraud, or unforeseen catastrophes will result in unexpected losses.
- **Legal—**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.
- **Strategic—**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.
- **Reputational—**Negative publicity, whether true or not, causes a decline in the customer base, costly litigation and/or revenue reductions.

A prospective risk is a residual risk that impacts future operations of an insurer. These anticipated risks arise due to assessments of company management and/or operations or risks associated with future business plans. Types of risks may include underwriting, investments, claims, and reinsurance. The analyst's understanding of the above nine risk classifications includes an assessment of the level of that risk and the ability of the insurer to appropriately manage the risk during the current period and prospectively. These prospective risks require assessment and identification of how they may evolve related to the insurer's overall risk profile. Understanding how risks that may or may not appear urgent now will potentially impact future operations and how management plans to address those risks is key to prospective risk analysis. The assessment of these nine risk classifications both currently and prospectively should be part of the quantitative and qualitative analysis completed within the Level 1, 2, 3 and Supplemental procedures. The *Financial Condition Examiners Handbook* provides guidance on prospective risks within Exhibit O (Examples of Risks) and Exhibit V (Prospective Risk Assessment).

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At the conclusion of the Level 1 Procedures, the analyst is asked to document an overall summary and conclusion regarding the financial condition of the insurer, assess the insurer's strengths and weaknesses, determine whether the insurer be considered a priority company, and decide whether one or more of the procedures in the Level 2 Annual Procedures should be completed. Because some items such as the Audited Financial Report and the holding company filings are not required to be filed until after most of the annual review is completed, the analyst will document a conclusion based on the Level 1 Procedures and the current analysis of the insurer. The Audited Financial Report and the holding company filings should be reviewed upon receipt, and if additional concerns are noted, the conclusion or the first quarter conclusion should be revised to reflect the most recent information. Similarly, as the analyst completes the procedures for Level 2, the Level 1 Summary and Conclusion should be reviewed and revised as necessary with any follow-up information or similar updates made to the first quarter summary and conclusion. At the completion of the analysis process, including any Level 1, 2, 3, or Supplemental Procedures, the analyst should update the Insurer Profile Summary, if applicable, and communicate with financial examination staff.

Insurer Profile Summary

The Insurer Profile Summary is a "living document" maintained by the state of domicile to "house" summaries of risk-focused examinations, financial analysis, internal and external changes, priority scores, supervisory plans, and other standard information.

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 insurer. The analyst should work with the examination staff to update the Insurer Profile Summary, including the Supervisory Plan, if applicable. The Supervisory Plan should be developed using the most recent examinations and annual and quarterly analysis results. 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 Supervisory Plan should include the type of surveillance planned, the resources dedicated to the oversight, and the coordination with other states.

Continual Review Process

The above-mentioned review of the Audited Financial Report and the Holding Company Analysis Procedures highlights the importance of a continual review process. This ongoing review process is obvious in these cases but is also necessary in other areas. For example, to the extent that an analyst completes the Level 1 Procedures for an insurer and has concerns with its reserves, the analyst would complete the Level 2 Procedures—B2. Unpaid Losses and LAE. Upon completion of the Level 2 Procedures, the analyst may have additional concerns and would complete the Level 3 Procedures—C2. Unpaid Losses and LAE. This analysis may result in questions posed to the insurer and additional information being supplied to the analyst. In some cases, the state may choose to perform a more in-depth analysis of the insurer's reserves, such as a targeted examination. This is just one of the many recommendations that could result from the ongoing analysis of an insurer. Other recommendations include requesting additional information from the insurer, obtaining the insurer's business plan, requesting additional interim reporting, engaging an independent expert, meeting with the insurer's management, and obtaining a corrective action plan from the insurer. These specific recommendations are included in the Financial Analysis Framework section of the *Handbook* and represent just a few of the potential actions that could result from the ongoing analysis of an insurer. Regardless of the final outcome, the results of ongoing analysis should be documented in the appropriate level of the analysis, including the Level 1 Summary and Conclusion, if applicable.

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Financial Examination Assessment

In performing the procedures related to financial examinations, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments is crucial during the consideration of these procedures. The analyst 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 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 should be structured and written to communicate to regulatory officials examination findings of regulatory importance. This type of communication also includes management letter comments, where appropriate.

These comments are similar to management letter comments frequently made by CPA firms as a result of their audit. Many insolvencies have been caused by mismanagement. When examiners identify systems, operational or management problems that exist, performance audit comments are an opportunity to alert management and other readers of the financial examination report to problems that, if left uncorrected, could ultimately lead to insolvency.

Management letter comments generally contain the following information: (1) a concise statement of the problem found; (2) the factors which caused or created the problem; (3) the materiality of the problem and its effect on the financial statements; (4) the financial condition of the insurer or the insurer's operations; and (5) the examiner's recommendation to the insurer 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 domiciliary state insurance department. Periodically, after a financial examination report has been issued, inquiries should be made to the insurer 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 utilize the financial analysts to perform this function. A lack of satisfactory corrective action by the insurer may be cause for further regulatory action.

Risk-Focused Examinations

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. Risks in addition to the financial reporting risks may be reviewed as part of the examination process.

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—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 reputation.
- 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.

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- Phase 4 – Determine Residual Risk—Once this risk is determined, the examiner can determine where to focus resources most effectively.
- Phase 5 – Establish/Conduct Examination Procedures—Upon completion of risk assessment, determine nature and extent of detail testing procedures.
- 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 Based on Findings—Incorporate into the examination report and management letter the results and observations noted during the examination.

The goals of the risk-focused examinations are to:

- Assess 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 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. To assist in this assessment, examiners may utilize board and audit committee minutes; lists of critical management and operating committees, their members and meeting frequencies; and Sarbanes-Oxley filings and initiatives, as applicable.
- Assess the risks that a company's surplus is materially misstated.

Discussion of Level 1 Annual Procedures

The Level 1 Annual Procedures are designed to identify potential areas of concern. As noted above, the principal areas of focus in Level 1 include the overall analysis of the insurer and its operations. The following provides a brief description of the purpose of each procedure.

Background Analysis

Procedure #1 provides guidance to the analyst in determining if any conclusions reached in prior-year analysis of the insurer should be considered in the work to be completed for the current year. Areas of concern noted in the prior year should be reviewed carefully in the current year. Insurers who were classified as priority companies in the prior year—either by the state's priority designation, the Scoring System results, IRIS ratios, the Analyst Team System Validated Level, or the RBC ratio and RBC Trend Test—should be reviewed carefully in the current year. The analyst should review the Insurer Profile Summary, including the Supervisory Plan, if applicable, for any concerns or risks that may require additional attention during the current analysis being performed.

Procedure #2 alerts the analyst to review all inter-departmental communication as well as communication with other state insurance departments and the insurer. Internal communication may include departments such as examination, licensing and admissions, consumer affairs, rate filings, policy/forms analysis, agents' licensing, legal, and market conduct. It may be necessary to communicate with other state departments if a multi-state domestic insurer writes a significant amount of business in other states. Additional communication with the insurer throughout the year should be reviewed to identify any items or areas that may require special attention during the analysis process. Refer to the Introductory Chapters for further discussion on internal and external communication.

Procedure #3 directs the analyst to determine whether the insurer was a party to a merger or consolidation, which can have a significant impact on the ongoing operations of the insurer. While organizational changes alone may not indicate a problem, knowledge of the change may help the analyst understand the insurer's future plans and goals. Additionally, the analyst should verify that Form A or additional filings have been approved.

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Procedure #4 requires the analyst to review General Interrogatories, Part 1, #6.1 and #6.2, to determine whether the insurer had any Certificates of Authority, licenses or registrations (including corporate registration if applicable) suspended or revoked by any governmental entity during the reporting period and investigate the reason(s) for the action(s).

Procedure #5 directs the analyst to identify if there are recent changes in the state's statutes and regulations that could have an impact on the insurer's financial position or reporting. If so, to the extent that information is available regarding the new statute or regulation, the analyst should determine if the insurer has failed to comply with the new state statutes and/or regulations that have been enacted during the period.

Procedure #6 requires the analyst to review the most recent rating agency report. In many cases, a rating agency downgrade may have an impact on the insurer's ability to generate new business or to retain existing business. The significance of the impact of a downgrade is generally dependent upon the type of product sold by the insurer and the level of the rating given by the agency.

Procedure #7 directs the analyst to review any industry reports, news releases or any emerging issues that have the potential to negatively impact the insurer. An example might include regulatory or media scrutiny of certain insurance lines of business, whether related to market conduct or financial issues. Another example would be changes in the economic environment that may negatively impact investment returns or result in material capital losses.

Procedure #8 directs the analyst to review the business plan of the insurer if it is available from recent surveillance activity, such as previous analysis or examinations, and if a review of the business plan is considered necessary based on the insurer's priority designation and financial condition. If reviewed, the analyst should assess if the plan is consistent with current operations and expectations of projected results. For example, consider if the insurer is writing more or less premium or different lines of business outlined in the plan. Consider if the plan is consistent with changes in the markets or geographical areas where business is being written, or new licenses obtained to write business. The analyst should assess significant variances in the business plan through review of the plan and/or through communication with the insurer. If a business plan is not available (or is not current) and, based on the analysis performed, if the analyst feels it is necessary to request a business plan and recommend further analysis in this area, a procedure exists at the end of Level 1 within the "Recommendations for Further Analysis" section.

Management Assessment

Procedure #9 assists the analyst in determining if changes in the insurer's management or board of directors have occurred. Changes such as these can have a significant impact on the ongoing operations of the insurer and management philosophy. Changes in the board of directors may also indicate changes in the audit committee. When assessing management, the analyst should take into consideration not only the changes in management but also the analyst's and examiner's knowledge about the current management team and any concerns that may exist regarding management. While management changes alone may not indicate a problem, knowledge of these changes may help the analyst understand other potential problems.

In regard to corporate governance, there are many aspects that require consideration, such as: adequate competency; independent and adequate involvement of the board of directors; multiple channels of communication; code of conduct between the board and management; sound strategic and financial objectives; support from relevant business planning; reliable risk management processes; sound principles of conduct; reporting of findings to the board; adoption of Sarbanes-Oxley provisions; and board oversight and approval of executive compensation and performance evaluations.

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The analyst should review the biographical affidavit for any new officers, directors, or trustees; follow-up on any areas of concern; and consider whether changes identified will alter management philosophy. The analyst should pay close attention to responses regarding any suspensions, revocations or non-approval of licenses, conflicts of interest, civil actions, or criminal violations. Communication with other state insurance departments may be necessary if the officer previously worked for an insurer domiciled in another state.

Balance Sheet Assessment

Procedure #10 directs the analyst in identifying significant changes in an insurer's assets, liabilities, and capital and surplus. Specific attention should be given to asset risk, receivables and recoverables, and changes in investment philosophy as well as loss reserves and loss reserve adequacy. The procedure also assists the analyst in determining if the overall amount of capital and surplus continues to meet RBC requirements. RBC creates a minimum standard for capital and surplus. Generally, an analyst should be careful not to extend the use of the RBC. For example, an insurer with a 600 percent RBC ratio is not necessarily stronger than an insurer with a 500 percent RBC ratio.

Operations Assessment

Procedure #11 assists the analyst in identifying significant changes in an insurer's income statement. Shifts in net income could indicate a change in premiums earned, a change in losses incurred, or other more complex issues that require further investigation. For this reason, it is critical that the analyst understand material changes within each income and expense category.

Procedure #12 assists the analyst in identifying unusual results within the Cash Flow. During the review of the Cash Flow, the analyst should understand shifts in cash inflows and cash outflows that impact cash from operations. The analyst should also investigate investment acquisitions and dispositions, and the insurer's investment strategies as well as the origin of other sources of cash.

Procedure #13 requires the analyst to identify material cessions as reported in Schedule F, Part 3—Ceded Reinsurance, and review all General Interrogatories pertaining to reinsurance. The analyst should understand the insurer's reinsurance programs and identify any credit risks. In addition, the analyst should be aware of the types of collateral held for reinsurance with non-admitted reinsurers.

Investment Practices

Procedure #14 assists the analyst in identifying unusual investment practices. These steps are specifically designed to assist the analyst in determining if the insurer has proper control over its investments.

Procedure #15 requires the analyst to review the Summary Investment Schedule to determine if the insurer uses any unusual methods for valuing its invested assets. The Summary Investment Schedule provides a comparison between the gross investment holdings, as valued in accordance with the *AP&P Manual*, and the admitted assets, as valued in accordance with the state of domicile's basis of accounting. This schedule should be reviewed in conjunction with the Notes to Financial Statements, Note #1, *Summary of Significant Accounting Policies*, Section A.

Procedure #16 requires the analyst to review the Supplemental Investment Risks Interrogatories to determine whether the insurer's investment portfolio is adequately diversified with the appropriate level of liquidity to meet cash flow requirements.

Procedure #17 assists the analyst in determining the amount of assets held as deposits with the states. These deposits are placed with the states to secure the settlement of the insurer's obligations to

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policyholders, claimants, and others. Insurers with greater than 10 percent of their assets held as deposits with states may hold greater liquidity risk in certain situations.

Review of Disclosures

Procedure #18 requires the analyst to review the Notes to Financial Statements to assist in identifying any relevant quantitative and qualitative information.

Procedure #19 requires the analyst to review the General Interrogatories and Schedule P Interrogatories to assist in identifying any unusual responses.

Assessment of Latest Examination Report and Results

Procedures #20, #21, and #22 assist the analyst in gathering specific information related to the insurer's most recent financial examination. During a review of the examination report, the analyst should note any items or areas that indicate further review is necessary. This might include such things as internal control issues, risk management, information technology, or other issues that could impact the insurer's priority. The analyst should also review the management letter comments which may include risks or progress on issues to which the analyst should give attention. Effective communication between the analyst and the examination staff is important in developing a good understanding of the insurer's management and financial position. As an example, the examination staff may have specific information on the reliability of the insurer's financial reporting. In addition, the analyst may want to utilize the Exam Tracking System on I-SITE. The analyst should consider the impact, if any, of the Financial Examination Report findings on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (i.e., complete additional supplemental procedures).

Assessment of Results From Prioritization and Analytical Tools

Procedure #23 requires the analyst to review and comment on the annual scoring ratios, which can assist in identifying any unusual financial results.

Procedure #24 requires the analyst to review and comment on the IRIS ratios, which can assist in identifying any unusual financial results.

Procedure #25 requires the analyst to review and understand the assigned Analyst Team System Validated Level, documented within the ATS Report and the ATS Validated Level Report on I-SITE. In addition, the analyst can reference the *ATS Procedures Manual* and ATS Level Definitions documents on I-SITE. The Analyst Team typically completes the validation process by mid-April.

Procedure #26 requires the analyst to review the Financial Profile Report, which can assist in identifying unusual trends and results.

Procedure #27 alerts the analyst to review any communication from the state's market analysis unit, including the results of market regulation exams and information drawn from the review of market analysis tools available on I-SITE, such as the Market Analysis Profile (MAP), Examination Tracking System (ETS), Market Analysis Review System (MARS), Regulatory Information Retrieval System (RIRS), Special Activities Database (SAD), Market Initiative Tracking System (MITS) and Complaints. Analysts should review any market conduct issues identified by market analysis staff (such as the Market Analysis Chief or the Collaborative Action Designee) or I-SITE tools and consider the financial implications those issues may have on the insurer, e.g. large fines levied by states, suspensions or revocations of licenses, market conduct exam settlements (whether financial or other), or other regulatory actions taken based on market conduct violations that may have a material impact on the financial solvency of the insurer.

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Assessment of Supplemental Filings

Procedure #28 requires the analyst to review the Statement of Actuarial Opinion to assess the adequacy of the insurer's reserves. See the Statement of Actuarial Opinion Supplemental Procedures for additional guidance in this area.

Procedure #29 requires the analyst to review the MD&A, which can provide additional information to the analysis of the insurer. See the MD&A Procedures for additional guidance.

Procedure #30 requires the analyst to review the Audited Financial Report, which helps to assess the reliance placed on the validity of the insurer's financial statements. The Audited Financial Report also contains additional financial information that is generally not included in the Annual Financial Statement and can be helpful to the analyst. See the Audited Financial Report Supplemental Procedures for additional guidance.

Procedure #31 requires the analyst to review the most recent financial statement of the holding company, as filed in the SEC 10-K Report. In addition, the analyst should review Forms A, B, D, E and Extraordinary Dividend/Distributions, if available. If there are affiliated insurers within the holding company group, the analyst should document communication with the domestic departments of insurance for those affiliated insurers.

Discussion of Level 1 Quarterly Procedures

The Level 1 Quarterly Procedures include procedures that are designed to help the analyst perform a general review of the insurer and its operations. The quarterly procedures are similar to the annual procedures because they are mostly broad-based questions. However, the quarterly procedures include questions that focus primarily on changes from the prior year. At the conclusion of the Level 1 Quarterly Procedures, the analyst is asked to develop and document an overall summary and conclusion regarding the financial condition of the insurer, determine whether the insurer be considered a priority company, and indicate whether one or more of the Level 2 Quarterly Procedures should be completed. As with the annual review, the Level 1 Summary and Conclusion should be reviewed and revised as necessary when subsequent procedures and follow-up with insurer is completed.

Discussion of Non-Routine Analysis

The Handbook contains procedures that assist an analyst in deriving an overall assessment of the insurer's financial condition; however, situations may exist when it is necessary to perform additional procedures and analysis not contained in the Handbook for one or more insurer.

On occasion, events or situations outside of the normal course of business occur that may have a material impact on the overall financial condition of an insurer. During these occasions state insurance regulators may need to perform non-routine analysis, which may require additional reporting from a specific insurer or from a group of insurers. A few examples of these occasions may include significant financial events such as material investment defaults, credit market stress, or catastrophic events. Non-routine analysis may also be appropriate and necessary in situations impacting a single insurer, a group, or a small group of insurers. For example, when permitted practices are granted, there may be a need to perform follow-up analysis of the situation requiring the permitted practice, including assessing the realizability of deferred tax assets. The state may conduct this analysis itself or enter into an agreed-upon procedures audit with a CPA firm to assist in the assessment and analysis of the projected future deferred tax assets and the impact to surplus.

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The following are a few examples of types of non-routine analysis that may be appropriate in an economic downturn, investment defaults, and changes in the credit markets (Note that some or all of these may be applicable in other non market or investment related situations as well).

- ☐ Focused analysis on asset quality where insurers hold higher amounts of riskier assets. The analyst should not only consider exposure to individual default events but also aggregate exposure. Additional review or explanation from the insurer may be requested when high amounts of other-than-temporary impairments, unrealized losses and/or large variances between book and market value are reported. The analyst should review the value of affiliated investments and assess indirect exposure to economic events that may result in the decline in the affiliated holdings. Analysts may consider other sources of analysis or information to assist in the review of investments. For example, an analyst may consider requesting a Portfolio Analysis Memorandum from the NAIC Securities Valuation Office.
- ☐ Analysts should consider the impact of tightened short-term credit markets on insurers or groups who depend on commercial paper, overnight repos, dollar repos, etc. Another area that could be impacted by changes in credit markets is the insurer's ability to obtain letters of credit (LOC) provided for XXX (life reserves) or other reinsurance reserves, and the costs of those LOCs for insurer dependent on LOCs.
- ☐ If the insurer engages in securities lending, the analyst may consider requesting detailed information about the program to review the types of assets (risk and duration match) within the program, gain an understanding of the structure and terms of the program, and, if material, monitor monthly changes in the program.
- ☐ Certain insurance products may be impacted more than others in an economic downturn. The analyst should consider the impact to an insurer that writes a material amount of products that are more likely to be accelerated (e.g., funding agreements, guaranteed interest contract–GICs) or where the liability can be accelerated (e.g., variable annuities, living benefit/death benefit on variable annuities).
- ☐ The analyst should consider the level of sensitivity of the insurer to ratings downgrades and the possible impact on the insurer or the group. For example, its ability to market new business or the impact of rating downgrades on any debt covenants. If an insurer is downgraded, the analyst may consider monitoring surrenders, new business sales as well as any changes in the insurer's business plans.
- ☐ Where liquidity is a concern, the analyst may also consider requesting interim reporting from the insurers on areas of risk specific to that insurer. For example, surrender activity, high-risk investment exposures, GICs, capital and surplus, available liquidity, available credit facilities and capital losses.
- ☐ Where significant concerns exist, the state may consider requesting the insurer to perform stress testing on the possible future impacts of additional equity losses, defaults, or other areas relevant to the situation.

Examples of types of non-routine analysis that may be appropriate in catastrophic events.

- ☐ Implement disaster reporting requests to appropriate insurers and monitor claims exposure during future periods following the event.
- ☐ Identify insurers and reinsurers with material exposure.
- ☐ Implement appropriate procedures to identify fraudulent activities.
- ☐ Perform an in-depth analysis of liquidity to ensure timely payment of claims.
- ☐ Engage legal staff to ensure appropriate claims payment practices.

Additional Reference Sources

1. *Financial Condition Examiners Handbook*, NAIC

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B. Levels 2 & 3

1. Investments
   a. Primer on Derivatives
2. Unpaid Losses and LAE
3. Income Statement and Surplus
4. Risk-Based Capital
5. Cash Flow and Liquidity
6. Reinsurance
7. Affiliated Transactions
8. MGAs and TPAs

Overview

Insurers receive premiums from policyholders in exchange for a promise to pay covered losses in the future. The premiums, net of operating expenses paid and capital and surplus funds, are invested in a variety of different types of investments until they are needed to pay losses. State insurance laws regulate an insurer's investments and prescribe the types of investments that may be acquired by insurers. These laws generally provide limitations on investments by type and issue. In most states, however, a large portion of the insurer's assets may be invested at the discretion of management or the board of directors, as long as it's 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 long-tail liability lines of business. In some cases, management may be pressured into strategies to maximize investment yields when losses are higher than anticipated at the time the products were priced. Higher investment yields generally involve greater risk and ownership of investments that are questionable in 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 losses. Poor matching may result in the insurer being forced to liquidate long-term investments at a loss to provide the currently needed cash flow.

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.

Historically, 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 over time. In the past, insurers were primarily concerned with the preservation of capital and generally invested in high quality bonds and stocks. However, insurers are now focusing more on investment returns. This change in focus has prompted some insurers to turn to assets of higher risk and lower quality in exchange for higher investment yields. Some property/casualty insurers currently have significant investments in non-investment grade bonds, privately placed bonds, multi-class residential mortgage backed securities, and other multi-class securities. Investments today are much more complex and sophisticated than they were in the past. This requires insurers to have investment advisors (in-house and/or contractual) with appropriate background and expertise, as well as analytical systems that are capable of continually monitoring the constantly changing marketplace.

As a result, investment analysis is more important today than it was in the past. The principal areas of concern to the analyst in reviewing an insurer's investment portfolio are diversification, liquidity, quality, and valuation. First, an insurer's investment portfolio should be adequately diversified to prevent 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 policyholders' 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 non-sinking fund preferred stocks, which are valued at their fair value. The analyst should track investments that may need to be written down to fair value due to impairments in the market.

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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. The analyst should be alert for property/casualty insurers with concentrations of investments that are riskier and/or less liquid than traditional bonds and common stocks. The analyst 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.

Discussion of Level 2 Annual Procedures

The Level 2 Annual Procedures are designed to identify potential areas of concern. As noted above, the principal areas of concern regarding an insurer's investment portfolio are diversification, liquidity, quality, and valuation. Most of the procedures are designed to assist the analyst in identifying undue concentrations of investments by type or issue and investments that have been improperly valued in the Annual Financial Statement.

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst 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 of directors.

Procedure #1 assists the analyst in determining whether the insurer's investment portfolio appears to be adequately diversified to avoid concentration of investments by type or issue. The ratios within the procedure are a measure of diversity of the insurer's investment portfolio by type of investment. The results of these ratios may provide some indication of the insurer's liquidity. Ratios are included for most types of investments, except for government and agency bonds and cash and short-term investments, which are generally highly liquid.

Procedure #2 assists the analyst in determining whether concerns exist regarding the level of investment in certain types of securities that tend to be riskier and/or less liquid than publicly traded bonds and stocks, and cash and short-term investments. Although most property/casualty insurers tend to invest primarily in publicly traded bonds and stocks, there are some insurers with significant concentrations of riskier investments.

Procedure #2a assists the analyst in determining whether concerns exist due to the level of investment in non-investment grade bonds. Bonds that have NAIC designations of 3, 4, 5, or 6 by the Securities Valuation Office (SVO) are considered non-investment grade bonds and represent a significantly higher credit or default risk than do investment grade bonds. In addition, the prices of non-investment grade bonds are frequently more volatile than the prices of investment grade bonds. The NAIC has adopted a Model Regulation on Investments in Medium Grade and Lower Grade Obligations. The Model Regulation establishes limitations on the concentration of non-investment grade bonds because of concerns that changes in economic conditions and other market variables could adversely affect insurers that have a high concentration of these types of bonds.

Procedure #2b assists the analyst in determining whether concerns exist due to the level of investment in multi-class securities. Multi-class securities include: 1) loan-backed bonds, 2) multi-class residential mortgage backed securities, and 3) other multi-class securities. Of the structured securities, multi-class residential mortgage backed securities are generally the most complex and volatile. Multi-class residential mortgage backed securities convert a pool of mortgage loans into a series of securities that have expected maturities that vary significantly from the underlying pool as a result of slicing the pool into numerous

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tranches with different repayment characteristics. These securities are either issued or backed by the U. S. government, carry very little credit risk, and are commonly stated at par value. As a result, many of these securities are designated investment grade category 1 by the SVO. However, the credit rating does not consider the prepayment or interest-rate risk inherent in these investments. If the underlying mortgage loans are repaid by the borrowers faster or slower than anticipated, the repayment streams will be affected, and the expected durations will either contract or extend. Thus, the cash flows on these investments are much more unpredictable than those for more traditional bonds and mortgage pass-through certificates. If the prepayments are significantly faster than anticipated, and the insurer had paid a large premium when it was acquired, the insurer could experience a significant loss on the investment even though the par value was received. In addition, cash flows are harder to match with corresponding payments on losses. This leads to the risk that prepayments may not be able to be reinvested in investments earning comparable yields in order to support liability payment streams.

Procedure #2c assists the analyst in determining whether concerns exist due to the level of investment in privately placed bonds. Significant investment in privately placed bonds may cause concerns regarding the insurer's liquidity because many of these types of investments cannot be resold. Those that can be resold frequently have restrictions as to whom they can be sold to. Also, there is no structured market for privately placed bonds like there is for publicly traded bonds. Therefore, even if the privately placed bonds can be sold, it may be difficult to find a willing buyer. Insurance companies commonly purchase these debt obligations in order to avoid the uncertainties of the market, to engage in private negotiations, and to avoid SEC restrictions.

Procedure #2d assists the analyst in determining whether concerns exist due to the level of investment in real estate and mortgage loans. These investments are less liquid than many other types of investments. The analyst may have concerns regarding the fair value of the real estate, whether it is the underlying investment or the collateral for a mortgage loan. Most states restrict mortgage loan investments to first liens on property, with some states allowing second liens in instances where the insurer also owns the first lien. Second liens are more risky because, in the event of default, the holder of the first lien would be repaid out of any proceeds from the sale of the underlying property prior to the holder of the second lien.

Procedure #2e assists the analyst in determining whether concerns exist due to the level of investment in other invested assets (Schedule BA). Schedule BA includes, but is not limited to, investments in collateral loans, joint ventures and partnerships interests, oil and gas production, and mineral rights. Joint ventures and partnerships typically involve real estate. These types of assets tend to be fairly illiquid and may contain significant credit risk.

In addition to the steps for the types of investments included in procedure #2, the analyst should review procedures #3 and #4 in Level 2—Affiliated Transactions, along with procedure #3 in Level 3—Affiliated Transactions.

Procedure #3 assists the analyst in determining whether the purchase and sale of all investments were approved by the board of directors and whether all securities owned as of December 31 of the current year were under exclusive control and in the actual possession of the insurer. Most states require investment transactions to be approved by the insurer's board of directors or a designated subordinate committee. General Interrogatories, Part 1, #14 indicates whether this has been done. General Interrogatories, Part 1, #22.1 and #22.2 indicate whether the stocks, bonds, or other securities of which the insurer has exclusive control (defined by the NAIC as the exclusive right by the insurer to dispose of an investment at will, without the necessity of making a substitution therefore) are in the actual possession of the insurer. If the insurer owns securities that are not in its possession, a custodian should hold them under a properly executed custodial agreement in order for them to be considered admitted assets. General Interrogatories, Part 1, #23.1 and #23.2 indicate whether any of the stocks, bonds, or other assets of the insurer are not

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exclusively under its control. Assets that are not under the insurer's control might not meet the state's requirements to be considered admitted assets.

Procedure #4 assists the analyst in determining whether the securities owned by the insurer have been valued in accordance with the standards promulgated by the SVO. Beginning in 2004, the Provisional Exemption (PE) identifier in the *Purposes and Procedures Manual of the NAIC Securities Valuation Office* (*SVO P&P Manual*) was changed to Filing Exempt (FE). This change expands the exemption to preferred stocks and all NAIC equivalent designations, and removes several of the optional requirements. In conjunction with this change, the SVO compliance certificate was changed to a general interrogatory in the investment section. According to NAIC requirements, all securities purchased that are not FE per the *SVO P&P Manual* should be submitted to the SVO for valuation within 120 days of purchase. In accordance with the *Annual Statement Instructions*, if the SVO provides an NAIC designation or price, that designation or price should be utilized. Insurers are required to complete the general interrogatory on compliance filing requirements of the *SVO P&P Manual* and list exceptions as a component of the Annual Financial Statement. This interrogatory should indicate that: (1) all prices or NAIC designations for the securities owned by the insurer that appear in the Valuations of Securities (VOS) have been obtained directly from the SVO; (2) all securities previously valued by the insurer and identified with a "Z" suffix (which indicates that the security is not FE, does not appear in the VOS, or has not been reviewed and approved in writing by the SVO) have either been submitted to the SVO for a valuation or disposed of; and (3) all necessary information on securities that have previously been designated NR (not rated due to lack of current information) by the SVO have been submitted to the SVO for a valuation or that the insurer has disposed of the securities. In addition, the analyst should review Schedule D, Part 1—Bonds and Schedule D, Part 2—Preferred Stocks and Common Stocks, to determine whether it appears that the insurer is complying with the requirement to submit securities to the SVO for valuation. There should be no securities that were acquired prior to the current year that have a "Z" suffix after the NAIC designation.

Procedure #5 assists the analyst in determining whether the statement value of bonds and sinking fund preferred stocks is significantly greater than their fair value. General Interrogatories, Part 1, #28 shows the aggregate statement value and the aggregate fair value of bonds and preferred stocks owned, and requires the insurer to indicate how the fair values were determined. If the statement value of bonds and sinking fund preferred stocks is significantly greater than the fair value, the insurer could realize significant losses if it were forced to sell these investments to cover unexpected cash flow needs due to larger than anticipated losses.

Procedure #6 assists the analyst in determining whether the fair value of common stock is significantly greater than or less than the actual cost. The analyst should review Schedule D, Part 2, Section 2—Common Stocks Owned December 31 of Current Year, to determine what the aggregate fair value position is in relation to aggregate actual cost of common stock. The analyst should also review individual stock issues to determine if the fair value is significantly above or below actual cost. If the fair value of a stock issue is significantly below cost (unrealized loss), the insurer may incur a loss upon disposition. If the fair value of an individual stock issue is significantly greater than actual cost (unrealized gain), the insurer may be reflecting an unrealized gain that will not be realized at disposition.

Procedure #7 assists the analyst in determining whether concerns exist due to significant purchases or sales of securities near the beginning and/or end of the year. The analyst can identify significant purchases or sales of securities by reviewing Schedule D, Part 3—Long-Term Bonds and Stocks Acquired During Current Year; Schedule D, Part 4—Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year; and Schedule D, Part 5—Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed of During Current Year. If significant purchases or sales of securities occurred near the beginning and/or end of the year, the insurer might have rented

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securities or engaged in window dressing of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring the same or similar lower quality investments after year-end) in an attempt to avoid additional regulatory scrutiny that would have occurred with the insurer's lower rated investment portfolio.

Procedure #8 assists the analyst in determining whether concerns exist due to the level of investment turnover. The analyst can identify significant turnover by reviewing Schedule D, Part 4—Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year; and Schedule D, Part 5—Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed of During Year. The turnover ratio represents the degree of trading activity in long-term bonds and preferred and common stock investments that occurred during the year. Investment turnover is an indication of whether a "buy-and-hold" or "sell based on short-term fluctuation" strategy is utilized. A high turnover of investments generally leads to greater transaction costs, operating expenses, and the acceleration of realized capital gains. Sales result from securities reaching a price objective, anticipated changes in interest rates, changes in credit worthiness of issuers, or general financial or market developments.

Procedure #9 assists the analyst in determining whether concerns exist due to the level of investment in derivative instruments. A derivative instrument is a financial market instrument that has a price, performance, value, or cash flow based primarily on the actual or expected price, performance, value, or cash flow of one or more underlying interests. Derivative instruments (which consist of options, caps, floors, collars, swaps, forwards, and futures) are used by some insurers to hedge against the risk of a change in value, yield, price, cash flow, or quantity or degree of exposure with respect to its assets, liabilities, or anticipated future cash flows. If an insurer invests in derivative instruments, it is important for the analyst to understand the impact that these derivative instruments have on the risk return profile of the insurer's cash market investment portfolio under different scenarios. For insurers with significant investments in derivative instruments, this will probably require the analyst to obtain the assistance of an actuary.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures are designed to identify if: (1) the insurer's investment portfolio is adequately diversified to avoid an undue concentration of investments by type or issue; (2) the insurer has significantly increased its holdings since the prior year-end in certain types of investments that tend to be riskier and/or less liquid than publicly traded bonds and stocks, and cash and short-term investments; (3) the insurer has significantly increased its holdings since the prior year-end in certain types of derivatives that tend to be riskier and/or less liquid than publicly traded bonds and stocks and cash and short-term investments; (4) all securities owned are under the control of the insurer and in the insurer's possession; or (5) the insurer has complied with the requirements of the *SVO P&P Manual*, which requires all securities to be valued in accordance with standards promulgated by the SVO.

Discussion of Level 3 Procedures

The procedures included in Level 3 are designed to assist the analyst in further investigating potential problems and concerns that were identified in either the Level 2 Annual or Quarterly Procedures. As emphasized throughout the Level 3 Procedures, the analyst should use judgment in determining which areas to investigate further.

Procedure #1 suggests additional steps the analyst may perform if there are concerns regarding whether the insurer's investment portfolio is adequately diversified in order to avoid concentration of investments by type or issue. The analyst should consider determining whether the insurer's investment portfolio is in compliance with the investment limitations and diversification requirements per the state's insurance laws. The analyst might also review the percentage distribution of assets for significant shifts in the mix

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of investments owned during the past five years. The analyst should compare the insurer's distribution of invested assets to industry averages to determine significant deviations. In addition, the analyst might also want 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 lines of business written, its liquidity and cash flow needs, and to determine whether the insurer appears to be adhering to its plan. The analyst might also review Schedule D, Part 1A—Quality and Maturity Distribution of All Bonds Owned, and consider the liquidity of the insurer's investments to help determine whether the insurer's investment portfolio appears reasonable based on the line(s) of business written. If the analyst has concerns regarding liquidity or cash flows, he or she should consider having a cash flow analysis performed by an actuary.

Procedures #2 through *#6* suggest additional steps the analyst may perform if there are concerns regarding the level of investment in certain types of investments that tend to be riskier and/or less liquid than publicly traded bonds and stocks, and cash and short-term investments. In addition to the steps for the types of investments included in these procedures, the analyst should also consider reviewing procedures #3 and #4 in Level 2 Procedures—Affiliated Transactions and procedure #3 in Level 3 Procedures—Affiliated Transactions regarding investments in affiliates.

Procedure #2 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in non-investment grade bonds. The analyst should consider reviewing Schedule D, Part 1A, Section 1—Quality and Maturity Distribution of All Bonds Owned, and compare the insurer's holdings of non-investment grade bonds to the limitations included in the NAIC's Investments in Medium Grade and Lower Grade Obligations Model Regulation by NAIC designation. The insurer should have a plan for investing in non-investment grade bonds that has guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, and geographic location. The analyst might consider requesting a copy of this plan from the insurer to determine whether they appear to be adhering to the plan. For the more significant non-investment grade bonds, the analyst might also consider requesting from the insurer audited financial statements and a rating agency report for the issuer of the bonds to assess the issuer's current financial position and ability to repay its debt.

Procedure #3 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in multi-class residential mortgage backed securities. The analyst should consider reviewing the multi-class securities categories in Schedule D, Part 1—Long-Term Bonds Owned for bonds with a book/adjusted carrying value that is significantly in excess of par value that could result in a loss being realized if bond prepayments occur faster than anticipated. The analyst should also consider reviewing a listing of the effective yield on each of the insurer's multi-class securities. The effective yield on most debt securities is generally linked to its credit risk and duration. However, significant prepayment risk can also increase the effective yield.

There are many different types of multi-class residential mortgage-backed securities, each having different characteristics and inherent risks. Therefore, the analyst might consider requesting information from the insurer regarding the amount of each type held, e.g., planned amortization class, support bonds, interest only and principal only, to help evaluate the risk of the portfolio. A glossary of various commercial mortgage obligations terms is available within the link entitled "Detailed Discussion of CMOs" at the top of the Financial Analysis Handbook Reports page on I-SITE. The document is entitled "An Investor's Guide to CMOs."

The analyst might consider requesting information from the insurer regarding estimated prepayment speeds on its multi-class residential mortgage backed securities. Several standardized forms of calculating the rate of prepayments of a mortgage security exist in the market. The Constant Prepayment Rate and the Standard Prepayment Model of the Bond Market Association are the most common models used to

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measure prepayments. For further discussion of prepayment speeds and other items that impact the interest rate risk and valuation risk of a mortgage backed security, see the "Mortgage Backed Securities" document included in the "Detailed Discussion of CMOs" link at the top of the Financial Analysis Handbook Reports page on I-SITE. The analyst should consider further analysis in those instances that prepayment risk appears high.

Procedure #4 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in privately placed bonds. The analyst should consider reviewing Schedule D, Part 1A, Section 1—Quality and Maturity Distribution of All Bonds Owned to determine the amount, issue type, NAIC designation, maturity distribution of privately placed bonds, and the amount of privately placed bonds that are freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A. For the more significant privately placed bonds, the analyst should also consider requesting from the insurer current audited financial information regarding the issuer to evaluate the issuer's financial position and ability to repay its debt.

Procedure #5 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in real estate and mortgage loans. If there are concerns regarding real estate owned, the analyst should consider reviewing Schedule A, Part 1—Real Estate Owned to determine whether updated appraisals should be obtained for any of the properties owned based on the location of the property, the book/adjusted carrying value, reported fair value, and the year of the last appraisal. In addition, for those properties with book/adjusted carrying values in excess of fair value, the analyst might consider whether the asset should be written down. The analyst should also consider investigating any instances where a property has a book/adjusted carrying value in excess of its cost and requesting information from the insurer regarding any increases in book/adjusted carrying value during the year. If there are concerns regarding mortgage loans, the analyst should consider reviewing Schedule B, Part 1—Mortgage Loans Owned to compare the book/adjusted carrying value of each loan to the value of the land and buildings mortgaged. The analyst should determine whether the mortgage loans are adequately collateralized and whether any of the mortgage loans are to officers, directors, or other affiliates of the insurer. For those loans that have had an increase in book/adjusted carrying value during the year, the analyst might consider requesting information from the insurer regarding the increase to determine whether the increase should be considered an admitted asset.

Procedure #6 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in other invested assets. The analyst should consider reviewing Schedule BA, Part 1—Other Long-Term Invested Assets to determine the amount and types of other invested assets owned, and to determine whether they are properly categorized as other invested assets. Information might be requested from the insurer to support any increases by adjustment in book/adjusted carrying value during the year. In addition, the analyst should consider requesting the current Annual Audited Financial Report and other documents (e.g., partnership agreements), necessary to support the book/adjusted carrying value of the insurer's investment in partnerships and joint ventures and information to support the book/adjusted carrying value of significant other invested assets (other than partnerships and joint ventures). For investments in collateral loans, the analyst may want to compare the fair value of the collateral to the amount loaned to determine whether the loan is adequately collateralized.

Procedure #7 suggests additional steps the analyst may perform if there are concerns regarding investment approval or control and possession. If there are concerns regarding investment approval, the analyst should consider requesting a copy of the insurer's formal adopted investment plan to determine who is authorized to purchase and sell investments and what approvals are required for investment transactions. If there are concerns regarding investments that are held by someone other than the insurer, the analyst should consider reviewing General Interrogatories, Part 1, #22 in more detail. It should be determined as to the reason the securities are not in the insurer's possession and who holds the securities

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in order to evaluate whether they qualify as admitted assets of the insurer under the state insurance laws or whether there are concerns regarding the insurer's ability to have access to the securities when needed. If there are concerns regarding investments that are not under the insurer's exclusive control, the analyst should consider reviewing General Interrogatories, Part 1, #23 in more detail. It should be determined as to the reason the assets are not under the insurer's exclusive control (e.g., loaned to others, subject to repurchase or reverse repurchase agreements, pledged as collateral, placed under option agreements), and who holds the assets in order to evaluate whether they qualify as admitted assets for the insurer under the state's insurance laws or whether there are other concerns.

Procedure #8 suggests additional steps the analyst may perform if there are concerns regarding whether securities have been valued in accordance with the standards promulgated by the SVO. The analyst should consider reviewing Schedule D, Part 1—Bonds to determine whether all bonds with an NAIC designation of 3, 4, 5, or 6 (non-investment grade bonds) have been valued at their fair value, and all other bonds have been valued at their book/adjusted carrying value in accordance with the NAIC's *Accounting Practices and Procedures Manual (AP&P Manual)*. The analyst should also consider reviewing Schedule D, Part 2—Preferred Stocks and Common Stocks to determine whether sinking fund preferred stocks have been valued at cost and all other stocks have been valued at fair value in accordance with the *AP&P Manual*. For those securities listed in Schedule D, Part 1—Bonds or Schedule D, Part 2—Preferred Stocks and Common Stocks with a "Z" suffix after the NAIC designation, the analyst might request verification from the insurer that the securities are filing exempt or have been submitted to and subsequently valued by the SVO. The analyst should compare the price or designation subsequently received from the SVO to that included in the Annual Financial Statement for significant securities. The analyst should also consider using Examination Jumpstart investment analysis (available on I-SITE) to compare the CUSIP number, NAIC designation, and fair value for each of the securities listed in Schedule D, Part 1—Bonds, Schedule D, Part 2—Preferred Stocks and Common Stocks, and Schedule DA—Short-Term Investments to information on the SVO master file.

Procedure #9 suggests additional steps the analyst may perform if there are concerns regarding the significance of any excess of the book/adjusted carrying value over the fair value of bonds and sinking fund preferred stocks. The analyst should consider reviewing Schedule D, Part 1—Bonds and Schedule D, Part 2—Preferred Stocks and Common Stocks, or request information from the insurer to determine which individual bonds and sinking fund preferred stocks have a book/adjusted carrying value significantly in excess of their fair value. The analyst should be aware that the fair value for those securities with an "AV" (amortized value) designation in the rate used to obtain the fair value column in Schedule D does not represent a true fair value for the securities. For those securities with a book/adjusted carrying value significantly in excess of their fair value, the analyst might consider verifying the NAIC designation assigned and determine whether it has recently been reviewed by the SVO. In addition, the analyst should review the current rating by an acceptable rating organization and evaluate whether there has been a permanent impairment in fair value. For bonds and sinking fund preferred stocks with permanent impairments, the analyst should also consider whether the investment should be written down to its fair value to properly reflect the investment. If the insurer has experienced negative cash flows or has other liquidity problems, the analyst should consider requesting information from the insurer regarding investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of their fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

Procedure #10 suggests additional steps the analyst may perform if there are concerns regarding the significance of any excess of cost over fair values of common stocks owned. The analyst should consider reviewing Schedule D, Part 2, Section 2—Common Stocks to determine which individual common stocks have a cost significantly in excess of their fair value. The analyst should also determine whether the stock is listed on a national exchange and verify the price per stock and the total fair value listed in the

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statement. If the NAIC designation of the stock is "A" (unit price of the share of common stock is determined analytically by the SVO), the analyst should determine when the price per share was last analyzed by the SVO. The analyst should also consider whether the common stock is permanently impaired by the market. The analyst should consider requesting the Annual Audited Financial Report and other documents necessary to support the value of the common stock. The analyst should also consider requesting information from the insurer regarding investment strategies and short-term cash flow needs.

Procedure #11 suggests additional steps the analyst may perform if there are concerns regarding significant purchases or sales of securities near the beginning and/or end of the year. The analyst should consider reviewing Schedule D, Part 3—Long-Term Bonds and Stocks Acquired During Current Year; Schedule D, Part 4—Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year; and Schedule D, Part 5—Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed of During Current Year to determine the types of securities purchased and sold at or near the beginning and the end of the year, the vendors used for investment purchases, and the purchasers of investments sold. This information can then assist the analyst in determining whether the insurer might have engaged in "window dressing" of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring lower quality investments after year-end) in an attempt to avoid additional regulatory scrutiny that would have occurred with the insurer's lower rated investment portfolio.

Procedure #12 suggests additional steps the analyst may perform if there are concerns regarding investment turnover. The analyst should consider reviewing Schedule D, Part 3—Long-Term Bonds and Stocks Acquired During Current Year; Schedule D, Part 4—Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year; and Schedule D, Part 5—Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed of During Current Year to determine the types of securities purchased and sold. This information can assist the analyst in determining the types of securities sold and acquired, as well as the length of time each security was held and the quality of the security. The analyst should also review realized capital gains from the sale of securities to determine any reliance on these gains. The analyst should also consider having a specialist review the insurer's investment program.

Procedure #13 suggests additional steps the analyst may perform if there are concerns regarding the level of investment in derivative instruments. The analyst 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 could 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, the analyst 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 *AP&P Manual* have been met. The analyst 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.

Additional Reference Sources

1. *Accounting Practices and Procedures Manual*, NAIC
2. *Annual Statement Instructions Property/Casualty*, NAIC
3. *Purposes and Procedures Manual of the NAIC Securities Valuation Office*, NAIC

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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 the *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, *Accounting for Derivative Instruments and Hedging Activities* of the *AP&P Manual.*

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 or more underlying interests. 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

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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 with 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 percent—semi-annually and receive a floating rate LIBOR (London Inter Bank Offer Rate), for example, plus a spread. Each six months, the insurer would pay the counterparty 3 percent times the notional amount—$10,000,000 for example—and would receive an amount equal to $10,000,000 times the then-current LIBOR 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 LIBOR 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

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 exceeds a predetermined value, sometimes called the stike/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.

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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.

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 traded 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.

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 *Model Investment Law (Defined Limits Version)* 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 that an insurer has acquired or incurred or anticipates acquiring or incurring.

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” (i.e., 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

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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 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 a third financial instrument. The following is a typical example of a replication transaction: The insurer holds a high quality corporate bond that pays one 7 percent coupon per year. The insurer can enter into a swap transaction with another party in which the insurer receives 2 percent 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

Derivative instruments are reported in Schedule DB of the statutory financial statement. Options, caps, and floors owned by the insurer are reported in Part A. Options, caps, and floors written by the insurer are reported in Part B. Collar, swap, and forward contracts are reported in Part C. Futures are reported in Part D, and replications are reported in Part F.

Schedule DB, Parts A through D, contains three sections: Section 1 identifies the contracts owned; Section 2 identifies contracts acquired during the year; and Section 3 identifies contracts terminated during the year.

Part E of Schedule DB 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 Blanks Instructions.

Schedule DB, Part F, Section 1 contains the underlying detail of replicated assets owned at the end of the year. Section 2 of Schedule DB, Part F is a reconciliation between years of replicated assets. The assumption underlying the NAIC RBC formula—that all derivative instruments are used for hedging purposes—is one of the central issues that the NAIC is exploring in its research on the subject of replication transactions.

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 Part B – 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, *Accounting for Derivative Instruments and Hedging Activities*. 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

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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 RBC.

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, a procedure included in the Level 3 Procedures.

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, and 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
  - 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.

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Overview

The single largest liability reported by most property/casualty insurers is the liability for unpaid losses (commonly known as loss reserves). Loss reserves are based on estimates rather than payments, thus cannot be precisely determined in advance. The underlying goal in estimating losses is for unpaid losses to reflect the outstanding liability, net of reinsurance, for all losses that have occurred and not paid as of the financial statement date. Except for claims-made policies, losses are recognized as they occur, not as they are reported. Typically, claims-made policies only cover losses that are reported during the policy period or renewal term. Under these policies, a loss is recognized when it is reported to the insurer rather than when it occurs, and the report date is substituted for the incurred date for the loss.

Unpaid losses are categorized as either "reported" or "incurred but not reported" (IBNR). Because the dollar amount of IBNR losses are not known as of the financial statement date, the estimate is highly subjective. Even with respect to those claims that have been reported to the insurer, the actual amount that the insurer will pay will not be known until the claims are settled in full, which could be years after the insurer initially established the reserve. Generally, an insurer is required to estimate the value of what its claims will be when they are ultimately settled. Excluding certain types of losses that an insurer may be allowed to discount, statutory accounting practices require that for every dollar of unpaid losses, an insurer reserves a dollar for the future payment of those losses.

In addition to unpaid losses, an insurer must also reserve for the future costs of settling the unpaid losses, otherwise known as loss adjustment expenses (LAE). The reserve for LAE is an estimate of all expenses that will be incurred in connection with the settlement of unpaid losses, which includes claims adjustment expenses, legal fees, court costs, investigation fees, claims processing, and payment expenses. LAE is classified as either "defense and cost containment payments" or "adjusting and other payments." Defense and cost containment payments are correlated with the loss amounts and include defense, litigation, and cost containment expenses, whether internal or external. Adjusting and other payments are correlated with claim, count, or are general loss adjusting expenses and include those expenses in the Underwriting and Investment Exhibit, Part 3—Expenses. The reserve for LAE should be the insurer's best estimate of the loss adjustment expenses that will be incurred in order to settle both reported and IBNR unpaid losses. In addition to these expenses, the insurer must also establish a liability for incurred but unpaid loss adjustment expenses and for incurred and unpaid general expenses.

Due to the complexity of reserving for unpaid losses and LAE, most insurers rely on actuaries or individuals with actuarial training to assist in estimating these liabilities. Although some insurers do not use actuaries to actually set their reserves, they are required to obtain annually an opinion regarding the reasonableness of the established reserves by a qualified actuary.

Since these liabilities must be estimated, they are generally considered a high-risk area for property/casualty insurers. The accuracy of an insurer's liabilities for unpaid losses and LAE must be closely monitored on an ongoing basis. A deficiency in these liabilities directly affects surplus, which affects the insurer's overall financial solvency. Therefore, the primary concern of the analyst in the review of unpaid losses and LAE is whether the liabilities established by the insurer are sufficient to cover the future costs of settling all of the insurer's covered losses that have occurred as of the financial statement date.

Discussion of Level 2 Annual Procedures

The Level 2 Annual Procedures are designed to identify potential areas of concern as to whether the insurer's reserves are sufficient to cover the costs of settling all of its losses that have occurred as of the financial statement date.

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In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst should also consider the insurer's corporate governance that 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 of directors.

Procedure #1 assists the analyst in determining whether an understatement in unpaid loss and LAE reserves would be significant to the insurer. The ratio of loss and LAE reserves to surplus is a leverage ratio that indicates the margin of error an insurer has in estimating its reserves. For an insurer with a reserve leverage ratio of 300 percent, a 33 percent understatement of its reserves would eliminate its entire surplus. In addition to the reserve leverage ratio, the analyst should consider the nature of the insurer's business. An insurer that writes primarily short-tail property lines might not be a concern, even though its leverage ratio is greater than 300 percent. The risk of significant understatement of its reserves is less than that of an insurer that writes primarily long-tail liability lines, such as medical professional liability.

Procedure #2 assists the analyst in determining whether unpaid losses and LAE appear to have been adequately reserved. The ratios of one-year reserve development to prior year-end surplus and two-year reserve development to second prior year-end surplus measure the adequacy of the loss reserves. Positive results for these ratios represent additional or adverse loss reserve development on the reserves originally established (the amount by which the reserves originally established has proved to be understated based on subsequent activity). If the insurer's ratio results consistently show adverse development, and/or the two-year reserve development to second prior year-end surplus result is consistently worse than the one-year reserve development to prior year-end surplus, this could be an indication that the insurer is intentionally understating its reserves.

The ratio of estimated reserve deficiency to surplus compares the estimated reserves needed by the insurer (calculated by multiplying the current net earned premiums by the average ratio of developed reserves to earned premiums for the last two years and subtracting the actual reserves established by the insurer) to the actual reserves established by the insurer and expresses the resulting difference as a percentage of the insurer's surplus. A positive ratio result reflects an estimated reserve deficiency. The results of this ratio can be effected by changes in product mix.

The loss ratio is also reviewed as a part of this procedure. Significant increases in this ratio might be indicative of reserve strengthening due to prior understatements, whereas significant decreases might be indicative of current reserve redundancies.

In addition, the mix of the insurer's business is reviewed for changes from prior years. A property insurer that begins writing significant liability business, for which it is more difficult to establish an accurate reserve and which the insurer does not have historical experience writing, might cause concern regarding the adequacy of the unpaid loss and LAE reserves.

Procedure #3 assists the analyst in determining whether unpaid losses and/or LAE have been discounted and, if so, whether concerns exist regarding the amount of the discount or the interest rate used. Present value discounting of property/casualty 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 permit insurers to discount other long-tail liability lines of business on a non-

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tabular basis, such as medical professional liability. All discounting, other than tabular discounting, must be approved by the domiciliary state insurance department and must be disclosed in Schedule P Interrogatories of the Annual Financial Statement. Schedule P, Part 1 is required to be completed gross of non-tabular discounting, and Schedule P, Parts 2 through 6 are required to be completed gross of all discounting. If loss reserves are discounted, the Underwriting and Investment Exhibit, Part 2A—Unpaid Losses and Loss Adjustment Expenses is completed net of discount, and disclosure of discounting is required in the Notes to Financial Statements, #31—Discounting of Liabilities for Unpaid Losses or Unpaid Loss Adjustment Expenses. This disclosure includes a discussion of the discount rates used and the basis for using those rates. In addition, 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.

Procedure #4 assists the analyst in determining whether anticipated salvage and subrogation has been included as a reduction of unpaid losses and LAE and, if so, whether concerns exist regarding the consideration of estimated salvage and subrogation in establishing unpaid losses and LAE. Salvage is the proceeds received by an insurer from the sale of property on which the insurer has paid a total loss to the insured. For example, when an insurer pays the insured the full value of a wrecked automobile, the insurer takes title to the automobile. The damaged automobile is then sold, and the proceeds represent salvage, which is applied by the insurer to reduce the amount of losses paid. Subrogation is the statutory or legal right of an insurer to recover from a third party who is wholly or partially responsible for a loss paid by the insurer under the terms of a policy. For example, when an insurer has paid the insured for a loss sustained to his or her automobile as a result of a collision, the insurer may collect the amount paid, or portion thereof, through the process of subrogation from the third party responsible for the accident. Subrogation recoverables are treated as a reduction of losses paid. Because of the difficulty in determining an estimate of anticipated salvage and subrogation on unpaid losses, it is generally recognized in the Annual Financial Statement only after it has been reduced to cash or its equivalent. However, if anticipated salvage and subrogation is included as a reduction of loss reserves and LAE reserves as reported in the Annual Financial Statement, whether explicitly or implicitly, the amount of such anticipated salvage and subrogation must be disclosed in Schedule P.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures are intended to identify significant changes in unpaid losses and LAE and in incurred losses and LAE that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement, significant adverse development on the liabilities for unpaid losses and LAE that were established as of prior year-end, and any significant changes pertaining to loss reserve discounting.

Discussion of Level 3 Procedures

The Level 3 Procedures are designed to assist the analyst in further investigating potential problems and concerns that were identified in Level 2 Annual or Quarterly Procedures.

Procedure #1 suggests additional steps the analyst may perform if there are concerns regarding the adequacy of unpaid loss and LAE reserves. The steps to consider include a review, by line of business, of some of the same items reviewed in Level 1 and 2 Procedures, including: one-year and two-year development in incurred losses; defense and cost containment LAE per Schedule P, Part 2 to determine which lines of business are developing adversely; and incurred loss and LAE ratios per Schedule P, Part 1 to determine any unusual fluctuations between years. If incurred loss and LAE reserve development or

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loss ratios appear unusual, they may be compared to industry averages to determine the reasonableness of the insurer's reserve for incurred losses and LAE. If the insurer's mix of business has shifted from property lines of business to liability lines of business, the ratio of estimated current reserve deficiency to surplus, which was reviewed as a part of the Annual Procedures, may be calculated separately for the major lines of business to help evaluate the current adequacy of the unpaid loss and LAE reserves.

Other steps to consider include the review of cumulative paid net losses and LAE by line of business in Schedule P, Part 3 to determine whether there were any unusual fluctuations or aberrations in payment patterns between accident years. The review of Schedule P, Interrogatory #7 is used to determine if there are any other factors that the insurer indicated should be considered in the analysis of the adequacy of unpaid losses and LAE. If there are still concerns regarding the adequacy of unpaid losses and LAE as a result of other supplemental steps performed, the analyst should consider performing a loss reserve analysis on the more volatile long-tail liability lines of business using Examination Jumpstart Tool or other loss reserve analysis software to project loss reserves based on incurred and on paid claims per Schedule P. However, the analyst should be aware that this loss reserve analysis tool merely projects reserves based on historical experience without considering changes in product design, pricing, claims payment practices, etc. If unusual results are obtained as a result of the loss reserve analysis performed, the analyst should consider having an actuary review the analysis performed.

Procedure #2 suggests additional steps the analyst may perform if there are concerns regarding the discounting of unpaid losses and/or LAE. The analyst should consider reviewing the information in the Notes to Financial Statements, #31—Discounting of Liabilities for Unpaid Losses and Unpaid LAE in more detail than was done as a part of the Level 2 Procedures. The analyst should review and compare the interest rates used to discount reserves to the insurer's investment yield and the appropriateness of the matching of the insurer's investment portfolio maturities to the expected payout patterns of the insurer's liabilities to determine the reasonableness of the reserve discount.

Procedure #3 suggests additional steps the analyst may perform if there are concerns regarding the use of anticipated salvage and subrogation as a reduction in unpaid losses and LAE. The analyst should consider reviewing Schedule P, Part 1 to determine which lines of business have reserves that have been reduced due to anticipated salvage and subrogation. For the more significant lines of business, the analyst might compare the ratio of anticipated salvage and subrogation to unpaid losses and LAE to the ratio of salvage and subrogation received to claims paid to help determine the reasonableness of the anticipated salvage and subrogation.

Additional Reference Sources

1. *Accounting Practices and Procedures Manual*, NAIC
2. *Annual Statement Instructions Property/Casualty*, NAIC
3. *Property-Liability Insurance Accounting*, IASA, 1998
4. Fitzgibbon, Walter J. Jr., *Evaluating Loss Reserves for Property/Casualty Insurance Companies*, Aetna Casualty and Surety Company, 1989

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Overview

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. 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 percent, 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 (IRIS ratio #5) and the return on surplus are two measures of overall operating performance that include investment income.

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.

In assessing the financial condition, considerable emphasis is placed on the adequacy of an insurer's surplus (see section B4 of the Analyst Reference Guide for a detailed discussion of RBC). Surplus provides a cushion for policyholders against adverse underwriting results, catastrophe, deficiency in loss reserves, insolvency of reinsurers, and fluctuations in the value of investments. In addition, surplus provides underwriting capacity and allows an insurer to expand its premium writings. The gross and net premiums written to policyholders' surplus ratios 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. Other surplus leverage ratios, which consider loss reserves and reinsurance, are discussed in sections B2—Unpaid Losses and LAE and B6—Reinsurance of the Analyst Reference Guide.

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 capital and 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. 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

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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 Notes to Financial Statements.

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 Notes to Financial Statements 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, the analyst 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.

Discussion of Level 2 Annual Procedures

The purpose of this section is primarily to assist the analyst in reviewing and analyzing the insurer's operating performance with emphasis on the level and change in the insurer's premium writings, underwriting income, investment income, and net income, along with changes in other components of the income statement and in policyholders' surplus. In addition, significant amounts of activity related to capital and surplus notes are identified. Separate sections of the Level 2 Annual Procedures provide specific guidance with respect to RBC, loss reserves, and reinsurance.

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst should also consider the insurer's corporate governance that 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 of directors.

Procedure #1 assists the analyst in determining whether concerns exist regarding the insurer's income statement or operating performance. In evaluating the insurer's operating performance, the analyst should review the combined ratio to measure underwriting profitability in conjunction with the two-year overall operating ratio (IRIS ratio #5). Another measure of the insurer's operating performance is the return on surplus, which considers net income as a percent of surplus. Other steps are designed to assist the analyst

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in identifying unusual trends and fluctuations in the insurer's income statement that could have an impact on operating performance.

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

Procedure #3 assists the analyst in determining whether the insurer is excessively leveraged due to the volume of premiums written. Surplus can be considered as underwriting capacity, and the ratios of gross premiums written to policyholders' surplus and net premiums written to policyholders' surplus measure the extent to which that capacity is being utilized and the adequacy of the insurer's surplus cushion to absorb losses due to pricing errors and adverse underwriting results. A gross premiums written to policyholders' surplus ratio result greater than 900 percent may indicate that the insurer is excessively leveraged, and special attention should be given to the adequacy of the insurer's reinsurance protection and the quality of the reinsurers. A net premiums written to policyolders' surplus ratio result greater than 300 percent may also indicate that the insurer is excessively leveraged and lacks sufficient surplus to finance the business currently being written. In evaluating these ratios, the analyst should also consider the nature of the insurer's business. For example, an insurer that has historically written primarily short-tail property lines of business might not be considered excessively leveraged even though it has higher ratio results, because the risk of significant underpricing or adverse underwriting results is less than that of an insurer that writes primarily volatile long-tail liability lines of business such as medical professional liability.

Procedure #4 assists the analyst in determining if the largest risks written by the insurer are properly reinsured. The concern is that the amount reported as a net risk could be larger if the underlying reinsurance contracts have treaty limits that restrict loss recoveries. If there are limitations, these recoveries may possibly be recouped if there is a reinstatement provision in the agreement that states that, for an additional premium, the insurer can have additional loss recoveries.

Procedure #5 assists the analyst in determining whether concerns exist regarding the amount of the insurer's policyholders' surplus. 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. Leverage ratios pertaining to premiums written (procedure #3 above), loss reserves (section B2 of the Analyst Reference Guide), and reinsurance (section B6 of the Analyst Reference Guide) must also be considered in evaluating the amount of an insurer's surplus. A measure of surplus adequacy that is commonly considered is the ratio of surplus to assets. The gross change in policyholders' surplus (IRIS ratio #7) measures the improvement or deterioration in the insurer's financial condition from the prior year. Even insignificant increases in the change in policyholders' surplus ratio may indicate instability or mask financial problems attributable to fundamental changes in the insurer.

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Another step is designed to assist the analyst in identifying dividend payments or declarations to determine if any necessary approvals were obtained. Other steps in procedure #5 are designed to assist the analyst in identifying significant amounts of capital and surplus notes and write-ins for special and other than special surplus funds. The final step in procedure #5 is designed to assist the analyst in identifying other activity during the year related to capital and surplus notes.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures are designed to identify whether concerns exist regarding the insurer's income statement or operating performance, concerns exist regarding changes in the volume of premiums written or the insurer's mix of business, the insurer is excessively leveraged due to the volume of premiums written, concerns exist regarding the amount of the insurer's policyholders' surplus or changes in surplus notes from the prior quarter, or concerns exist regarding the declaration or payment of dividends.

Discussion of Level 3 Procedures

The Level 3 Procedures are designed to assist the analyst in further investigating potential problems and concerns that are identified in either the Level 2 Annual or Quarterly Procedures—Income Statement and Surplus.

Procedure #1 suggests additional steps the analyst may perform if there are concerns regarding the insurer's income statement or operating performance. The results of the combined ratio could be reviewed for the past five years to identify unusual fluctuations or trends, and the results could be compared to the industry average. Earned premiums and incurred losses by line of business per Schedule P, Part 1 may be reviewed for unusual fluctuations or trends if concerns exist regarding changes in these amounts in total. Loss ratios by line of business, the expense ratio, commission ratios, and investment yield ratios could also be compared to industry averages. If write-ins for underwriting deductions or other income are significant, the analyst should consider reviewing the individual components of these amounts for reasonableness. In addition, the detail of investment income may be reviewed if there are concerns regarding the investment yield to determine if there are significant invested assets that are not producing an adequate return.

Procedure #2 suggests additional steps the analyst may perform if there are concerns regarding the insurer's operating performance as it relates to expenses overall or by line of business. It focuses on the Insurance Expense Exhibit (IEE), a supplemental property/casualty schedule filed by April 1. The IEE includes an interrogatories section and three major parts. Part I—Allocation to Expense Groups shows, for each expense line item included in the Annual Financial Statement, the allocation to five expense groups: (1) loss adjustment expense; (2) acquisition, field supervision, and collection expenses; (3) general expenses; (4) taxes, licenses, and fees; and (5) investment expenses. Part II—Allocation to Lines of Business Net of Reinsurance shows major categories of expenses and the allocation to each line of business. Part III—Allocation to Lines of Direct Business Written is similar to Part II except that premiums are reflected on a direct basis. While the IEE is not a primary source of information for solvency analysis, it does provide meaningful information for evaluating an insurer's operations and overall profitability. In addition, the IEE may be used in the rate-making process or for evaluating an insurer's performance by line of business.

Procedure #3 suggests additional steps the analyst may perform if there are concerns regarding changes in the volume of premiums written or changes in the insurer's mix of business. The analyst should consider reviewing premiums written by line of business to determine which lines increased or decreased significantly and whether any new lines of business are being written. The analyst should also consider

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verifying that the insurer is authorized to write all lines of business being written. If new lines of business are being written or if premiums are being written in new states, the analyst should consider determining whether the insurer has expertise in the new lines of business or new sales territories. This would include expertise in distribution, underwriting, claims, and reserving. There is no information in the Annual Financial Statement to assist the analyst in making this determination. However, there may be helpful information in the insurer's MD&A. Otherwise, information may be requested from the insurer. The analyst should also consider determining if, as a result of changes in the mix of business, the insurer's business is concentrated in specific geographic areas, which could result in the insurer being potentially exposed to catastrophic losses.

Procedure #4 suggests additional steps the analyst may perform if there are concerns relating to the insurer's participation in involuntary pools and assigned risk plans. In general, involuntary pools and assigned risk plans are administered by each state and are facilities established to provide access to insurance coverage for those that are considered high risk and therefore do not meet normal underwriting criteria. One such program is referred to as the Fair Access to Insurance Requirements (FAIR) plan. FAIR plans are state administered plans that underwrite property coverages (normally homeowners) that the standard insurance market avoids because of excessive risk. The plans are funded by assessments made on insurers based on the amount of premium volume written in the state. In addition to FAIR plans, other types of involuntary markets exist for the primary purpose of providing everyone, even the high-risk individuals and businesses, with access to insurance. Many states have also established pools for high-risk automobile coverages. These types of mechanisms either assign the risk to the insurers writing business in the state (i.e., require them to write the business), or assess each insurer a pro-rata portion of the state's cost of operating the plan. While the type of involuntary mechanism may vary widely from state to state in terms of complexity, legal requirements, and financial impact, the overall concern to the analyst in this area is that the financial impact of involuntary pools and assigned risk plans, which is normally negative, is properly recorded on a timely basis on the insurer's financial statements.

Procedure #5 suggests additional steps the analyst may perform if there are concerns regarding whether the insurer may be excessively leveraged due to the volume of premiums written. The analyst should consider reviewing the net premiums written by line to determine which lines of business are being written. An insurer that writes primarily short-tail property lines may be able to write at higher levels of premiums to surplus than an insurer that writes primarily long-tail liability lines, because the risk of underpricing and significant adverse underwriting results is less with the short-tail property lines of business. The analyst should also consider comparing the ratios of gross premiums written to policyholders' surplus and net premiums written to policyholders' surplus to industry averages to help evaluate the insurer's leverage. If the insurer is a member of an affiliated group of insurers, the analyst might want to compute the net and gross premiums written to policyholders' surplus ratios on a consolidated basis to help evaluate whether the affiliated group of insurers is excessively leveraged. If the net and gross premiums written to policyholders' surplus ratios results are high, the analyst should consider determining that the insurer has adequate reinsurance protection against large losses and catastrophes and that the reinsurers are of high quality. Procedures #1 and #3 in Level 3—Reinsurance section can assist the analyst in making this determination.

Procedure #6 suggests additional steps the analyst may perform if there are concerns regarding the amount of the insurer's policyholders' surplus. If there are concerns regarding the adequacy of the insurer's surplus, the analyst should consider reviewing the Level 3 Procedures for RBC. In addition, 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, the analyst should consider reviewing the information in the Notes to Financial Statements, #11 and #13. If either were issued or repaid, or if interest was paid during the year, the analyst should consider determining that these transactions were approved by the domiciliary

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state insurance department. In addition, if surplus notes represent a significant portion of policyholders' surplus, the analyst should consider recalculating important ratios, excluding the surplus notes, to determine their affect on the ratio results. Other steps to consider include the review of the detail of unrealized gains(losses) and the review of other components of surplus.

Additional Reference Sources

1. *Accounting Practices and Procedures Manual*, NAIC
2. *Annual Statement Instructions Property/Casualty*, NAIC
3. *Property-Liability Insurance Accounting*, IASA, 1998
4. *Financial Condition Examiners Handbook*, NAIC

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Overview

Beginning with the 1994 annual reporting year, property/casualty insurers became subject to an Annual Financial Statement requirement that they calculate and report an estimated level of capital that is dependent upon the insurer's risk profile. The basic formula compares reported capital to estimated Risk-Based Capital (RBC), as determined by the formula. An insurer's RBC requirement is calculated by applying 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 adjusted capital (i.e., actual capital) divided by its authorized control level RBC (i.e., required capital). States that enact the RBC for Insurers Model Act 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. The new Model Act supplements the system of absolute minimums and considers the risk profile of each individual insurer.

The RBC formula and Model Act were the result of several years of work by insurance regulators, actuaries, and other industry representatives. The formula is detailed and lengthy, but in concept is quite simple. There are five major categories of risk requirements: (1) Asset Risk—Subsidiary Insurance Companies; (2) Asset Risk—Fixed Income; (3) Asset Risk—Equity; (4) Asset Risk—Credit; and (5) Underwriting Risk—Reserves and Premiums. Each is discussed in more detail below.

1. 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 subsidiary, the capital requirement is the lessor 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 are included in this risk component, as well as non-controlled assets, guarantees for affiliates, contingent liabilities, etc.

2. 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.

3. 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.

4. 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

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balances, such as recoverable from affiliates and from mandatory pools and associations, are exempt.

5. Underwriting Risk—Reserves and Premiums

There are two components to underwriting risk, reserve risk and premium or pricing risk.

Reserve risk attempts to measure the risk of adverse development in excess of expected investment income from loss reserves. Since 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.

The Model Act requires a comparison between total adjusted capital and authorized control level RBC. The Model Act 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:

> 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**

Every insurer, regardless of the level in which it falls, is 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 percent 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 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. The RBC Model Act provides 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

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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.

Discussion of Level 2 Annual Procedures

The Level 2 Annual Procedures are designed to identify potential areas of concern regarding RBC.

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst should also consider the insurer's corporate governance that 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 of directors.

Procedure #1 assists the analyst in understanding the insurer's RBC position. 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 percent 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. The procedure also identifies significant changes in the RBC Ratio components compared to the prior year. The analyst should document the leading underlying causes for changes in the Authorized Control Level and Total Adjusted Capital.

Procedure #2 determines for the analyst whether the insurer failed the RBC Trend Test. An RBC Trend Test failure could potentially place the insurer in Company Action Level.

Procedure #3 directs the analyst to obtain a copy of the insurer's RBC plan if the insurer has triggered an RBC action event. If applicable in your state, the analyst 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 that 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; and (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.

The analyst 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.

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Additional Reference Sources

1. *Annual Statement Instructions Property/Casualty*, NAIC
2. Risk-Based Capital for Insurers Model Act, NAIC
3. *Property/Casualty Risk-Based Capital Report Including Overview and Instructions for Companies*, NAIC

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Overview

Cash Flow is one of several core financial statements presented in the Annual Financial Statement of property/casualty insurers. It provides information about the primary sources of cash (inflow) and applications of cash (outflow). Cash Flow is organized to readily identify the net cash flow from underwriting separately from the net cash flow from investments. Other important sources and applications of cash are also shown, such as dividends to stockholders. The net change in cash and short-term investments, as reflected on Cash Flow, reconciles to the change in the balance sheet accounts of cash and short-term investments for the year.

While Cash Flow provides information about historical sources and applications of cash, the analyst should analyze the liquidity of the balance sheet in order to evaluate the insurer's ability to fund loss reserves and other demands for cash in the future. One common way of accomplishing this is to compare the total adjusted liabilities of the insurer in relation to its liquid assets.

Discussion of Level 2 Annual Procedures

The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. One concern relates to identifying situations where negative cash flow is being generated in the current year or prior year. Another concern focuses on the amount of special deposits not for the benefit of all policyholders. The final concern relates to evaluating the liquidity of the insurer's balance sheet in terms of its ability to fund future liabilities.

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst should also consider the insurer's corporate governance that 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 of directors.

Procedure #1 assists the analyst in identifying situations where the insurer's operations are generating negative cash flow. By analyzing the components of net cash from operations, the analyst will determine whether a fluctuation in cash inflow or cash outflow or both are resulting in a negative value. Material changes in cash inflows may be impacted by shifts in premiums collected as a result of changes in reinsurance, unearned premiums, or agents' balances, or other issues that require additional investigation. Shifts in cash outflows may be impacted by changes in loss reserves or reinsurance recoverable, or the insurer's overall expenses, etc. In conjunction with the review of net cash from operations, it is also important for the analyst to review net cash from investments, or financing and miscellaneous sources to identify any potential impact to cash and short-term investments. Negative cash flow from operations should be evaluated closely for persistent negative trends by reviewing the five-year trend within the Financial Profile Report.

Procedure #2 assists the analyst in determining if the insurer is exposed to greater-than-normal liquidity risk with respect to special deposits. Special deposits are segregated into two sections: (1) for the benefit of all policyholders and (2) all other special deposits. Both categories reflect amounts aggregated by state. Deposits for the benefit of all policyholders are held by individual states. The assets composing these deposits are held on the various investment schedules in the financial statement. However, the assets are not held in custody of the insurer, and restrictions are placed on their disposal. In a situation of a rehabilitating or troubled insurer, these restrictions on assets may cause concerns, particularly those not held for the benefit of all policyholders.

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This procedure also assists the analyst in determining if the domiciliary state may be having difficulty in calling deposits that are deemed "all other special deposits." This procedure specifically applies when the level of deposits that are not for the benefit of all policyholders as a percentage of total assets is high, or in cases when the insurer has been determined to be troubled. The analyst may consider this assessment necessary in either of those cases because, once the insurer has moved into rehabilitation, the cash flow position of the insurer may deteriorate rapidly.

Procedure #3 assists the analyst in evaluating the insurer's overall liquidity. The calculation of liquidity compares the insurer's adjusted liabilities with its liquid assets available to fund such liabilities in the future. Affiliated holdings are removed from liquid assets because these investments are considered less liquid and may not be readily converted to cash for paying claims. The analyst should also consider reviewing the five-year trend of liquidity within the Financial Profile Report and identifying any significant fluctuations and the underlying cause(s).

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures are intended to identify significant changes in cash flow and liquidity that have occurred since the prior year Annual Financial Statement or the prior Quarterly Financial Statement.

Additional Reference Sources

1. *Annual Statement Instructions Property/Casualty*, NAIC

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Overview

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 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 they assume 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.

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: 2008 Data*, which was produced by the Reinsurance Association of America (RAA), the U.S. cedes premiums to approximately 2,613 offshore reinsurers. Total U.S. premiums ceded to offshore insurers in 2008, affiliated and unaffiliated, totaled $58.2 billion, and net recoverables totaled $121.2 billion. In 2008, 55.4 percent of the U.S. ceded premiums went to Bermuda-based reinsurers, 14.7 percent went to Switzerland-based reinsurers, and 6.9 percent went to Germany-based reinsurers. Bermuda-based reinsurers represented 43.6 percent of the net total recoverables, whereas Switzerland represented 18.4 percent, and Germany represented 13.2 percent.

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:

1. **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.

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2. 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.

3. 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.

4. 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 policyholders' 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.

Discussion of Level 2 Annual Procedures

The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. Reinsurance is a complicated and potentially high-risk area for the insurer. While there are many legitimate business uses for reinsurance, it can be used to mask an insurer's financial problems or expose the insurer to significant collectibility or credit risk. Reinsurance abuses have been linked to several major insolvencies in the property/casualty industry.

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst should also consider the insurer's corporate governance that 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 of directors.

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Procedure #1 assists the analyst in determining whether the insurer has a reinsurance program in place that adequately supports its overall risk profile. The objective is to determine whether the insurer is taking on more risk than its level of surplus can reasonably absorb. Insurers that primarily write long-tail liability lines of business (e.g., medical professional liability, other liability, workers' compensation, products liability, etc.) without adequate reinsurance protection may be absorbing a higher-than-prudent level of risk. In addition, insurers with significant concentrations of risks in specific geographic areas may be potentially exposed to catastrophic losses.

Procedure #2 assists the analyst in determining whether significant errors exist relating to the accounting for reinsurance. Generally, the major concern will relate to the manner in which the insurer accounts for credits or reductions in the liability for loss reserves relating to recognition of estimated reinsurance recoverables. The Model Law on Credit for Reinsurance defines the specific circumstances when the insurer can record such a credit or reduction in the liability for loss reserves. In summary, a credit for reinsurance can be recorded when the assuming insurer is authorized, i.e., licensed or approved by the ceding insurers' state of domicile or accredited. When the assuming insurer is unauthorized (i.e., neither licensed or approved by the ceding insurer's state of domicile nor accredited) then a credit for reinsurance may only be recorded when adequate security exists in the form of trust accounts, letters of credit, etc.

A second important accounting issue relates to the provision for reinsurance. Under statutory accounting practices, the insurer must establish a liability by a formula that considers the amount of overdue reinsurance recoverable on paid losses due from authorized insurers and the amount of reinsurance recoverable on paid and unpaid losses due from unauthorized insurers. A final accounting issue may involve the treatment of disputed amounts. Occasionally, a reinsurer will question whether an individual claim is covered under a reinsurance contract or may even attempt to nullify an entire treaty. A ceding insurer, depending on the individual facts, may or may not choose to continue to take credit for such disputed balances. The ceding insurer may not take credit for reinsurance recoverables in dispute with an affiliate.

Procedures #3 and *#4* assist the analyst in determining whether reinsurance recoverables are significant and, if so, whether the amounts are collectible. Under a reinsurance contract, the primary insurer 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. 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. As a result, the collectibility of the recoverables, as well as the overall credit-worthiness of the reinsurers, is a key concern.

The I-SITE application Global Receivership Information Database (GRID) allows the regulator to review the status of a receivership (conservatorship, rehabilitation, or liquidation). GRID provides information including contacts, company demographics, post receivership data, creditor class/claim data, legal data, financial data, and reporting data. Receivables and recoverables due from companies in liquidation proceedings may be partially collected; however, collection will likely be delayed. It is practically certain that balances due at the time a liquidation is closed (the last action date that may be entered in GRID) will never be collected. Evaluating the collectibility of reinsurance recoverables requires understanding of the specific facts and circumstances relating to each reinsurer. However, this evaluation is frequently oriented towards the type of reinsurer from whom the reinsurance was obtained.

Reinsurance is generally obtained from one of two types of insurers:

1. Professional reinsurers—The main business of professional reinsurers is assuming reinsurance from non-affiliated insurers. In general, the large and well-capitalized professional reinsurers will not pose a serious collectibility concern.

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2. Reinsurance departments of primary insurers—Many insurers assume reinsurance from non-affiliates that also write significant business on a direct basis. These types of insurers may pose a larger collectibility concern than professional reinsurers because the insurer may not posess historical reinsurance expertise.

Procedure #5 assists the analyst in identifying whether reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another. 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. 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.

Procedure #6 assists the analyst in determining whether reinsurance is being used for fronting purposes and, if so, whether any potential abuses exist. Fronting is a procedure under which the ceding company (the primary or fronting company) cedes the risk it has underwritten to its reinsurers with the ceding company retaining none or a very small portion of that risk for its own account. Fronting 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 company 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 #7 assists the analyst in determining whether any significant and/or unusual reinsurance intermediary or reinsurance assumed agreements exist. While some major professional reinsurers are direct marketers, intermediaries (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.

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Procedure #8 assists the analyst in identifying 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.

The analyst should be particularly alert to two unusual types of transactions—commutations and loss portfolio transfers (LPT). A commutation 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. Commutations frequently occur because of the perceived financial instability of the reinsurer, inefficiencies associated with the run-off of longer tailed liabilities, significantly different evaluation of ultimate loss costs, or the reinsurer's withdrawal from the reinsurance marketplace. In 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 as its liability and the cash received as a negative paid loss, thus creating a reduction in policyholders' surplus equal to the difference between the ultimate and present value of the loss reserve.

An 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.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures are intended to identify whether amounts recoverable from reinsurers are significant, amounts recoverable from reinsurers are collectible, any significant changes may have been made to the insurer's reinsurance program, or any unusual reinsurance transaction was completed during the quarter.

Discussion of Level 3 Procedures

The procedures included in Level 3 are designed to assist the analyst in further investigating potential problems that were identified in the Level 2 Annual and/or Quarterly Procedures.

Procedure #1 suggests additional steps the analyst may perform if there are concerns that the reinsurer's risk profile is not adequately supported by its reinsurance program. A particularly helpful source of information in this regard is the supporting reinsurance information the insurer prepares for the rating agencies. While this information is not a required filing to the insurance department, the major rating agencies generally require it in connection with the rating process. For example, if the insurer has elected to apply for an A.M. Best rating, a detailed questionnaire on reinsurance must be prepared. This

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questionnaire requires the insurer to describe each major reinsurance contract, disclose the maximum exposure (gross and net) on any single loss, and provide extensive information about exposures to catastrophes. Questions such as these can provide excellent background information to the analyst.

Procedure #2 suggests additional steps the analyst may perform if there are concerns regarding the insurer's accounting treatment of ceded reinsurance. The analyst should consider reviewing the largest reinsurers, as well as a random selection of the remaining reinsurers, to ensure that the reinsurers are classified correctly, security balances appear reasonable, and provisions for unauthorized and overdue authorized reinsurance were calculated properly.

Procedures #3 and *#4* and selected aspects of some of the remaining procedures suggest additional steps the analyst may perform if collectibility concerns exist. The fundamental issue involved with evaluating collectibility is an assessment of the financial stability of the underlying reinsurers and, if applicable, specific retrocessionaires involved throughout the chain of reinsurance. To evaluate the collectibility of reinsurance recoverables, the analyst should consider the need to collect as much financial information as possible about the reinsurers. In addition to reviewing the reinsurer's Analyst Team Validated Level, the analyst should consider various regulatory and governmental filings, rating agency reports, and financial analyses available from industry analysts.

Procedure #5 suggests additional steps the analyst may perform if there are concerns with reinsurance between affiliates that involve shifting of risk from one affiliate to another. It is important to ensure that there is an actual transfer of risk that was consummated. It is also important for any assets that may be transferred to an affiliate to be held at fair value.

Procedure #6 assists the analyst in determining whether pyramiding exists. The chain of reinsurance does not end once a primary insurer cedes business to a reinsurer. Since a reinsurer purchases reinsurance for the same reasons as a primary insurer, the reinsurer may, in turn, retrocede a portion of its assumed reinsurance business to another reinsurer. Each ceding company may rely on many reinsurance agreements with multiple reinsurers participating in each agreement. Therefore, retrocessions further complicate assessing how reinsurance affects an insurer's financial condition. Retrocessions serve to spread the risk of loss on reinsurance throughout the industry, both domestically and worldwide. While shifting the loss exposure among individual insurers, retrocessions do not reduce the overall liability to the primary insurer for policies sold to the policyholder. The primary insurer remains directly liable to the policyholder for the full amount of the policy. However, as each party deducts its commissions and fees from the premiums, the costs of extra layers of retrocessions and intermediaries can reduce funds available to the ultimate assuming company to cover losses. Retrocessions by the apparent reinsurer may transfer risk to parties unknown to the original ceding company. However, it is difficult to track the retrocession chain from the original ceding company to the ultimate reinsurers. The Annual Financial Statement for an insurer identifies its reinsurers and the amounts recoverable on reinsurance. Similarly, reinsurers list their retrocessionaires on the Annual Financial Statement. Reinsurers and retrocessionaires also disclose their ceding companies and the amounts payable on reinsurance. Despite these disclosures in the Annual Financial Statement, a ceding company cannot readily assess the identity or financial condition of each retrocessionaire from its reinsurers' Annual Financial Statement. While a ceding company remains liable for all claims filed by its policyholders before seeking reimbursement from its reinsurers, an insurer's continued solvency may be impaired if the reinsurance chain fails. In addition, the insolvency of retrocessionaires can ripple through the reinsurance chain to affect the original ceding companies.

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Procedure #7 suggests additional steps the analyst may perform to ensure reinsurance is collectible and was not established for fronting purposes. There are a few different Model Acts the analyst may refer to for further clarification.

Procedures #8 and *#9* suggest additional steps the analyst may perform to ensure that funds withheld for payment are valid and appropriately segregated for payment of losses. Also, for unusual reinsurance transactions regarding commutation and portfolio transfer agreements, the analyst may want to seek additional guidance to ensure that agreements actually transfer risk and that they are properly mirrored. It is important to review the contract terms and objectives to make sure everything seems appropriately reported and accounted for.

Additional Reference Sources

1. *Troubled Insurance Company Handbook*, NAIC
2. *Annual Statement Instructions Property/Casualty*, NAIC
3. *Accounting Practices and Procedures Manual*, NAIC
4. Insurance Regulatory Information System Ratio Results, NAIC
5. Credit for Reinsurance Model Law, NAIC
6. *Financial Condition Examiners Handbook*, NAIC
7. Disclosure of Material Transactions Model Act, NAIC
8. Reinsurance Intermediary Model Act, NAIC
9. Managing General Agents Act, NAIC

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Overview

An affiliate is an entity that through one or more intermediaries, directly or indirectly, controls, is controlled by, or is under common control with another entity. Control means the possession, direct or indirect, of the power to direct or cause the direction of management through the ownership of voting securities. 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 percent or more of the voting securities.

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 or sell, 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 policyholders' surplus without any other demonstrable and measurable improvement is not an economic transaction.

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

1. 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 re-marketing agreement or a commitment to operate the property.
2. 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.
3. Repayment of debt that constitutes the principal consideration in the transaction dependent on the generation of sufficient funds from the asset transferred.
4. Limitations or restrictions on the purchaser's use of the asset transferred or on the profits from it.
5. 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.

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When accounting for a specific affiliated transaction, the following valuation methods should be used:

1. Economic-based transfers between affiliates should be recorded at prevailing fair values at the date of the transfer.
2. Non-economic-based transfers between affiliated insurers should be recorded at the lower of existing book/adjusted carrying values or prevailing fair values at the date of the transfer.
3. Non-economic-based transfers 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 transfer. However, to the extent that the transfer results in a gain, that gain should be deferred until such time as permanence can be verified.
4. 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.

Discussion of Level 2 Annual Procedures

The Level 2 Annual Procedures are designed to identify potential areas of concern to the analyst. The challenge to the analyst in this area is to understand, in substance, the various transactions between affiliates and recognize those transactions that are intended to circumvent existing regulations. Many of the procedures may require a prior knowledge of the insurer or a past knowledge of the holding company structure. A review of the insurer's holding company files may assist in this regard.

In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst should also consider the insurer's corporate governance that 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 of directors.

Procedure #1 assists the analyst in understanding the insurer's corporate structure. Significant changes in corporate structure may materially impact the insurer's future financial condition and generally require prior regulatory approval. The analyst should closely analyze changes in corporate structure in order to understand the motivation for the change. By understanding the corporate structure, the analyst may be able to foresee future problems and take appropriate action. For example, a common corporate structure the analyst may encounter involves a holding company whose only significant asset is the stock of the insurer. The holding company may have financed the acquisition of the insurer through bank financing or other debt where the debt service by the holding company is completely dependent upon dividends paid by the insurer. This type of corporate structure warrants close attention by the analyst to ensure that dividends are valid and in compliance with the applicable dividend restrictions, and that any other payments by the insurer to the holding company are legitimate, rather than dividends in disguise. The analyst should also be alert to a corporate structure that includes affiliated brokers or intermediaries that may be recording unusual or significant levels of commissions and fees. When a corporate structure is

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involved that includes multiple tiers of affiliates where significant levels of policyholders' surplus are composed of investments in affiliates, the analyst should focus on the level of policyholders' surplus on a consolidated basis.

Procedure #2 assists the analyst in understanding and evaluating the summary of transactions reported in Schedule Y, Part 2. Several types of affiliated transactions are reported in Schedule Y, Part 2, and explanatory comments are provided in the Notes to Financial Statements, #10—Information Concerning Parent, Subsidiaries, and Affiliates. The analyst should refer to both sources of information in order to develop an understanding of the underlying affiliated transactions.

The following briefly describes the key concerns to the analyst for several of the major affiliated transactions. For shareholder dividends, the major concern relates to whether the level of dividends is within the regulatory guidelines and whether the dividends should be considered extraordinary, and it therefore requires prior regulatory approval. For capital contributions from the insurer to another affiliate, the analyst should determine that such contributions do not substantially impact the financial condition of the insurer. For non-cash capital contributions into the insurer, the analyst should determine that the infusion is recorded at fair value so as to not arbitrarily inflate policyholders' surplus. In the case of purchases, sales or exchanges of loans, securities, real estate, mortgage loans, or other investments, the concern to the analyst is primarily one of valuation. These types of transfers should be at arm's length and recorded at fair value. The analyst should also be alert to possible abuses regarding the transfer of assets between property/casualty and life/health affiliates merely to impact the risk-based capital calculation of the affiliates. For management agreements and service contracts, the main concerns to the analyst relate to the type of service being performed and the reasonableness of the cost. This is a common area for abuse when parent companies desire to withdraw funds from the insurer but do not want to or would not be permitted to classify it as a shareholder dividend. The analyst should understand why the parties were motivated to enter into such contracts and particularly, the benefit to the insurer.

Procedures #3 and *#4* assist the analyst in determining whether investments in affiliates are significant 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 affiliates. It is only through this process that the analyst can detect situations where the investment may be substantially overvalued.

Procedure #5 assists the analyst in evaluating all other affiliated transactions. The analyst's primary objective in this area is to understand the substance of the transactions and to determine whether they are economic-based. The analyst should review the extent of transactions with officers and directors to ensure that the transactions are at arm's length and are not detrimental to the financial condition of the insurer. The analyst should closely monitor other affiliated transactions to ensure that the insurer is not exposed to significant collectibility risk. For example, if the insurer is included in a consolidated federal income tax return and a significant asset for federal income tax recoverable is recorded on the financial statements of the insurer, the analyst should closely review the financial statements of the parent to determine the parent's ability to repay the receivable. Structured settlements acquired from an affiliated life insurance company may also represent a collectibility risk to the insurer. When the amounts of structured settlements are significant, the analyst should review and understand the financial statements of the life insurance affiliate.

Discussion of Level 2 Quarterly Procedures

The Level 2 Quarterly Procedures are intended to identify whether the insurer is a member of a holding company group and, if so, whether the corporate structure or any changes in the corporate structure elevate concerns about affiliated transactions. Additionally, the procedures are intended to identify whether major transactions with affiliates are economic-based and in compliance with regulatory

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guidelines, whether investments in affiliates are significant, whether other affiliated transactions are legitimate and are recorded properly, or any other significant or unusual transactions that may involve an affiliate or other related party.

Discussion of Level 3 Procedures

The Level 3 Procedures are designed to assist the analyst in further investigating potential problems that are identified in the Level 2 Annual and/or Quarterly Procedures.

Procedure #1 suggests additional steps the analyst may perform if the insurer's corporate structure elevates concerns about affiliated transactions. The primary objective is to understand the financial position of the parent company. By understanding the financial commitments of the parent, the analyst will be able to better understand the parent's motivation for entering into transactions with the insurer or other affiliates. Financial statements of affiliates may reveal unauthorized transactions in progress.

Procedures #2 and *#4* suggest additional steps the analyst may perform when there are concerns that transactions with affiliates may not be economic-based or at arm's length. For those services provided by an affiliate where a market already exists, such as data processing, actuarial, or investment management, an effective way for the analyst to determine whether an arm's length transaction exists is to contact one of the vendors and request a proposal or fee estimate for a similar service.

Procedure #3 suggests additional steps the analyst may perform when investments in affiliates are significant and valuation of such investments is a concern. In particular, the analyst should review the level of return on the investment in the affiliate, including the source of the investment income (e.g., cash or merely an increase in the accrual). The analyst should not only be alert to the level of investments in the affiliate but also the level of accrued interest relating to investments in the affiliate.

Additional Reference Sources

1. *Annual Statement Instructions Property/Casualty*, NAIC
2. *Accounting Practices and Procedures Manual*, NAIC
3. Disclosure Requirements for Business Transacted with a Property/Casualty Insurer Act, NAIC
4. Insurance Holding Company System Regulatory Act, NAIC
5. An Act Concerning Insider Trading of Domestic Stock Insurance Company Equity Securities, NAIC
6. Regulation Regarding Proxies, Consents, and Authorizations of Domestic Stock Insurers, NAIC
7. Stockholders Information Supplement (Schedule SIS), NAIC

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Overview

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. (See section B6 of the Analyst Reference Guide for a detailed discussion of reinsurance, including reinsurance intermediaries, fronting, etc.). Insurers are required to have written contracts with MGAs and TPAs that set forth the specific responsibilities of each party. MGAs and TPAs 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 and TPAs, 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 and TPAs between writing quality business and being compensated by commissions based on the volume of business written. When MGAs and TPAs are compensated based on the volume of business written, their incentive is to write as much business as possible, which may compromise underwriting. These types of conflicts have played a significant part in the failure of several insurers. 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 and TPAs, insurers should obtain and review the MGAs' and TPAs' annual independent financial examinations and financial reports. In addition, the Model Acts regarding MGAs and TPAs require insurers to periodically perform on-site reviews of the underwriting and claims processing operations of each MGA and TPA 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.

The Managing General Agents 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 five percent of the insurer's policyholders' surplus in any one quarter or year and either adjusts or pays claims or negotiates reinsurance on behalf of the insurer. However, the 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.

The NAIC Third Party Administrator 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 Statute exempts certain persons from being considered TPAs including, among others, insurers, 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.

Discussion of Level 2 Annual Procedures

The Annual Financial Statement contains information regarding the MGAs and TPAs utilized, the types and amount of direct premiums written by each, and the types of authority granted to each. The Level 2 Annual Procedures are designed to assist the analyst in identifying those insurers that may have problems due to significant reliance on MGAs and TPAs.

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In performing the following procedures, the analyst should review the Supervisory Plan and Insurer Profile Summary for additional information obtained through the risk-focused surveillance approach. Communication and/or coordination with other departments are crucial during the consideration of these procedures. The analyst should also consider the insurer's corporate governance that 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 of directors.

Procedures #1a–b assist the analyst in determining whether a significant amount of the insurer's direct premiums are being written through MGAs and TPAs. While the amount of direct premiums written by MGAs and TPAs is not necessarily an indication of a problem or concern, these procedures alert the analyst of the insurer's exposure to potential abuse by MGAs and TPAs. MGAs and TPAs who had been delegated significant authority without insurer oversight have played a major role in the insolvency of several large insurers.

Discussion of Level 2 Quarterly Procedure

The Level 2 Quarterly Procedure assists in identifying any significant changes regarding the terms of agreements with MGAs or TPAs that have occurred since the prior year Annual Financial Statement and/or the prior Quarterly Financial Statement.

Discussion of Level 3 Procedures

The procedures included in Level 3 are designed to assist the analyst in further investigating potential problems and concerns regarding MGAs and TPAs identified in either Level 2 Annual or Quarterly Procedures.

Procedures #1a–k suggest additional steps the analyst may perform if there are concerns regarding the insurer's use of MGAs and TPAs. The analyst should consider reviewing the information in the Notes to Financial Statements, #19—Direct Premiums Written/Produced by Managing General Agents/Third-Party Administrators, in more detail than was done as a part of the Level 2 Procedures to determine which MGAs and TPAs are being utilized, whether any of the MGAs or TPAs are affiliated with the insurer, the types and amount of direct premiums written by each, and the types of authority granted to each by the insurer. The analyst might compare incurred loss and LAE ratios for those lines of business in which a significant amount of the insurer's direct premiums are written through MGAs and TPAs to industry averages. The analyst might also compare incurred loss and LAE ratios on the business written by MGAs and TPAs to those for the business written directly by the insurer for the same lines of business to determine whether it appears that underwriting standards may have been relaxed by the MGAs and TPAs.

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

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by the insurer are properly licensed and whether the TPAs utilized by the insurer hold valid Certificates of Authority.

The more authority that is delegated to an MGA or TPA, the more important it is for the insurer to provide active ongoing oversight into the MGA's or TPA's operations. To evaluate the insurer's oversight of significant MGAs and TPAs, the analyst should consider requesting from the insurer copies of its contracts with the MGAs and TPAs to determine compliance with the minimum contract provisions per the Managing General Agents Act and the Third Party Administrator Statute and/or the applicable provisions of the Insurance Code. The analyst should also consider requesting from the insurer copies of financial statements for the significant MGAs and TPAs and documentation supporting the insurer's periodic (at least semi-annual) review of the underwriting and claims processing systems. If an MGA establishes loss reserves, the analyst should consider requesting a copy of the Actuarial Opinion attesting to the adequacy of those loss reserves established for losses incurred and outstanding on business produced by the MGA. If there are concerns regarding the business placed with the insurer by an MGA or TPA, the analyst should consider determining if other insurers are utilizing the same MGA or TPA and compare the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether they are similar, i.e., contain the same commission rates. The analyst should also consider comparing the insurer's loss and LAE ratios on the business placed by the MGA or TPA with those of the other insurers utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the insurer may be receiving a disproportionate amount of underperforming business from the MGA or TPA.

Additional Reference Sources

1. *Annual Statement Instructions Property/Casualty*, NAIC
2. *Troubled Insurance Company Handbook*, NAIC
3. Managing General Agents Act, NAIC
4. *Third-Party Administrator Statute*, NAIC

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C. Supplemental

1. Audited Financial Report
2. Statement of Actuarial Opinion & Actuarial Opinion Summary
3. Management's Discussion and Analysis
4. Holding Company Analysis
5. Captives and/or Insurers Filing on a U.S. GAAP Basis

Overview

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 their 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 the analyst regarding the accuracy of the financial information in the Annual Financial Statement.

Per the *Annual Statement Instructions Property/Casualty*, insurers are required to file an audited statutory financial report by June 1 each year, which includes an opinion by an independent certified public accountant or accounting firm (hereinafter referred to as CPA) regarding the financial statements audited. The independent CPA's opinion may be unqualified, unqualified with explanatory language added, qualified, adverse, or there may be a disclaimer of opinion. 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 unqualified opinion, additional explanatory language included in the opinion may flag a potential problem. For example, the CPA might issue an unqualified 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.

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 letter further states that the CPA will agree to make all workpapers 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.

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 capital and surplus 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.

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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 Supplemental Procedures outlined in the Audited Financial Report section of the *Handbook* are designed to assist the analyst in reviewing the Audited Financial Report and identifying significant information and explanatory language regarding the insurer, which has been emphasized by the independent CPA. In addition, the Audited Financial Report Supplemental Procedures includes procedures for the review of the independent CPA's letter of qualifications and, if applicable, the report of significant deficiencies in the insurer's internal control structure.

Procedures Related to the Level 1 Annual Procedures

Generally, the Audited Financial Report will not be available at the time of the Annual Financial Statement review. There is one question within the Level 1 Annual Procedures that is used to identify if any unusual items were noted in the Audited Financial Report, if received. However, an analyst should consider performing a review of information related to the potential filing of an Audited Financial Report that is available within the Annual Financial Statement itself. Any unusual responses at this preliminary stage should be noted within the Level 1 Annual Procedures. The Annual Financial Statement Supplemental Exhibits and Schedules Interrogatories ask whether the insurer will file an Audited Financial Report by June 1, and require an explanation if one will not be filed. Every insurer required to file an Annual Financial Statement is also required to file an Audited Financial Report by an independent CPA as a supplemental filing to the Annual Financial Statement on or before June 1. However, there are two exemptions to this requirement:

1. Insurers having direct premiums written that total less than $1 million nationwide in the calendar year <u>and</u> fewer than 1,000 policyholders or certificate-holders of directly written policies nationwide at the end of the calendar year shall be exempt from this requirement for that year (unless the domiciliary commissioner makes a specific finding that compliance is necessary in order to carry out statutory responsibilities), except that insurers having assumed premiums written pursuant to contracts and/or treaties of reinsurance totaling $1 million or more will not be so exempt.

2. The domiciliary commissioner may grant an exemption from compliance with this requirement upon written application from an insurer if the domiciliary commissioner finds that compliance with this requirement would constitute a financial or organizational hardship for the insurer.

Discussion of Supplemental Procedures

The analysis of the Audited Financial Report is documented in the Supplemental Procedures rather than any level of procedures for the Annual Financial Statement. This is due to its significance, along with the filing due date of June 1 rather than on March 1 with the Annual Financial Statement. The Audited Financial Report Procedures are organized into the following key areas: Audited Financial Report, Internal Controls, CPA's Letter of Qualifications, and Change in CPA.

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Audited Financial Report

Procedure #1 assists the analyst in determining that the financial statements included in the Audited Financial Report have been prepared in conformity with statutory accounting practices prescribed or otherwise permitted by the domiciliary state insurance department. The insurer may not file audited financial statements prepared in conformity with Generally Accepted Accounting Principles (GAAP).

Procedure #2 assists the analyst in determining whether the financial statements included in the Audited Financial Report are those of the insurer on a separate company stand-alone basis. While most insurers are required to file audited financial statements on a separate company stand-alone basis, an insurer may make written application to the domiciliary commissioner to file audited consolidated or combined financial statements if the insurer is a part of a group of insurance companies that utilizes a pooling or 100-percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool.

Procedure #3 should be completed in those instances where audited consolidated or combined financial statements are filed. This procedure assists the analyst in determining whether the domiciliary commissioner approved the insurer's application to file on a consolidated or combined basis due to a pooling or 100-percent reinsurance agreement, and that a consolidating or combining worksheet has been included with the financial statements. This worksheet shows amounts for each insurer separately, includes explanations for consolidating and eliminating entries, and has reconciliation for any differences between the amounts shown for an individual insurer and the amounts per the insurer's Annual Financial Statement. This allows the analyst to reconcile from the audited consolidated or combined financial statements to the Annual Financial Statement filed by the individual insurer being analyzed.

Procedure #4 assists the analyst in determining the type of audit opinion that was issued by the independent CPA. The opinion may be unqualified, unqualified with explanatory language added, qualified, adverse, or there may be a disclaimer of opinion. Following is a discussion of each of these types of audit opinions:

<u>Unqualified Opinion</u>
An unqualified opinion states that the financial statements present fairly, in all material respects, the financial position, results of operations, changes in capital and surplus, and cash flows of the insurer in conformity with the accounting practices prescribed or permitted by the domestic state insurance department. (This is the standard "clean" opinion.)

<u>Unqualified Opinion With Explanatory Language Added</u>
Certain circumstances, while not affecting the independent CPA's unqualified opinion, may require that the independent CPA add an explanatory paragraph or other explanatory wording to the report. This explanatory paragraph may either precede or follow the opinion paragraph in the independent CPA's report. Examples of circumstances that may require the independent CPA to add explanatory language to the report include the following: The financial statements are affected by uncertainties concerning future events, the outcome of which cannot be reasonably estimated as of the date of the independent CPA's report; there is substantial doubt about the insurer's ability to continue as a going concern; there has been a material change in accounting practices or in the method of their application between periods being reported on; or that the independent CPA's opinion is based, in part, on the report of another auditor.

<u>Qualified Opinion</u>
A qualified opinion states that, except for the effects of the matter or matters to which the qualification relates, the financial statements present fairly, in all material respects, the financial position, results of operations, changes in capital and surplus, and cash flows of the insurer in conformity with the

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accounting practices prescribed or permitted by the domestic state insurance department. When the independent CPA issues a qualified opinion, the reasons for the qualification are disclosed in one or more separate explanatory paragraphs preceding the opinion paragraph of the report, and these paragraphs are referenced in the opinion paragraph. Qualified opinions are issued when there is a lack of sufficient competent evidential matter; or there are restrictions on the scope of the audit that have led the independent CPA to conclude that an unqualified opinion cannot be expressed and a conclusion has been made not to disclaim an opinion; or the independent CPA believes that as a result of the audit, the financial statements contain a departure from accounting practices prescribed or permitted by the domestic state insurance department, the effect of which is material, and the independent CPA has concluded not to express an adverse opinion.

Adverse Opinion
An adverse opinion states that the financial statements do not present fairly the financial position, results of operations, changes in capital and surplus, and cash flows of the insurer in conformity with accounting practices prescribed or permitted by the domestic state insurance department. When the independent CPA issues an adverse opinion, the reasons for the adverse opinion and the principal effects of the subject matter of the adverse opinion on the financial position, results of operations, changes in capital and surplus, and cash flows, if practicable, are disclosed in one or more separate explanatory paragraphs preceding the opinion paragraph in the CPA's report, and these paragraphs are referenced in the opinion paragraph. If the effects are not reasonably determinable, this should be indicated in the independent CPA's report. Adverse opinions are issued when, in the independent CPA's judgment, the financial statements are not presented in conformity with accounting practices prescribed or permitted by the domestic state insurance department.

Disclaimer of Opinion
A disclaimer of opinion states that the independent CPA does not express an opinion on the financial statements and is issued when the independent CPA has not performed an audit sufficient in scope to allow the CPA to form an opinion on the financial statements. When the independent CPA issues a disclaimer of opinion because of a scope limitation, the reasons why the audit did not comply with generally accepted auditing standards should be disclosed in one or more separate paragraphs, and the report should state that the scope of the audit was not sufficient to warrant the expression of an opinion on the financial statements.

Procedure #5 should be completed in those instances where the independent CPA's audit opinion is other than the standard, unqualified, clean opinion. The analyst should document the reason(s) for the deviation. The comments should be as detailed as possible based on information in the audit opinion and in the Notes to Financial Statements, and should include the effect of the cause of the deviation, if applicable, on the insurer's financial position.

Procedure #6 assists the analyst in determining that total assets, net income, and policyholders' surplus per the Audited Financial Report agree with the amounts per the insurer's Annual Financial Statement that has previously been analyzed. If differences exist, the independent CPA is required to include in the Notes to Financial Statements a reconciliation of the differences between the Audited Financial Report and the Annual Financial Statement along with a written description of the nature of these differences.

Procedure #7 should be completed in those instances where differences exist between the Audited Financial Report and the Annual Financial Statement. This procedure requires the analyst to document these differences and the reasons for the differences based on a review of the independent CPA's reconciliation in the Notes to Financial Statements. The analyst should also consider the impact of the audit adjustments made by the independent CPA on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis (i.e., complete

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additional procedures for items impacted by the audit adjustments) on the Annual Financial Statement information.

Procedure #8 assists the analyst in reviewing the Notes to Financial Statements included in the Audited Financial Report and noting any items of significance including, but not limited to, investments (i.e., fair value and duration/maturity of bonds and realized and unrealized gains and losses); reserves (i.e., variability of reserves, the impact of any estimated salvage and subrogation, and/or discounting); reinsurance (i.e., reserve credits taken, recoverables, transfer of risk, and collectibility); affiliated transactions (i.e., pooling, administrative agreements and fees, dividends, and transfers); and contingent liabilities (i.e., litigation and assessments). The information included in the Notes to Financial Statements is an integral part of the information included in the Audited Financial Report and should be closely scrutinized by the analyst. The comments included by the analyst in this procedure should focus on all significant items noted and not just those with a negative impact on the insurer's current financial position.

Procedure #9 should be completed in those instances where transactions with affiliates are significant. This procedure suggests that the analyst consider comparing information regarding affiliated relationships and transactions per the Audited Financial Report to information reported by the insurer in the Annual Financial Statement and in the various holding company filings (Form B—Annual Registration Statement, Form C—Summary of Registration Statement, Form D—Prior Notice of a Transaction, Form E—Pre-Acquisition Notification regarding Potential Competitive Impact of a Proposed Merger or Acquisition, and Extraordinary Dividend/Distribution) to verify the information in these other filings and to determine that all appropriate filings were made by the insurer.

Internal Controls

In addition to the Audited Financial Report, insurers are required to furnish the domiciliary state insurance department with a written report by the independent CPA describing significant deficiencies in the insurer's internal control structure as noted by the independent CPA during the audit, if applicable. Such a report is not required if the CPA does not identify significant deficiencies. In those instances where significant deficiencies were noted, the insurer is also required to provide a description of remedial actions taken or proposed to correct the significant deficiencies if such actions are not described in the CPA's report.

Procedure #10 assists the analyst in the review of the Report of Significant Deficiencies, if applicable (the report is only prepared if significant deficiencies are noted by the CPA during the audit), and the improvements made or proposed by the insurer. In addition to commenting on any deficiencies noted, the analyst should also comment on the adequacy of the improvements made or proposed by the insurer to correct the deficiencies.

CPA's Letter of Qualifications

This section of the Audited Financial Report Supplemental Procedures should be completed whenever there has been a change in the independent CPA from the prior year and may be completed annually whether or not there has been a change in independent CPA.

Procedure #11 should be completed in order to determine if the independent CPA must also furnish to the insurer, in connection with and for inclusion in the filing of the Audited Financial Report, a letter of qualifications that includes all of the statements listed in the procedure. The analyst should verify that the independent CPA included all of the statements in his or her letter of qualifications.

Procedure #12 assists the analyst in documenting any deviations or omissions from the required statements in the independent CPA's letter of qualifications. In addition, if the analyst has concerns

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regarding the independent CPA's qualifications, these concerns should also be documented as a part of this procedure.

Change in CPA

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

Procedure #13 assists the analyst in determining whether the independent CPA who issued the opinion on the insurer's financial statements is the same CPA who issued the opinion in the prior year.

Procedure #14 is to be completed in those instances where the CPA who issued the opinion on the insurer's financial statements in the current year is different from the CPA in the prior year. This procedure assists the analyst in determining whether the domiciliary state insurance department was notified of the change and whether the letters from the insurer and the former CPA regarding any disagreements were filed.

Procedure #15 should be completed in those instances where disagreements were noted in the letter from either the insurer or the former CPA. This procedure directs the analyst to comment on the disagreements noted. In commenting on the disagreements noted, the analyst should consider the impact of the disagreements on any other analysis of the insurer performed by the analyst.

Audit Committee

Procedure #16 is intended to verify that the insurer has established an audit committee as required at January 1, 2010. As of this date, every insurer required to file an audited financial report shall also be required to have designated an audit committee. The procedures also ask the analyst to verify that audit committee membership meets state requirements.

Revisions to the Annual Financial Reporting Model Regulation (Model Audit Rule) – Effective January 1, 2010

Amendments to the Annual Financial Reporting Model Regulation, commonly known as the Model Audit Rule, become effective on January 1, 2010. The purpose of this regulation is to improve a state's surveillance of the financial condition of insurers by requiring an independent annual audit of the financial statements by CPAs. The revisions deal primarily with three areas: auditor independence, corporate governance and internal control over financial reporting.

Auditor Independence

Significant revisions to the model related to auditor independence are as follows:

- The lead audit partner may not serve in that capacity for more than five consecutive years and may not rejoin in that capacity for a period for more than five consecutive years. Previously, the requirement was seven and two years, respectively.

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- Includes various non-audit services that, if performed by the auditor, 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 engagement may not serve as a member of the Board of Directors, President, Chief Executive Officer, Controller, Chief Financial Officer or other similar position of the insurer if employed by the independent public accounting firm that audited the insurer during the one-year period that preceded the most current statutory opinion.

Corporate Responsibility/Governance
Significant revisions to the model related to corporate responsibility/governance are as follows:

- Every insurer required to file an audited financial report shall also be required to have an audit committee that is directly responsible for the appointment, oversight and compensation of the auditor. Insurers with less than $500 million in direct and assumed premium may apply for a waiver from this requirement based on hardship.

- Based on various premium thresholds, a certain percentage of the audit committee members must be independent from the insurer. However, if domiciliary law requires board participation by otherwise non-independent members, such law shall prevail and such members may participate in the audit committee.

Internal Control over Financial Reporting
Significant revisions to the model related to internal control over financial reporting are as follows:

- Management of insurance companies with more than $500 million in direct and assumed premium shall file a report with the state insurance department regarding its assessment of internal control over financial reporting. This report will include a statement by management whether these controls are effective to provide reasonable assurance regarding the reliability of the statutory financial statements and disclosure of any unremediated material weaknesses in internal control over financial reporting. At this premium threshold, nearly 90% of all premiums are captured, with only 40% of companies needing to comply with the requirements, a vast majority of which are already SEC registrants. In fact, at this premium threshold, only 6% of non-public companies would have to comply with the proposed internal control reporting requirements. That is only 190 companies out of a population of 3,061.

- No CPA attestation (or opinion) will be required of management's assessment. This CPA attestation can be costly, and the elimination of such emphasizes the regulator's understanding of the need to balance the costs and benefits.

With the exception of Audit Committee requirements as discussed in procedure #16 above, these amendments do not impact 2009 Annual *Financial Analysis Handbook* procedures. However, analysts should be aware that changes to the Annual 2010 *Financial Analysis Handbook* guidance and procedures are anticipated

2010 annual statement instructions will refer to state statutes or regulations that require an annual audit of their insurance companies by an independent CPA based on the NAIC's Annual Financial Reporting Model Regulation. For guidance regarding this model, see the Implementation Guide for the Annual Financial Reporting Model Regulation in Appendix G of the *Accounting Practices and Procedures Manual*.

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Additional Reference Sources

1. *Annual Statement Instructions for Property/Casualty Companies*, NAIC
2. Annual Financial Reporting Model Regulation, *Model Laws, Regulations and Guidelines*, NAIC
3. *Accounting Practices and Procedures Manual*, NAIC

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Overview

A. Actuarial Opinion

The Statement of Actuarial Opinion can be a valuable piece of information in determining whether the insurer requires further regulatory attention.

While the *Annual Statement Instructions* (*Instructions*) as a whole are directed to the insurer, Section 1 identifies the specific responsibilities of the insurer regarding appointment of a qualified actuary, the definition of a qualified actuary, required notification to regulators and exemptions from the requirement. Most of this is straightforward. The Casualty Actuarial and Statisitical (C) Task Force has defined a qualified actuary with consideration of Standards of Practice and a Code of Conduct that bind members of identified professional organizations. With respect to filing exemptions, it should be noted that a commissioner is not obligated to grant an exemption merely due to the presence of one or more conditions. Consideration of an exemption request should include the size and uncertainty in the reserves, both the direct and assumed as well as the net.

Another thing to keep in mind is that the Actuarial Opinion is not independent from the Annual Financial Statement itself. Everything that follows in describing the Opinion should be expected to be consistent with all other elements of the Annual Financial Statement, including but not limited to the General Interrogatories, Notes to Financial Statements, MD&A, and Independent Auditors' Report.

The remainder of the *Instructions* provides guidance to the company and its appointed actuary regarding the information that is expected. Section 2 provides that the Opinion should contain four clearly designated sections: Identification, Scope, Opinion, and Relevant Comments. While illustrative language is provided in the instructions, specific language is not required, provided the information is clearly conveyed.

Section 3 (Identification) is self-explanatory. No appointed actuary should have difficulty providing clarity. The actuary is rendering his or her opinion as an individual, not the firm the actuary represents.

Section 4 (Scope) is similarly self-explanatory. Required reserve amounts upon which the Opinion is based are consolidated into Exhibit A. Required disclosure amounts are consolidated into Exhibit B. The exhibit structure lends itself to easier identification of zero and non-zero amounts and comparison to amounts in the Annual Financial Statement.

Section 4 also calls for the actuary to identify the person upon whom the actuary relied for the data used in the reserve analysis. This reliance is expected to be a single individual with both authority and responsibility for relevant data systems of the company. A company actuary may choose to accept responsibility for the data without reliance on another. Deviation from this requirement should be called to the attention of the insurer, and an amendment should be provided.

Section 5 (Opinion) presents the first opportunity for the regulator to see a need for immediate attention. The illustrative language is not required. The actuary is required to explicitly identify his or her opinion within one of five categories. The illustrative language is based on the most commonly rendered opinion—that the carried reserves make a reasonable provision. Should any other category of opinion be presented, the opinion calls for immediate further attention and determination of the need for follow-up action.

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Section 6 (Relevant Comments) identifies specific areas in which the actuary is required to comment. The purpose of this requirement is to provide the regulator with information that numbers alone cannot convey. The most important relevant comment relates to the Risk of Material Adverse Deviation (RMAD). The actuary must explicitly state whether or not he or she reasonably believes there are significant risks and uncertainties that could result in material adverse deviation. The actuary must identify the materiality standard and the basis for establishing it.

Often the materiality standard chosen will be a percentage of surplus or reserves, but other standards may also be appropriate. The standard chosen helps to quantify the degree of risk the appointed actuary believes to be present in the reserves. The standard may vary based on the solvency position of the insurer. The materiality section of the Preamble to the *Accounting Practices and Procedures Manual* contains excellent guidance regarding the selection of a materiality threshold. Using this guidance, an actuary for two companies with comparable business and comparable reserves could have different RMAD statements. For example, an insurer with an RBC ratio of 205 percent could possibly need only a small change in reserves to put it in Company Action Level, whereas a similar insurer with an RBC of 600 percent may be seen as having little or no RMAD.

The following calculation is suggested for use as a bright line indicator regarding the need for an RMAD statement:

> If 10 percent of the insurer's net loss and loss adjustment expense (LAE) reserves is greater than the difference between the total adjusted capital and Company Action Level capital, the appointed actuary should be asked to explain why they do not feel there is an RMAD.

A similar comparison could be made between 10 percent of the insurer's net reserves and the size of their underwriting or operating income. It should be noted that the RMAD might increase with more volatile exposures such as asbestos and environmental, excess casualty, and other commercial lines.

Collectively the relevant comments should reveal exposures, transactions, historical developments, processes, and uncertainty that contribute to the appointed actuary's opinion. Some of the comments call for judgment on the part of the actuary. The disclosures in Exhibit B are required to ensure that the actuary acknowledges consideration of certain items in reaching his or her opinion.

Section 7 (the Actuarial Report) provides guidance for both the actuary (regarding required content of the report) and for the regulator (regarding what to expect from the report if more information is desired). The NAIC places a high level of trust in a qualified actuary. The presumption is that professional qualifications and adherence to Standards of Practice and a Code of Conduct result in a product that assists the regulator in understanding a balance sheet entry that is management's best estimate, but an estimate that can have considerable uncertainty. That trust is only justified if the actuary can readily provide support for the opinion provided. That support should be available in the Actuarial Report.

Section 8 (Signature) is self-explanatory.

Section 9 (Error Correction) addresses infrequent events that occur at a later date. No action is necessary as part of Opinion review. Should an appointed actuary provide such notification, immediate attention should be given to such information to determine if additional regulatory action is needed.

B. Actuarial Opinion Summary

The Actuarial Opinion Summary (Summary) provides valuable insight to an appointed actuary's conclusion regarding the reasonability of the carried reserves. Nearly all opinions submitted provide a

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qualitative statement that the carried reserves are "reasonable." The Summary provides quantitative information to more clearly show the analyst what the appointed actuary means in reaching that conclusion. With that added information, the analyst can make a judgment regarding the need for further regulatory attention.

As with the Opinion, the *Annual Statement Instructions* are directed to the insurer.

Section 1 of Supplemental Instructions 23-1 (Actuarial Opinion Summary Supplement) identifies the specific responsibilities of the insurer regarding this document. The analyst should first determine if the domiciliary state requires the Summary. If so, review of the Summary should be completed and factored into recommendations for further action regarding the Statement of Actuarial Opinion.

Sections 2 restates regulatory expectations that the Summary is consistent with professional standards that guide a "qualified actuary" as defined in the Opinion Instructions.

Section 3 restates Exemption considerations.

Section 4 addresses confidentiality. As noted above, the analyst should have advanced knowledge of the state's requirements for submission of the Summary.

Section 5 provides guidance to the company and its appointed actuary regarding the specific content that is expected in the Summary. This is the quantitative information that the analyst should focus on in order to develop a recommendation for further regulatory action.

Subsections A, B, C and D in combination call for a comparison that can be presented in a simple table. Regardless of how the information is presented, the intention is to translate for the regulator the qualitative/subjective opinion regarding "reasonableness" into a quantitative/objective financial comparison.

Subsections A and B allow the actuary to make a choice in presenting the comparison, using a point estimate, range or both. In either case, the comparison is always made to the carried loss and loss adjustment expense reserves, on both a net and gross of reinsurance basis. These amounts should agree with the amounts presented in Exhibit A of the Opinion and the Annual Financial Statement. The analyst should note that the amounts provided in the Summary will likely be the combined Loss & Loss Adjustment Expense amounts (Exhibit A Lines 1 & 2 for Net; Lines 3 & 4 for Direct & Assumed). If the amounts do not agree, that may be a first sign of weak controls within the company. Regardless of the source of the error, it is an indication of a lapse in communication between the actuary and the company.

The comparisons will likely result in one of the following situations. Note that the tables in these illustrations show both point and range estimates by the actuary. In most cases the actuary will present one or the other, but not both.

Situation 1: Actuary's Point Estimate or Range Midpoint = Carried Reserves

	Net Loss + LAE Reserves				Direct & Assumed Loss + LAE Reserves		
	Low	Point	High		Low	Point	High
B. Actuary's Estimates	17,000	20,000	23,000		21,500	25,000	28,000
C. Company Recorded Reserves		20,000				25,000	
D. Difference	3,000	0	(3,000)		3,500	0	(3,000)

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This example is the simplest, but not the most common. It can represent a situation in which the company relies completely on the appointed actuary and records his or her estimate. In that case there is no difference between the actuary's estimate and the recorded amount. There may be small variations on this case in which the actuary's estimate is "close to" the Company Recorded Reserves. The question facing the analyst is "How close is close enough?" With the regulatory emphasis on solvency, an initial consideration might be the impact on surplus of management's decision to record an amount different from the actuary's estimate. If the recorded reserves are higher than the actuary's estimate, then surplus is more conservatively stated. Further action is generally not necessary.

Situation 2: Actuary's Point Estimate or Range Midpoint < Carried Reserves

	Net Loss + LAE Reserves				Direct & Assumed Loss + LAE Reserves		
	Low	Point	High		Low	Point	High
B. Actuary's Point Estimates	17,000	20,000	23,000		21,500	25,000	28,000
C. Company Recorded Reserves		21,000				26,500	
D. Difference	4,000	1,000	(2,000)		5,000	1,500	(1,500)

In this case, if a "Reasonable" opinion is issued, the company is recording a reserve amount greater than the actuary's recommended point estimate or is carrying reserves in the high end of the actuary's range. From a solvency perspective, surplus is more conservatively stated, and no further action is necessary.

However, if the actuary's estimate is greater than the recorded reserves, the question of "How close is close enough?" becomes more relevant. This brings one to a more challenging situation.

Situation 3: Actuary's Point Estimate or Range Midpoint > Carried Reserves

	Net Loss + LAE Reserves				Direct & Assumed Loss + LAE Reserves		
	Low	Point	High		Low	Point	High
B. Actuary's Point Estimates	17,000	20,000	23,000		21,500	25,000	28,000
C. Company Recorded Reserves		17,100				22,000	
D. Difference	100	(3,000)	(5,900)		500	(3,000)	(6,000)

When the carried reserves are less than the actuary's point estimate or range midpoint, calculate the difference between the carried reserves and the point estimate or range midpoint. If the actuary has issued a "Reasonable" opinion, the analyst should consider the following factors in making a judgment to accept this difference or to seek more information:

- The difference as a percent of surplus
- The difference as a percent of carried loss + loss adjustment expense reserves
- The company's risk-based capital position

At this point, the analyst might consider an alternate question: "If the company had recorded the actuary's higher estimate and surplus was comparably reduced, would my evaluation of the company's financial condition change to a less favorable one?" If the answer to that question is "yes," then the analyst should consider requesting management's rationale and documentation to support the lower recorded reserve amount(s). In addition, the analyst might require the company to have the actuary provide more detailed information with a range of estimates. This information may be available in the Actuarial Report supporting the opinion.

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Next consider the comments in the Summary regarding the risk of material adverse deviation. If a range is provided, is the material adverse deviation standard less than the difference between the recorded reserves and the high end of the actuary's range? This implies that the actuary's range of reasonable reserve estimates encompasses the amount the actuary considers to be a material adverse deviation. Does the actuary conclude "yes" in Exhibit B that there is significant risk of material adverse deviation and provide extensive discussion of risks and uncertainties? The analyst should document any comments or concerns.

Regardless of the analyst's concerns, it is important to remember that the recorded reserves are the responsibility of management. The appointed actuary may or may not be part of management. In nearly all cases, the initial questions should be directed to company management for rationale and documentation of decisions regarding recorded amounts.

Subsection E addresses what the Casualty Actuarial and Statistical (C) Task Force calls "persistent adverse development." It calls for explicit discussion of the causes or actions that contributed to having a one-year adverse development in excess of 5 percent of surplus as measured by Schedule P, Part 2 in at least three of the past five calendar years. The one-year adverse development ratio can be found in the five-year historical exhibit.

Comment can reflect common questions that regulators have, such as:

- Is the development concentrated in one or two exposure segments, or is it broad across all segments?
- How does the development in the carried reserve compare to the change in the actuary's estimates?
- Is the development related to specific and identifiable situations that are unique to the company?
- Is the development judged to be random fluctuation attributable to loss emergence?
- Does either the development or the reasons for development differ depending on the individual calendar or accident years?

Consider also the following situations:

Situation A. Prior summaries suggest that the company relies on the actuary's indications. If persistent adverse development occurs, one might then infer that the actuary's methods and assumptions have a bias toward underestimation.

Situation B. Prior summaries indicate that the company regularly records amounts lower than the point estimate or low in the actuary's range. If persistent adverse development occurs, one might then infer that management sets the actuary's indications aside and takes a more optimistic view of its liabilities.

Considerations

The Statement of Actuarial Opinion and/or the Actuarial Opinion Summary may contain broad general caveats. These include generalizations about the unpredictability of future jury awards, coverage expansions, etc. They are not to be confused with disclosures about a specific source of uncertainty, such as new lines of business or territories, new claims/underwriting/marketing/systems initiatives, etc. These specific disclosures should be viewed as areas for formal investigation through an examination or informal investigation through correspondence or conversation.

Initial Steps

The Statement of Actuarial Opinion Supplemental Procedures and the Actuarial Opinion Summary Supplemental Procedures provide guidance for a reviewing analyst. The procedures should be

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supplemented with comments and questions as needed. The Opinion and the Summary should both be reviewed and considered together before any action is taken. At the completion of the procedures, the analyst should be able to conclude what, if any, further action is needed.

Consult with the regulatory property/casualty actuary, if available

If the insurance department has a regulatory property/casualty actuary on staff, they may be consulted about any questions or concerns the analyst may have.

Contact the insurer

The analyst may need to contact the insurer for additional information, particularly if the RMAD is large relative to surplus or if the insurer's RBC is likely to fall below the Company Action Level. Some of the items that may need clarification are a concern over reinsurance collectibility, a change in method for determining the carried loss and LAE reserves, or other risk items noted in the Relevant Comments section as having the potential for material adverse deviation. Typically, items of a general nature, such as the risk from a change in the legal or regulatory environment, would not require further investigation.

Collectibility of reinsurance can be a concern when noted in the Relevant Comments section. Contracts with reinsurers who are not financially strong, reinsurance coverage obtained under a program that is no longer offered, or reinsurance coverage on unusual risks the company was writing as a primary insurer could increase the uncertainty regarding reinsurance collectibility. Also, a change in reinsurance contract language, a change in reinsurers, or writing a new program in a new type of business or a new class of business may affect the uncertainty concerning reinsurance collectibility if the insurer does not have a good understanding of the primary coverage written and the reinsurance coverage obtained.

A change in the method for determining the loss and LAE reserves could also be identified in the Relevant Comments section. If an insurer has recently implemented loss reserve discounting or if the discount rate used to determine the reserves has changed, then the impact on the reserve estimate arising from these changes should be ascertained by the examiner or analyst. The impact of any changes in the reserving methodology should be investigated, particularly with regard to its effect on the provision for material adverse deviation and its potential impact on RBC levels.

Any exceptional values for IRIS ratios #11, #12, and #13 should be explained in the Statement of Actuarial Opinion. An explanation that identifies risk elements that are part of the insurer's operations rather than a one-time occurrence would merit further investigation. It is generally not sufficient to explain an IRIS ratio, outside the usual range, by simply stating the insurer has strengthened reserves. Specific detail regarding lines of business, accident years, or changes in operations should be requested if they have not been provided in the explanation for the specific IRIS ratio.

Obtain a copy of the Actuarial Report

If there are particular items identified as significant in the Relevant Comments section or there is significant risk of the insurer falling below the RBC Company Action Level, reviewing the Actuarial Report supporting the Statement of Actuarial Opinion can give the analyst insights about the nature and severity of the risks identified. If one or more portions of the carried reserves are excluded from the Opinion, the Actuarial Report may give the analyst insight as to the relative amount of any excluded items and the reasons why any of the items were excluded from the Opinion.

If the analyst believes the Actuarial Report needs to be requested, perhaps only the narrative component needs review. It should contain the summary exhibits and the appointed actuary's point estimate and/or range. Oftentimes, this section is referred to as the Executive Summary. The technical component will

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likely contain the loss development triangles and factors. Normally, the technical component would be requested for a full-scope examination or limited-scope examination that includes an evaluation of the carried reserves by an actuary.

If the relevant comments or provision for material adverse deviation mention the use of loss portfolio transfers or financial reinsurance as a potential source for subsequent adverse impact, then the analyst needs to understand how these agreements may affect the insurer's financial position. The Actuarial Report may include information about the impact of these contracts under various scenarios or consider the possible range of outcomes under different circumstances.

Any items in the insurer's carried reserves that were identified in the Statement of Actuarial Opinion as not quantifiable require further investigation. The particular reasons or circumstances given can provide guidance on how to proceed. The analyst should consult with the actuary who prepared the report to find out why there was not an opinion rendered on a portion of the reserves.

Consult with the in-house actuary

If the appointed actuary is an employee of the insurer, the analyst should consider contacting that actuary regarding any issues noted in the Opinion or the Summary.

The classes of business for which the insurer has provided coverage can greatly affect the type of liabilities that arise. Pollution liabilities are particularly difficult to estimate and are often determined by models that look at the risk profile of the company's insureds, particularly when insurer loss history has limited predictability. The results from these models can often have a wide range in estimates for loss and LAE reserves. Construction defect claims have a 10-year reporting period in some states, making their liabilities particularly difficult to estimate. Other uncertainties can arise over asbestos or mass tort claims. A request for additional information from a company's in-house actuary should be considered if an RMAD from these types of claims is identified.

Next Steps

Engage an independent actuary to review insurer's reserves

For items that were not quantified in the Statement of Actuarial Opinion or any liability items for which there is significant concern, the analyst may recommend engaging an independent actuary to provide a review of the carried reserves in question. This independent review can also be valuable if there is a significant difference between management's view and the appointed actuary's view concerning a material item identified in the actuarial report.

Meet with the insurer's management

Meeting with the insurer's management is an option for an analyst to recommend when there are items in the Actuarial Report that need clarification or require the insurer to take further action. This could include developing a business plan, setting up interim reporting, developing a corrective action plan, or providing additional information about the underlying factors contributing to the risk in the insurer's financial report. Any concerns with company financial data or reconciling various data sources should be investigated with the insurer's management. Concerns about a company's exposure due to policy coverage terms or lack of available data should be investigated as warranted.

Refer the insurer to the examination section for a target examination

The analyst may recommend a target examination if, after obtaining further information, there is still concern about the financial risk of the insurer. The target examination should determine if the insurer is

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taking proper steps to mitigate the adverse impact arising from the risks identified in the Statement of Actuarial Opinion.

Discussion of Supplemental Procedures

A. Actuarial Opinion

The analysis of the Statement of Actuarial Opinion, although filed with the Annual Financial Statement, is documented separate from the Annual Procedures because of its significance.

GENERAL

Procedures #1 through *#7* assist the analyst in determining whether (1) a Statement of Actuarial Opinion was filed and prepared by a qualified actuary who was appointed by the insurer's board of directors prior to December 31 of the year for which the opinion pertains, or (2) the insurer has an exemption from filing the Statement of Actuarial Opinion that was approved by the domiciliary state insurance department.

SCOPE

Procedures #8 through *#11* assist the analyst in determining whether the Scope paragraph of the Statement of Actuarial Opinion contains verbiage, covers the reserves and premium amounts required to be reviewed (as shown in Exhibit A) according to the *Annual Statement Instructions Property/Casualty*, and whether the reserve amounts included in the Statement of Actuarial Opinion agree with the amounts per the Annual Financial Statement. If the reserve amounts included in the Statement of Actuarial Opinion do not agree with the amounts per the Annual Financial Statement, the analyst should (1) comment on the reasons for the differences, (2) consider the impact of the differences on the conclusions reached as a result of the analysis of the Annual Financial Statement, and (3) consider the need to perform additional analysis on the Annual Financial Statement.

Procedure #12 assists the analyst in determining whether the actuary indicated that the data used in forming his or her opinion on the loss and LAE reserves were reconciled to Schedule P, Part 1 of the insurer's Annual Financial Statement. Schedule P, Part 1 is then required to be tested by the independent CPA as a part of the audit of the insurer. These procedures were designed to prevent the problem of the actuary relying on unaudited data in analyzing the insurer's reserves.

OPINION

Procedures #13 through *#17* assist the analyst in determining whether the Statement of Actuarial Opinion states that the reserves meet the requirements of the insurance laws of the state of domicile, are computed in accordance with accepted loss reserving standards and principles, makes a reasonable provision for all unpaid loss and LAE obligations of the insurer under the terms of its policies and agreements, and whether all portions of the insurer's reserves are covered by the Statement of Actuarial Opinion. If the Actuarial Opinion deviates from these statements or if any portion of the insurer's reserves are excluded from the Statement of Actuarial Opinion (e.g., pools and associations, reserves for asbestos or environmental exposures, etc.), the analyst should (1) comment on the deviations or exclusions, (2) consider their impact on the conclusions reached as a result of the analysis of the Annual Financial Statement, and (3) consider the need to perform additional analysis on the Annual Financial Statement.

RELEVANT COMMENTS AND EXHIBIT B DISCLOSURES

Procedures #18 through *#23* assist the analyst in determining whether the actuary commented on various topics and issues in Exhibit B of the Statement of Actuarial Opinion (including the materiality standard,

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discounting, salvage and subrogation, asbestos and environmental, reinsurance collectibility, etc.) as required by the *Annual Statement Instructions Property/Casualty*. The Statement of Actuarial Opinion should also indicate if the insurer failed the reserving IRIS ratios and discuss any exceptional values. The analyst should summarize any pertinent comments made by the actuary and consider the impact, if any, of the actuary's comments on the conclusions reached as a result of the analysis of the Annual Financial Statement and determine the need to perform additional analysis on the Annual Financial Statement.

CONCLUSIONS/RECOMMENDATIONS

Procedures #24 through *#26* assist the analyst in determining whether the actuary indicated that an Actuarial Report has been prepared that supports the findings expressed in the Statement of Actuarial Opinion and suggest that the analyst consider obtaining a copy of the Actuarial Report. The Actuarial Report is a document that describes the sources of data, material assumptions, methods used, and supports the appointed actuary's opinion. The Actuarial Report generally includes relevant loss and LAE data triangles and discusses significant issues that affected the appointed actuary's interpretation of the data. Examples of significant issues that may be discussed by the appointed actuary include changes in the following: management of the insurer, claims payment philosophy, the claims reporting process, computer systems, contract limits or provisions, and reinsurance. While not required to be filed with the Statement of Actuarial Opinion, the Actuarial Report is required to be retained by the insurer for a period of seven years and available for regulatory examination.

B. Actuarial Opinion Summary

The Actuarial Opinion Summary Supplemental Procedures provide a guide for a reviewing analyst. The procedures should be supplemented with comments and questions as needed.

Procedure #1 verifies the regulatory requirements for filing the Summary and the company's compliance with the requirement.

Procedure #2 verifies consistency between the Summary and the Opinion with respect to the recorded reserves of the company. Inconsistencies indicate weak controls within the company.

Procedure #3 identifies the type of comparison that the actuary presents (recorded reserves to the actuary's point estimate and/or recorded reserves to the actuary's range). The analyst should note concerns regarding recorded amounts that appear significantly low relative to the actuary's estimate(s). See the Analysts Reference Guide for guidance on evaluating the comparison.

Procedure #4 verifies consistency between the appointed actuary's opinion found in the Statement of Actuarial Opinion and the comparison presented in the Summary.

Procedures #5 verifies compliance with the Summary reporting requirement regarding persistent adverse development. The analyst should note concerns regarding the nature of historical adverse development. See the above discussion for guidance on evaluating the comments provided by the actuary.

Additional Reference Sources

1. *Accounting Practices and Procedures Manual*, NAIC
2. *Annual Statement Instructions Property/Casualty*, NAIC

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Overview

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 the analyst 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 the analyst's understanding. However, where trend information is relevant, reference to the 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.

Discussion of Supplemental Procedures

The analysis of the MD&A is documented in the Supplemental Procedures rather than any level of procedures for the Annual Financial Statement, due to its significance, along with the filing due date of April 1 rather than on March 1 with the Annual Financial Statement.

Procedure #1 assists the analyst in evaluating the overall completeness of the MD&A. Specifically, it should address the two-year period covered in the insurer's Annual Financial Statement and discuss any material changes.

Procedure #2 assists the analyst in determining if the insurer was required to prepare the MD&A on a non-consolidated basis, unless the following conditions were met: (1) the insurer is part of a consolidated group of insurers that utilizes a pooling arrangement or a 100-percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves, and the insurer ceded substantially all of its direct and assumed business to the pool (an insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if they have less than $1 million total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement, and the net income of the business not subject to the pooling arrangement represents less than 5 percent of the company's capital and surplus), or (2) the insurer's state of domicile permits audited consolidated financial statements.

Procedure #3 assists the analyst in determining if results of operations have been disclosed. Insurers should describe any unusual or infrequent events or transactions or any significant economic changes that materially affected the amount of reported net income or other gains/losses in surplus and, in each case, indicate the extent to which net income or surplus was affected. In addition, the analyst should describe any other significant components of income in order to understand the insurer's results of operations.

Insurers should describe any known trends or uncertainties that have had or are reasonably probable to have a material favorable or unfavorable impact on premiums, net income, or other gains/losses in

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surplus. If the insurer knows of events that will cause a material change in the relationship between expenses and premium, the change in the relationship shall be disclosed.

To the extent that the Annual Financial Statement discloses material increases in premium, reporting entities should provide a narrative discussion of the extent to which such increases are attributable to increases in prices, increases in the volume or amount of existing products being sold, or the introduction of new products.

Procedure #4 assists the analyst in determining if results of prospective information have been disclosed. Insurers are encouraged to supply forward-looking information. The MD&A may include discussions of known trends or any known demands, commitments, events, or uncertainties that will result in or that are reasonably likely to result in the reporting entity's liquidity improving or deteriorating in any material way. Further, descriptions of known material trends in the insurer's capital resources and expected changes in the mix and cost of such resources should be included. Disclosure of known trends or uncertainties that the insurer reasonably expects will have a material impact on premium, net income, or other gains/losses in surplus is also encouraged.

Procedure #5 assists the analyst in determining if material changes have been disclosed. Insurers are required to provide adequate disclosure of the reasons for material year-to-year changes in line items, or discussion and quantification of the contribution of two or more factors to such material changes. An analysis of changes in line items is required where material, where the changes diverge from modifications in related line items of the Annual Financial Statement, where identification and quantification of the extent of contribution of each of two or more factors is necessary to an understanding of a material change, or where there are material increases or decreases in net premium.

Procedure #6 assists the analyst in determining if liquidity, asset/liability matching, and capital resources have been disclosed. The discussion of liquidity shall include a discussion of the nature and extent of restrictions on the ability of subsidiaries to transfer funds to the reporting entity in the form of cash dividends, loans, or advances, and the impact, if any, such restrictions may have on the ability of the reporting entity to meet its cash obligations. Generally, short-term liquidity and short-term capital resources cover cash needs up to 12 months into the future. These cash needs and the sources of funds to meet such needs relate to the day-to-day operating expenses of the reporting entity and material commitments coming due during that 12-month period.

The discussion of long-term liquidity and long-term capital resources must address material expenditures, significant balloon payments or other payments due on long-term obligations, and other demands or commitments, including any off-balance sheet items, to be incurred beyond the next 12 months, as well as the proposed sources of funding required to satisfy such obligations. Insurers should identify any known trends or any known demands, commitments, events, or uncertainties that will result in or that are reasonably likely to result in the reporting entity's liquidity increasing or decreasing in any material way. If a material decline in liquidity is identified, indicate the course of action that the insurer has taken or proposes to take to remedy the decline. Also, identify and separately describe internal and external sources of liquidity, and briefly discuss any material unused sources of liquid assets. Insurers should describe any known material trends, favorable or unfavorable, in their capital resources, and indicate any expected material changes in the mix and relative cost of such resources. The discussion shall consider changes between equity, debt, and any off-balance sheet financing arrangements. Insurers should present a balanced discussion dealing with cash flows from operations, investing, and financing activities.

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Procedure #7 assists the analyst in determining if loss reserves have been disclosed. The MD&A should include a discussion of those items that affect the insurer's volatility of loss reserves, including a description of those risks that contribute to the volatility.

Procedure #8 assists the analyst in determining if off-balance sheet arrangements have been disclosed. Insurers should consider the need to provide disclosures concerning transactions, arrangements, and other relationships with entities or other persons that are reasonably likely to materially impact liquidity or the availability of or requirements for capital resources. Material sources of liquidity and financing, including off-balance sheet arrangements and transactions with limited purpose entities, should be discussed.

Procedure #9 assists the analyst in determining if participation in high-yield financing, highly leveraged transactions, or non-investment grade loans and investments has been disclosed. In view of these potentially greater returns and potentially greater risks, disclosure of the nature and extent of an insurer's involvement with high yield or highly leveraged transactions and non-investment grade loans and investments may be required, if such participation or involvement has had or is reasonably likely to have a material effect on financial condition or results of operations. For each such participation or involvement or grouping thereof, there shall be identification consistent with the Annual Financial Statement schedules or detail, description of the risks added to the reporting entity, associated fees recognized or deferred, amount (if any) of loss recognized, the insurer's judgment whether there has been material negative effects on the insurer's financial condition, and the insurer's judgment whether there will be a material negative effect on the financial condition in subsequent reporting periods.

Procedure #10 assists the analyst in determining if preliminary merger/acquisition negotiations have been disclosed.

Additional Reference Sources

1. *Annual Statement Instructions Property/Casualty*, NAIC

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Overview

State insurance regulators examine and analyze the financial condition of individual insurers domiciled or licensed in their respective states based on individual state statutes, regulations, policies and procedures, and in accordance with the handbooks and other tools developed and adopted by the NAIC. Consistent with state law and the related regulatory structure, exam and analytical procedures are more focused on the legal entity level rather than on the overall holding company system. Notwithstanding the structural need to focus on the legal entity level, state regulators have for years recognized that individual company analysis may require a more broad understanding of the overall insurance group. Also, as more companies merge and consolidate and insurance reporting becomes more complex, the need to further understand the group organizational structure becomes greater.

The purpose of this section is to provide state insurance regulators with a common set of tools and the related guidance necessary to gain an understanding of the holding company structure and the impact its management, business practices, and financial condition have on its insurance subsidiaries. The information provided will assist in analyzing holding companies and their insurance subsidiaries and supplement the efforts among state regulators to more fully coordinate regulatory activities.

Holding Company Structure

A holding company 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. In the case of a stock company, the holding company may own any percentage of another company's stock as long as it is sufficient to provide the holding company control over the operations of the company. The controlling entity often delegates operational functions to subsidiaries so that it can focus on the management of the overall group. Some holding company structures are established to hold only insurance operations, while others may be more complex and engage in multiple types of businesses.

In order to identify a holding company with insurance subsidiaries, refer to statutory filings submitted to state insurance regulators and/or the NAIC. Some examples of the filings include initial applications for licensure, holding company registration statements (Form B), or organizational charts (Schedule Y). It is important to identify all insurance subsidiaries within a holding company structure, in addition to identifying all states responsible for regulating those subsidiaries.

There can be variations as to how a holding company is classified. The most common types of holding company structures are described below:

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. Transactions that result from the public holding company are approved by the board of directors. Public holding companies may be obligated to pay dividends in order to maintain expectations of their shareholders. Additionally, these companies are subject to reputational risk should they suffer a decline in financial performance.

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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.

Mutual Insurers

Mutual insurance companies are formed and bound by their policyholders. Mutual insurers do not issue stock, and therefore do 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 a holding company system. It may also create a subsidiary to act as a holding company for downstream affiliates.

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, including through the issuance of stock. Such a conversion is subject to the approval of the policyholders and the domiciliary state's commissioner.

Understanding the Holding Company Structure

It is important for the analyst to gain a thorough understanding of the organizational structure in order to properly analyze how each subsidiary in the holding company operates. Organizational structures can vary significantly between 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. Smaller holding company systems may be closely held and maintain only a few subsidiaries. Others may be partially held by different individuals and companies or have indirect ownership relationships.

The most readily available source for gaining an understanding of a holding company structure is through review of the statutory filings submitted by insurers. Insurers are required to submit an organizational chart and details of affiliated transactions in Schedule Y—Information Concerning Activities of Insurer Members of a Holding Company Group, Part 1—Organizational Chart, and Part 2—Summary of Insurer's Transactions With Any Affiliates. Part 1 includes the organizational chart that illustrates the relationships within the holding company group to the ultimate controlling person(s) or entity. Additionally, all insurers are required to report their state of domicile. This schedule provides valuable insight into the ownership structure, insurance holdings, locale, and affiliated relationships within the holding company group.

Under guidance from SSAP 25, Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties, insurers are also required to provide detailed information on related party transactions and relationships in Note 10—Information Concerning Parent, Subsidiaries, and Affiliates. Refer to section VII. Guidance for Notes to Financial Statements of the *Handbook*.

The MD&A and Audited Financial Statement also contain information on the 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, products lines, marketing systems, and actions such as corporate restructuring, acquisitions, and dispositions.

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The Audited Financial Statement provides background, operational information, affiliated transactions, mergers, and subsidiary holdings. 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 the analyst to gain an understanding of how the different entities within the holding company operate together.

Disclosures on non-insurance entities found within the holding company may be limited. For publicly traded companies, the analyst can reference reports filed with the SEC to gain insight on the 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 10-K that may provide valuable background information include:

Business

This section includes a general discussion of the entity's business, financial information, and industry segments. The industry segment section allows the analyst to assess the organization by its major operating business segments.

Directors and Executive Officers

This section helps the analyst 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

The analyst can find discussion on affiliated transactions and business relationships in this section.

Form 10-Q is used to report quarterly financial data and is much more limited in scope than Form 10-K, but 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.

Understanding the Lead State Role

It is important for the analyst to understand the concept of a lead state in order to determine how states coordinate regulatory activities in their review of insurance groups. Typically, the lead state is the state where the parent company is domiciled or, if there is no insurance parent, the state where the largest (as determined by direct premiums written volume reported in the most recently filed Annual Financial Statement) insurance subsidiary is domiciled. The passage of the Gramm-Leach-Bliley Act (GLBA) stresses the importance of a lead state. It also may be necessary for other financial regulators, including the Federal Reserve Bank and other federal and state banking agencies and securities regulators, to identify a central point of contact. State regulators should communicate with federal regulators if the insurance company is affiliated with a bank, thrift or security firm that reports to a federal agency. Communication between state and federal regulators will allow for more effective and efficient regulation on key issues impacting the insurer or financial institution.

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The concept of a lead state is not intended to relinquish the authority of any state, nor is it intended to increase any state's statutory authority or to put any state at a disadvantage. It is intended to facilitate efficiencies when one or more states coordinate the regulatory processes of all states involved.

Other factors that may be considered when determining a lead state:

- State with the largest number of domestic insurance companies in the group
- State with large or largest premium volume or exposure
- Domiciliary state 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
- Expertise in the area of concern and expertise of staff in like situations
- State whose regulatory requirements have driven the design of the organization's infrastructure

The Lead State Summary Report is a valuable resource available on I-SITE, within Summary Reports. The Report provides each state a listing of the insurance groups and their respective lead state(s). The Report also provides up-to-date information on direct and gross premiums written, admitted assets, and last examination date for each company. It can be sorted on a particular NAIC group code to determine the lead state for that group.

The role of the lead state encompasses many responsibilities that may vary depending upon the situation creating the need for regulatory coordination of activities of the regulators involved. However, of utmost importance is maintaining confidentiality of all information, which includes implementing confidentiality arrangements with other states and regulators. The lead state and other interested states also perform a review of the consolidated group, which includes an analysis of the group's financial results and overall business strategy.

The operations of an insurance company often are not limited to one state. In some cases, when multiple states are involved in monitoring the activities or approving the transactions of a company or group of companies, multiple states may coordinate regulatory efforts. These coordinated efforts have increased over the last few years as the insurance industry has consolidated and as insurance holding companies with insurers domiciled in more than one state have increased.

These coordinated activities may include:

- The establishment of procedures to communicate information regarding troubled insurers with other state insurance departments
- The participation on joint examinations of insurers
- Consensus assignment of specific regulatory tasks to different state insurance departments in order to achieve efficiency and effectiveness in regulatory efforts and to share personnel resources and expertise
- The establishment of a task force consisting of personnel from various state insurance departments to carry out coordinated activities

These types of coordinated efforts may be effective for both regulators and the insurance companies involved.

Once the lead state or states are determined, there are a number of responsibilities that the state must assume in order for the oversight process to function effectively and efficiently. These responsibilities may include designating a lead person involved in the specific transaction or monitoring. If necessary, the lead state should contact other identified states to establish points of contact and to determine the amount of

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interest in participating in the multi-state coordination. The lead state should then establish lines of communication and serve as regulatory contact with top management of the organization.

Procedures should be established as to how information will be shared with other states and regulators. This step is critical in establishing the lead state as a coordinator by supplying states and other regulators with pertinent information. If necessary, verbal or written briefings that are arranged by the lead state in conjunction with company management have been the most effective.

Early in the oversight process, the lead state should collect information on the status of company filings, analysis, examinations, and other activity from each of the other states.

The lead state should also obtain information on the group as a whole. In order to gain this understanding, the lead state should focus on the holding company and subsequently on the underlying affiliated relationships. This information will be helpful in preparing for discussions with insurance company and holding company management.

Data Collection

There are a number of sources of information available to assist the analyst in analyzing holding companies. The most useful sources include the insurance company statutory financial statements, consolidated statutory financial statements for property/casualty insurers, GAAP financial statements filed with the SEC, MD&A, audited statutory financial report, and the holding company's annual shareholder's report. However, other external sources of information exist, including rating reports and analysis from an Acceptable Rating Organization, press releases from the holding company, and news and other analytical profiles from various financial and news organizations.

Sources of Information

The Annual Financial Statements contain statutory information on the financial condition of the insurance company. Schedule Y, the General Interrogatories, and Notes to Financial Statements provide holding company information, such as the holding company structure, the ultimate controlling person(s), affiliated relationships, investments, and other transactions.

Combined statutory financial statements are required for property/casualty insurers only. These statements have been adjusted for intercompany transactions and affiliated investments.

Form 10-K, 10-Q, 8-K, and other SEC filings can be accessed via the SEC Website. Form 10-K provides annual consolidated financial information on a GAAP basis, whereas Form 10-Q provides quarterly consolidated financial information, and Form 8-K is required when interim material transactions or events occur. (Please refer to section I3.—External Information of the *Handbook* for more discussion on the information available in these SEC filings.) The report of the independent public accountant should include not only a report on the audited financial statements but also a report on the assessment of internal controls and management's assessment of internal controls. Also included should be a statement of management's responsibility for establishing and maintaining adequate internal control over financial reporting for the company, a statement identifying the framework used by management to evaluate the effectiveness of this internal control, management's assessment of the effectiveness of this internal control as of the end of the insurer's most recent fiscal year, and a statement that its auditor has issued an attestation report on management's assessment.

The MD&A is a supplement to the Annual Financial Statement. The MD&A is a narrative that provides information to regulators to enhance their understanding of the insurer's financial position, results of

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operations, changes in capital and surplus, and cash flows. The report often explains transactions or events that have occurred during the year that impact the financial condition of the insurer. It may also contain information about affiliated relationships or changes in those relationships.

Audited Statutory Financial Reports are a required supplement to the Annual Financial Statements. All insurers are required to have an annual audit by an independent certified public accountant. This report contains the auditor's opinion, financial position, summary of operations, cash flows, and notes to the financial statements for the insurer.

Shareholder's reports are generally available on a holding company's Web site. The scope of the shareholder's report may vary between companies but is generally reported on a consolidated GAAP basis and may contain segment information. A holding company'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 Web site can be obtained from the Jurat page of the insurer's Annual Financial Statement. Links to company Web sites can also be obtained from the rating agency Web sites, as well as other financial Web sites or through tools such as Bloomberg Financial.

Acceptable Rating Organizations, each with their own unique methodology for assigning ratings, often provides 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, Moody's Investor Services, Standard and Poor's, and Weiss Research.

NAIC Database and I-SITE provides information primarily on the insurance companies, rather than the group, with the exception of property and casualty consolidated statutory financial statements. However, other information or resources on I-SITE may be helpful when reviewing collectively the insurance companies within a group. In addition to the financial statement and financial analysis solvency tools, other reports exist such as summary reports, the Lead State Report, and market analysis information. Line reports may be useful in collecting selected lines of data from the financial statements for all insurers within a group.

The Internet offers a variety of Web sites that contain information on the financial background of publicly traded companies. Some financial Web sites 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 include prior analysis performed on the group, 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.

International Data Sources

When a holding company is domiciled in a foreign country, it is necessary to determine the supervisory authority in that country and the filing requirements for the holding company. 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 Web site 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 Web site.

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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 Web sites.

Holding Company Analysis

The following process can be followed in analyzing a holding company system or insurance group:

Scope

Review the holding company structure and flowchart in order to determine how much detail is relevant in the group analysis. Obtain a thorough understanding of the insurance company and the relationships and interdependencies with its affiliates. Utilize statutory filings, specifically Schedule Y. Determine the scope of the review by selecting the companies and/or entities based on the material segments within the group.

A thorough review of a holding company's 10-K or other filings assists the analyst in understanding the factors and/or segments that are driving adverse results in the organization. The analyst should concentrate on identifying the legal entities within the holding company structure that have significantly contributed to the adverse results of the organization.

Rating Agencies

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 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 that 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, who may already be coping with various financial issues such as high debt servicing requirements.

Consolidated GAAP Financial Information

Review the holding company's 10-K filing for consolidated GAAP financial information, including total assets, liabilities, debt, stockholder's equity, revenues, expenses, net income, and net cash provided by operations, if applicable. If a 10-K filing is unavailable, research Internet sources or directly contact the group's management. Compare current-year results with prior-year results, noting any positive or negative trends.

Stock Price Evaluation

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. The analyst should strive to determine the factors impacting 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.

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History of the Holding Company and Insurer

Utilize the financial filings and the Internet to determine the group's organizational history and corporate structure. Include relevant information regarding mergers and/or acquisitions, and consider potential effects on the stability of the group. The analyst should become familiar with geographic diversification, dates of organization, and relevant changes made to the holding company structure.

Plan of Operation

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 if 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 that 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.
- *Management's Philosophy*—Gain an understanding of the group's culture, management's expertise, and management's future vision of the group.

Reinsurance

Determine whether the reinsurance programs in place appear to 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 collectibility. 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.

Recent News

Research recent news relevant to the group. 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 lay-offs, losses of key personnel, and issues with customers or providers.

For the following analysis sections, consider both the financial review of insurance and non-insurance entities within the group. In certain cases, the review of non-insurance entities may be mitigated by the lack of interdependence of the entities.

Assets

Review 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

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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.

Analyze 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 recoverables and receivables and miscellaneous balances. Also, assess the risk related to any miscellaneous assets such as goodwill or other intangible assets.

Liabilities

Review the liabilities of the group, noting any significant increases or decreases from the prior reporting period. Assess reserves and reserve development to determine the trending and historical accuracy. Determine if debt exists at the holding company level that may be 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.

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 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. The analyst should take note of the trend over past reporting periods and the factors that have significantly influenced an increase or decline.

Profitability

The profitability of a holding company is measured by its ability to generate earnings and is 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 earnings drain on the holding company. These operations should be investigated thoroughly to identify the types of operations involved, expected durations, and their impact on holding company earnings.

Operations

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 the analyst 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.

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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)—Identifies business produced by MGAs or TPAs. For additional information regarding MGAs and TPAs, the analyst should refer to Part III. Analyst Reference Guide—Section B8.—MGAs and TPAs of the *Handbook*.

The analyst 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, the analyst may wish to obtain a greater understanding of the causes.

Cash Flow and Liquidity

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.

The analyst should assess the level of liquid assets to current liabilities to determine the proper matching of assets to claims obligations. The analyst should also assess the material risk associated with low quality assets and understated reserves.

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. The analyst may find that the investor's page of publicly held international holding companies' Web sites 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 Economic Community organizations, accounting treatment and reporting is somewhat consistent and is improving due to the efforts of many groups working with the International Accounting Standards Board. However, for many organizations domiciled in offshore countries, such as Ireland, those located in the Caribbean, and others, no regulation regarding public financial reporting exists.

The analyst 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. The analyst 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 than similar transactions between two domestic entities.

Foreign holding companies invest in their U.S. subsidiaries to nurture profitable operations, to compliment existing operations, or to add to existing capacity. As opposed to their U.S. counterparts, foreign holding companies may not be under the same obligation to ensure the continued viability of their U.S. enterprises.

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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.

The analyst should be aware of a holding company's stated commitment to ensure the continued stability of U.S. operations. This commitment may include written or verbal parental guarantee.

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 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

Discussion of Supplemental Procedures

The analysis of the holding company is documented in the Supplemental Procedures rather than any level of procedures for the Annual Financial Statement. This is due to its significance along with the difference in the timing of holding company financial data.
The procedures may be completed in part or in total at the discretion of the analyst, depending on the level of concern, the area in which the risk was identified, and the degree of interdependence within the holding company entities.

Procedures #1 through *#15* assist the analyst in identifying and understanding the type of holding company system in which the group operates. Various documents are available as a resource in helping to understand the historical formation of the group and its business purpose.

Procedures #16 through *#19* assist the analyst in determining the lead state and establishing lines of communication between states. Refer to the Framework for Insurance Holding Company Analysis following this chapter.

Procedures #20 through *#43* guide the analyst through procedures for reviewing the primary sections of a holding company's financial statements. The primary sections include assets, liabilities, equity, profitablilty, writings, and cash flow.

Procedures #44 through *#46* offer procedures to identify the foreign supervisory authority, establish communication, and convert foreign currency.

Procedure #47 and the *Supplemental Form Procedures* assist the analyst in reviewing Forms A, B, D, E (or other required information) and Extraordinary Dividend/Distributions.

Forms A, B, D, E and Extraordinary Dividend/Distribution

Form A, B, 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 these Forms.

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

The NAIC *Insurance Holding Company System Regulatory Act* (the Holding Company Act) outlines specific filing requirements for persons 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

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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 of 1999 (GLBA) is limited to 60 days prior to the effective date of the transaction. Under section 104(c)(2) of the GLBA, 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

The Holding Company Act is the model that defines insurance holding companies and the related registration, disclosure, and approval requirements. Form B is the insurance holding company system annual registration statement. The Holding Company Act requires every insurer that 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 a member of a holding company system and authorized to do business in the state, and 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 persons, one or more of which is an insurer. An affiliate is an entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another entity. Control is presumed to exist when an entity or person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities.

Form D—Prior Notice of a Transaction

The Holding Company Act 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 percent of the insurer's admitted assets or 25 percent of policyholder's surplus; and for life insurers, 3 percent of the insurer's admitted assets, each as of the most recent prior December 31st. Some states have stricter definitions of materiality in their holding company regulations.

Holding company regulations require that affiliated transactions be fair and reasonable to the interests of the insurer. Generally, affiliated management or service agreements should be based on actual cost in order to meet the fair and reasonable standard.

The appropriate statement of statutory accounting principle should be reviewed within the *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

The Holding Company Act indicates that any domestic insurer, together with any person controlling a domestic insurer, or proposing a merger or acquisition, file a Form E or other required information pre-acquisition notification form. Any differences between the Holding Company Act and the applicable state regulations should be considered. The insurer may also be required to file documents with the Federal Trade Commission under the Hart-Scott-Rodino Act.

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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 Section 104(c)(2) of the GLBA, 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

The Holding Company Act 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 may be 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, the Holding Company Act 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:

- Ten percent of the insurer's surplus as regards to policyholders as of December 31st 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 12 months ending December 31st of the prior year. This should not include pro-rata distributions of any class of the insurer's own securities.

Discussion of Supplemental Procedures

The analysis of Forms A, B, D, E (or Other Required Information), and Extraordinary Dividend/Distribution are documented in the separate Holding Company Supplemental Procedures due to the significance of the filings and the timing of these filings.

Form A

Procedures #1–19 assist the analyst in reviewing the Form A filing for completeness. They guide the analyst through each of the major items of information required by Form A.

Procedures #20–32 assist the analyst in assessing the impact of the acquisition or merger on the domestic insurer and policyholders.

Form B

Procedure #1 assists the analyst in reviewing Form B for completeness. It guides the analyst through each of the major items of information required by Form B.

Procedure #2 assists the analyst in determining whether dividends to shareholders were proper and in accordance with regulatory guidelines. The analyst should be particularly alert to extraordinary dividends, which require prior regulatory notification.

Procedures #3–6 assist the analyst in reviewing other types of transactions involving the insurer and other entities in its holding company system. It guides the analyst through each type of transaction that requires prior regulatory notification. The analyst should identify disclosures about the holding company that may

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potentially affect the insurer. The analyst should focus specifically on shareholders that may also have a relationship with the insurer, and on litigation or administrative proceedings involving the holding company that may affect the insurer, such as bankruptcy, receivership, or other corporate reorganizations. The analyst 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. The analyst 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.

Form D

Procedures #1–15 assist the analyst in reviewing the Form D filing for completeness and help guide the analyst through major items of information required by Form D.

Form E (or Other Required Information)

Procedures #1 and *#2* provide the analyst with names and addresses of all of the parties involved with the proposed merger or acquisition.

Procedures #3–6 assist the analyst in gaining a clear understanding of the rationale and goals of the proposed merger or acquisition.

Extraordinary Dividend/Distribution

Procedures #1–6 assist the analyst in ensuring that any extraordinary dividend or distribution was approved by all of the appropriate channels, was fair and reasonable, and did not result in inadequate surplus for the insurer.

Additional Reference Sources

1. *Insurance Holding Company System Regulatory Act*, NAIC
2. *Framework for Insurance Holding Company Analysis*, NAIC
3. *Accounting Practices and Procedures Manual,* NAIC

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Overview

The purpose of a captive insurer is to provide insurance for a specific sector or group of individuals that may be experiencing a need for insurance from a potentially more cost effective captive organization rather than to the traditional market. A captive insurance company is owned and operated by its insureds similar to a mutual insurer. Although there are five types of captives the most notable are the single parent captive, or pure captive, and the group captive. The pure captive is typically owned and operated by a single company which is usually its parent and provides insurance to that parent and affiliated entities. The group captive is typically owned and operated by two or more entities to which the group captive provides insurance. The other three types of captives include the rent-a-captive where a sponsor owns the company and manages it, protected cell companies which provide complete separation of each cell's assets, and an agency captive which is owned by groups of intermediaries or brokers.

Most captive insurers file their financial statement on a modified United States Generally Accepted Accounting Principles (GAAP) basis. The NAIC Annual Statement Blank and Instructions and corresponding Financial Solvency Tools have not been adjusted for insurers that prepare their financial statements on a basis other than NAIC Statutory Accounting Principles (SAP). There are several differences between SAP and GAAP, including differences in presentation. Although GAAP requires items to be presented in a certain manner on the face of the financial statements, the exhibits and schedules are designed to present specific data elements from the reporting entity. For example, Schedule P, Part 1 as well as different parts of the Underwriting and Investment Exhibit require information regarding direct, assumed and ceded reserves. All of this information should be completed in the exhibits in order to maximize the information available to the analyst to assist in understanding the reporting entity's business. Consequently, identification of information to the regulator should take precedence over any crosschecks that may fail as a result of the completion of such information. Similarly, when the schedule allows the reporting entity to disclose the most applicable information to the regulator (e.g., reporting "trading" and "available for sale" bonds at fair value in Schedule D), it should be so reported.

Similar variances may also be noted for other GAAP filing insurers that are not captives, such as risk retention groups organized as traditional insurers, as well as mutual, reciprocal, Lloyds, and stock insurers as identified in General Interrogatories, Part 1, #17.

Discussion of Supplemental Procedures

Management Assessment

Procedure #1 refers to the Level 1 Analyst Reference Guide regarding the business plan review.

Procedure #2 addresses two facets that relate to the need to assess the degree to which the insurer relies on a management company, TPA, or MGA, and the amount of expense incurred by the insurer to maintain those agreements. The first consideration is to determine whether the agreement is affiliated and whether it was established in an arms-length transaction. Through this review, the analyst should determine that the fees related to the services provided are reasonable and consistent with industry. Assess the impact of the costs by closely reviewing and tracking changes in the insurer's expense ratio. Excessive cost will be reflected in a high expense ratio. Increased contracted expenses from year to year should be justified by an increase in workload related to the services provided in the contracts, such as a significant rise in writings. In addition, to effectively assess the services, it's critical to evaluate the history of the contracted companies. For example, it is important to know the number of years the contractors have been in business, the level of expertise of the employees, and the amount of staff turnover. It is critical to evaluate any contracted companies and their expertise. It's also important to assess the level of communication between the insurer and the contractor.

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Balance Sheet Assessment

Procedure #3 directs the analyst to focus on key considerations during the review of the balance sheet. For example, during the review of the RBC ratio, the analyst might consider whether RBC is required by the state and the degree to which the insurer is capitalized via a letter of credit (LOC) allowed under the modified GAAP method. Although the LOC is allowed, the analyst should continue to monitor changes in the value, language, or issuing bank. The issuing bank should be part of the Federal Reserve System and the LOC should be approved by the Commissioner.

Some additional considerations when reviewing an LOC:

- The terms irrevocable and evergreen (automatically extended) are used within the LOC.
- If the bank elects not to extend, will the commissioner/director be notified in writing prior to the expiration date?
- Determine that the captive has no obligation to reimburse the bank, and the bank has no right of set off against any funds held by the bank for the captive in the event the LOC is drawn down, in whole or in part.
- Determine that the bank waives any common law, statutory or contractual right of reimbursement or set off against the captive that may arise in the event the LOC is drawn down, in whole or in part.
- Determine that the LOC terms are set forth and shall not in any way be modified, amended or amplified by reference to any note, document, instrument, statute, regulation or agreement.

Regarding the assessment of capital sufficiency, see NAIC staff for possible resources or techniques to assist in this evaluation.

For review of the liquidity calculation it's important to note that GAAP, FAS 113 allows the insurer to report reinsurance recoverables for unpaid claims as an asset rather than a contra liability. Therefore the liquidity calculation may not provide a meaningful result because a typical SAP filer would include these balances as a liability. The analyst should examine the reinsurance recoverables balance to determine those amounts that relate to paid claims in order to appropriately understand the aging and any overdue amounts.

GAAP allows the insurer to discount its loss reserves under certain circumstances. The analyst should determine if unpaid losses and/or LAE have been discounted as disclosed in Notes to Financial Statements, Note #1, *Summary of Significant Accounting Policies.* The analyst should research the method and its reasonableness used to determine the discount.

GAAP allows the insurer to consolidate subsidiaries versus using the equity method to value the investment in subsidiary as SAP requires. The analyst needs to consider this impact to the financial results. One consideration may be to request the insurer to provide a footnote reconciliation in the audited financial report in order to isolate the results of the insurer to the NAIC blank.

GAAP allows the insurer to defer acquisition costs (DAC) when writing new policies through the establishment of DAC on the balance sheet. This allows the insurer to spread the cost over time by reclassifying the asset as an expense when premiums are earned, enabling the matching of expenses associated with acquiring policies to premiums earned. The analyst should be aware of impacts on financial results, as statutory accounting requires the insurer to recognize all acquisition costs at the onset of the policy.

The analyst should consider a sensitivity test to supplement the total adjusted capital component of the RBC calculation (Exhibit 1 following Supplemental Procedures). The purpose of this test is to highlight

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the impact that LOCs, GAAP/SAP investment differences, and/or DACs could have on total adjusted capital, which, as the preceding paragraphs indicate, could be significant.

Operations Assessment

Procedure #4 assists the analyst in understanding the impact of fair value reporting for trading securities (securities that are bought and held principally for the purpose of selling them in the near term) and their respective change, typically reported as either an aggregate write-in or investment income/realized gain or losses. Also, the analyst should consider the impact of loss reserve discounting on net income and ultimately on policyholders' surplus. This discount is typically reported through losses incurred, however, it may be reported as an aggregate write-in. The analyst might consider reviewing a five-year trend of discounting to determine the significance and any upward trending.

Investment Practices

Procedure #5 guides the analyst to review the impact of fair value reporting of securities available for sale and any resulting impact to policyholders' surplus for changes in fair value. Close attention to fair value reporting is particularly necessary during volatile market conditions as the shift in fair value may have a material impact on policyholders' surplus.

Review of Disclosures

Procedure #6 directs the analyst to review Notes to Financial Statements, Note #1, *Summary of Significant Accounting Policies.* This note should be reviewed carefully to grasp a firm understanding of how the insurer's financial filing deviates from SAP. The disclosure should include a detailed description of the practice along with any necessary supporting tables that illustrate the deviation from SAP. Also, the disclosure should illustrate any monetary reconciliation between prescribed and permitted practice regarding net income or policyholders' surplus.

Procedure #7 refers to the Level 1 Analyst Reference Guide regarding the General Interrogatories. Specific attention should be given to General Interrogatories, Part 2, #13, the largest net aggregate risk written. This exposure should be measured as a percent of surplus to ensure that it is in compliance with state guidelines. If all or a portion of the risk is reinsured, the analyst should review all reinsurance contracts. Specifically, the analyst should ensure that limits of recovery would not increase the net risk reported in the General Interrogatories.

Assessment of Results from Prioritization and Analytical Tools

Procedure #8 alerts the analyst that the insurer is reporting on a GAAP or modified GAAP basis and that many of the ratios may not be applicable or may report results that are outside of the normal range. Careful attention should be given to the ratios individual components and the variation of the accounting used from SAP. For example, under a modified GAAP basis the insurer may be allowed to report its loss reserves on a gross basis which would alter the leverage ratio for loss and LAE reserves to policyholders' surplus and the typical range for assessing the result. It is necessary to review the ratios in conjunction with the disclosure provided in Notes to Financial Statements, Note #1, *Summary of Significant Accounting Policies.* Some additional examples of ratios that may not provide meaningful results, as typically seen with SAP reporting, include, but are not limited to, the liquidity ratio, the combined ratio and its respective components, and other ratios that utilize policyholders' surplus as a denominator. It may be necessary for the analyst to recalculate some ratios.

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RBC Sensitivity Test Exhibit
Exhibit Lines 18-21

This sensitivity test is meant to estimate any potential impact on total adjusted capital if the financial statements had been completed on a statutory accounting basis. The RBC Sensitivity Test provides a "what if" scenario eliminating certain amounts from the calculation of total adjusted capital. The sensitivity test has no effect on the risk-based capital amounts reported in the annual statement and is purely for analytical purposes.

Additional Reference Sources

1. *Accounting Practices and Procedures Manual*, NAIC
2. *Annual Statement Instructions Property/Casualty*, NAIC
3. TRACS: The Road to Successful Captive Management, Towers Perrin
4. Web site: www.captive.com
5. Web site: www.vermontcaptive.com

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IV. Annual Procedures

A. Level 1

Background Analysis

1. Review the analysis performed on the insurer for the prior year and prior quarters.

    a. Indicate the state's priority designation or any prioritization tool result as of the last review and start of the current review:

    State's Priority Designation _____
    Scoring System Result _____
    IRIS Ratio Result _____
    Analyst Team System Validated Level _____
    RBC Ratio and Trend Test _____

    b. Were there any issues or concerns noted in previous annual or quarterly analysis completed in the prior year? If "yes," discuss the issues or concerns, the follow-up conducted, and include any correspondence with the insurer, along with any conclusions.

    c. As the domestic regulator, review the Insurer Profile Summary, including the Supervisory Plan, if applicable, and document any areas of concern that impact the current analysis.

2. Review any inter-departmental communication, as well as communication with other state insurance departments and the insurer. Note any unusual items or areas that indicate further review or follow-up is necessary.

3. Review General Interrogatories, Part 1, #5.1 and #5.2. Has the insurer been a party to a merger or consolidation? If "yes," review the list of the companies involved in the merger/consolidation. Also, ensure Form A or additional filings have been approved.

4. Review General Interrogatories, Part 1, #6.1 and #6.2. Has the insurer had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? If "yes," review the reason(s) stated for the revocation or suspension.

5. Are there any changes in the state's statutes and/or regulations that could impact the insurer's financial position or reporting? If "yes," to the extent information is available, has the insurer failed to comply with the new state's statutes and regulations enacted during the period?

6. Review the most recent report from a nationally recognized rating agency. Also, note the current financial strength and credit ratings and briefly discuss the explanation of the ratings or any change in the ratings.

7. Review any industry reports, news releases and emerging issues that have the potential to negatively impact the insurer.

8. Review the most recent business plan and financial projections, if available from recent surveillance activity and if considered necessary based on the insurer's priority designation and financial condition.

    a. If significant changes in business plan or philosophy have occurred, assess the insurer's ability to attain the expectations of the business plan.

    b. Are actual results consistent with management's expectations?

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Management Assessment

9. Review the Annual Financial Statement, Jurat page.

   a. Did the insurer fail to properly execute and notarize the Jurat page?

   b. Has there been any change(s) in officers, directors, or trustees since the previous Annual Financial Statement filing (indicated by a "#" after the name)? If "yes," indicate the position(s) in which the change(s) occurred. Review the Biographical Affidavit(s) for any new officers, directors, or trustees indicated above and note any areas of concern that would indicate further review is necessary.

      - ☐ President
      - ☐ Secretary
      - ☐ Treasurer
      - ☐ Vice Presidents (number: ____)
      - ☐ Directors or Trustees (number: ____)
      - ☐ Other

   c. Assess any significant corporate governance changes and determine whether these changes appear to indicate a shift in management philosophy, or whether management has made any changes in business culture or business plan.

Balance Sheet Assessment

10. Review the Annual Financial Statement, Assets and Liabilities, Surplus and Other Funds.

   a. Is policyholders' surplus below the statutory minimum amount required?

   b. Has policyholders' surplus increased by more than 25 percent or declined by more than 15 percent from the prior year-end?

   c. Is the RBC ratio (total adjusted capital divided by authorized control level risk-based capital, shown in the Annual Financial Statement, Five-Year Historical Data) less than or equal to 250 percent?

   d. Did the insurer fail the RBC Trend Test?

   e. Has there been any change in surplus notes compared to the prior year-end? If "yes," 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.

   f. Has there been any change in capital notes compared to the prior year-end? If "yes," 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.

   g. Is the amount of any non-invested asset category greater than 10 percent of total admitted assets? If "yes," indicate the asset category and amount.

   h. Has any individual asset category that is greater than 5 percent of total admitted assets changed by more than +/– 20 percent from the prior year-end? If "yes," indicate the asset category, current year-end balance, and the percentage change from the prior year-end. The analyst should also consider shifts within individual asset categories, i.e., between

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investment grade and non-investment grade bonds, and between publicly traded and privately placed securities.

i. Is the amount of any individual liability category, other than losses, loss adjustment expenses, and unearned premiums, greater than 10 percent of total liabilities? If "yes," indicate the liability category and amount.

j. Has any individual liability category that is greater than 5 percent of total liabilities changed by more than +/– 20 percent from the prior year-end? If "yes," indicate the liability category, current year-end balance, and the percentage change from the prior year-end.

k. Is the ratio of total liabilities to policyholders' surplus greater than 350 percent?

Operations Assessment

11. Review the Annual Financial Statement, Statement of Income.

    a. Does net income exceed +/– 10 percent of policyholders' surplus? If "yes," has net income increased by more than 30 percent or decreased by more than 15 percent from the prior year-end?

    b. Has any individual income or expense category, for which the current or prior year balance was greater than 5 percent of policyholders' surplus, changed by greater than +/– 20 percent from the prior year-end? If "yes," indicate the percentage change from the prior year-end, the income or expense category, and the current year-end balance.

    c. Are net unrealized capital gains/losses more than 10 percent of prior year-end policyholders' surplus?

12. Review the Annual Financial Statement, Cash Flow. Is net cash from operations negative?

13. Evaluate any material cessions as reported in Schedule F, Part 3—Ceded Reinsurance and review all General Interrogatories pertaining to reinsurance and note any areas of concern.

Investment Practices

14. Evaluate the insurer's investment management practices.

    a. Review General Interrogatories, Part 1, #14. Has the purchase or sale of any investments not been approved by the board of directors or a subordinate committee thereof?

    b. Review General Interrogatories, Part 1, #22.1. Were any securities owned that the insurer has exclusive control of, not in the actual possession of the insurer, except as shown on Schedule E, Part 3—Special Deposits?

    c. Review General Interrogatories, Part 1, #23.1. Were any assets owned not exclusively under the control of the insurer?

    d. Review General Interrogatories, Part 1, #19.1 and #19.2. Were any assets subject to a contractual obligation to transfer to another party without the liability for such obligation being reported? If "yes," indicate the amount at December 31 of the current year.

15. Review the Annual Financial Statement, Summary Investment Schedule. Note any unusual valuation methods or areas that indicate further review is necessary.

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16. During the review of the Supplemental Investment Risks Interrogatories, did the analyst note any unusual items that indicate a non-diversified portfolio?

17. Review the Annual Financial Statement, Schedule E, Part 3—Special Deposits. Is the book/adjusted carrying value of total special deposits greater than 10 percent of assets?

Review of Disclosures

18. Review the Annual Financial Statement, Notes to Financial Statements.

    a. Have any notes required per the *Annual Statement Instructions Property/Casualty* been omitted?

    b. Provide an explanation for any unusual items.

19. Review the Annual Financial Statement, General Interrogatories and Schedule P Interrogatories and note any unusual responses.

Assessment of Latest Examination Report and Results

20. Review General Interrogatories, Part 1, # 3 and determine if a financial examination report was released by the domiciliary state since the last review.

    a. As of what balance sheet date was the latest financial examination of the company?

    b. As of what balance sheet date was the latest financial examination report available from either the state of domicile or the company?

    c. As of what release date was the latest financial examination report available from the state of domicile or the company?

    d. Have any financial statement adjustments within the latest financial examination report not been accounted for in a subsequent financial statement filed with the Department?

    e. Have any of the recommendations within the latest financial examination report not been complied with?

    If "yes," or if follow-up was required from the review of the examination report in a previous analysis period, complete the following procedures.

    f. If the answers to 20d or 20e are "yes," follow up with the insurer regarding the implementation of recommendations in the Financial Examination Report.

    g. Assess the current and future impact of any financial statement adjustments on the insurer's financial condition.

21. During the review of the latest state examination report, the results from the examination and communication with the examiner-in-charge (for domestic insurers), did the analyst note any items or areas that indicate further review is essential?

22. Follow-up and document any management letter comments that should be addressed in the current period, if applicable.

Assessment of Results from Prioritization and Analytical Tools

23. Review the insurer's NAIC Annual Scoring results.

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a. Indicate the insurer's total score: _____

b. Provide an explanation on each individual ratio result that received a score of 50 points or more.

24. Review the insurer's IRIS ratio results.

a. Indicate the number of ratio results that fell outside the usual range: _____

b. Provide an explanation in the comment section on each of the ratios that fell outside the usual range.

25. Review and understand the assigned Analyst Team System Validated Level.

26. Review the Financial Profile Report and provide an explanation for any unusual or significant fluctuations or trends noted.

27. Review any market conduct information including information available from the state's market analysis department (such as the Market Analysis Chief or the Collaborative Action Designee) and the NAIC market analysis tools and databases (MAP, ETS, MARS, RIRS, SAD, MITS, and Complaints). The analyst should note any unusual items that translate into financial risks or indicate further review and/or additional communication is needed with the insurance department's market analysis staff.

Assessment of Supplemental Filings

28. During the review of the Statement of Actuarial Opinion (SAO) and the Summary of Actuarial Opinion, document any unusual items or areas that indicate further review is necessary. Also, consider utilizing the I-SITE SAO Verification tool.

29. During the review of the MD&A, did the analyst note any unusual items or areas that indicate further review is necessary?

30. During the review of the Audited Financial Report, did the analyst note any unusual items or areas that indicate further review is essential?

31. Review the most recent Annual Financial Statement of the insurer's holding company and its subsidiaries and holding company filings (such as Form, A, B, D, E (or other required information), Extraordinary Dividend/Distribution, and SEC forms 10-K and 8-K), if available.
    a. During the review, did the analyst note any new or unusual items or areas of concern that may potentially impact the insurer?
    b. If other insurers within the group exist, note any communication with the domestic state insurance departments for those affiliated insurers.

Recommendation for Further Analysis

Based on the Level 1 procedures performed, do you recommend that the Level 2, 3, or Supplemental Annual Procedures or other procedures listed below be completed? If "yes," indicate the sections that you recommend be completed:

A. Perform Level 2 and/or Level 3 Procedures:

All Sections ☐
Investments ☐
Unpaid Losses and LAE ☐

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- Income Statement and Surplus ☐
- Risk-Based Capital ☐
- Cash Flow and Liquidity ☐
- Reinsurance ☐
- Affiliated Transactions ☐
- MGAs and TPAs ☐

B. Perform Supplemental Procedures:

- Annual Audited Financial Report ☐
- Actuarial Opinion/Summary ☐
- Management's Discussion & Analysis ☐
- Holding Company Analysis ☐
  - Form A ☐
  - Form B ☐
  - Form D ☐
  - Form E ☐
  - Extraordinary Dividend/Distribution ☐
- Captives and/or Insurers Filing on U.S. GAAP ☐

C. Request and review the current business plan and financial projections.

i. If significant changes in the business plan or philosophy have occurred, assess the insurer's ability to attain these expectations.

ii. Determine if actual results are tracking with projections and note any significant variances and the reason(s).

Summary and Conclusion

After completion of any Level 2 or subordinate procedures, develop and document an overall summary and conclusion based on the findings. In developing a conclusion, the analyst should consider the above procedures, as well as any other factors that, in the analyst's judgment, are relevant to evaluating the insurer's overall financial condition. The discussion should include details regarding the insurer's strengths and weaknesses. In addition, update the Insurer Profile Summary, including the Supervisory Plan, if applicable, for the results of the analysis performed.

Do you recommend that the insurer be designated a priority as a result of the procedures performed? If "yes," indicate the recommended priority designation and rationale.

Describe the rationale for these recommendations.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

Correspondence

The analyst should document any follow-up regarding the Level 1, 2, 3, and Supplemental Procedures.

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B. Level 2

1. Investments
2. Unpaid Losses and LAE
3. Income Statement and Surplus
4. Risk-Based Capital
5. Cash Flow and Liquidity
6. Reinsurance
7. Affiliated Transactions
8. MGAs and TPAs

1. Determine whether the insurer's investment portfolio appears to be adequately diversified to avoid concentration of investments by type or issue.
    a. Is the total of industrial and miscellaneous bonds and credit tenant loans owned greater than 25 percent of total admitted assets?
    b. Are multi-class securities owned greater than 20 percent of total admitted assets?
    c. Are foreign bonds owned greater than 5 percent of total admitted assets?
    d. Are preferred stocks owned greater than 10 percent of total admitted assets?
    e. Are common stocks owned greater than 20 percent of total admitted assets?
    f. Are mortgage loans owned greater than 5 percent of total admitted assets?
    g. Is real estate owned, including home office real estate, greater than 5 percent of total admitted assets?
    h. Are total derivatives greater than +/– 5 percent of total admitted assets?
    i. Is the counterparty exposure or potential exposure of derivative instruments open greater than 5 percent of total admitted assets?
    j. Are other invested assets (Schedule BA) greater than 5 percent of total admitted assets?
    k. Are aggregate write-ins for invested assets greater than 5 percent of total admitted assets?
    l. Are affiliated investments greater than 10 percent of total admitted assets?
    m. Is any one single investment (excluding federal issues and affiliated investments) greater than 3 percent of total admitted assets?
    n. Has the insurer failed to comply with state-specific investment laws, regulations, or guidelines for diversity and limitations? Document any concerns in the comment section.

2. Determine whether there are concerns due to the level of investment in certain types of securities that tend to be riskier and/or less liquid than publicly traded investment grade bonds, stocks, and cash and short-term investments.
    a. Determine whether there are concerns due to the level of investment in non-investment grade bonds.
        i. Is the ratio of non-investment grade bonds to policyholders' surplus greater than 10 percent?
        ii. If non-investment grade bonds exceed 5 percent of policyholders' surplus, have such investments increased by greater than 10 percent over the prior year?
    b. Review Schedule D, Part 1A—Section 2 to determine whether there are concerns due to the level of investment in multi-class securities.
        i. Is the ratio of multi-class securities (residential, commercial, and other) owned to policyholders' surplus greater than 50 percent?
        ii. If investments in multi-class securities (residential, commercial, and other) exceed 15 percent of policyholders' surplus, have these investments increased by greater than 20 percent over the prior year?

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iii. Is the ratio of multi-class residential mortgage backed securities to policyholders' surplus greater than 5 percent?

c. Determine whether there are concerns due to the level of investment in privately placed bonds.

i. Is the ratio of privately placed bonds to policyholders' surplus greater than 15 percent?

ii. If privately placed bonds exceed 5 percent of policyholders' surplus, have such investments increased by greater than 15 percent over the prior year?

d. Determine whether there are concerns due to the level of investment in real estate and mortgage loans.

i. Review General Interrogatories, Part 1, #11.1. Does the insurer own any securities of a real estate holding company or otherwise hold real estate indirectly?

ii. Is the ratio of total real estate and mortgage loans to policyholders' surplus greater than 15 percent?

iii. If total real estate and mortgage loans exceed 10 percent of policyholders' surplus, have such investments increased by greater than 15 percent over the prior year?

e. Determine whether there are concerns due to the level of investment in other long-term invested assets (Schedule BA).

i. Is the ratio of other long-term invested assets to policyholders' surplus greater than 10 percent?

ii. If other long-term invested assets exceed 5 percent of policyholders' surplus, have such investments increased by greater than 10 percent over the prior year?

3. Determine whether the purchase or sale of all investments were approved by the board of directors and whether all securities owned as of December 31 of the current year, over which the insurer had exclusive control and actual possession, except as shown in Schedule E, Part 3—Special Deposits.

a. Review General Interrogatories, Part 1, #14. Has the purchase or sale of any investments not been approved by the board of directors or a subordinate committee thereof?

b. Review General Interrogatories, Part 1, #22.1 and #22.2. Are any stocks, bonds and other securities owned, over which the insurer has exclusive control, not in the actual possession of the insurer, except as shown on Schedule E, Part 3—Special Deposits?

c. Review General Interrogatories, Part 1, #23.1 and #23.2. Are any stocks, bonds or other assets owned by the insurer not exclusively under the control of the insurer?

4. Determine whether securities owned have been valued in accordance with the standards promulgated by the NAIC Securities Valuation Office (SVO).

a. Review General Interrogatories, Part 1, #30.1.

i. Has the insurer failed to follow the filing requirements of the *Purposes and Procedures Manual* of the SVO?

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ii. If the answer to 4ai is "yes," document the exceptions listed in General Interrogatories, Part 1, #30.2.

b. Review Schedule D, Part 1—Bonds and Schedule D, Part 2—Preferred Stocks and Common Stocks. Does it appear that the insurer is not complying with the requirement to submit securities to the SVO for a valuation, i.e., there are securities that were acquired prior to the current year with a "Z" suffix after the NAIC designation and/or there is a significant number of securities that were acquired during the current year with a "Z" suffix after the NAIC designation?

5. Determine whether the statement value of bonds and sinking fund preferred stocks is significantly greater than their fair value.

a. Review General Interrogatories, Part 1, #28, which shows the aggregate statement value and the aggregate fair value of bonds and preferred stocks owned. Is the cumulative excess of the statement value over the fair value of bonds and preferred stocks owned greater than 10 percent of the statement value of bonds and preferred stocks owned?

b. Is the cumulative excess of the statement value over the fair value of bonds and preferred stocks owned greater than 20 percent of policyholders' surplus?

6. Determine whether the fair value of common stock is significantly greater than or less than the cost.

a. Review Schedule D, Part 2, Section 2—Common Stocks. Is the aggregate fair value of common stock below the actual cost?

i. If the answer to 6a is "yes," is the difference greater than 10 percent of policyholders' surplus?

b. Review Schedule D, Part 2, Section 2—Common Stocks. Is the aggregate actual cost of common stock below the fair value?

i. If the answer to 6b is "yes," is the difference greater than 10 percent of policyholders' surplus?

c. If an investment in one issue of common stock exceeds 5 percent of invested assets, does the fair value of the common stock exceed the actual cost by greater than 30 percent, or is the fair value less than the actual cost by greater than 20 percent?

7. Determine whether concerns exist due to significant purchases or sales of securities near the beginning and/or end of the year.

a. Scan Schedule D, Part 3—Long-Term Bonds and Stocks Acquired During Current Year. Were significant amounts of bonds or stocks purchased near the beginning or the end of the year?

b. Review the Annual Financial Statement, Liabilities, Surplus and Other Funds. Is payable for securities greater than 10 percent of invested assets?

c. Scan Schedule D, Part 4—Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year. Were significant amounts of bonds or stocks disposed of near the beginning or the end of the year?

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d. Review the Annual Financial Statement, Assets. Is receivable for securities greater than 10 percent of invested assets?

e. Scan Schedule D, Part 5—Long-Term Bonds and Stocks Acquired During Current Year and Fully Disposed of During Current Year. Were significant amounts of bonds or stocks acquired near the beginning of the year and disposed of near the end of the year?

8. Determine whether concerns exist due to significant turnover of long-term bonds, preferred stocks, or common stocks during the year.

a. Review Schedule D, Part 4—Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year and Schedule D, Part 5—Long-Term Bonds and Stocks Acquired During Current Year. Is the long-term bond turnover ratio greater than 50 percent?

b. Review Schedule D, Part 4—Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year and Schedule D, Part 5—Long-Term Bonds and Stocks Acquired During Current Year. Is the stock turnover ratio greater than 50 percent?

c. Review Schedule D, Part 4—Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year and Schedule D, Part 5—Long-Term Bonds and Stocks Acquired During Current Year. Is the total long-term bond and stock turnover ratio greater than 50 percent?

9. Determine whether there are concerns due to the level of investment in derivative instruments.

a. Review the Notes to Financial Statements, #1, #5, and #8, General Interrogatories, Part 1, #22–24, write-ins for assets and liabilities, Exhibit of Net Investment Income, Exhibit of Capital Gains and Losses, Schedule DB—all parts, MD&A, and the Audited Financial Report. Is the insurer engaging in derivative activity?

If the answer to 9a is "no," do not proceed with the derivative procedures and skip to the conclusion of the investment section.

b. Determine whether derivative holdings at year-end are significant.

i. Review Schedule DB, Parts A, C, D, and F, Section 1. Is the total statement value at year-end greater than 10 percent of policyholders' surplus? If "yes," list the total statement value and percentage of policyholders' surplus for hedging, other, and total derivative transactions.

ii. Review Schedule DB, Part B, Section 1—Options, Caps, Floors, and Insurance Futures Options Written and In-force December 31 of Current Year. Is the statement value at year-end greater than 10 percent of policyholders' surplus? If "yes," list the total statement value and percentage of policyholders' surplus for hedging, income generation, other, and total derivatives transactions.

c. Determine whether derivative activity during the year is significantly greater than holdings at year-end.

i. Review Schedule DB, Parts A, C, D, and F. For each part, is the total cost (original value) of derivatives acquired or opened during the year as reported in Section 2 greater than 150 percent of the cost (original value) of derivatives owned or open at year-end as reported in Section 1?

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ii. Review Schedule DB, Part B. Is the consideration received on options, caps, floors, and insurance futures options written during the current year as reported in Section 2 greater than 150 percent of the consideration received for options, caps and floors written and in-force at year-end as reported in Section 1?

d. Review the Exhibit of Net Investment Income. Is the ratio of derivative investment income to net investment income greater than 5 percent?

e. Review the Exhibit of Capital Gains and Losses.

i. Is the amount of realized capital loss attributed to derivatives greater than the amount of any gain attributed to derivatives?

ii. If 9ei above is "yes," is the amount of realized capital loss attributed to derivatives greater than 10 percent of policyholders' surplus?

f. Review Schedule DB, Parts A, B, and C, Section 3, columns 14, 15, and 16, and Part D, Section 3, columns 11, 12, and 13. Is the sum of the aggregate losses greater than 10 percent of policyholders' surplus? If "yes," list the net gain/loss and percentage of policyholders' surplus for recognized, used to adjust basis, and deferred.

g. Review Schedule DB, Part E, Section 1—Counterparty Exposure for Derivative Instruments Open. Is the ratio of total off balance sheet exposure to policyholders' surplus greater than 10 percent?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst's judgment, are relevant to evaluating the insurer's investments under the specific circumstances involved.

Do you recommend that one or more of the procedures within Level 3—Investments be completed?

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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1. Determine whether an understatement of unpaid loss and loss adjustment expense (LAE) reserves would be significant.
   a. Is the loss and LAE reserves to policyholders' surplus ratio greater than 250 percent?
   b. Is the net premiums written (long-tail lines) to net premiums written (total) ratio greater than 25 percent?
   c. Has the net premiums written (long-tail lines) to net premiums written (total) ratio increased by greater than 25 points from the prior year-end?

2. Determine whether unpaid losses and LAE appear to have been adequately reserved.
   a. Is the one-year reserve development to prior year-end policyholders' surplus ratio (IRIS ratio #11) greater than 20 percent?
   b. Review the Five-Year Historical Data in the Annual Financial Statement. Has there been an adverse trend or unusual fluctuation in the one-year loss reserve development within the last five years?
   c. Is the two-year reserve development to the second prior year-end policyholders' surplus ratio (IRIS ratio #12) greater than 20 percent?
   d. Review the Five-Year Historical Data in the Annual Financial Statement. Has there been an adverse trend or unusual fluctuation in the two-year loss reserve development within the past five years?
   e. Is the estimated current reserve deficiency to policyholders' surplus ratio (IRIS ratio #13) greater than 25 percent?
   f. Has there been a significant change in the loss ratio from the prior year (+/– 15 points) or over each of the past five years (+/– 20 points)?
   g. Has there been a shift in the mix of business from short-tail property lines to long-tail liability lines within the past five years?
   h. Were net premiums written from loss sensitive contracts more than 15 percent of total net premiums written?
   i. Were net unpaid losses and LAE from loss sensitive contracts more than 15 percent of total net unpaid losses and LAE?
   j. Review the Notes to Financial Statements, #32—Asbestos/Environmental Reserves.
      i. Is there exposure to asbestos and environmental liability?
      ii. Are net asbestos and environmental unpaid loss and LAE reserves greater than 15 percent of policyholders' surplus?
      iii. If the change in net asbestos and environmental unpaid loss and LAE reserves is greater than 5 percent of policyholders' surplus, have those reserves increased by more than 15 percent over the prior year?

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3. Determine whether unpaid losses and/or LAE reserves have been discounted (non-tabular) and, if so, whether concerns exist regarding the loss reserve discounting.
   a. Review Schedule P, Part 1—Summary. Have unpaid losses and/or LAE been discounted for the time value of money?
   b. Is the non-tabular discount on unpaid losses and LAE to policyholders' surplus ratio greater than 5 percent?
   c. Review the Notes to Financial Statements, #31—Discounting of Liabilities for Unpaid Losses and Unpaid LAE.
      i. Have any lines of business been discounted, other than workers' compensation tabular indemnity reserves and long-term disability claims, that have not been permitted by the insurance department?
      ii. Is the interest rate used to discount reserves greater than 5 percent on any single line?

4. Determine whether anticipated salvage and subrogation has been included as a reduction of unpaid losses and LAE and whether concerns exist regarding the use of anticipated salvage and subrogation in the development of unpaid losses and LAE.
   a. Review Schedule P, Part 1—Summary. Has anticipated salvage and subrogation been included as a reduction of unpaid losses and LAE?
   b. Is the anticipated salvage and subrogation to policyholders' surplus ratio greater than 10 percent?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding unpaid losses and LAE. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst's judgment, are relevant to evaluating unpaid losses and LAE under the specific circumstances involved.

Do you recommend that one or more procedures within Level 3—Unpaid Losses and LAE be completed?

Describe the rationale for these recommendations.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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1. Determine whether concerns exist regarding the insurer's Statement of Income or operating performance.
   a. Is the combined ratio greater than 105 percent or less than 80 percent?
   b. Has the combined ratio increased more than 10 points or decreased more than 25 points from the prior year?
   c. Is the return on policyholders' surplus ratio greater than 20 percent or less than 5 percent?
   d. Is the two-year operating ratio (IRIS ratio #5) greater than 100 percent?
   e. Has there been a +/– 25 percent change in net earned premiums from the prior year?
   f. Has there been a + 20 or – 35 percent change in net incurred losses from the prior year?
   g. Has there been a +/– 20 point change in the loss ratio from the prior year?
   h. Is the gross expenses and commissions to gross premiums written ratio greater than 40 percent or less than 10 percent?
   i. Is the change in gross expenses and commissions ratio more than +/– 30 percent?
   j. Is the investment yield ratio (IRIS ratio #6) greater than 6.5 percent or less than 3 percent?
   k. Are net realized capital gains or losses more than +/– 3 percent of policyholders' surplus and +/– 25 percent of net income?
   l. Is other income more than +/– 3 percent of policyholders' surplus and +/– 25 percent of net income?

2. Determine whether concerns exist regarding changes in the volume of premiums written or changes in the insurer's mix of business (lines of business written and/or geographic location of premiums written).
   a. Is the change in gross premiums written greater than +/– 25 percent?
   b. Is the change in net premiums written greater than +/– 25 percent?
   c. Review the Five-Year Historical Data of the Annual Financial Statement. Has there been a shift in the mix of gross premiums written or net premiums written from property lines to liability lines within the past five years?
   d. Have direct premiums written for any line of business changed by greater than +/– 33 percent?
   e. If premiums are being written within any new lines, do they account for more than 5 percent of the total direct premiums written?
   f. Review the direct premiums written by state section in the Financial Profile Report on I-SITE.
      i. Has there been a significant change (+/– 50 percent) in direct premiums written in any one state where direct premiums written exceed 10 percent of total direct premiums in either the current or prior year?

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ii. If premiums are being written in any new states, does any one new state account for more than 5 percent of total direct premiums written?

g. Review the Annual Financial Statement, Schedule T—Exhibit of Premiums Written for new direct business written in any state where the insurer is not licensed.

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

a. Is the gross premiums written to policyholders' surplus ratio (IRIS ratio #1) greater than 900 percent?

b. Is the net premiums written to policyholders' surplus ratio (IRIS ratio #2) greater than 300 percent?

c. Is the net premiums written (long-tail lines) to total net premiums written ratio greater than 25 percent?

d. Has the net premiums written (long-tail lines) to total net premiums written ratio increased by greater than 25 points from the prior year-end?

4. Review General Interrogatories, Part 2, #13.1, #13.2, and #13.3, and identify the company's largest aggregate amount insured in any one risk (excluding workers' compensation).

a. Does any reinsurance contract considered in the calculation of this amount include an aggregate limit of recovery without also including a reinstatement provision?

5. Determine whether concerns exist regarding the amount of the insurer's policyholders' surplus.

a. Review the Five-Year Historical Data of the Annual Financial Statement. Is the RBC ratio (total adjusted capital divided by authorized control level risk-based capital) less than or equal to 250 percent?

b. Is the policyholders' surplus to assets ratio less than 20 percent?

c. Is the gross change in policyholders' surplus ratio (IRIS ratio #7) greater than 50 percent or less than –10 percent?

d. Review the Five-Year Historical Data of the Annual Financial Statement. Has the insurer's policyholders' surplus decreased by more than 10 percent from the ending balance for any of the prior four years?

e. Did the insurer declare dividends to stockholders during the year?

i. If the answer to 5e is "yes," was the amount of the stockholder dividend at a level that required prior regulatory approval or notification?

ii. If the answer to 5ei is "yes," did the insurer fail to obtain proper regulatory approvals?

f. Is the ratio of capital and/or surplus notes to policyholders' surplus greater than 10 percent?

g. Are write-ins for special surplus funds and/or write-ins for other than surplus funds greater than 10 percent of policyholders' surplus?

h. Are unassigned funds negative?

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i. Does the absolute value of the current year change exceed 3 percent of current year policyholders' surplus for any of the following items: (1) net unrealized capital gains/losses, (2) net unrealized foreign exchange capital gains/losses, (3) net deferred taxes, (4) nonadmitted assets, (5) provision for reinsurance, (6) surplus notes, or (7) change in accounting principle?

j. Review footnote (h) in the Exhibit of Net Investment Income. Did the insurer report interest expense on capital or surplus notes during the year?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the insurer's Statement of Income and policyholders' surplus. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst's judgment, are relevant to evaluating the insurer's Statement of Income and policyholders' surplus under the specific circumstances involved.

Do you recommend that one or more procedures within Level 3—Income Statement and Surplus be completed?

Describe the rationale for these recommendations.

Analyst _____ Date _____

Comments as a result of supervisory review.

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1. Determine whether concerns exist regarding the insurer's Risk-Based Capital (RBC) position.
   a. Review the Annual Financial Statement, Five-Year Historical Data, RBC analysis and/or the RBC filing, and consider the following:
      i. Is the ratio of Total Adjusted Capital divided by Authorized Control Level less than or equal to 250 percent?
      ii. If the current RBC ratio is less than or equal to 300 percent, has there been a significant change, +/–30 points, in the RBC ratio from the prior year?
      iii. Has the RBC ratio declined each of the past two years? If "yes," show the percentage-point decline over the two years and the current year RBC ratio.
      iv. Has Total Adjusted Capital declined by 15 percent or greater from the prior year?
      v. Has Authorized Control Level increased by 15 percent or greater from the prior year? If "yes," review the five RBC risk factors for material changes from the prior year and document the leading underlying causes for the changes.
2. Did the insurer fail the RBC Trend Test? If "yes," discuss the plans to address the RBC Trend Test failure.
3. If the insurer has triggered an action level RBC event and if authorized by statute:
   a. Obtain and review a copy of the insurer's RBC plan and monitor the plan and overall progress in implementing plan initiatives and improving the RBC level.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding RBC. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating RBC. The summary and conclusion should include details regarding strengths and weaknesses.

Describe the rationale for these recommendations.

Analyst _____ Date _____

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1. Determine whether concerns exist regarding the insurer's cash flow. Review the Annual Financial Statement, Cash Flow.

   a. If net cash from operations is negative, determine the underlying reasons and calculate the net cash from operations to policyholders' surplus ratio.

   b. Review the net cash from operations trend in the Financial Profile Report for the past five years and document any unusual fluctuations or negative trends.

2. Review Schedule E, Part 3—Special Deposits and determine whether concerns exist regarding the insurer's special deposits.

   a. Is the book/adjusted carrying value of all other special deposits (not for the benefit of all policyholders) greater than 50 percent of total special deposits?

   b. Is the percentage difference between the book/adjusted carrying value of total special deposits and the fair value of total special deposits greater than 5 percent?

   Consider the following procedures to provide further depth to the analysis:

   c. If there are concerns regarding the amount of special deposits held by the insurer not for the benefit of all policyholders, and there is overall liquidity risk regarding the insurer, consider performing one or more of the following:

      i. Review Schedule E, Part 3—Special Deposits, all other special deposits held by the insurer and consider the number of states in which the insurer has these types of deposits (the greater the number, the more difficult it may be for the domiciliary state to call on these deposits in a rehabilitation) and the amount of concentration in any one particular state.

      ii. Contact the domiciliary state or perform research to determine if any of the states have restrictions on the ability of those deposits to be called by the domiciliary state during a rehabilitation.

3. Determine whether concerns exist regarding the insurer's overall level of liquidity.

   a. Review the five-year trend for the liquidity ratio within the Financial Profile Report and document any unusual fluctuations.

   b. Have liquid assets increased greater than 50 percent or decreased by more than 15 percent?

   c. Is the adjusted liabilities to liquid assets ratio (IRIS ratio #9) greater than 105 percent?

   Consider the following procedure to provide further depth to the analysis:

   d. Compare the insurer's adjusted liabilities to liquid assets ratio with industry and peer group averages in order to identify significant deviations.

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Summary and Conclusion

Develop and document an overall summary and conclusion regarding cash flow and liquidity. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst's judgment, are relevant to evaluating cash flow and liquidity under the specific circumstances involved.

Describe the rationale for these recommendations.

Analyst _____ Date _____

Comments as a result of supervisory review.

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1. Determine whether the insurer has a reinsurance program in place that adequately supports its risk profile.
    a. Is the gross premiums written to policyholders' surplus ratio (IRIS ratio #1) greater than 900 percent?
    b. Is the net premiums written to policyholders' surplus ratio (IRIS ratio #2) greater than 300 percent?
    c. Are gross premiums written (from liability lines of business) to policyholders' surplus greater than 300 percent?
    d. Are net premiums written (from liability lines of business) to policyholders' surplus greater than 150 percent?
    e. Review General Interrogatories, Part 2, #13.1. Is the largest net amount insured in any one risk (excluding workers' compensation) greater than 10 percent of policyholders' surplus?
    f. Review 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 workers' compensation contract issued without limit of loss?

2. Determine whether the insurer's accounting for reinsurance ceded is proper and in accordance with the *Annual Statement Instructions Property/Casualty*.
    a. Briefly scan the individual reinsurers listed in Schedule F, Part 3. Determine whether any of the reinsurers listed as authorized appear to be improperly classified.
    b. Review Schedule F, Part 5. Is the provision for unauthorized reinsurance as a percentage of reinsurance recoverables from unauthorized reinsurers greater than 30 percent?
    c. Review Schedule F, Part 6. Is the provision for overdue authorized reinsurance as a percentage of reinsurance recoverables in dispute less than 20 percent?

3. Determine whether amounts recoverable from reinsurers are significant.
    a. Are non-affiliated reinsurance recoverables on paid losses greater than 10 percent of policyholders' surplus?
    b. Are non-affiliated reinsurance recoverables on unpaid losses greater than 50 percent of policyholders' surplus?

4. Determine whether amounts recoverable from reinsurers are collectible.
    a. Are overdue paid losses and LAE reinsurance recoverables (91 days or more) greater than 10 percent of policyholders' surplus?
    b. Are reinsurance recoverables from unauthorized reinsurers greater than 25 percent of policyholders' surplus?
    c. Are reinsurance recoverables from alien reinsurers greater than 10 percent of policyholders' surplus?
    d. Review the Notes to Financial Statements, #22—Reinsurance.
        i. Are unsecured reinsurance recoverables greater than 25 percent of policyholders' surplus?

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ii. Are reinsurance recoverables from any unauthorized reinsurer greater than 10 percent of policyholders' surplus?

iii. Are reinsurance recoverables from any alien reinsurer greater than 5 percent of policyholders' surplus?

iv. Are reinsurance recoverables in dispute greater than 5 percent of policyholders' surplus?

v. Is the maximum amount of net return commissions due reinsurers in the event of cancellation of all reinsurance greater than 15 percent of policyholders' surplus?

vi. Is uncollectible reinsurance greater than 5 percent of policyholders' surplus?

e. Review the results of the Statement of Actuarial Opinion. Were any concerns noted regarding the collectibility of reinsurance recoverables?

5. Determine whether reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another.

a. Are assumed premiums written from affiliates greater than 50 percent of gross premiums written?

b. Are affiliated ceded premiums written greater than 50 percent of gross premiums written?

c. Has there been a significant change in either of the above two ratios within the past five years? Compare the current year to the prior year (+/– 25 points) and the current year to the remaining years (+/– 50 points).

d. Are reinsurance recoverables from affiliates greater than 20 percent of policyholders' surplus?

e. Review the Notes to Financial Statements, #10—Information Concerning Parent, Subsidiaries, and Affiliates, and #25—Intercompany Pooling Arrangements. Were there any changes in intercompany pooling agreements during the year?

f. Review Schedule F, Part 2. Were there any premium portfolio transfers involving affiliates?

6. Determine whether reinsurance is being used for fronting purposes and if so, whether any potential abuses exist.

a. Are ceded premiums written greater than 75 percent of gross premiums written?

b. Are ceded premiums written for any significant line of business (defined as a line of business where gross premium written is greater than 20 percent of total gross premiums) greater than 90 percent of gross premiums written?

c. Are ceded commissions to ceded premiums written more than 30 percent of the insurer's underwriting expense ratio?

7. Determine whether any unusual reinsurance intermediary agreements or reinsurance assumed agreements exist.

a. Are assumed premiums written from non-affiliates greater than 50 percent of gross premiums written?

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b. Is the total amount of funds withheld for payment of losses by ceding companies greater than 10 percent of policyholders' surplus?

c. If assumed premiums written exceed 20 percent of gross premiums written, is the assumed loss ratio significantly higher or lower (+/– 25 points) than the gross loss ratio?

8. Determine whether any unusual reinsurance transactions were completed during the year.

a. Were any portfolio transfer transactions consummated that, individually or in the aggregate, resulted in an increase in policyholders' surplus greater than 5 percent?

b. Review the Notes to Financial Statements, #22E. Were any commutation agreements consummated that, individually or in the aggregate, resulted in a significant change in policyholders' surplus (+/– 5 percent)?

c. Review 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 percent?

d. Is the surplus aid to policyholders' surplus ratio (IRIS ratio #4) greater than 15 percent?

e. Review General Interrogatories, Part 2, #7.1. Has the company reinsured any risk under a quota share reinsurance contract that would limit the reinsurers' losses below the stated quota share percentage?

f. Review General Interrogatories, Part 2, #9.1. 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 percent 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 percent 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.

g. Review General Interrogatories, Part 2, #9.2. 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 percent of prior year-end surplus as regards policyholders, or for which it reported calendar-year written premium ceded or year-end

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loss and loss expense reserves ceded greater than 5 percent 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 percent or more of the entire direct and assumed premium written by the reinsurer based on its most recently available financial statement; or
- Twenty-five percent 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.

h. Review General Interrogatories, Part 2, #9.4. Except for transactions meeting the requirements of paragraph 32 of SSAP No. 62, *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?

i. Review General Interrogatories, Part 2, #8.1. Were there any agreements to release reinsurers from liability during the year?

j. Review General Interrogatories, Part 2, #10. If the insurer has assumed risks from another 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?

k. Review General Interrogatories, Part 2, #11.1. Has the insurer guaranteed any policies issued by another company and now in force?

l. Review the results of the Statement of Actuarial Opinion. Were any concerns expressed relating to loss portfolio transfers or financial reinsurance?

m. In accordance with the Disclosure of Material Transaction Model Act, did the insurer report any material non-renewals, cancellations, or revisions of ceded reinsurance agreements?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding reinsurance. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures that, in the analyst's judgment, are relevant to evaluating reinsurance under the specific circumstances involved.

Do you recommend that one or more procedures within Level 3—Reinsurance be completed?

Describe the rationale for these recommendations.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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

   a. Review General Interrogatories, Part 1, #1.1, #1.2, and #1.3.

      i. Is the insurer a member of an insurance holding company system consisting of two or more affiliates, one or more of which is an insurer? If "yes," what is the name of the ultimate controlling person or entity as reported on the holding company system registration statement?

      ii. Is the answer for 1ai different from the prior year?

      iii. Briefly scan Schedule Y, Parts 1 and 2, along with the General Interrogatories and the Notes to Financial Statements. Is there any information noted that contradicts the above response to 1ai?

      iv. Is the company required to file a holding company registration statement with the insurance department?

      If responses to questions 1ai through 1aiv are all "no," do not proceed with Affiliated Transactions Procedures and skip to the next financial analysis topic.

      v. Did the insurer fail to file a registration statement in accordance with the Insurance Holding Company System Regulatory Act?

   b. Review Schedule Y, Part 1—Organizational Chart for the current and prior year.

      i. Were there any significant changes to the corporate structure during the year, e.g., acquisitions, divestitures, mergers?

      ii. If the answer to 1bi above is "yes," and the change involved ownership of the insurer or a transaction with an affiliate, did the insurer fail to receive proper regulatory approvals?

      iii. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company?

      iv. Does the insurer have an agency or brokerage subsidiary?

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

   a. Review Schedule Y, Part 2—Summary of Insurer's Transactions With Any Affiliates.

      i. Are any unusual items noted, such as significant new affiliated transactions from the prior year or significant increases in transaction amounts?

      ii. Does it appear that a different schedule is included for other affiliates?

      iii. Has the insurer forwarded to any affiliate funds greater than 15 percent of the insurer's policyholders' surplus?

      iv. Were the management fees paid to affiliates greater than 15 percent of total expenses incurred?

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b. Review the Notes to Financial Statements, #10—Information Concerning Parent, Subsidiaries, and Affiliates.

i. Are any unusual items noted, such as significant new affiliated transactions or significant increases in transaction amounts?

ii. Do any transactions described appear to conflict with the transactions disclosed in Schedule Y, Part 2—Summary of Insurer's Transactions With Any Affiliates?

iii. Are any transactions disclosed with an affiliate that is not listed on Schedule Y, Part 2—Summary of Insurer's Transactions With Any Affiliates?

iv. Do affiliated undertakings resulting in a contingent liability to the insurer involve financial exposure greater than 25 percent of policyholders' surplus?

v. Review the description of management agreements and service contracts. Is an allocation basis involved other than one designed to estimate actual cost?

c. Review the Notes to Financial Statements, #13—Capital and Surplus, Shareholders' Dividend Restrictions, and Quasi-Reorganizations.

i. If the insurer paid a dividend, was the amount at a level that required prior regulatory approval or notification?

ii. If the response to 2ci is "yes," did the insurer fail to obtain proper prior regulatory approvals?

iii. Does the amount of the dividend differ from the amount reported in the Annual Financial Statement, Cash Flow?

iv. Does the amount of the dividend differ from the amount reflected in the Annual Financial Statement, Statement of Income, Gains and (Losses) in Surplus?

3. Determine whether affiliated investments are significant.

a. Is the total of all investments in affiliates (Five-Year Historical Data) greater than 20 percent of policyholders' surplus?

b. Has the total of all investments in affiliates changed by greater than +/– 20 percent from the prior year-end?

c. Has there been a shift in any affiliated investment category of more than +/– 10 percent from the prior year-end?

d. Are affiliated investments in violation of state statutes?

4. Determine whether investments in affiliates are properly valued in accordance with statutory accounting practices.

a. If investments in common stocks of parent, subsidiaries, and affiliates involve publicly traded securities, are the investments valued on a basis other than fair value?

b. If investments in common stocks of parent, subsidiaries, and affiliates do not involve publicly traded securities, are the investments valued on a basis other than the net worth/policyholders' surplus of the affiliate?

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5. Determine whether other affiliated transactions are legitimate and properly accounted for.

   a. Review the Annual Financial Statement, Assets, Receivables from Parent, Subsidiaries and Affiliates; and Liabilities, Surplus, And Other Funds, Payable to Parent, Subsidiaries and Affiliates. Are either of these items greater than 10 percent of policyholders' surplus?

   b. Review Schedule E, Part 1—Cash.

      i. Were any open depositories a parent, subsidiary, or affiliate?

      ii. Based upon a review of the holding company financial statements, are there any holding company lenders that appear as open depositories of the insurer?

   c. Review the Notes to Financial Statements, #9—Income Taxes.

      i. Is the insurer included in a consolidated federal income tax return?

      ii. If the answer to 5ci is "yes," are there any concerns about the manner in which federal income taxes are allocated to the insurer?

      iii. Are federal income tax recoverables greater than 5 percent of policyholders' surplus?

      iv. If the answer to 5ciii is "yes," are federal income tax recoverables due from an affiliate?

   d. Review the Notes to Financial Statement, #26—Structured Settlements.

      i. Has the insurer acquired structured settlements from an affiliated life insurance company?

      ii. If the answer to 5di is "yes," is the amount of the loss reserves eliminated by annuities greater than 15 percent of policyholders' surplus?

   e. Review General Interrogatories, Part 2, #5. In the case of reciprocal exchanges:

      i. Are any unusual items noted regarding compensation of the attorney-in-fact?

      ii. Is there an approved agreement on file with the insurance department?

      iii. If the response to 5eii is "yes," review the Articles of Agreement.

   f. Review General Interrogatories, Part 1, #7.1 and #7.2.

      i. Does any foreign entity directly or indirectly control 10 percent or more of the insurer?

      ii. If the response to 5fi is "yes," did the insurer fail to properly disclose the investment on Schedule Y, Part 2—Summary of Insurer's Transactions With Any Affiliates?

   g. Review General Interrogatories, Part 1, #18.1 and #18.2.

      i. Was the total amount loaned during the year to directors, other officers, or stockholders greater than 10 percent of statutory net income?

      ii. Was the total amount of loans outstanding at the end of the year to directors, other officers, or stockholders greater than 5 percent of policyholders' surplus?

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h. Review General Interrogatories, Part 1, #16.

   i. Has the insurer failed to establish a conflict of interest disclosure policy?

   ii. Is there any evidence that activities of directors, officers, or shareholders were in violation of state statutes?

i. Review Schedule SIS—Stockholder Information Supplement. Are any unusual items noted regarding transactions with, or compensation to, directors and officers?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding affiliated transactions. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures that, in the analyst's judgment, are relevant to evaluating affiliated transactions under the specific circumstances involved.

Do you recommend that one or more procedures within Level 3—Affiliated Transactions be completed?

Describe the rationale for these recommendations.

Analyst _____ Date _____

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

   a. Review General Interrogatories, Part 1, #4.1 and #4.2. Did any agent, general agent, broker, sales representative, non-affiliated sales/service organization, or any combination thereof under common control (other than salaried employees of the insurer) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of either the sale of new business or renewals?

   b. Review the Notes to Financial Statements, #19—Direct Premiums Written/Produced by Managing General Agents/Third-Party Administrators. Was the aggregate amount of direct premiums written through MGAs and TPAs greater than 10 percent of total direct premiums written?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding whether concerns exist due to a significant amount of the insurer's direct premiums being written through MGAs and TPAs. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures that, in the analyst's judgment, are relevant to evaluating the insurer's use of MGAs and TPAs under the specific circumstances involved.

Do you recommend that one or more procedures within Level 3—MGAs and TPAs be completed?

Describe the rationale for these recommendations.

Analyst _____ Date _____

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C. Level 3

1. Investments
2. Unpaid Losses and LAE
3. Income Statement and Surplus
4. Reinsurance
5. Affiliated Transactions
6. MGAs and TPAs

1. If there are concerns regarding whether the insurer's investment portfolio is adequately diversified to avoid an undue concentration of investments by type or issue (Level 2 Annual Procedures—Investments, procedure #1), consider performing one or more of the following procedures:

   a. Determine whether the insurer's investment portfolio is in compliance with the investment limitations and diversification requirements per the state's insurance laws.

   b. Compare the insurer's distribution of cash and invested assets to total assets in the Financial Profile Report to industry averages, and determine any significant deviations.

   c. Request a copy of the insurer's formal 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. Determine whether the insurer appears to be adhering to their investment plan.

   d. Review the maturity distribution of bonds in Schedule D, Part 1A, Section 1—Quality and Maturity Distribution of All Bonds Owned, and consider the liquidity of the insurer's investments to determine whether its investment portfolio appears reasonable based on the types of business written.

   e. If the insurer's investments include a significant amount of foreign bonds, consider the insurer's potential foreign currency exposure from bonds denominated in a foreign currency.

   f. If there are concerns regarding liquidity or cash flows, consider having a cash flow analysis performed by an actuary.

2. If there are concerns regarding the level of investment in non-investment grade bonds (Level 2 Annual Procedures—Investments, procedure #2a), consider performing one or more of the following procedures:

   a. Review Schedule D, Part 1A, Section 1—Quality and Maturity Distribution of All Bonds Owned, and compare the insurer's holdings of non-investment grade bonds to the limitations included in the NAIC's Investments in Medium Grade and Lower Grade Obligations Model Regulation.

      i. Determine whether the aggregate amount of all bonds owned that are rated 3, 4, 5, or 6 by the SVO are less than 20 percent of total admitted assets.

      ii. Determine whether the aggregate amount of all bonds owned that are rated 4, 5, or 6 by the SVO are less than 10 percent of total admitted assets.

      iii. Determine whether the aggregate amount of all bonds owned that are rated 5 or 6 by the SVO are less than three percent of total admitted assets.

      iv. Determine whether the aggregate amount of all bonds owned that are rated 6 by the SVO are less than one percent of total admitted assets.

   b. Request a copy of the insurer's plan for investing in non-investment grade bonds and review the guidelines for the quality of issues invested in and diversification standards pertaining to issuer, industry, duration, liquidity, and geographic location.

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c. Determine whether the insurer appears to be adhering to its plan for investing in non-investment grade bonds.

d. For the more significant non-investment grade bonds, request from the insurer the following current information regarding the issuer to determine the issuer's financial position and ability to repay its debt:

- Audited Financial Statement
- Report from an Acceptable Rating Organization—e.g., Moody's Investors Service, Standard and Poor's, or Fitch

3. If there are concerns regarding the level of investment in multi-class securities (Level 2 Annual Procedures—Investments, procedure #2b), consider performing one or more of the following procedures:

a. Review the multi-class securities categories in Schedule D, Part 1—Long-Term Bonds Owned, for bonds with a book/adjusted carrying value significantly in excess of par value, which could result in a loss being realized if bond prepayments occur faster than anticipated.

b. Review the multi-class securities categories in Schedule D, Part 1—Long-Term Bonds Owned, for bonds with an unusually high effective yield.

c. Request information from the insurer regarding the percentage distribution of the amounts of each type of multi-class residential mortgage-backed security held, planned amortization class, support bonds, interest-only tranches, and principal-only tranches to evaluate the level of prepayment risk in the portfolio.

d. Request and examine information from the insurer regarding the estimated prepayment speeds on its multi-class residential mortgage-backed securities.

A document is available in the link at the top of the Financial Analysis Handbook Reports page on I-SITE that discusses mortgage-backed securities and their pricing/valuation, prepayment models, measures of prepayments, extension risk and contraction risk, average life, option-adjusted spread, effective duration, and convexity.

e. Request information from the insurer regarding the 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.

f. Consider having the commercial mortgage obligations modeled by an actuary as part of a cash flow analysis.

4. If there are concerns regarding the level of investment in private placement bonds (Level 2 Annual Procedures—Investments, procedure #2c), consider performing one or more of the following procedures:

a. Review Schedule D, Part 1A, Section 1—Quality and Maturity Distribution of all Bonds Owned and determine the following:

i. The total amount of privately placed bonds owned.

ii. The issue types of privately placed bonds.

iii. The NAIC designations of the privately placed bonds.

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iv. The maturity distribution of the privately placed bonds.

v. The amount of total privately placed bonds that are freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.

b. For the more significant privately placed bonds, request from the insurer current audited financial information regarding the issuer and evaluate the issuer's financial position and ability to repay its debt.

5. If there are concerns regarding the level of investment in real estate and mortgage loans (Level 2 Annual Procedures—Investments, procedure #2d), consider performing one or more of the following procedures:

a. Review Schedule A, Part 1—Real Estate Owned to determine whether updated appraisals should be obtained for any of the properties owned based on the location of the property, the book/adjusted carrying value and reported fair value of the property, and the year of the last appraisal.

b. Review Schedule A, Part 1—Real Estate Owned and:

i. Investigate any instances where a property has a book/adjusted carrying value in excess of its cost.

ii. Request information from the insurer regarding any increases by adjustment in book/adjusted carrying value during the year.

c. Review Schedule A, Part 1—Real Estate Owned for any properties owned that have a book/adjusted carrying value in excess of fair value and determine whether the asset should be written down.

d. Review Schedule B, Part 1—Mortgage Loans Owned and:

i. Compare the book value of each loan to the value of the land and buildings mortgaged to determine whether the mortgage loans are adequately collateralized.

ii. Request information from the insurer regarding any increases by adjustment in book value during the year.

iii. Determine whether any of the mortgage loans are to an officer, director, parent, subsidiary, or affiliate.

6. If there are concerns regarding the level of investment in other long-term invested assets (Level 2 Annual Procedures—Investments, procedure #2e), consider performing one or more of the following procedures:

a. Review Schedule BA, Part 1—Other Long-Term Invested Assets Owned to determine the amount and types of other invested assets owned and whether they are properly categorized as other invested assets.

b. Request information from the insurer to support significant increases by adjustments in book/adjusted carrying values during the year.

c. Request the current Audited Financial Statement and other documents (partnership agreements, etc.) necessary to support the book/adjusted carrying value of the insurer's investment(s) in partnerships and joint ventures.

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d. Request information necessary to support the book/adjusted carrying value of significant other invested assets other than partnerships and joint ventures.

e. Request information necessary to determine the fair value of collateral to the amount loaned to ensure the loan is adequately collateralized.

7. If there are concerns regarding investment approval or control and possession (Level 2 Annual Procedures—Investments, procedure #3), consider performing one or more of the following procedures:

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

   b. If the insurer has securities under its exclusive control that are not in its actual possession, review General Interrogatories, Part 1, #22.1 to determine the reason the securities are not in the insurer's possession, who holds the securities, and whether they qualify as admitted assets of the insurer.

   c. If the insurer owns assets that are not under its exclusive control, review General Interrogatories, Part 1, #23.1 to determine the reason the assets are not under the insurer's exclusive control, who holds the assets, and whether they qualify as admitted assets of the insurer.

8. If there are concerns regarding whether securities have been valued in accordance with the standards promulgated by the SVO (Level 2 Annual Procedures—Investments, procedure #4), consider performing one or more of the following procedures:

   a. Review Schedule D, Part 1—Long-Term Bonds Owned to determine whether all bonds with an NAIC designation of 3, 4, 5, or 6 (non-investment grade bonds) have been valued at the lesser of book/adjusted carrying value or fair value and all other bonds have been valued at book/adjusted carrying value.

   b. Review Schedule D, Part 2—Preferred Stocks and Common Stocks Owned, to determine whether sinking fund preferred stocks have been valued at cost and all other stocks have been valued at fair value.

   c. If securities are listed in Schedule D, Part 1—Long-Term Bonds Owned or Schedule D, Part 2—Preferred Stocks and Common Stocks Owned with a "Z" suffix after the NAIC designation:

      i. Request verification from the insurer that the securities have been submitted to and subsequently valued by the SVO.

      ii. Compare the price or designation actually received from the SVO to that included in the Annual Financial Statement for significant securities.

   d. For each of the securities listed in Schedule D, Part 1—Long-Term Bonds Owned, Schedule D, Part 2—Preferred Stocks and Common Stocks Owned, and Schedule DA, Part 1—Short-Term Investments Owned, compare the CUSIP number, NAIC designation, and fair value included in the Annual Financial Statement to information on the SVO master file using Examination Jumpstart Investment Analysis, and contact the insurer to follow up on any exceptions noted.

9. If there are concerns regarding the significance of any excess of the book/adjusted carrying value over the fair value of bonds and sinking fund preferred stocks owned (Level 2 Annual

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Procedures—Investments, procedure #5), consider performing one or more of the following procedures:

a. Review Schedule D, Part 1—Long-Term Bonds Owned and Schedule D, Part 2—Preferred Stocks and Common Stocks Owned, or request additional information from the insurer to determine which individual securities have a book/adjusted carrying value significantly in excess of their fair value. For those securities:

   i. Verify the NAIC designation assigned and determine whether it has been recently updated by the SVO.

   ii. Determine the current rating by an Acceptable Rating Organization—e.g., Moody's Investors Service, Standard and Poor's, and/or Fitch.

   iii. Determine whether there has been a permanent impairment of the fair value.

b. Request information from the insurer regarding investment strategies and short-term cash flow needs to determine whether investments with a book/adjusted carrying value significantly in excess of their fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

10. If there are concerns regarding the significance of any excess of the cost over the fair value of common stocks owned (Level 2 Annual Procedures—Investments, procedure #6), consider performing one or more of the following procedures:

a. Review Schedule D, Part 2, Section 2—Common Stocks Owned, or request additional information from the insurer to determine which individual common stocks have a cost significantly in excess of their fair value. For those securities:

   i. If the stock is listed on a market or exchange (designated by the symbol L or U), such as the New York Stock Exchange, the American Stock Exchange, the NASDAQ National Market system, or a foreign exchange, verify the price and total fair value.

   ii. If the stock is designated "A" (unit price of the share has been analytically determined by the SVO), determine whether the rating has been updated recently by the SVO.

   iii. Determine whether there has been a permanent impairment in the fair value of the common stock.

b. Request information from the insurer regarding investment strategies and short-term cash flow needs to determine whether common stock with a cost significantly in excess of its fair value will need to be sold at a loss to satisfy short-term cash flow requirements.

11. If there are concerns regarding significant purchases or sales of securities near the beginning and/or the end of the year (Level 2 Annual Procedures—Investments, procedure #7), consider performing one or more of the following procedures:

a. Review Schedule D, Part 3—Long-Term Bonds and Stocks Acquired During Current Year and Schedule D, Part 5—Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year, to determine the types of securities purchased at or near the beginning and the end of the year and the vendors used for those purchases.

b. Review Schedule D, Part 4—Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year and Schedule D, Part 5—Long-Term Bonds and Stocks Acquired and Fully Disposed of During Current Year, to determine the types

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of securities sold at or near the beginning and the end of the year and the purchasers of those securities.

c. Based on the results of 11a and 11b above, determine whether the insurer might have engaged in "window dressing" of its investment portfolio (replacing lower quality investments with higher quality investments near year-end and then re-acquiring lower quality investments after year-end).

12. If there are concerns regarding the level of turnover of long-term bonds and both preferred and common stock (Level 2 Annual Procedures—Investments, procedure #8), consider performing one or more of the following procedures:

a. Determine that all brokers used by the company for investment transactions are licensed and in good standing with the SEC.

b. Review Schedule D, Part 4—Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed of During Current Year and Schedule D, Part 5—Long-Term Bonds and Stocks Acquired and Fully Disposed of During the Current Year, to determine the amount of bonds and stocks disposed of during the current year.

i. Review Schedule D, Part 3—Long-Term Bonds and Stocks Acquired During Current Year to determine the quality of bonds acquired, noting any "Z" rated (not yet rated by the SVO) securities. Also note any NAIC designations of 3, 4, 5, or 6 (non-investment grade bonds).

ii. Review Schedule D, Part 3—Long-Term Bonds and Stocks Acquired During Current Year to determine the quality of preferred and common stocks acquired. Evaluate any "U" (unlisted) or "A" (analytically determined) rated stocks.

c. High turnover of investments can result in realized capital gains. Review the Exhibit of Capital Gains (Losses) to determine the degree of reliance on capital gains to increase surplus or to offset underwriting losses.

13. If there are concerns regarding the level of investment in derivative instruments (Level 2 Annual Procedures—Investments, procedure #9), consider performing one or more of the following procedures:

a. Request and review a comprehensive description of the insurer's hedge program in order to gain an understanding of the insurer's use of derivative instruments 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.

ii. Determine whether the insurer appears to be adhering to the description of the hedge program.

b. Review Schedule DB—Derivative Instruments. For significant derivative instruments that are open at year-end, request the following information from the insurer:

i. A description of the methodology used to verify the continued effectiveness of the hedge provided.

ii. A description of the methodology to determine the fair value.

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iii. A description of the determination of the book/adjusted carrying value.

c. 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.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments based on the Level 3 Procedures performed.

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
- ☐ Refer concerns to examination section for targeted examination
- ☐ Engage an independent appraiser to value particular investments
- ☐ Engage an independent actuary to perform cash flow analysis
- ☐ Meet with the insurer's management
- ☐ Obtain a corrective plan from the insurer
- ☐ Other (explain)

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1. If there are concerns regarding whether unpaid losses and loss adjustment expenses (LAE) have been adequately reserved (Level 2 Annual Procedures—Unpaid Losses and LAE, procedure #2), consider performing one or more of the following:

   a. Review, by line of business, the one and two-year development in incurred net losses and defense and cost containment expenses by accident year reflected in Schedule P, Part 2, or review the loss reserve development section in the Financial Profile Report.

   b. Compare, by line of business, the one and two-year development in incurred losses and defense and cost containment expenses by accident year reflected in Schedule P, Part 2 to the industry average to determine any significant deviations.

   c. If the insurer has experienced a shift in its mix of business from short-tail property lines to long-tail liability lines, calculate the ratio of estimated current reserve deficiency to policyholders' surplus (IRIS ratio #13) separately for the major lines of business.

   d. Review, by line of business, the incurred loss and LAE ratio by accident year in Schedule P, Part 1, and note any unusual fluctuations or trends between accident years.

   e. Compare, by line of business, the incurred loss and LAE ratio in Schedule P, Part 1 to the industry average to determine any significant deviations.

   f. Review, by line of business, the cumulative net paid losses and defense and cost containment expenses by accident year in Schedule P, Part 3 and comment on any unusual fluctuations or aberrations in loss and expense payment patterns between accident years.

   g. Review Schedule P Interrogatories, #7.1 for any information provided regarding significant events, coverage, retention, or accounting changes that have occurred that should be considered when analyzing the data provided in Schedule P to estimate the adequacy of the current loss and LAE reserves.

   h. Perform loss reserve analysis on the more volatile long-tail liability lines of business using Examination Jumpstart or other loss reserve analysis software to project loss reserves based on incurred claims data in Schedule P, Part 2 and paid claims data in Schedule P, Part 3. Compare the projected reserves to the reserves established by the insurer.

2. If there are concerns regarding the discounting of unpaid losses and/or LAE (Level 2 Annual Procedures—Unpaid Losses and LAE, procedure #3), consider performing one or more of the following procedures:

   a. Review the Notes to Financial Statements, #31—Discounting of Liabilities for Unpaid Losses and Unpaid LAE, and consider the following:

      i. The lines of business with discounted reserves.

      ii. The interest rates used to discount reserves, including the basis indicated for using those rates.

      iii. The amount of discount in relation to policyholders' surplus.

      iv. If the interest rates used to discount the prior accident years' reserves have changed from the previous Annual Financial Statement, document the change in discounted reserves due to the change in interest rate assumptions and the effect on policyholders' surplus.

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b. Determine whether the interest rates used to discount reserves appear to be reasonable considering the insurer's investment yield and the insurer's comments in the Notes to Financial Statements, #31 regarding the basis for the interest rates used.

3. If there are concerns regarding the use of anticipated salvage and subrogation as a reduction in unpaid losses and LAE (Level 2 Annual Procedures—Unpaid Losses and LAE, procedure #4), consider performing one or more of the following procedures:

   a. Review Schedule P, Part 1 to determine which lines of business have unpaid losses and LAE that have been reduced due to consideration of anticipated salvage and subrogation.

   b. For the more significant lines of business, review Schedule P, Part 1 and compare the anticipated salvage and subrogation to unpaid losses and LAE ratio (gross of anticipated salvage and subrogation) to the salvage and subrogation received to claims paid ratio (gross of salvage and subrogation received) to determine the reasonableness of anticipated salvage and subrogation.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding unpaid losses and LAE based on the Level 3 Procedures performed.

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
- ☐ Refer concerns to examination section for targeted examination
- ☐ Engage an independent actuary to review insurer's reserves
- ☐ Meet with the insurer's management
- ☐ Obtain a corrective plan from the insurer
- ☐ Other (explain)

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1. If there are concerns regarding the insurer's income statement or operating performance (Level 2 Annual Procedures—Income Statement and Surplus, procedure #1), consider performing one or more of the following procedures:

   a. Review the combined ratio for the past five years and note any unusual fluctuations or trends between years.

   b. Compare the return on policyholders' surplus ratio to the industry average to determine any significant deviation.

   c. Review, by line of business, earned premiums by year in the Financial Profile Report for shifts in the mix of business between years.

   d. Review, by line of business, the incurred loss and LAE ratios in the Financial Profile Report and note any unusual fluctuations or trends between accident years.

   e. Compare, by line of business, the incurred loss and LAE ratio in Schedule P, Part 1 to the industry average to determine any significant deviations.

   f. Review the expense ratio and note any unusual fluctuations or trends between years.

   g. Compare the expense ratio to the industry average to determine any significant deviation.

   h. Review the loss ratios for direct, assumed, and ceded business, as well as contingent commissions per the Commissions and Brokerage Ratios in the Financial Profile Report and note any unusual fluctuations or trends between years.

   i. Compare the commission ratios per the Commissions and Brokerage Ratios in the Financial Profile Report to the industry average to determine any significant deviations.

   j. Review the write-ins for underwriting deductions in the Statement of Income for reasonableness. Also review aggregate write-ins for underwriting deductions in the Financial Profile Report and note any unusual fluctuations or trends between years.

   k. Review the detail of investment income in the Exhibit of Net Investment Income and the detail of realized gains (losses) in the Exhibit of Capital Gains (Losses) for reasonableness.

   l. Review the yield on invested assets in the Financial Profile Report and note any unusual fluctuations or trends between years.

   m. Compare the yield on invested assets in the Financial Profile Report to the industry average to determine significant deviation.

   n. Review the components of other income in the Statement of Income, including write-ins for miscellaneous income, for reasonableness.

2. If there are concerns regarding the insurer's operating performance as it relates to expenses overall or by line of business (Level 2 Annual Procedures—Income Statement and Surplus, procedure #1), review General Interrogatories, Part 1, #31-33, or consider obtaining the insurer's Insurance Expense Exhibit (IEE) and performing one or more of the following procedures:

   a. Review the IEE.

      i. Investigate unusual items, especially situations where expenses were allocated to lines of business using methods not defined in the *Annual Statement Instructions*. The *Annual Statement Instructions* are included in the Supplements section and additional guidance in this regard is included in the *Financial Condition Examiners Handbook*.

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b. Review the IEE, Part I—Allocation to Expense Groups.

i. Investigate significant fluctuations in expenses by expense groups between years.

ii. Compare expenses by expense group for the insurer with industry averages.

c. Review the IEE, Part II—Allocation to Lines of Business Net of Reinsurance and Part III—Allocation to Lines of Direct Business Written.

i. Investigate significant fluctuations in expenses by lines of business between years.

ii. Compare expenses by lines of business with industry averages.

iii. Determine whether the totals agree with financial statement line items included in the Annual Financial Statement.

d. Review General Interrogatories, Part 1, #32.1 and #32.2, concerning legal expenses paid during the year.

i. Investigate significant increases in legal expenses over the prior years.

ii. Compare legal expenses with industry averages.

3. If there are concerns regarding changes in the volume of premiums written or changes in the insurer's mix of business (lines of business written and/or geographic location of premiums written), consider performing one or more of the following procedures:

a. Review the net premiums written by line of business in the insurer's Financial Profile Report.

i. Determine whether there has been a significant increase or decrease in premiums written for any line of business.

ii. Determine whether any new lines of business are being written.

b. Verify that the insurer is authorized to write all lines of business written.

c. Determine whether the insurer has expertise, e.g., distribution network, underwriting, claims, and reserving, in the lines of business written. Consider reviewing the insurer's MD&A and/or seeking additional information from the insurer to determine the insurer's expertise in the lines of business written.

d. Review the writings section in the Financial Profile Report that shows the top ten states in terms of direct premiums and the percentage of total direct premiums written in those states. Based on the lines of business written, determine whether there appears to be large concentrations of premiums in areas especially prone to catastrophic events.

4. If there are concerns regarding the insurer's participation in involuntary pools and assigned risk plans resulting from specific lines of business and geographic concentrations of business (Level 2 Annual Procedures—Income Statement and Surplus, procedure #2), consider performing one or more of the following procedures:

a. Verify that the insurer is participating in and properly accounting for its participation in involuntary pools and assigned risk plans in the various states.

i. Determine the insurer's method of accounting for involuntary pools by reference to the Audited Financial Report and/or Annual Financial Statement.

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ii. Determine whether the insurer's method of accounting for involuntary pools is consistent with prior years.

iii. Review the insurer's prior examination reports to determine whether the insurer properly participated in the various involuntary pools and assigned risk plans and properly accounted for such participation.

b. Review the insurer's mix of business by line and state in order to identify concerns relating to involuntary pools and assigned risk plans, such as:

i. Plans with known significant timing delays in reporting results to the insurers.

ii. Plans with known adverse development trends.

5. If there are concerns regarding whether the insurer may be excessively leveraged due to the volume of premiums written (Level 2 Annual Procedures—Income Statement and Surplus, procedure #3), consider performing one or more of the following procedures:

a. Review the net premium written by line of business in the Financial Profile Report to determine which lines of business are being written.

b. Compare the gross premium written to policyholders' surplus ratio and the net premium written to policyholders' surplus ratio to the industry averages to determine any significant deviations from the industry averages.

c. If the insurer is a member of an affiliated group of insurers, compute the gross premium written to policyholders' surplus ratio and the net premium written to policyholders' surplus ratio on a consolidated basis to determine if the affiliated group of insurers appears to be excessively leveraged.

d. Determine that the insurer has adequate reinsurance protection against large losses and catastrophes and that the reinsurers are of high quality (review Level 3 Annual Procedures—Reinsurance, #1 and #3).

e. Obtain an explanation from the insurer for unusual results for IRIS ratios #1 and #2.

6. If there are concerns regarding the amount of the insurer's policyholders' surplus (Level 2 Annual Procedures—Income Statement and Surplus, procedure #5), consider performing one or more of the following procedures:

a. Review the procedures in Level 2 Annual Procedures—Risk-Based Capital.

b. Compare the policyholders' surplus to assets ratio to the industry average to determine any significant deviation.

c. If the insurer has outstanding surplus notes or capital notes issued, review the Notes to Financial Statements, #13—Capital and Surplus, Dividend Restrictions, and Quasi-Reorganizations, and Note #11—Debt to determine the following information:

- Date issued
- Interest rate
- Amount of note and current value
- Interest paid—current year-end total
- Accrued interest
- Date of maturity
- Name of holder (and indication of whether the holder is an affiliated entity)
- Description of assets received

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- Repayment conditions or restrictions

d. If capital or surplus notes were issued during the year, determine whether they were approved by the domiciliary state insurance department.

e. If principal was repaid and/or interest was paid on surplus notes during the year, determine that the principal repayments and/or the interest payments were approved by the domiciliary state insurance department.

f. If surplus notes represent a significant portion of policyholders' surplus, recalculate important ratios excluding the amount of surplus notes to determine the effect of surplus notes on the ratio results.

g. Review the write-ins for special surplus funds and for other than special surplus funds for reasonableness.

h. Review the Capital and Surplus section in the Financial Profile Report for unusual fluctuations or trends in the changes in policyholders' surplus between years.

i. Review the detail of unrealized gains (losses) in the Exhibit of Capital Gains (Losses) for reasonableness.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the insurer's income statement and policyholders' surplus based on the Level 3 Procedures performed.

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
- ☐ Refer concerns to examination section for targeted examination
- ☐ Meet with the insurer's management
- ☐ Obtain a corrective plan from the insurer
- ☐ Other (explain)

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1. If there are concerns that the insurer's risk profile is not adequately supported by its reinsurance program (Level 2 Annual Procedures—Reinsurance, procedure #1), consider completing one or more of the following procedures:

   a. Review, for each line of business included in Schedule P, the trends in accident year loss ratios, on both a gross and net basis, for indications of deteriorating underwriting results.

   b. Review Schedule T and determine whether there appears to be large geographic concentrations of premiums in areas especially prone to catastrophic events.

   c. Obtain a copy of the insurer's A.M. Best Supplemental Ratings Questionnaire and review the reinsurance section.

   d. Review General Interrogatories, Part 2, #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?

   e. Review General Interrogatories, Part 2, #13.3. Is the number of reinsurance contracts considered in the calculation of the largest net aggregate risk amount cause for concern?

   f. Review General Interrogatories, Part 2, #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?

   g. Briefly scan the individual reinsurers listed on Schedule F, Part 5—Provision for Unauthorized Reinsurance.

      i. Determine if there are any significant new reinsurers known to engage in financial reinsurance transactions that may trigger concerns as to transfer of risk with respect to this specific insurer.

      ii. 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.

2. If there are concerns regarding the insurer's accounting treatment for reinsurance ceded (Level 2 Annual Procedures—Reinsurance, procedure #2), consider completing one or more of the following procedures:

   a. Further investigate whether specific reinsurers classified as authorized on Schedule F, Part 3 are, in fact, authorized.

      i. Select the five largest individual reinsurers based on the total reinsurance recoverables and determine whether they are authorized.

      ii. On a test basis, select a sample from among the remaining reinsurers and determine whether they are authorized, as necessary.

   b. Review, by individual reinsurer, the amounts shown as security. Identify any unusual trends and determine the need to examine the underlying security in more detail to ensure its validity.

   c. Review Schedule F, Parts 3 and 5 and determine that the total provision for unauthorized reinsurance was calculated properly.

   d. Review Schedule F, Part 6 and determine that the provision for overdue authorized reinsurance was calculated properly.

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e. Review Schedule F, Part 7 and determine that the provision for reinsurance was calculated properly, and reconcile the amount to Liabilities, Surplus and Other Funds.

f. Run the I-SITE Examination Jumpstart analysis to determine whether ceding company credits are appropriately "mirrored" by the reinsurer after considering the possibility of normal timing delays.

3. If there are concerns regarding the collectibility of reinsurance recoverables from significant individual unauthorized reinsurers (Level 2 Annual Procedures—Reinsurance, procedure #4), consider completing one or more of the following procedures:

a. Determine the current ratings of the reinsurer from the major rating agencies, and investigate significant changes during the past 12 months.

b. Review the reinsurer's current and prior year Analyst Team priority designations. For any reinsurer that has received a Validated Level "A" or "B," request a copy of the reinsurance agreement(s) and confirm amounts included on Schedule F, Part 5.

c. Review information about the reinsurer that is available from industry analysts and benchmark capital adequacy with top performers and peer groups.

d. Request a copy of the insurer's A.M. Best Supplemental Ratings Questionnaire and review the reinsurance section for unusual items.

e. Obtain and review the Audited Financial Report and Annual Financial Statement of the reinsurer for additional insight regarding collectibility.

f. Review SEC filings of the reinsurer, if applicable, for insight regarding collectibility.

g. Obtain and review the Statement of Actuarial Opinion of the reinsurer for additional insight regarding collectibility.

h. Determine whether adequate levels of acceptable collateral (LOCs, trust funds, etc.) are being maintained to secure outstanding losses.

i. Contact the domiciliary state to determine whether any regulatory actions are pending against the reinsurer.

j. Review the reinsurer's historical payment patterns of recoverables and comment on findings.

k. Using the Global Receivership Information Database (GRID) within I-SITE, review the status of any relevant multi-state, single state, or alien reinsurance company departmental or jurisdictional supervised receivership (i.e., conservatorship, rehabilitation, or liquidation proceedings).

4. If there are concerns regarding the collectibility of reinsurance recoverables from significant individual authorized reinsurers (Level 2 Annual Procedures—Reinsurance, procedure #4), consider completing one or more of the following procedures:

a. Review analysis and supporting documentation that is already available within the insurance department, e.g., examination reports, recent analysis, current financial statements, etc.

b. Determine the current ratings of the reinsurer from the major rating agencies and investigate significant changes during the past 12 months.

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c. Review information about the reinsurer available from industry analysts and benchmark capital adequacy with top performers and peer groups.

d. Obtain and review the Audited Financial Report and Annual Financial Statement of the reinsurer for additional insight regarding collectibility.

e. Review SEC filings of the reinsurer, if applicable, for insight regarding collectibility.

f. Obtain and review the Statement of Actuarial Opinion of the reinsurer for additional insight regarding collectibility.

g. Determine whether adequate levels of acceptable collateral (LOCs, trust funds, etc.) are being maintained to secure outstanding losses.

h. Review the reinsurer's history of payments of recoverables, and comment on findings.

i. Using the GRID within I-SITE, review the status of any relevant multi-state, single state, or alien reinsurance company departmental or jurisdictional supervised receivership (i.e., conservatorship, rehabilitation, or liquidation proceedings).

5. If there are concerns that reinsurance between affiliates involves any unusual shifting of risk from one affiliate to another (Level 2 Annual Procedures—Reinsurance, procedure #5), consider completing one or more of the following procedures:

   a. Obtain and review the underlying agreements that support the transaction(s) in question.

   b. Critically assess the substance of the transaction in terms of the following criteria:

      i. The transaction must be economic-based and at arm's length.

      ii. The transaction must result in the transfer of risk and represent a consummated or permanent act.

      iii. Any assets transferred to an affiliate must be transferred at fair value in an economic-based transaction.

      iv. In the case of a portfolio transfer involving an affiliate, the transaction may not be allowable under state law or may require prior regulatory approvals.

6. Determine whether pyramiding may be occurring that could cause significant collectibility risk to the insurer.

   a. Review the individual authorized reinsurers listed in Schedule F, Part 3. Are any of the reinsurers generally known to enter into significant retrocession agreements?

   b. For the five largest individual unauthorized reinsurers listed in Schedule F, Part 3, consider the need to obtain the reinsurer's Annual Financial Statement and determine the extent to which the reinsurer has engaged in retrocession agreements. If considered necessary, was it determined that any of these unauthorized reinsurers have ceded reserves greater than 50 percent of total gross reserves?

   c. If there are concerns that pyramiding exists, consider completing one or more of the following procedures:

      i. Obtain the Annual Financial Statement of selected large reinsurers and determine the extent to which the reinsurer cedes business to other reinsurers.

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ii. On a test basis, as considered necessary, obtain the Annual Financial Statement of the retrocessionaire and determine the extent to which that reinsurer cedes business to other reinsurers.

Proceed with this process as long as concerns regarding pyramiding continue to exist. Throughout this process, be alert to declines in the overall quality level of reinsurers throughout the chain of reinsurance. If significant collectibility concerns surface as a result of these procedures, perform the appropriate procedures to evaluate collectibility (also procedures #3 and #4 within this chapter).

7. If there are concerns that reinsurance is being used for fronting purposes (Level 2 Annual Procedures—Reinsurance, procedure #6), evaluate the collectibility of reinsurance recoverables (see procedures #3 and #4 within this chapter).

8. If there are concerns that significant and/or unusual reinsurance intermediary agreements or reinsurance assumed agreements exist (Level 2 Annual Procedures—Reinsurance, procedure #7), consider completing one or more of the following procedures:

   a. Obtain and review underlying documents relating to the use of the reinsurance intermediary.

   b. Determine whether the agreement is at arm's length and has economic substance.

   c. Verify by direct contact or confirmation that funds withheld for payment are valid and adequately segregated for payment of losses.

   d. Determine whether the requirements of the Reinsurance Intermediary Model Act have been met.

   e. Determine whether the requirements of the Managing General Agents Model Act have been met.

9. If there are concerns as to significant or unusual reinsurance transactions (Level 2 Annual Procedures—Reinsurance, procedure #8), consider completing one or more of the following procedures:

   a. Obtain and review significant commutation agreements.

      i. Determine that transfer of risk criteria have been met.

      ii. Obtain the Annual Financial Statement of the other insurer that is party to the commutation agreement, and determine that the transaction has been properly mirrored.

   b. Obtain and review significant portfolio transfer agreements.

      i. Determine that transfer of risk criteria has been met.

      ii. Obtain the Annual Financial Statement of the other insurer that is party to the portfolio transfer agreement, and determine that the transaction has been properly mirrored.

   c. If the insurer utilizes financial reinsurance:

      i. Review a summary of the reinsurance contract terms.

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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 if the reinsurance contract has been accounted for properly, and note any special accounting treatment, including any difference in treatment between GAAP and SAP.

d. Review any disclosures made by the insurer in accordance with the Disclosure of Material Transactions Model Act regarding material nonrenewals, cancellations, or revisions of ceded reinsurance agreements.

i. Obtain and review supporting documentation of such material transactions.

ii. Determine whether, in the judgment of the analyst, any additional procedures are considered necessary.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the insurer's reinsurance based on the Level 3 procedures performed.

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
- ☐ Refer concerns to examination section for targeted examination
- ☐ Engage an independent actuary or reinsurance expert to review reinsurance contracts
- ☐ Meet with the insurer's management
- ☐ Obtain a corrective plan from the insurer
- ☐ Other (explain)

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1. If the insurer's corporate structure elevates concerns about affiliated transactions (Level 2 Annual Procedures—Affiliated Transactions, procedure #1), consider completing one or more of the following procedures:

    a. Obtain and review the financial statements of the parent holding company (available with Form B filing) in order to understand its debt and equity structure.

    b. Determine the level of debt service required by the holding company, and gain an understanding of its primary sources of revenue.

    c. If the primary sources of revenue are dividends and fees from the insurer, evaluate these sources to determine their validity and reasonableness.

    d. Obtain and review SEC filings, if available.

2. If there are concerns that major transactions with affiliates are not economic-based or that they are not in compliance with regulatory guidelines (Level 2 Annual Procedures—Affiliated Transactions, procedure #2), consider completing one or more of the following procedures:

    a. Verify that all regulatory approvals were received and that the transactions recorded in the Annual Financial Statement reflect the transactions as approved.

    b. If the concern relates to the economic substance of the transaction, obtain and review supporting documents.

    c. If the concern relates to the fair value used to record the transaction:

        i. Obtain and review an appraisal of the asset transferred.

        ii. Consider consulting an independent appraiser.

    d. If the concern involves a management agreement or service contract:

        i. Determine that appropriate regulatory approvals were received and that the insurer is complying with the terms as approved.

        ii. Obtain and review the supporting contract.

        iii. Determine that the amounts involved are reasonable approximations of actual costs.

        iv. Determine that the actual amounts paid are in agreement with the supporting contract.

        v. For any agreement based on a cost plus formula or percent of premiums formula, request justification from the insurer for amounts in excess of the actual cost of providing the service.

        vi. For those services being performed by/for an affiliate and which are also provided by unrelated third-party vendors (e.g., data processing, actuarial, investment management), contact such vendors or review vendor pricing schedules in order to determine the reasonableness of the intercompany transfer pricing level.

        vii. Evaluate whether any portion of such fees is in substance dividends that should be evaluated in the context of dividend regulations.

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3. If investments in affiliates are significant or if there are concerns whether investments in affiliates are properly valued in accordance with statutory accounting practices (Level 2 Annual Procedures—Affiliated Transactions, procedures #3 and #4), consider completing one or more of the following procedures:

   a. Review details of affiliated investments as reported in Schedules A, B, and D, and compare with prior years.

   b. Obtain an understanding of the primary business activity of the affiliate and determine that such an investment complies with regulatory requirements.

   c. Review the components of investment income reflected on the Exhibit of Net Investment Income and Exhibit of Capital Gains (Losses).

      i. Calculate the return on investment for current and prior years.

      ii. Review the components of investment income, and determine whether the source is cash or merely an increase in accrued interest income.

      iii. If a substantial portion of investment income relates to an increase in the accrual, determine whether such revenue recognition is legitimate and reasonable.

      iv. Determine whether accrued interest on investments in affiliates has grown to a significant level.

   d. Obtain and review the Audited Financial Report and Annual Financial Statement of the affiliate, if available.

   e. Determine the current ratings of the affiliate from the major rating agencies, if available.

   f. Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.

   g. Obtain and review the Statement of Actuarial Opinion of the affiliate, if available.

   h. Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.

   i. Using the Global Receivership Information Database (GRID) within I-SITE, review the status of any relevant multi-state, single state, or alien reinsurance company under departmental or jurisdictional supervised receivership (i.e., conservatorship, rehabilitation, or liquidation proceedings).

4. If there are concerns whether other affiliated transactions are legitimate and are properly accounted for (Level 2 Annual Procedures—Affiliated Transactions, procedure #5), consider completing one or more of the following procedures:

   a. If the concern relates to federal tax recoverables from a parent or affiliates:

      i. Obtain and review the financial statements of the parent or affiliates and evaluate any collectibility risk to the insurer.

      ii. Review the tax sharing agreement and verify that the terms are being followed.

      iii. Verify that the amount recoverable from the prior year-end has been paid.

   b. If the concern relates to structured settlements acquired from an affiliated life insurance company:

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i. Determine the current ratings of the affiliates from the major rating agencies, if available.

ii. Review information about the affiliate from industry analysts and benchmark capital adequacy with top performers and peer groups.

iii. Obtain and review the Statement of Actuarial Opinion of the affiliate, if available.

iv. Contact the domiciliary state to determine whether any regulatory actions are pending against the affiliate.

v. Determine that any required regulatory approvals were obtained.

c. Assemble a list of all affiliates and other related parties.

i. Summarize the financial impact of each transaction.

ii. Identify any other unusual transactions and investigate for reasonableness.

iii. Determine that any required regulatory approvals were obtained.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the insurer's affiliated transactions based on the Level 3 Procedures performed.

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
- ☐ Request consolidating holding company schedules
- ☐ Require additional interim reporting from the insurer
- ☐ Refer concerns to examination section for targeted examination
- ☐ Consult an independent appraiser to evaluate transactions involving material transfers of assets
- ☐ Meet with the insurer's management
- ☐ Recommend that a cease and desist order and/or fines be issued for holding company violations that were detected during the review
- ☐ Obtain a corrective action plan from the insurer
- ☐ Recommend that action be taken to reverse or modify contracts that are harmful to insurer
- ☐ Other (explain)

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1. If there are concerns due to a significant amount of the insurer's direct premiums being written through MGAs and TPAs (Level 2 Annual Procedures—MGAs and TPAs, procedure #1), consider performing one or more of the following procedures:

   a. Review the Notes to Financial Statements, #19—Direct Premiums Written/Produced by Managing General Agents/Third-Party Administrators (which lists all individual MGAs and TPAs whose direct writings are greater than five percent of policyholders' surplus) to determine (1) which MGAs and TPAs are being utilized and whether any are affiliated with the insurer, (2) the types and amount of direct business written by the MGAs and TPAs, and (3) the types of authority granted to the MGAs and TPAs by the insurer.

   b. For those lines of business in which a significant amount of the insurer's direct premiums are written through MGAs and TPAs, determine if the incurred loss and LAE ratios are comparable to industry averages (review procedure #1e in Level 3 Annual Procedures—Unpaid Losses and LAE).

   c. For those lines of business in which a significant amount, but not all, of the insurer's direct business written is written through MGAs and TPAs, request information from the insurer to evaluate the comparability of the incurred loss and LAE ratios on the business written by the MGAs and TPAs with that written directly by the insurer.

   d. For the more significant MGAs and TPAs, request information from the insurer to determine whether the business produced by the MGA or TPA is ceded to a particular reinsurer and, if so, whether that reinsurance was arranged for by the MGA or TPA. If the MGA or TPA arranged for the reinsurance, determine whether the MGA or TPA is affiliated with the reinsurer, and consider reviewing the reinsurance agreements to determine whether the terms are reasonable.

   e. For the more significant MGAs and TPAs, request information from the insurer regarding commission rates and any other amounts paid to the MGAs and TPAs. Review the information for reasonableness and compare the commission rates to those paid by the insurer to other agents.

   f. Determine whether the MGAs utilized by the insurer are properly licensed and whether the TPAs utilized by the insurer hold valid Certificates of Authority. In some states, an insurer may utilize an MGA who is not licensed if biographical questionnaires have been submitted for each individual owning more than 10 percent of the MGA. If this provision is applicable and the MGA is not licensed, verify that the required biographical questionnaires have been submitted.

   g. Request copies of the contracts between the insurer and its more significant MGAs and review to determine that the contracts include the minimum required provisions per Section 4 of the Model Managing General Agents Act and/or the applicable sections of the Insurance Code.

   h. Request copies of the contracts between the insurer and its more significant TPAs and review to determine that the contracts include the minimum required provisions per Sections 2, 4, 6, 7, and 8 of the Model Third Party Administrator Statute and/or the applicable sections of the Insurance Code.

   i. For the more significant MGAs utilized by the insurer, request and review the following:

      i. The most recent independent CPA audit of the MGA.

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ii. If the MGA establishes loss reserves, the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA.

iii. Documentation supporting the insurer's periodic (at least semi-annual) on-site review of the MGA's underwriting and claims processing operations.

j. For the more significant TPAs utilized by the insurer, request and review the following:

i. The most recent annual report of the TPA.

ii. Documentation supporting the insurer's periodic (at least semi-annual) review of the operations of the TPA. (The NAIC Managing General Agents Model Act requires at least one of the semi-annual reviews to be an on-site audit of the operations of the TPA.)

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

i. Compare the contract between the insurer and the MGA or TPA with the contracts between the other insurers and the MGA or TPA to determine whether they are similar, i.e., contain the same commission rates.

ii. Compare the insurer's loss and LAE ratios on the business placed by the MGA or TPA with those of the other insurers utilizing the same MGA or TPA to determine whether the ratios are similar or whether it appears that the insurer may be receiving a disproportionate amount of "bad" business from the MGA or TPA.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the insurer's use of MGAs and TPAs based on the Level 3 Procedures performed.

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

- ☐ Contact the insurer for explanations or additional information
- ☐ Obtain the insurer's business plan
- ☐ Require additional interim reporting from the insurer
- ☐ Refer concerns to examination section for targeted examination
- ☐ Refer concerns regarding a particular MGA or TPA to examination section for examination of the MGA or TPA
- ☐ Meet with the insurer's management
- ☐ Obtain a corrective plan from the insurer
- ☐ Other (explain)

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V. Supplemental Procedures

A. Audited Financial Report

B. Statement of Actuarial Opinion & Actuarial Opinion Summary

C. Management's Discussion and Analysis

D. Holding Company Analysis

1 Form A

2 Form B

3 Form D

4 Form E (or Other Required Information)

5 Extraordinary Dividend/Distribution

E. Captives and/or Insurers Filing on a U.S. GAAP Basis

Audited Financial Report

1. Were the financial statements included in the Audited Financial Report prepared based on statutory accounting practices?

2. Were the financial statements included in the Audited Financial Report specific to the insurer rather than on a consolidated or combined basis?

3. If the financial statements included in the Audited Financial Report were prepared on a consolidated or combined basis, answer the following questions:

   a. Was this basis approved by the domiciliary commissioner upon application by the insurer due to a pooling or a 100-percent reinsurance agreement with affiliates?

   b. Was a consolidating or combining worksheet included with the financial statements that:

      i. Shows amounts separately for each insurer (non-insurance operations may be shown on a combined or individual basis)?

      ii. Provides explanations for consolidating and eliminating entries?

      iii. Includes a reconciliation of any differences between the amounts shown for an individual insurer and the amounts per the insurer's Annual Financial Statement?

4. What type of opinion was issued by the CPA?

   - ☐ Unqualified
   - ☐ Unqualified with explanatory language added
   - ☐ Qualified
   - ☐ Adverse
   - ☐ Disclaimer of opinion

5. If the opinion was other than unqualified, comment on the reasons for the deviation.

6. Do total assets, net income, and policyholders' surplus per the Audited Financial Report agree with the amounts per the insurer's Annual Financial Statement?

7. If total assets, net income, and/or policyholders' surplus do not agree with the amounts per the Annual Financial Statement, review the reconciliation of differences and comment on the differences and the reasons based on the Notes to Financial Statements. Also consider the impact of the audit adjustments made by the independent CPA on the conclusions reached as a result of the analysis of the Annual Financial Statement, and consider the need to perform additional analysis—e.g., complete additional Supplemental Procedures for items impacted by the audit adjustments, etc.—on the Annual Financial Statement information.

8. Review the Notes to Financial Statements and comment on items of significance including, but not limited to: investments, reserves, reinsurance, transactions with affiliates, contingent liabilities, and the summary of ownership and relationships with affiliated companies. Also consider the impact, if any, of the information in the Notes to Financial Statements on the conclusions reached as a result of the analysis of the Annual Financial Statement, and consider the need to perform additional analysis, e.g., complete additional Supplemental Procedures, etc., on the Annual Financial Statement information.

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9. If affiliated transactions are significant, consider comparing information regarding affiliated relationships and affiliated transactions per the Audited Financial Report to information reported by the insurer in the Annual Financial Statement and in the various holding company filings, and comment on any discrepancies noted.

Internal Controls

10. Review the Report of Significant Deficiencies in the insurer's internal control structure prepared by the CPA, if applicable (the report is only prepared if the insurer is an SEC registrant or significant deficiencies are reported in the CPA report) and comment on the deficiencies noted and the improvements made or proposed by the insurer to correct those deficiencies.

CPA's Letter of Qualifications

This section of the Audited Financial Report should be completed whenever there has been a change in the independent CPA from the prior year and may be completed annually whether or not there has been a change in the independent CPA.

11. Confirm that the CPA's letter of qualifications includes the following:

    a. A statement that the CPA is independent with respect to the insurer and conforms to the standards of the profession.

    b. Information regarding the background and experience, including the experience in audits of insurers, of the staff assigned to the audit, and whether each is a CPA.

    c. A statement that the CPA understands that the domiciliary commissioner will be relying on the Audited Financial Report, and the CPA's opinion thereon, in the monitoring and regulation of the financial position of the insurer.

    d. A statement that the CPA is properly licensed by an appropriate state licensing authority.

    e. A statement that the CPA is in compliance with the following qualifications, which are specified in #7 of the instructions for Annual Audited Financial Reports in the *Annual Statement Instructions Property/Casualty*:

        i. The CPA is in good standing with the American Institute of Certified Public Accountants and with all states in which the CPA is licensed to practice or, for a Canadian or British insurer, is a chartered accountant.

        ii. The CPA conforms to the standards of the profession.

        iii. The partner or other person responsible for rendering the Audited Financial Report has not acted in that capacity for more than seven consecutive years and, following any such period of service, that person shall be disqualified from serving in that or a similar position for the same insurer for a period of two years.

        iv. The domiciliary commissioner has not ruled that the CPA is unqualified for purposes of expressing an opinion on the financial statements included in the Audited Financial Report.

    f. A statement that the CPA agrees to:

        i. Make available for review by the domiciliary state insurance department examiners, at any reasonable place designated by the domiciliary commissioner,

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all workpapers prepared in the conduct of the audit and any communications between the CPA and the insurer related to the audit.

ii. Retain the audit workpapers and communications until the domiciliary state insurance department has filed an examination report covering the period of the audit but no longer than seven years from the date of the audit report.

iii. Allow copies of pertinent audit workpapers to be made and retained by the domiciliary state insurance department examiners.

12. Comment on any deviations between the statements in the CPA's letter of qualifications and the required statements per the *Annual Statement Instructions Property/Casualty* as summarized in procedure #1 within this chapter.

Change in CPA

13. Was the CPA who issued the opinion on the insurer's financial statements the same CPA who issued the opinion on the insurer's financial statements in the prior year?

14. If the CPA who issued the opinion on the insurer's financial statements this year is different from the CPA in the prior year:

    a. Was the domiciliary state insurance department notified of the change?

    b. Has a letter from the new CPA been filed with the domiciliary state insurance department that states that the CPA is aware of the provisions of the Insurance Code and the rules and regulations of the domiciliary state insurance department that relate to accounting and financial matters, and that affirms that the CPA will express an opinion on the financial statements of the insurer in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that department, specifying such exceptions as the CPA may believe appropriate?

    c. Did the insurer file a letter with the domiciliary state insurance department stating whether, in the 24 months preceding the change in CPAs, there were any disagreements with the former CPA regarding accounting principles or practices, financial statement disclosure, or auditing scope or procedure which, if not resolved to the satisfaction of the former CPA, would have caused the CPA to make reference to the subject matter of the disagreement in connection with the CPA's opinion?

    d. With regard to the letter referred to in procedure #14c, did the insurer also file a letter from the former CPA stating whether the CPA agrees with the statements regarding disagreements in the insurer's letter?

15. Comment on any disagreements noted in the letters from either the insurer or the former CPA.

Audit Committee

16. Effective January 1, 2010, every insurer is required to have designated an Audit Committee, a percentage of whose members should be independent from the insurer depending upon premium volumes.

    a. Has the insurer established an Audit Committee?

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b. Does the Audit Committee membership meet independence requirements of the domicilary state insurance laws?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the Audited Financial Report. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures that, in the analyst's judgment, are relevant to evaluating the Audited Financial Report under the specific circumstances involved. In documenting the conclusion, the analyst should comment specifically on the reasons for anything but a standard unqualified opinion.

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

- ☐ Contact the insurer seeking explanations or additional information from the insurer or the independent CPA
- ☐ Obtain the insurer's business plan
- ☐ Require additional interim reporting from the insurer
- ☐ Refer concerns to examination section for targeted examination
- ☐ Meet with the insurer's management
- ☐ Obtain a corrective plan from the insurer
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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A. ACTUARIAL OPINION

GENERAL

1. Was a Statement of Actuarial Opinion filed with the Annual Financial Statement?

2. Determine whether any exemptions for filing the Statement of Actuarial Opinion were granted.

   a. Did the insurer receive an exemption from the requirement to file a Statement of Actuarial Opinion?

   b. If the answer to 2a is "yes," was the exemption attached to the Annual Financial Statement?

   c. Reason for exemption (if known):

      - ☐ Small company
      - ☐ Under supervision or conservatorship
      - ☐ Nature of business
      - ☐ Financial hardship
      - ☐ Other

IDENTIFICATION

3. Name of appointed actuary (Exhibit B, Item #1):

4. Relationship of appointed actuary to insurer (Exhibit B, Item #2):

   - ☐ Officer/employee of insurer ("E")
   - ☐ Associated with firm ("C")

5. The appointed actuary can be qualified to sign a Statement of Actuarial Opinion by meeting one or both of the specified qualifications, check those that apply (Exhibit B, Item #3).

   - ☐ Appointed actuary is a member of the Casualty Actuarial Society (CAS) (may be demonstrated by the presence of "ACAS" or "FCAS" designation) ("F" or "A")
   - ☐ Appointed actuary is a member of the American Academy of Actuaries (MAAA designation) but not the CAS ("M") – approval letter from the AAA must be attached to the Opinion
   - ☐ Other ("O")

6. Was the actuary appointed by the board of directors (or its equivalent) or by a committee of the board by December 31 of the calendar year for which the Opinion was rendered?

7. Is this the same actuary who was appointed for the previous Statement of Actuarial Opinion?

   a. If "no," did the insurer notify the domiciliary state insurance regulator within 5 days of the replacement?

   b. Within 10 business days of the above notification, did the insurer also provide an additional letter stating whether or not there were any disagreements with the former actuary and also in writing request the former actuary for a letter of agreement?

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SCOPE

8. Is Exhibit A attached to or made part of the Opinion? Exhibit A should list those items and amounts with respect to which the Appointed Actuary is expressing an opinion.

9. Does the Scope paragraph contain a sentence such as one of the following?

   - ☐ "I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Financial Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 20__."
   - ☐ "I have examined the reserves listed in Exhibit A, as shown in the Annual Financial Statement of the company as prepared for filing with state regulatory officials, as of December 31, 20__."
   - ☐ Other or none (provide comments).

10. Exhibit A lists amounts for specific items; these amounts should match the corresponding Annual Financial Statement references. The analyst should document whether the items in Exhibit A match, do not match, are not listed, or any other concerns or unusual findings. *The cross-check report should validate this as well.*

11. Exhibit A may also list premium amounts. The analyst should document concerns for any of the following items that contain premium amounts.

    a. Reserve for direct and assumed unearned premiums for long duration contracts.

    b. Reserve for net unearned premiums for long duration contracts.

    c. Other premium reserve items such as premium deficiency reserves (list and discuss).

12. Does the Scope paragraph contain statements regarding the formation of the actuary's opinion on the loss and LAE reserves that includes the following:

    a. The individual (company officer) that was relied upon for data preparation.

    b. The actuary evaluated that data for reasonableness and consistency.

    c. The actuary reconciled or reviewed the reconciliation of that data to Schedule P, Part 1 of the company's current Annual Financial Statement. If the data was not reconciled, the analyst should provide additional comments on the issue.

    d. The actuary's examination included a review of the actuarial assumptions and methods used and tests of the calculations are considered necessary.

OPINION

13. Does the Opinion state that the amounts shown in Exhibit A meet the requirements of the insurance laws of the state of domicile? The analyst should document any reasons provided by the actuary as to why the amounts did not meet the requirements.

14. Does the Opinion state that the amounts shown in Exhibit A are computed in accordance with accepted actuarial standards and principles? The analyst should document any alternate standards and principles that were possibly applied to the Opinion and whether or not those standards and principles are appropriate.

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15. Does the Opinion state that the amounts shown in Exhibit A make a Reasonable ("R") provision (stated reserve is within the actuary's range of reasonable reserve estimates) for all unpaid loss and LAE obligations of the insurer under the terms of its contracts and agreements? (Exhibit B, Item #4)

    a. If "no," does the appointed actuary state that the amounts in Exhibit A are:

    - ☐ *Deficient or Inadequate "I"* (stated reserve is less than the minimum amount needed to be considered reasonable)
    - ☐ *Redundant or Excessive "E"* (stated reserve is greater than the maximum amount needed to be considered reasonable)
    - ☐ *Qualified "Q"* (the reserves for certain items are in question because they cannot be reasonable estimates or because the actuary is unable to render an opinion on those items)
    - ☐ *No opinion "N"* (the actuary cannot reach a conclusion due to deficiencies or limitations in the data, analysis, assumptions, or related information)

    If applicable, comment on the reasons why the Opinion states the reserves do not make a reasonable provision for unpaid loss and LAE obligations. Include a discussion of (1) the differences between the actuary's indicated reserves (or range of reasonable reserves) and those carried by the insurer, (2) the impact of the differences on the insurer's policyholders' surplus and/or, (3) the reasons why a "Qualified" Opinion or "No Opinion" was given. Consider the impact of the differences on the conclusions reached as a result of the analysis of the Annual Financial Statement and consider the need to perform additional analysis on the Annual Financial Statement, such as additional supplemental procedures for the item impacted.

    b. If the appointed actuary issues a "Qualified" Opinion, does the actuary also state whether the reserves make a reasonable provision for the liabilities, except for the item(s) to which the qualification relates? The analyst should provide comments on the reserves, e.g., what amount of reserves could not be estimated and why? Are these reserves material?

16. If the Scope section includes unearned premium reserves for long duration contracts, does the Opinion state that the amount shown in Exhibit A makes a reasonable provision for the unearned premium reserves for long duration contracts? The analyst should comment on the reasons why the Opinion states the reserves do not make a reasonable provision for long duration contracts (See Procedure #15b for types of appropriate comments).

17. Does the appointed actuary rely on the Actuarial Opinion of another actuary?

    a. If "yes," for what segment of the reserves?

    - ☐ Pools
    - ☐ Subsidiary
    - ☐ Special line of business
    - ☐ Other

    b. If stated in the Opinion, what percentage of the total reserves are the segmented reserves?

    c. Name(s) of actuary(ies):

    d. Affiliation(s) of actuary(ies):

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RELEVANT COMMENTS AND EXHIBIT B DISCLOSURES

18. Risk of Material Adverse Deviation:

    a. Does the Opinion list the Materiality Standard in Exhibit B (Item #5)?

    b. If "no," inquire why; otherwise, describe the standard, e.g., "X"% of surplus.

    c. What is the actuary's basis for establishing this standard?

    d. Does the actuary believe that there are significant risks or uncertainties that could result in material adverse deviation (Exhibit B Item #6)?

    e. Note any major risk factors or explanations discussed by the actuary.

    Bright Line Indicator Test: This indicator is triggered if 10 percent of the insurer's net reserves (Liabilities, Surplus and Other Funds page, sum of Losses and Loss adjustment expenses) are greater than the difference between the Total Adjusted Capital (Five-Year Historical Data page) and Company Action Level RBC (twice the authorized control level risk-based capital amount in the Five-Year Historical Data page). Is the Bright Line Indicator triggered? If "yes," comments from the actuary should be pursued if the actuary does not address material adverse deviation in his/her opinion.

    A special report is located on StateNet under the Financial Analysis link.

19. Exhibit B lists the amounts for the following items, these amounts should match the corresponding Annual Financial Statement references. Also, the actuary should include paragraphs describing the significance of these disclosure items in the Opinion narrative if necessary. Provide comments below each item, including a summary of the actuary's comments if necessary.

    a. Surplus (Exhibit B, Item #7), Liabilities, Surplus and Other Funds page, Surplus as regards policyholders'.

    b. Net salvage and subrogation (Exhibit B, Item #8), Schedule P, Part 1.

    c. Non-tabular discount (Exhibit B, Item #9.1), Notes to Financial Statements.

    d. Tabular discount (Exhibit B, Item #9.2), Notes to Financial Statements.

    e. Voluntary and involuntary pools and associations (Exhibit B, Item #10), refer to Schedule F, Parts 1 and 3 for limited information.

    f. Net asbestos (Exhibit B, Item #11.1) and environmental (Exhibit B, Item #11.2) reserves, Notes to Financial Statements.

    g. Extended loss and expense reserves (Exhibit B, Item #12.1 and #12.2), Schedule P, Interrogatories.

    h. Comment on other items (Exhibit B, Item #13).

20. Reinsurance

    a. Does the insurer have retroactive reinsurance? (Review Liabilities, Surplus and Other Funds page for write-in items and Notes to Financial Statements).

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i. Does the actuary discuss retroactive reinsurance? The analyst should document any concerns.

b. Does the insurer have financial reinsurance? (Review the Management's Discussion and Analysis, Reinsurance Attestation Supplement, and the General Interrogatories for any possible information).

i. Does the actuary discuss financial reinsurance? The analyst should document any concerns.

c. Does the insurer have reinsurance collectibility issues? (Review Schedule F, Part 7 and Notes to Financial Statements).

i. Does the actuary discuss reinsurance collectibility? Check all that apply.

- ☐ No
- ☐ Yes, with little comment
- ☐ Actuary solicited information from management
- ☐ Actuary reviewed ratings of reinsurers
- ☐ Actuary reviewed Schedule F

21. The insurer failed the following IRIS ratios (check all that apply):

- ☐ None
- ☐ One-year development (Schedule P, Part 2) divided by prior year's Surplus (Five-Year Historical Data)
- ☐ Two-year Development (Schedule P, Part 2) divided by two-prior year's Surplus (Five-Year Historical Data)
- ☐ Estimated current reserve deficiency to policyholders' surplus cannot be easily calculated but can be found on I-SITE along with the other IRIS ratios

a. Did the actuary discuss any exceptional values? The analyst should document any concerns.

22. Does the actuary indicate that there has been a material change in the actuarial assumptions and/or methods from those previously employed in determining the amounts of the insurer's reserves, if applicable? The analyst should document any comments or concerns.

23. Does the actuary comment on any other topics, e.g., lack of historical data for a line of business, if applicable? The analyst should document any comments or concerns.

CONCLUSIONS/RECOMMENDATIONS

24. Does the Opinion conclude with the signature of the appointed actuary, the date the Opinion was rendered, and the address and telephone number of the appointed actuary?

25. Does the actuary indicate that an Actuarial Report has been prepared, which supports the findings expressed in the Statement of Actuarial Opinion and that this report will be maintained at the company and available for regulatory examination for seven years?

26. For a small number of cases, the analyst may consider requesting a copy of the Actuarial Report (particularly if the Opinion is unusual in some way). Answer this question if a Report was provided; indicate whether the Actuarial Report includes the following required elements:

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a. Narrative component (should provide sufficient detail to clearly explain the actuary's findings and conclusions, as well as their significance).
b. Technical component (actuarial exhibits).
c. An exhibit which compares the actuary's conclusions to the carried reserves.
d. Summary exhibit(s) of either the actuary's best estimate, range of reasonable estimates, or both, that led to the actuary's conclusion.
e. Documentation of the reconciliation of the data used for analysis to Schedule P.
f. Extended comments related to risks that could result in material adverse deviation.
g. Extended comments on factors that led to unusual reserve IRIS Ratios and how these factors were addressed in current and prior year analyses.
h. Review the Narrative and indicate any significant issues which affected the actuary's interpretation of the data and the resulting Opinion issues. Provide any additional comments regarding the Actuarial Report.

B. ACTUARIAL OPINION SUMMARY

1. Does the domiciliary state insurance regulator require a confidential Statement of Actuarial Opinion Summary?

   If "yes," was the Actuarial Opinion Summary submitted by March 15 or the date requested by the regulator and signed by the same actuary who provided the Statement of Actuarial Opinion?

2. Are the company's recorded loss and loss adjustment expense reserves in the Actuarial Opinion Summary consistent with the corresponding reserves presented in Exhibit A of the Statement of Actuarial Opinion and the Annual Statement?

3. Did the actuary provide a comparison of the recorded reserves to a point estimate, a range estimate, or both?

   If the booked reserves are below the actuary's point estimate or below the midpoint of the actuary's range, how material is the difference?

   - As a percent of surplus?
   - As a percent of booked reserves?
   - In relation to the company's risk-based capital position?
   - Is the difference greater or less than the material adverse deviation standard?

   The analyst should judge the relative materiality of the difference and document any concerns.

4. Is the Summary consistent with the Opinion's conclusion that the amounts shown in Exhibit A are *Reasonable*, *Deficient or Inadequate, Redundant or Excessive, Qualified,* or *No opinion*?

   Consistency is defined by the following situations:

   - Opinion conclusion is "Reasonable"; booked reserves are at or near the actuary's point estimate and/or within the actuary's range
   - Opinion conclusion is "Deficient"; booked reserves are materially below the actuary's point estimate and/or below the low end of the actuary's range

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- Opinion conclusion is "Redundant"; booked reserves are materially above the actuary's point estimate and/or above the high end of the actuary's range

If the booked reserves are deficient and/or the Summary is not consistent with the Opinion, document any concerns.

5. Did the company experience one-year development in excess of 5 percent of surplus as measured by Schedule P, Part 2 Summary in at least three of the last five calendar years?

   If "yes," did the actuary provide explicit discussion of reserve elements and/or management decisions that were the reasons for such consistent adverse development? Was the discussion more detailed than in the Opinion? Note that merely stating that the development was due to "reserve strengthening" is insufficient. The analyst should document any concerns.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the Statement of Actuarial Opinion. In developing a conclusion, consider the above procedures as well as any other information that are, in the analyst's judgment, relevant to evaluating the actuarial opinion. This includes reviewing the Actuarial Opinion Summary (AOS), a confidential supplemental filing, if required. The AOS supplemental procedures should be performed before taking any further action as recommended below.

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

- ☐ Consult with the regulatory P/C actuary, if available
- ☐ Obtain the insurer's business plan
- ☐ Require additional interim reporting from the insurer
- ☐ Refer concerns to examination section for targeted examination
- ☐ Consult with the in-house (Company) actuary
- ☐ Engage an independent actuary to review insurer's reserves
- ☐ Meet with the insurer's management
- ☐ Obtain a corrective plan from the insurer
- ☐ Contact the insurer
- ☐ Obtain the Actuarial Report
- ☐ Develop a corrective plan
- ☐ Other (explain)

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1. Did the Management's Discussion and Analysis (MD&A) filed in accordance with the Annual Financial Statement instructions include the following overall content?

   a. Discussion of short and long-term analysis of the business of the insurer.

   b. Discussion of the two-year period covered in the Annual Financial Statement, including year-to-year comparisons.

   c. Reference to the Five-Year Historical Data exhibit and other exhibits or schedules where trend information is relevant.

   d. Explanation of accounting policies applied, judgments made in their application, and changes in assumptions or conditions that result in materially different reported results.

   e. Discussion of material events known to management that would cause reported financial information not to be necessarily indicative of future operating results or of future financial position.

2. Was the MD&A prepared on a non-consolidated basis? If "no," does the domiciliary state permit audited consolidated financial statements or does the insurer cede substantially all of its direct and assumed business to a pool?

3. Did the MD&A include a discussion regarding the insurer's results of operations?

   a. Describe any unusual or infrequent events, transactions, significant economic changes that materially impact income or other gains/losses in surplus or any significant components of income.

   b. Describe any known trends or uncertainties that are likely to have a material impact on premiums, income, or surplus.

   c. Describe known changes in the relationship of expenses and premiums.

   d. Discuss the extent to which material increases in premiums are due to increases in prices or volume of existing products or new products being sold.

4. Did the MD&A include a discussion regarding prospective information?

   a. Discuss known trends or uncertainties that are reasonably likely to impact liquidity, capital resources, and the mix and cost of such resources.

   b. Discuss known trends or uncertainties that are reasonably likely to impact premiums, net income, and surplus.

5. Did the MD&A include disclosure of reasons for material changes to line items or discussion and quantification of the contribution of two or more factors to such material changes?

6. Did the MD&A include a discussion on liquidity, asset/liability matching, and capital resources?

   a. Indicate those balance sheet, income statement, or cash flow items that the insurer believes may be indicators of its liquidity condition.

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b. Discuss the nature and extent of restrictions on the ability of subsidiaries to transfer funds to the insurer and the impact such restrictions may have on the ability of the insurer to meet cash obligations.

c. Identify any known trends, demands, commitments, events, or uncertainties that are reasonably likely to result in material changes in the insurer's liquidity. If any are identified, describe the course of action taken by the insurer to remedy a deterioration in liquidity.

d. Describe internal and external sources of capital available to improve liquidity and any material unused sources of liquid assets.

e. Describe any material trends in the insurer's capital resources, including any material changes in the mix or relative cost of such resources.

f. Discuss cash flows from investing and financing.

g. Discuss off-balance sheet financing if liquidity is dependent on such arrangements.

h. Disclose circumstances that materially effect liquidity, such as market price changes, economic declines, defaults on guarantees, etc.

7. Did the MD&A include a discussion on those items that affect the volatility of loss reserves?

8. Did the MD&A include a discussion on off-balance sheet arrangements?

a. Discuss off-balance sheet arrangements and transactions with limited-purpose entities.

b. Describe the extent of the insurer's reliance on off-balance sheet arrangements.

c. Disclose uncertainties where contingencies inherent in the arrangements are reasonably likely to affect the continued availability of a material historical source of liquidity and finance.

9. Did the MD&A include a discussion on participation in high-yield financings, highly leveraged transactions, or non-investment grade loans and investments?

a. Identify transactions or investments and the nature and extent of the insurer's involvement in such transactions or investments, if participation or involvement is reasonably likely to have a material effect on financial condition or results of operations.

b. Describe additional risks to the insurer as well as associated fees and recognized losses.

c. Describe the insurer's judgment as to the material effect, if any, on the financial condition of the insurer.

10. Did the MD&A include a discussion on preliminary merger/acquisition negotiations, where disclosure is otherwise required or has been made by or on behalf of the insurer?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the MD&A. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures that, in the analyst's judgment, are relevant to evaluating MD&A under the specific circumstances involved.

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

- ☐ If the insurer's MD&A is not sufficient, request the insurer re-submit the MD&A with more disclosure
- ☐ Obtain the insurer's business plan
- ☐ Require additional interim reporting from the insurer
- ☐ Refer concerns to examination section for targeted examination
- ☐ Consult with the in-house actuary
- ☐ Meet with the insurer's management
- ☐ Obtain a corrective plan from the insurer
- ☐ Other (explain)

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Special Note: The following procedures may be completed in part or in total at the discretion of the analyst depending on the level of concern, the area in which the risk was identified, and the degree of interdependence within the holding company entities.

Identify and Understand the Holding Company Structure

1. Identify the organization structure, e.g., public, non-public, mutual, etc.

2. Evaluate the insurer's Schedule Y and Notes to Financial Statements in conjunction with the financial filings of the holding company. Identify and understand the following:

   - ☐ Ultimate controlling entity or person(s)
   - ☐ Intermediate holding companies
   - ☐ Insurance vs. non-insurance entities
   - ☐ Ownership structure

3. Review the insurer's General Interrogatories, Part 1, #8.1 through #8.4 and identify other regulatory bodies that have authority over the group: Federal Reserve, Office of the Comptroller of the Currency, Office of Thrift Supervision, etc.

   Identify the following:
   - ☐ Controlling federal regulatory services agency
   - ☐ Any federally regulated action taken
   - ☐ Any communication between state and federal regulators that has been planned or initiated

4. Utilize the following financial filings to summarize the group's background:

   - ☐ SEC filings (if applicable)
   - ☐ Management's Discussion and Analysis
   - ☐ Statutory and GAAP Auditor's Report(s)
   - ☐ Statutory filings including combined filings and forms
   - ☐ Annual report to shareholders

5. Is the ultimate holding company a shell dedicated only to the insurance subsidiary's benefit? If so, identify the intermediate holding company to be analyzed.

6. Review the insurer's Jurat page and identify changes in officers and directors.

7. Review the insurer's Notes to Financial Statements, General Interrogatories, and Holding Company Form B, as well as recent examination reports. Identify and understand the following types of agreements the insurer has in place with the holding company and/or affiliates.

   - ☐ Management agreements
   - ☐ Third-party agreements
   - ☐ Managing general agent agreements
   - ☐ Investment management pools
   - ☐ Reinsurance agreements and pools
   - ☐ Income tax pool

8. Describe the nature of the insurance subsidiaries' interdependence on the holding company or affiliated entities for business operations or financial stability, e.g., employees, services provided, reinsurance, and/or capital support in the near term.

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9. Determine and describe the level of reputational risk that the holding company poses to the insurance subsidiaries.

10. Determine if income of the insurance subsidiaries is being used to finance holding company debt or other corporate initiatives.

11. Determine the level of holding company debt, e.g., corporate debt, borrowed money, and other types of debt, and its relative value to equity. If significant, summarize the following:

    - Type of debt
    - Terms of the debt covenants
    - Maturity schedules
    - Interest payment schedules
    - Ability to meet payments
    - Business purpose
    - Collateral

12. Determine the level of reliance on cash flows from subsidiaries to fund the holding company's interest and principal payments on the debt.

13. Have any subsidiaries of the 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 policyholders' surplus as well as the materiality of the insurance company dividends.

    b. Did the domiciliary department of insurance approve extraordinary dividends in order to support the holding company?

14. Understand and evaluate the method in which the group markets its products through a review of the legal entity's marketing plan.

15. Review the holding company and legal entity reports of the independent public accountant. Comment on the following:

    - Auditor's Opinion
    - Notes to Financial Statements
    - Management's assessment on internal controls
    - Auditor's assessment on management's assessment on internal controls
    - Material differences between statutory and GAAP opinions where relevant

I-SITE Lead State Report and Interstate Coordination

16. Using the I-SITE Lead State Summary Report, identify the lead state(s).

17. Identify a lead person or team of experts in order to create a contact list of key individuals within other interested states.

18. Establish a plan for communicating and coordinating with the lead state(s) if significant events, material concerns, or prospective risks are identified.

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19. Has your department considered implementing any of the following methods of communication with other states if significant events or material concerns are identified:

    - ☐ Establish a multi-state team of regulators
    - ☐ Establish a structure for obtaining updated information
    - ☐ Conference calls
    - ☐ Status e-mails
    - ☐ Disseminating relevant insurer documents and reports
    - ☐ Holding meetings with the insurer and relevant regulators

Evaluate the Financial Condition of the Holding Company Group

For the following procedures, utilize the shareholders' report, combined financial statements, SEC filings, audited financial statements, media releases, confidential information from other regulatory bodies, and any other available sources.

Assets

20. Review the distribution of invested assets and assess the overall asset quality, noting any shift in the mix.

21. 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.

22. Review the distribution of the non-invested assets and assess the overall collectibility risk.

23. Determine the level of goodwill and intangible assets relative to the value of equity. If significant, summarize the following:

    - ☐ Nature of intangible assets
    - ☐ Change or trend in goodwill
    - ☐ Source of goodwill
    - ☐ Impairment of goodwill

Liabilities (also see procedures #10, #11 & #12 regarding holding company debt within this chapter)

24. Assess loss reserves and loss reserve development and note any unusual trends.

25. Have loss reserves shown an increasing pattern while writings have remained flat? If "yes," explain any unusual changes.

26. Review the holding company's commitments and contingent liabilities.

    a. Has the holding company been subject to substantial complaints, class action lawsuits, or other litigation or investigations? If so, document the nature and outcome of those matters.

    b. Are any contingencies expected to have a material impact on the financial condition of the holding company? If so, document whether the holding company estimated the potential costs and established a reserve liability.

27. Review all other liabilities, including off-balance sheet risks, and assess any material risks.

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Shareholders' Equity (also see procedure #13 regarding dividends within this chapter)

28. Review the holding company's Statement of Shareholders' Equity. Has equity decreased significantly since the prior year or deteriorated over the past three years? If "yes," describe the reason(s) for the decline.

29. If publicly traded, review the historical prices of the holding company's stock. Has the value of common stock declined significantly over the past year? If "yes," explain the reason(s) for the decline.

30. If publicly traded, review the changes in the 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.

31. Assess the holding company's sources of capital and access to capital markets.

Segmented Information

32. Review the revenue of the group.
    a. Identify and understand the lines of business and any non-insurance business.
    b. Has the holding company entered into any new lines of business or types of non-insurance business or discontinued any business?
    c. Has the volume of business increased or decreased significantly over the prior year? If so, explain the reason for the change.

33. Review the holding company's gross and net writings leverage ratios. Are the ratios within an acceptable range?

34. If the holding company places a significant amount of gross business with reinsurers, assess the following regarding reinsurance agreements:
    - ☐ Risk transfer
    - ☐ Collateralization to unauthorized reinsurance
    - ☐ Recent reinsurance transactions
    - ☐ Credit quality of the reinsurer
    - ☐ Collectibility of recoverables
    - ☐ Level of surplus aid

Statement of Operations

35. Review the holding company's Statement of Operations.
    a. Did the holding company report material operating losses or overall net losses?
    b. Review the trend in net earnings. Has it declined over the prior year or over the past five years?

36. Evaluate the earnings trend for insurance operations vs. any non-insurance operations, and note the cause(s) for weak and/or deteriorating performance by business segment.

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37. Review investment income and realized capital gains and losses.
    a. Has net investment income significantly increased or decreased over the prior year? If so, explain the reason for the change.
    b. Document the amount of investment income that is attributed to dividends received from insurance subsidiaries.
    c. Calculate the investment yield. Has the yield decreased materially over the prior year? If so, explain the reason for the change.
    d. Has investment income from any asset category changed significantly over the prior year? If so, explain the reason for the change.
    e. Did the holding company report material realized capital gains/losses? If so, identify the cause of the loss.
38. Review all other sources of revenue and note any material changes or weaknesses.
39. Review benefits and expenses.
    a. Have insurance policy losses increased or decreased substantially over the prior year? If so, explain the reason for the change.
    b. Have administrative and other expenses increased significantly over the prior year? If so, explain the reason for the change.
    c. Summarize the loss and expense ratios by line of business and review the trend.
40. Has the holding company reported any non-recurring revenues or expenses that materially inflate or reduce earnings? If so, describe the reason for the revenue or expense.
41. Did the holding company report income or losses from discontinued operations? If so, summarize the nature of those operations and evaluate the earnings from those operations.

Statement of Cash Flows

42. Examine the holding company's Statement of Cash Flows.
    a. Has there been a negative trend in operating activities over the past five years?
    b. Has there been a negative trend in investing activities over the past five years?
    c. Has there been a negative trend in financing activities over the past five years?
43. Evaluate any downstream payments.

International

44. If applicable, develop an overall understanding of the relevant regulatory requirements of the domiciliary country as well as the appropriate supervisory authority.
45. If necessary, identify the appropriate channels of communication with the supervisory authority.
46. Ensure proper monetary conversion of financial data to U.S. currency.

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Supplemental Forms

47. If any of the following forms have been filed and the analyst has concerns, consider completing the applicable procedure.

	Analyst Recommendation
Form A (Acquisition of Control or Merger)	☐
Form B (Insurance Holding Company System)	☐
Form D (Prior Notice of a Transaction)	☐
Form E (Pre-Acquisition Notification)	☐
Extraordinary Dividend/Distribution	☐

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company analysis. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures that, in the analyst's judgment, are relevant to evaluating holding company analysis under the specific circumstances involved.

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
- ☐ Refer concerns to examination section for targeted examination
- ☐ Meet with the insurer's management
- ☐ Obtain a corrective plan from the insurer
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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Note: The following procedures do not supercede state regulation but are merely additional guidance that an analyst may consider useful.

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

Model Act and Database Procedures

1. Review the Form A database to determine whether or not the Form A is pending or has been approved, denied, or withdrawn in another state.

2. Perform a query of the Form A database on the name of the applicant, directors, executive officers, or owners of 10 percent or more of the voting securities of the applicant to identify the nature of other filings made in other states by similar individuals.

3. Establish contacts with other states to discuss the status and/or disposition of the current and prior filings made with those states.

4. Does Form A provide a brief description of how control is to be acquired?

5. Does Form A contain the following information:
   - Name and address (legal residence for an individual or street address if not an individual) of the applicant.
   - State the nature of the applicant's business operations for the past five years, if the applicant is not an individual.
   - Describe the business to be performed by the applicant and its subsidiaries.
   - Determine if the organization chart identifies and states the relationship of every member of the insurance holding company system, except for affiliates with total assets less than 0.5 percent of the total assets of the ultimate controlling person within the holding company system.

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

7. Does 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?

8. If amounts will be borrowed, does 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? Although not specifically required, if amounts will be borrowed, are the sources of funds to be used to service the debt stated?

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

10. Does Form A describe any plans or proposals for which the applicant may have to declare an extraordinary dividend, liquidate the insurer, enter into material agreements, including

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affiliated agreements, sell the insurer's assets, merge the insurer with any person or persons, or make any other material change in the insurer's business operations, corporate structure, or management?

11. Does Form A state the number of each class of shares of the insurer's voting securities that the applicant, its affiliates, and any person plan to acquire and the terms of the offer, request, invitation, agreement, or acquisition and a statement as to the method by which the fairness of the proposal was determined?

12. Does Form A state 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?

13. Does Form A give 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.

14. Does Form A 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?

15. Does Form A describe any recommendations to purchase any voting securities of the insurer made by the applicant, its affiliates, or any person, or by anyone based upon interviews or the suggestion of the applicant, its affiliates, or any person during the 12 calendar months preceding the filing of the Form A?

16. Does Form A 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?

17. Does Form A summarize the financial statements and exhibits attached to the filing?
    - ☐ Annual Audited Financial Statements of persons identified in the Form A.
    - ☐ 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.
    - ☐ Management's assessment of internal controls accompanied by an independent public accountant's report to the effect that the applicant maintained effective internal control.

18. Does Form A 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; 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?

19. Does Form A contain the required signature and certification?

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Assessment of the Change in Control

20. After the change of control, will the insurer be able to satisfy the requirements for the issuance of a license to write the classes of insurance for which it is presently licensed?

21. 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?

22. Is the financial condition of any acquiring person such that it might jeopardize the financial stability of the insurer or prejudice the interest of the insurer's policyholders?

23. Will dividends from the insurer be required to support debt payments of the applicant or the applicant's subsidiaries?

24. Are the competence, experience, and integrity of those persons who would control the operation of the insurer such that it would not be in the interest of the insurer's policyholders and of the public to permit the acquisition of control?

25. After the change in control, will the insurer's policyholders' surplus be reasonable in relation to its outstanding liabilities and adequate for its financial needs?

26. Review financial projections for both 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 and are based on reasonable expectations.

27. 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 cash flows appear adequate to cover such obligations without relying heavily on cash flows from the insurer.

28. 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 arms-length, fair, and reasonable to the insurer.

29. 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.?

30. Has the application been publicized to all interested persons both inside and outside of the insurance department in accordance with the department's policy or applicable laws?

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

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

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form A. In developing a conclusion, the analyst should consider the above procedures, as well as any other

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procedures that, in the analyst's judgment, are relevant to evaluating holding company Form A under the specific circumstances involved.

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
- ☐ Refer concerns to examination section for targeted examination
- ☐ Meet with the insurer's management
- ☐ Obtain a corrective plan from the insurer
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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Note: The following procedures do not supercede state regulation but are merely additional guidance that an analyst may consider useful.

Form B—Insurance Holding Company System Annual Registration Statement

1. Did the registration statement filed in accordance with the Model Holding Company System Regulatory Act include the following current information:

   a. 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.

   b. The identity and relationship of every member of the insurance holding company system, except affiliates with total assets equal to or less than 0.5 percent of the total assets of the ultimate controlling person within the holding company system.

   c. The following agreements in force and transactions currently outstanding or that have occurred during the last calendar year between the insurer and its affiliates:

      i. Loans, other investments, purchases, sales, or exchanges of securities of the affiliates by the insurer or vice versa, involving 0.5 percent or more of the registrant's admitted assets as of December 31 of the most recent prior year ended.

      ii. Purchases, sales, or exchange of assets involving 0.5 percent or more of registrant's admitted assets as of December 31 of the most recent prior year ended.

      iii. Transactions not in the ordinary course of business.

      iv. Guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, involving 0.5 percent or more of registrant's admitted assets as of December 31 of the most recent prior year ended, other than insurance contracts entered into in the ordinary course of the insurer's business.

      v. All reinsurance or management agreements, service contracts, consolidated tax allocation agreements, and cost-sharing arrangements.

      vi. Dividends and other distributions to shareholders

   d. 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.

   e. 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.

   f. A summary outlining all items in the current registration statement representing changes from the prior registration statement (Form C).

2. If the response is "yes" to any of the questions in 1c–1e above, did the insurer provide a description of the transaction or agreement that would permit a proper evaluation by the commissioner, including at least the nature and purpose of the transaction, the nature and

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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.

3. Did each registered insurer properly report dividends and other distributions to shareholders in accordance with the following Model Holding Company System Regulatory Act requirements?

   a. Were all dividends and other distributions to shareholders reported within 15 business days following the declaration thereof?

   b. Were any dividends and other distributions to shareholders considered extraordinary?

   c. If the answer to 3b above is "yes," did the transaction receive proper regulatory approval?

4. Did any transaction that occurred during the last calendar year involving the insurer and others in its holding company system require prior regulatory approval?

   a. Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments where the transactions equal or exceed:

      i. With respect to non-life insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of policyholders' surplus as of December 31 of the most recent prior year ended.

      ii. With respect to life insurers, 3 percent of the insurer's admitted assets as of December 31 of the most recent prior year ended.

   b. 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 make investments in, any affiliate of the insurer making the loans or extensions of credit, provided the transactions are equal to or exceed:

      i. With respect to non-life insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of policyholders' surplus as of December 31 of the most recent prior year ended.

      ii. With respect to life insurers, 3 percent of the insurer's admitted assets as of December 31 of the most recent prior year ended.

   c. Reinsurance agreements or modifications thereto in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds 5 percent of the insurer's policyholders' surplus as of December 31 of the most recent prior year ended, including those agreements that 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, any portion of such assets will be transferred to one or more affiliates of the insurer.

   d. All management agreements, service contracts, and cost-sharing arrangements.

   e. Any material transactions specified by regulation that the commissioner determines may adversely affect the interest of the insurer's policyholders.

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f. If the answer to any of the questions in 4a–4e above is "yes," did the insurer receive proper prior regulatory approval?

5. Based upon a review of the registration statement, were any significant and/or unusual items noted, such as the following:

   a. Persons holding 10 percent 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.

   b. Biographical information about directors or officers that may elevate concerns such as convictions of crimes.

   c. Any litigation or administrative proceeding involving the ultimate controlling entity or any of its directors and officers, such as criminal prosecutions or proceedings that may have a material effect upon the solvency or capital structure of the ultimate holding company, such as bankruptcy, receivership, or other corporate reorganization.

   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.

   e. Unusual information included in the holding company financial statements, such as:

      i. Heavy reliance on dividends from the insurer to fund any holding company debt service requirements.

      ii. Lenders of the holding company that are open depositories of the insurer.

      iii. Evidence of any financial problems that may potentially impact the insurer.

6. Were there any inconsistencies between responses indicated in the Affiliated Transactions Procedures and the response in this Form B Procedures?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form B. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures that, in the analyst's judgment, are relevant to evaluating holding company Form B under the specific circumstances involved.

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
- ☐ Refer concerns to examination section for targeted examination
- ☐ Meet with the insurer's management
- ☐ Obtain a corrective plan from the insurer
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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Note: The following procedures do not supercede state regulation but are merely additional guidance that an analyst may consider useful.

Form D—Prior Notice of a Transaction

1. If a material transaction has occurred, did the insurer file a Form D with its domestic state? (Section 5 of the NAIC's Insurance Holding Company System Regulatory Act 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:

   - ☐ 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 that Form D filing is being made
   - ☐ A statement as to the nature of the transaction
   - ☐ 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, etc.

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 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

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arrangements? Does the 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 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, purchase the assets of, or 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, 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 whether 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)

13. For cost-sharing arrangements, determine whether 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

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- ☐ A description of when amounts are settled and a provision for interest in the event that settlements are not timely made

14. Review Form D for any significant and/or unusual items or inconsistencies. Determine if the transaction appears fair and reasonable in relation to the following:

    a. For reinsurance agreements, are the general terms, settlement provision, and pricing consistent with those of non-affiliated agreements?

    b. For management, service, or cost-sharing agreements, are the 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 *Accounting Practices and Procedures Manual*?

    f. Do unusual circumstances or concerns exist?

15. Determine whether the transaction was accounted for properly based on statutory accounting principles within the *Accounting Practices and Procedures Manual*.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form D. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures that, in the analyst's judgment, are relevant to evaluating a holding company Form D under the specific circumstances involved.

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
- ☐ Refer concerns to examination section for targeted examination
- ☐ Meet with the insurer's management
- ☐ Obtain a corrective plan from the insurer
- ☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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Note: The following procedures do not supersede state regulation, but are merely additional guidance an analyst 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 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 Form E.

1. Does Form E or other required information state the names and addresses of the persons 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 persons affiliated with the persons 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 persons 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 persons identified in questions 1 and 2 currently benefit from in this state
   - Historical market and market share data for each person identified in questions 1 and 2 for the past five years
   - The sources of the above information

6. If 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?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the holding company Form E or other required information. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating holding company Form E or other required information under the specific circumstances involved. The summary and conclusion should include details regarding the company's strengths and weaknesses.

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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_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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Note: The following procedures do not supersede state regulation, but are merely additional guidance an analyst 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

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 Extraordinary Dividend/Distribution. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures which, in the analyst's judgment, are relevant to evaluating holding company Extraordinary Dividend/Distribution under the specific circumstances involved. The summary and conclusion should include details regarding the company's strengths and weaknesses.

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_____

Comments as a result of supervisory review.

Reviewer _____ Date_____

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Note: These Supplemental Procedures are designed for captives and/or insurers filing to the NAIC on a U.S. GAAP (or modified GAAP) basis, after the analyst has completed the traditional Level 1 Procedures.

Management Assessment

1. Refer to the Level 1 Procedures for the review of the insurer's most recent business plan.

2. Summarize the insurer's level of reliance on captive managers, TPAs or MGAs to run its business operations (e.g., underwriting, claims, record and reporting)?

   a. If significant reliance exists, describe the services provided, any affiliated relationships, whether the expense ratio is in line with industry standards, and whether those parties service other insurers.

Balance Sheet Assessment

3. Review the Annual Financial Statement, Assets and Liabilities, Surplus and Other Funds.

   a. If risk-based capital is required, the analyst should consider reassessing the impact to total adjusted capital if the insurer recorded assets typically non-admitted according to the NAIC *Accounting Practices and Procedures Manual*. If risk-based capital is not required, the analyst might consider various methods to assess the capital sufficiency of the insurer.

      i. Has the analyst considered the potential impact letters of credit, differences between GAAP and SAP investments, and/or deferred acquisition costs could have on the total adjusted capital component of the RBC calculation? (See Modified Calculation of Total Adjusted Capital at the end of this chapter.)

   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.

   c. Review any new letters of credit, principal or interest paid and whether any necessary approvals were obtained, if required.

   d. Review Note 1 of the Notes to Financial Statements and document any individual asset category that is greater than 5 percent of total admitted assets that would typically be non-admitted according to the NAIC *Accounting Practices and Procedures 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.

   e. Under U.S. GAAP, FAS 113 requires insurers to present their 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.

   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 policyholders' surplus.

   g. Under U.S. GAAP, reserves can be discounted in some instances.

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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.

h. Under U.S. GAAP, insurers are not 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 policyholders' surplus.

Operations Assessment

4. Under U.S. GAAP, FAS 115 provides that debt and equity securities that are "being traded" (i.e. trading securities) 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.

Investment Practices

5. 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.

Review of Disclosures

6. Review the Notes to Financial Statements to assess the adequacy of disclosures regarding the reconciliation from the NAIC *Accounting Practices and Procedures 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.

7. Refer to the Level 1 Procedures for the review of the General Interrogatories. Specifically, identify the insurer's largest net aggregate risk insured as disclosed in General Interrogatories, part 2, #13.

Assessment of Results from Prioritization and Analytical Tools

8. The analyst should be aware that the Financial Analysis Solvency Tools were designed to assess potential risks within statutorily filed financial statement in conformity with the NAIC *Accounting and Practices and Procedures Manual* and not in conformity with GAAP. Based on the reconciliation found in Notes to Financial Statement #1 as well as observations made with the aforementioned questions, the analyst should 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.)

Summary and Conclusion

After completion of the supplemental procedures, return to the Level One, and develop and document an overall summary and conclusion based on the findings.

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MODIFIED CALCULATION OF TOTAL ADJUSTED CAPITAL

		Annual Statement Reference	(1) Statement Value*	Factor	(2) Adjusted Capital
(1)	Capital and Surplus	P3 C1 L35	0	1.000	0
(2)	Non-Tabular Discount - Losses	Sch P P1-Sum C32 L12	0	1.000	0
(3)	Non-Tabular Discount - Expense	Sch P P1-Sum C33 L12	0	1.000	0
(4)	Discount on Medical Loss Reserves Reported as Tabular in Schedule P	Company Records	0	1.000	0
(5)	Discount on Medical Expense Reserves Reported as Tabular in Schedule P	Company Records	0	1.000	0
(6)	P&C Subs Non-Tabular Discount - Losses	Subs' Sch P Pt1-Sum C32 L12	0	1.000	0
(7)	P&C Subs Non-Tabular Discount - Expense	Subs' Sch P Pt1-Sum C33 L12	0	1.000	0
(8)	P&C Subs Discount on Medical Loss Reserves Reported as Tabular in Schedule P	Subs' Company Records	0	1.000	0
(9)	P&C Subs Discount on Medical Expense Reserves Reported as Tabular in Schedule P	Subs' Company Records	0	1.000	0
(10)	AVR - Life Subs	Subs P3 C1 L24.1	0	1.000	0
(11)	Dividend Liability - Life Subs	Subs P3 C1 L6.1 + L6.2	0	0.500	0
(12)	Total Adjusted Capital Before Capital Notes	L(1)-L(2)-L(3)-L(4)-L(5)-L(6)-L(7)-L(8)-L(9)+L(10)+L(11)			0
	Credit for Capital Notes				
(13.1)	Surplus Notes	Page 3 Column 1 Line 31	0		
(13.2)	Limitation on Capital Notes	0.5x[Line(12)-Line(13.1)]-Line 13.1, but not less than zero	0		
(13.3)	Capital Notes Before Limitation	PR025 Column (4) Line (18)	0		
(13.4)	Credit for Capital Notes	Lesser of Column (1) Line (13.2) or Line (13.3)			0
(14)	Total Adjusted Capital (Post-Deferred Tax)	Line (12) + Line (13.4)			0
	Sensitivity Test - DTA/DTL:				
(15)	Deferred Tax Assets	Page 2, Line 16.2	0	1.000	0
(15.1)	Deferred Tax Liabilities	Page 3, Line 7.2	0	1.000	0
(16)	Deferred Tax Assets for Subsidiary	Company Record	0	1.000	0
(16.1)	Deferred Tax Liabilities for Subsidiary	Company Record	0	1.000	0
(17)	Total Adjusted Capital For **DTA/DTL** Sensitivity Test	Line (14) - Line (15)+(15.1)-(16)+(16.1)			0
	Sensitivity Test - Risk Retention Groups:				
(18)	**Letters of Credit**	**Notes to the Financial Statements #1A, in part**	**0**	**1.000**	**0**
(19)	**Difference Between GAAP and SAP Investments**	**Notes to the Financial Statements #1A, in part**	**0**	**1.000**	**0**
(20)	**Deferred Acquisition Costs**	**Notes to the Financial Statements #1A, in part**	**0**	**1.000**	**0**
(21)	**Total Adjusted Capital For RRG Sensitivity Test**	**Line (14) - Line (18) - (19) - (20)**			**0**

* Report amounts in this column as whole dollars.

Denotes items that must be manually entered on the filing software.

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VI. Quarterly Procedures

A. Level 1

Background Analysis

1. Review the analyses performed on the insurer for the prior year and prior quarters.

   a. Indicate the state's priority designation or any prioritization tool result as of the last review and start of the current review:

      State's Priority Designation _____
      Scoring System Result _____
      IRIS Ratio Result _____
      Analyst Team System Validated Level _____
      RBC Ratio and Trend Test _____

   b. Were there any issues or concerns noted in previous annual or quarterly analysis completed in the current year? If "yes," discuss the issues or concerns, the follow-up conducted, and include any correspondence with the insurer, along with any conclusions.

   c. As the domestic regulator, review the Insurer Profile Summary, including the Supervisory Plan, if applicable, and document any areas of concern that impact the current analysis.

2. Review any inter-departmental communication, as well as communication with other state insurance departments and the insurer. Note any unusual items or areas that indicate further review or follow-up is necessary.

3. Review General Interrogatories, Part 1, #4.1. Has the insurer been a party to a merger or consolidation? If "yes," review the list of the companies involved in the merger/consolidation. Also, ensure Form A or Additional filings have been approved.

4. Review General Interrogatories, Part 1, #7.1. Has this insurer had any Certificates of Authority, licenses, or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? If "yes," document the reason(s) stated for the revocation or suspension.

5. Are there any changes in the statutes and regulations that could impact the insurer's financial position or reporting? If "yes," to the extent information is available, has the insurer failed to comply with the new state's statutes and regulations enacted during the period?

6. Review the most recent report from an Acceptable Rating Organization. Note the current financial strength and credit ratings, and briefly discuss the explanation of the ratings or any change in the ratings.

7. Review any industry reports, news releases and emerging issues that have the potential to negatively impact the insurer.

8. Review the most recent business plan and financial projections, if available from recent surveillance activity and if considered necessary based on the insurer's priority designation and financial condition.

   a. If significant changes in business plan or philosophy have occurred, assess the insurer's ability to attain the expectations of the business plan.
   b. Are actual results consistent with management's expectations?

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9. Below is a list of supplemental filings to the annual statement. Have any been received or reviewed since the last analysis? If "yes," complete or review the corresponding procedures related to these items.

   - ☐ Financial Examination Report
   - ☐ Audited Financial Report
   - ☐ Actuarial Opinion
   - ☐ MD&A
   - ☐ Holding Company Form(s)

   Review any other items received from the insurer or related to the insurer since the last analysis, and comment on them as necessary.

Management Assessment

10. Review the Quarterly Financial Statement, Jurat page.

    a. Did the insurer fail to properly execute and notarize the Jurat page?

    b. Has there been any change(s) in officers, directors, or trustees since the previous financial statement (indicated by a "#" after the name)? If "yes," indicate the position(s) in which the change(s) occurred, Review the Biographical Affidavit(s) for any new officers, directors, or trustees indicated above and note any areas of concern that would indicate further review is necessary.

       - ☐ President
       - ☐ Secretary
       - ☐ Treasurer
       - ☐ Vice Presidents (number: ____)
       - ☐ Directors or Trustees (number: ____)
       - ☐ Other _____

    c. Assess any significant corporate governance changes and determine whether these changes appear to indicate a shift in management philosophy, or whether management has made any changes in business culture or business plan.

Balance Sheet Assessment

11. Review the Quarterly Financial Statement, Assets and Liabilities, Surplus and Other Funds.

    a. Is policyholders' surplus below the statutory minimum amount required?

    b. Has policyholders' surplus increased by more than 25 percent or declined by more than 15 percent from the prior year-end?

    c. Has the insurer issued any capital or surplus notes, which in the aggregate are greater than 10 percent of policyholders' surplus? If so, review any notes issued, principal or interest paid, or any other changes made, and whether any necessary approvals were obtained.

    d. Is the amount of any individual asset category, other than cash and invested assets, greater than 10 percent of total admitted assets? If "yes," indicate the asset category and amount.

    e. Has any individual asset category, for which the current or prior year-end balance was greater than 5 percent of total assets, changed by more than +/– 20 percent from the prior

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year-end? If "yes," indicate the asset category, current balance, and the percentage change from the prior year-end.

f. Is the amount of any individual liability category, other than losses, LAE, and unearned premiums, greater than 10 percent of total liabilities? If "yes," indicate the liability category and amount.

g. Has any individual liability category, for which the current or prior year-end balance was greater than 5 percent of total liabilities, changed by more than +/– 20 percent from the prior year-end? If "yes," indicate the liability category, current balance, and the percentage change from the prior year-end.

Operations Assessment

12. Review the Quarterly Financial Statement, Statement of Income.

    a. Does net income (loss) exceed +/– 5 percent of policyholders' surplus? If "yes," has it changed by more than +/– 20 percent from the prior year-to-date?

    b. Has any individual income or expense category, for which the current or prior year-to-date balance was greater than 5 percent of policyholders' surplus, changed by more than +/– 20 percent from the prior year-to-date? If "yes," indicate the line item, current balance, and the percentage change from the prior year-to-date.

    c. Have any of the profitability ratios (loss, LAE, expense, dividend, or combined) changed by more than +/– 10 percentage points from the prior year-to-date? If "yes," indicate the ratio, current result, and the percentage point change.

13. Review the Quarterly Financial Statement, Cash Flow. Is net cash from operations negative?

14. Has the liquidity ratio changed by more than +/– 10 percentage points from the prior year-end? If "yes," indicate the current result and the percentage point change from the prior year-end.

15. Have any of the leverage ratios (rolling GPW/PHS, rolling NPW/PHS, Paid Reinsurance Recoverable/PHS, or Reserves/PHS) changed by more than +/– 10 percentage points from the prior year-end? If "yes," indicate the ratio, current result, and the point change from the prior year-end.

16. Has direct, assumed, ceded or net premiums written changed by more than +/– 20 percent from the prior year-to-date? If "yes," indicate the category, current balance, and the percentage change from the prior year-to-date.

Investment Practices

17. Review Schedule D, Part 1B—Acquisitions, Dispositions and Non-Trading Activity During the Current Quarter for all Bonds and Preferred Stock by Rating Class.

    a. Has the percentage of investment or non-investment grade bonds to total bonds at the end of the quarter changed by greater than +/– 10 percentage points from the beginning of the quarter?

    b. Has the percentage of investment or non-investment grade preferred stock to total preferred stock at the end of the quarter changed by greater than +/- 10 percentage points from the beginning of the quarter?

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Review of Disclosures

18. Review the Quarterly Financial Statement, Notes to Financial Statements, General Interrogatories, Supplemental Exhibits, and Schedules Interrogatories, noting any unusual responses.

Assessment of Results from Prioritization & Analytical Tools

19. Review the I-SITE Quarterly Financial Profile Report. Were any unusual trends noted based on your review?

20. Review the insurer's Quarterly Scoring ratio results.

    a. Indicate the insurer's total score: _____

    b. Provide an explanation on each individual ratio result that received a score of 50 points or more.

21. During a review of market conduct information (including information available from the state's market analysis department or data available on I-SITE, including MAP, ETS, MARS, RIRS, SAD, MITS and the Complaints Database), did the analyst note any unusual items that indicate further review and or additional communication is needed with the department's market analysis staff?

Assessment of Latest Examination Report and Results

22. Review General Interrogatories, Part 1, #6 and determine if a financial examination report was released by the domiciliary state since the last review.

    a. As of what balance sheet date is/was the latest financial examination of the insurer?

    b. As of what balance sheet date is the latest financial examination report available from either the state of domicile or the insurer?

    c. As of what release date is the latest financial examination report available from either the state of domicile or the insurer?

    d. Have any financial statement adjustments within the latest financial examination report not been accounted for in a subsequent financial statement filed with the Department?

    e. Have any of the recommendations within the latest financial examination report not been complied with?

    If "yes," or if follow-up was required from the review of the examination report in a previous analysis period, complete the following procedures.

    f. If the answers to 22.d. or 22.e. are "yes," follow up with the insurer regarding the implementation of recommendations in the Financial Examination Report.

    g. During the review of the latest state examination report, the results from that examination and communication with the examiner-in-charge (for domestic insurers), did the analyst note any items or areas that indicate further review is warranted?

    h. Follow-up and document on any management letter comments that should be addressed in the current period, if applicable.

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Recommendation for Further Analysis

Based on the Level 1 Procedures performed, do you recommend that any Level 2, 3, or Supplemental Procedures be completed? If "yes," indicate the sections that you recommend be completed:

A. Perform Level 2 or 3 Procedures:

- All Sections ☐
- Investments ☐
- Unpaid Losses and LAE ☐
- Income Statement and Surplus ☐
- Risk-Based Capital ☐
- Cash Flow and Liquidity ☐
- Reinsurance ☐
- Affiliated Transactions ☐
- MGAs and TPAs ☐

B. Perform Supplemental Procedures:

- Annual Audited Financial Report ☐
- Statement of Actuarial Opinion & AOS ☐
- Management's Discussion & Analysis ☐
- Holding Company Analysis ☐
  - Form A ☐
  - Form B ☐
  - Form D ☐
  - Form E ☐
  - Extraordinary Dividend/Distribution ☐
- Captives and/or Insurers Filing on GAAP ☐

C. Request and review the current business plan and financial projections.

i. If significant changes in the business plan or philosophy have occurred, assess the insurer's ability to attain these expectations.

ii. Determine if actual results are tracking with projection and note any significant variances and the reason(s).

Summary and Conclusion

After completion of any Level 2 or subordinate procedures, develop and document an overall summary and conclusion based on the findings. In developing a conclusion, the analyst should consider the above procedures, as well as any other factors that, in the analyst's judgment, are relevant to evaluating the insurer's overall financial condition. The discussion should include details regarding the insurer's strengths and weaknesses. In addition, update the Insurer Profile Summary, including the Supervisory Plan, if applicable, for the results of the analysis performed.

Do you recommend that the insurer be designated a priority as a result of the procedures performed? If "yes," indicate the recommended priority designation and rationale.

Describe the rationale for these recommendations.

Analyst _____ Date _____

Comments as a result of supervisory review.

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Correspondence

The analyst should document any follow-up regarding the Level 1, 2, 3, and Supplemental Procedures.

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B. Level 2

1. Investments
2. Unpaid Losses and LAE
3. Income Statement and Surplus
4. Cash Flow and Liquidity
5. Reinsurance
6. Affiliated Transactions
7. MGAs and TPAs

1. Determine whether the insurer's investment portfolio appears to be adequately diversified to avoid concentration of investments by type or issue.
   a. Are preferred stocks owned greater than 10 percent of total admitted assets?
   b. Are common stocks owned greater than 20 percent of total admitted assets?
   c. Are non-investment grade bonds owned greater than 3.5 percent of total admitted assets?
   d. Are mortgage loans owned greater than 5 percent of total admitted assets?
   e. Is real estate owned, including home office real estate, greater than 5 percent of total admitted assets?
   f. Are other invested assets (Schedule BA) greater than 5 percent of total admitted assets?
   g. Are aggregate write-ins for invested assets greater than 5 percent of total admitted assets?
   h. Are affiliated investments greater than 10 percent of total admitted assets?

2. Determine whether the insurer has increased its holdings in investments that tend to be riskier and/or less liquid than investment grade bonds, stocks, cash, and short-term investments.
   a. If non-investment grade bonds exceed 5 percent of policyholders' surplus, have such investments increased by greater than 10 percent over the prior year-end?
   b. If total real estate and mortgage loans exceed 10 percent of policyholders' surplus, have such investments increased by greater than 15 percent over the prior year-end?
   c. If other invested assets (Schedule BA) exceed 5 percent of policyholders' surplus, have such investments increased by greater than 10 percent over the prior year-end?
   d. If aggregate write-ins for invested assets exceed 10 percent of policyholders' surplus, have such investments increased by greater than 20 percent over the prior year-end?
   e. If affiliated investments exceed 10 percent of policyholders' surplus, have such investments increased by greater than 20 percent over the prior year-end?

3. Determine whether the insurer increased its holdings in derivatives that tend to be riskier and/or less liquid than investment grade bonds, stocks, cash, and short-term investments.
   a. Review Schedule DB, Part A, Section 1—Showing all Options, Caps, Floors, Collars, Swaps and Forwards Open as of Current Statement Date. Is the total book/adjusted carrying value greater than 10 percent of policyholders' surplus? If "yes," list the book/adjusted carrying value and percentage of policyholders' surplus for hedging, replication, income generation, other, and total derivative transactions.
   b. Review Schedule DB, Part B, Section 1—Showing Future Contracts Open as of the Current Statement Date. Is the total book/adjusted carrying value greater than 10 percent of policyholders' surplus? If "yes," list the book/adjusted carrying value and percentage of policyholders' surplus for hedging, replication, income generation, other, and total derivative transactions.
   c. Review Schedule DB, Part D—Counterparty Exposure for Derivative Investments Open as of Current Statement Date. Is the total book/adjusted carrying value net of collateral

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greater than 10 percent of policyholders'surplus? If "yes," list the book/adjusted carrying value net of collateral and percentage of policyholders' surplus for total derivatives.

4. Determine whether all securities owned are under the control of the insurer and in the insurer's possession. Review General Interrogatories, Part 1, #11.1. Were any of the assets of the insurer loaned, placed under option agreement, or otherwise made available for use by another person (excluding securities under securities lending agreements)?

5. Determine whether securities owned have been valued in accordance with the standards promulgated by the NAIC's Securities Valuation Office (SVO).

   a. Review General Interrogatories, Part 1, #17.1.

      i. Has the insurer failed to follow the filing requirements of the *Purposes and Procedures Manual* of the SVO?

      ii. If the answer to 5ai is "yes," document the exceptions listed in General Interrogatories, Part 1, #17.2.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding investments. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures, which in the analyst's judgment are relevant to evaluating the insurer's investments under the specific circumstances involved.

Do you recommend that one or more procedures within Level 3 Procedures—Investments be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

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1. Determine whether significant changes in unpaid losses or LAE have occurred since the prior year-end or whether significant changes in incurred losses or LAE have occurred since the prior year-to-date.

   a. Have loss reserves changed by greater than +/– 15 percent from the prior year-end?

   b. Have LAE reserves changed by greater than +/– 15 percent from the prior year-end?

   c. Have net losses incurred changed by greater than +/– 25 percent from the prior year-to-date?

   d. Has LAE incurred changed by greater than +/– 25 percent from the prior year-to-date?

2. Determine whether there has been significant adverse development in the liabilities for unpaid losses and LAE, which were established as of the end of the prior year.

   a. Is the loss and LAE reserves to policyholders' surplus ratio greater than 250 percent?

   b. Has the loss and LAE reserves to policyholders' surplus ratio changed by greater than +/– 25 percentage points from the prior year-end?

   c. Review, by line of business, the year-to-date incurred loss ratio on direct business for the current and prior year in Part 1—Loss Experience. Has the incurred loss ratio on direct business for any line of business changed by greater than +/- 10 points?

   d. Has there been a significant change in the overall net incurred loss ratio from the prior year-end by greater than +/– 15 points or from the prior quarter by greater than +/– 20 points?

   e. Review the year-to-date reserve development of the prior year-end's loss and LAE reserves (case and IBNR components shown separately) in Part 3—Loss and LAE Reserves Schedule.

      i. Is the year-to-date reserve development of the prior year-end case reserves greater than +/– 30 percent of prior year-end case reserves?

      ii. Is the year-to-date reserve development of the prior year-end IBNR reserves greater than +/– 30 percent of prior year-end IBNR reserves?

      iii. Is the year-to-date reserve development of the prior year-end total loss and LAE reserves (case and IBNR) greater than 20 percent of prior year-end policyholders' surplus?

3. Determine whether there have been any significant changes pertaining to loss reserve discounting.

   a. Review General Interrogatories, Part 2, #4.1. Have unpaid losses and/or LAE been discounted at a rate of interest greater than zero?

   b. If 3a is "yes," is the total discount on unpaid losses and LAE to policyholders' surplus ratio greater than 20 percent?

   c. Have any lines of business been discounted for the first time this quarter?

   d. Is the interest rate used to discount reserves greater than 5 percent for any single line of business?

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Summary and Conclusion

Develop and document an overall summary and conclusion regarding unpaid losses and LAE. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst's judgment, are relevant to evaluating unpaid losses and loss adjustment expenses under the specific circumstances involved.

Do you recommend that one or more procedures within Level 3 Procedures—Unpaid Losses and LAE be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

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1. Determine whether concerns exist regarding the insurer's income statement or operating performance.
   a. Is the combined ratio greater than 105 percent or less than 80 percent?
   b. Is the change in the combined ratio greater than a 10-percentage-point increase or more than a 20-percentage-point decline from the prior year-to-date?
   c. Have net premiums earned changed by greater than +/– 20 percent from the prior year-to-date?
   d. Have net losses incurred changed by greater than +/– 25 percent from the prior year-to-date?
   e. Review Part 1—Loss Experience. Has the incurred loss ratio on direct business for any line of business changed by greater than +/– 10 percentage points from the prior year-to-date?
   f. Are net realized capital gains or losses more than +/– 3 percent of policyholders' surplus and +/– 25 percent of net income?
   g. Is other income more than +/– 3 percent of policyholders' surplus and +/– 25 percent of net income?

2. Determine whether concerns exist regarding changes in the volume of premiums written or changes in business mix (lines of business and/or geographic location).
   a. Review, by line of business, the current and prior year-to-date direct premiums written in Part 2—Direct Premiums Written.
      i. Have direct premiums written for any line of business changed by greater than +/– 33 percent?
      ii. If direct premiums are being written in any new lines, do they account for more than 5 percent of the total direct premiums written?
   b. Review, by state, the current and prior year-to-date direct premiums written in Schedule T—Exhibit of Premiums Written.
      i. Has there been a significant change (+/– 50 percent) in premiums written in any one state where direct premiums written exceed 10 percent of total direct premiums in either the current or prior year?
      ii. If premiums are being written in any new states, do they account for more than 5 percent of the total direct premiums?
   c. Have total net premiums written changed by greater than +/– 50 percent from the prior year-to-date?

3. Determine whether the insurer is excessively leveraged due to the volume of premiums written.
   a. Is the gross premiums written (rolling year) to policyholders' surplus ratio greater than 900 percent?
   b. Is the net premiums written (rolling year) to policyholders' surplus ratio greater than 300 percent?

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4. Determine whether concerns exist regarding the amount of the insurer's policyholders' surplus or changes in surplus notes from the prior quarter.
   a. Has policyholders' surplus increased by more than 25 percent or decreased by more than 10 percent from the prior year-end?
   b. Is the policyholders' surplus to assets ratio less than 20 percent?
   c. Has the insurer issued any surplus notes or capital notes during the quarter, which in the aggregate are greater than 10 percent of policyholders' surplus?
   d. Has the insurer repaid any principal and/or paid any interest on surplus or capital notes during the quarter?
   e. Are write-ins for special surplus funds and/or write-ins for other than surplus funds greater than 10 percent of policyholders' surplus?
   f. Are unassigned funds negative?

5. Determine whether concerns exist regarding the declaration or payment of dividends. Review the Dividends to Stockholders line under the Capital and Surplus Account section of the Statement of Income.
   a. Has the insurer declared any dividends to stockholders during the quarter?
      i. If the answer to 5a is "yes," is the amount at a level that required prior regulatory approval or notification?
      ii. If the answer to 5ai is "yes," did the insurer fail to obtain proper prior regulatory approvals?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the insurer's statement of income and policyholders' surplus. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst's judgment, are relevant to evaluating the insurer's income statement and policyholders' surplus under the specific circumstances involved.

Do you recommend that one or more of the procedures within Level 3 Procedures—Statement of Income and Surplus be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

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1. Determine whether concerns exist regarding the insurer's cash flow. Review the Cash Flow for the current quarter and prior year quarter.
   a. Is net cash from operations negative?
   b. Does the decline in net cash from operations from the prior year-to-date exceed 5 percent of policyholders' surplus?
2. Determine whether concerns exist regarding the insurer's overall level of liquidity.
   a. Is the ratio of adjusted liabilities to liquid assets greater than 105 percent?
   b. Has the liquidity ratio changed by greater than +/– 10 percentage points from the prior quarter or +/– 20 percentage points from the prior year-end?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding cash flow and liquidity. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures that, in the analyst's judgment, are relevant to evaluating cash flow and liquidity under the specific circumstances involved.

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

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1. Determine whether reinsurance recoverables are significant.
   a. Are reinsurance recoverables on paid losses greater than 10 percent of policyholders' surplus?
   b. If the answer to 1a is "yes," have reinsurance recoverables on paid losses changed by greater than +/– 10 percent from the prior quarter or +/– 35 percent from the prior year-end?

2. Determine whether amounts recoverable from reinsurers are collectible.
   a. Is the provision for reinsurance greater than 10 percent of policyholders' surplus?
   b. If the current or prior period provision for reinsurance is/was greater than 5 percent of policyholders' surplus, has it changed by greater than +/– 10 percent from the prior quarter or +/– 20 percent from the prior year-end?

3. Determine whether any significant changes may have been made to the insurer's reinsurance program.
   a. Have ceded premiums earned changed by greater than +/– 20 percent from the prior year-to-date?
   b. Has the ceded premiums to gross premiums written ratio changed by greater than +/– 10 percentage points from the prior quarter or from the prior year-end?
   c. Have assumed premiums earned changed by greater than +/– 20 percent from the prior year-to-date?
   d. Has the assumed premiums to gross premiums written ratio changed by greater than +/– 10 percentage points from the prior quarter or from the prior year-end?
   e. Review Schedule F—Ceded Reinsurance. Were any new reinsurers added since the prior quarter?
      i. If "yes," were any unauthorized?
      ii. Does the provision for reinsurance equal the amount reported at the prior year-end?
   f. Review General Interrogatories, Part 2, #1. If the Company is a member of a pooling arrangement, did the agreement or the Company's participation change?

4. Determine whether any unusual reinsurance transactions were completed during the quarter.
   a. Review General Interrogatories, Part 2, #2. Were there any agreements to release reinsurers from liability during the quarter?
   b. Review General Interrogatories, Part 2, #3.1. Were there any cancellations of primary reinsurance contracts during the quarter?
   c. Review General Interrogatories, Part 1, #1.1. 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?

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i. If the answer to 4c is "yes," did the insurer fail to make the appropriate filing of a Disclosure of Material Transactions with the state of domicile?

d. Was the change in the ceded pure loss ratio from the prior year-end significantly greater (+/– 30 percentage points) than the change in the gross pure loss ratio?

e. Was the change in the assumed pure loss ratio from the prior year-end significantly greater (+/– 30 percentage points) than the change in the gross pure loss ratio?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding reinsurance. In developing a conclusion, the analyst should consider the above procedures, as well as any other procedures that, in the analyst's judgment, are relevant to evaluating reinsurance under the specific circumstances involved.

Do you recommend that one or more of the procedures within Level 3—Reinsurance be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

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1. Determine whether the insurer is a member of a holding company group and, if so, whether the corporate structure or any changes in the corporate structure elevate concerns pertaining to affiliated transactions.

    a. Was the insurer a member of an insurance holding company system as of the prior year-end?

        i. Review Schedule Y—Information Concerning Activities of Insurer Members of a Holding Company Group, along with the General Interrogatories. Is there any information noted that contradicts the answer to the above question?

    b. Has the Department directed the insurer to file a Holding Company Registration Statement?

    c. Did the insurer fail to file a registration statement in accordance with the Model Holding Company System Regulatory Act?

If the answers to the above procedures are all "no," do not proceed with Affiliated Transactions Procedures. Skip to the next financial analysis topic.

    d. Review General Interrogatories, Part 1, #2.1. Has there been a change in the insurer's capital structure?

    e. Review General Interrogatories, Part 1, #3. Have there been substantial changes in the organizational chart?

        i. If the answer to 1e is "yes," and the change involved ownership of the insurer or a transaction with an affiliate, did the insurer fail to receive proper regulatory approvals?

    f. Are there any indications the corporate structure may include a holding company whose primary asset is the stock of the insurance company?

    g. Does the insurer have an agency or brokerage subsidiary?

    h. Review General Interrogatories, Part 1, #5. Have there been changes to any management agreement in terms of the agreement or principals involved?

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

    a. Has the insurer declared dividends to stockholders during the quarter?

        i. If the answer to 2a is "yes," was the amount at a level that required prior regulatory approval or notification?

        ii. If the answer to 2ai is "yes," did the insurer fail to obtain proper prior regulatory approvals?

    b. Review Schedule A, Part 2—Real Estate Acquired and Additions Made During the Current Quarter and Schedule BA, Part 1—Other Long-Term Invested Assets Acquired and Additions Made During the Current Quarter.

        i. Did any such acquisitions involve an affiliate or other related party?

        ii. Is the amount of the acquisition greater than 5 percent of policyholders' surplus?

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iii. If the answers to 2bi and 2bii are "yes," is there any reason to believe that the acquisition was recorded on a basis other than fair value?

c. Review Schedule A, Part 3—Real Estate Disposed During the Current Quarter and Schedule BA, Part 3—Other Long-Term Invested Assets Disposed, Transferred or Repaid During the Current Quarter.

i. Did any such dispositions involve an affiliate or other related party?

ii. Is the amount of the disposition greater than 5 percent of policyholders' surplus?

iii. If the answers to 2ci and 2cii are "yes," is there any reason to believe the sale was recorded on a basis other than fair value?

3. Determine whether investments in affiliates are significant.

a. Is the total of all investments in affiliates greater than 20 percent of policyholders' surplus?

b. Has the total of all investments in affiliates changed by greater than +/– 20 percent from the prior year-end?

4. Determine whether other affiliated transactions are legitimate and are recorded properly.

a. If federal income tax recoverables exceed 5 percent of policyholders' surplus, have they increased more than 10 percent from the prior quarter or 20 percent from the prior year-end?

b. If the receivable from parent, subsidiaries, and affiliates is greater than 10 percent of policyholders' surplus, has it changed by greater than +/– 25 percent from the prior year-end?

c. If the payable to parent, subsidiaries, and affiliates is greater than 10 percent of policyholders' surplus, has it changed by greater than +/– 25 percent from the prior year-end?

d. Review Schedule E, Part 1—Cash (Month-End Depository Balances).

i. Were any open depositories a parent, subsidiary, or affiliate?

ii. Based upon a review of the holding company financial statements, are there any holding company lenders that appear as open depositories of the insurer?

5. Identify any other significant or unusual transactions that may involve an affiliate or other related party, and document any concerns.

Summary and Conclusion

Develop and document an overall summary and conclusion regarding affiliated transactions. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures that, in the analyst's judgment, are relevant to evaluating affiliated transactions under the specific circumstances involved.

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Do you recommend that one or more procedures within the Level 3 Procedures—Affiliated Transactions be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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1. Review General Interrogatories, Part 1, #5. If the Company is subject to a management agreement, have there been any significant changes regarding the terms of any agreements with MGAs or TPAs?

Summary and Conclusion

Develop and document an overall summary and conclusion regarding the insurer's use of MGAs and TPAs. In developing a conclusion, the analyst should consider the above procedures as well as any other procedures that, in the analyst's judgment, are relevant to evaluating the insurer's use of MGAs and TPAs under the specific circumstances involved.

Do you recommend that one or more procedures within Level 3—MGAs and TPAs be completed (if not completed during the analysis of the Annual Financial Statement) or re-completed?

Describe the rationale for this recommendation.

Analyst _____ Date _____

Comments as a result of supervisory review.

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VII. Guidance for Notes to Financial Statements

Note 1—Summary of Significant Accounting Policies

This Note is split into three primary sections. The first section (A) focuses on the insurer's accounting policies compared to the NAIC *Accounting Practices and Procedure Manual* (*AP&P Manual*) and is required as a result of SSAP No. 1, *Disclosure of Accounting Policies, Risks and Uncertainties, and Other Disclosures*. Section (B) is also required by SSAP No. 1 and is focused on the insurer's compliance with the *Annual Statement Instructions,* the *AP&P Manual,* and the insurer's use of estimates. Section (C), also required by SSAP No. 1, focuses on disclosure of all accounting policies that materially affect the assets, liabilities, capital and surplus, or results of operations. These sections provide information that an analyst should use in evaluating the accounting procedures of the insurer.

Section (A) of this Note is broken into two parts. The first part of the first section addresses accounting policies that differ from the *AP&P Manual*. The second part of the first section addresses accounting policies not discussed in the *AP&P Manual*.

The analyst should use the information provided in the first part of section (A) of this Note to determine if an insurer's financial position would be different if all the accounting rules of the NAIC were followed. Not only does the disclosure require the insurer to indicate permitted practices that have been provided by the state of domicile (a disclosure that was previously required by the Model Audit Rule), but it also requires that prescribed differences be disclosed. 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. 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 5 percent or greater as a result of applying the NAIC methods. A difference of this magnitude indicates that the insurer's financial position may vary significantly from what is reported using the accounting rules that have been established by the state of domicile.

The analyst should use the information provided in the second part of section (A) of this Note to determine if the insurer has any unusual transaction(s) for which the NAIC has not developed any standard accounting rules. 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 analyst should review the insurer's disclosure to obtain an understanding of the transaction(s). 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 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.

The second section (B) of this Note requires the insurer to disclose its compliance with the NAIC *Annual Statement Instructions*. 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.

The analyst should use the information provided in the third section (C) of this Note to determine if the insurer has used any unusual accounting methods for its invested assets. 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

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SSAP No. 1 and Appendix 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.

Note 2—Accounting Changes and Corrections of Errors

Section (A) focuses 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*. Section (A) includes three parts that require additional details regarding the accounting changes and corrections of errors. The information provided in section (A) of this Note can be helpful in assessing the continuing operations of the insurer.

The analyst should use the information provided in section (A) of 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 percent 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.

The analyst should also use the information provided in section (A) of this Note to understand any errors the insurer has corrected and determine the financial impact of the correction. In cases where the insurer's total capital and surplus decreased by 5 percent or greater, special attention should be given. 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 Extraordinary 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.

The analyst should also use the information provided in section (A) of this Note to understand any change in 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.

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.

Note 3—Business Combinations and Goodwill

This Note has three primary sections. Section (A) focuses on statutory purchases, section (B) focuses on statutory mergers, and section (C) focuses on impairment losses.

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For the first part of business combinations, the statutory purchase method is addressed in section (A) and 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. 88, *Investments in Subsidiary, Controlled and Affiliated Entities*. One of the most significant aspects of SSAP No. 68 as superseded by SSAP No. 88 provides that 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 pertintent 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.

The second type of business combination, the statutory merger, is addressed in section (B) of the Note. The accounting guidance for this type of business combination is also discussed in SSAP No. 68. The SSAP 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 occured. Section (B) of this Note focuses on the transaction that occurred and requires the insurer to disclose all pertintent information related to the merger. This includes financial information on each of the companies before they 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.

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) 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.

Note 4—Discontinued Operations

This Note is split into five different sections, and each requires the insurer to report certain information on discontinued operations. The analyst should use the information provided in the Note to obtain a greater understanding of the operations that have been discontinued and determine the effect that the decision to discontinue could have on the current and future periods. 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, i.e., no separate line item presentation.

The first section requires an insurer to disclose the segment of business that has been or will be discontinued. The second section requires an insurer to disclose the date of disposal, and the third section requires the insurer to disclose the manner of disposal. All of this information should be used to obtain a greater understanding of the transaction. Sometimes, the insurer's decision to dispose of a segment of business is voluntary, and might 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 might 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 company 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

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policyholders. The analyst should use the information provided to gain a greater understanding of why the segment was discontinued. The analyst should consider if the disposal was approved by the domiciliary state and if a plan of run-off was also approved.

As noted above, although the run-off of certain lines of business can alleviate certain problems of an insurer, it might not always be in the best interests of all policyholders. The analyst should consider the type of business being discontinued and the geographic locations of the business to better understand the potential problems that could develop from the run-off. Generally, run-off of business with longer tails represents a greater risk to insurers and should be reviewed more closely. However, run-off of shorter tail business still represents a risk to insurers because, in some cases, the run-off can lead to greater utilization such as that which is experienced in accident and health business. In all cases, the analyst should understand the assumptions used and the work that was performed to ensure that the assets will be sufficient to run-off outstanding losses, such as that performed by a consulting actuary. However, in some cases, where an independent review of the payout pattern was not performed, the insurer might have obtained an irrevocable guarantee from its parent. The insurer may have also arranged for a portfolio transfer of the business through a reinsurance arrangement.

The fourth section requires an insurer to describe the remaining assets and liabilities of the segment at the balance sheet date. The fifth section requires an insurer to quantify the effect on the financial statements, including the balance sheet and the income statement. The analyst should use the information provided in these sections to better understand the potential impact on the insurer. By using this information, the analyst will be able to determine if the business being discontinued is significant in terms of premium volume and reserve levels. Using this information, the analyst might be able to determine if the results of the discontinued operations will be positive or negative. The analyst should not only consider the positive impact that the discontinued operations might have on the profitability of the insurer, but also the impact that the decision will have on cash flow and liquidity. In making this determination, the analyst should also understand how the insurer has accounted for the transaction. As noted above, SSAP No. 24 requires that discontinued operations be reported with an insurer's continuing operations. In addition, the risk the insurer is exposed to under the discontinuance is of utmost importance and should be considered as part of the financial impact.

Note 5—Investments

This Note is split into seven primary sections. Section (A) focuses on the 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*. Section (B) focuses on the recording of the investment in loans that have been recognized as impaired as required by SSAP No. 36, *Troubled Debt Restructuring*. Section (C) focuses on 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*. Section (D) focuses on determining prepayment assumptions for yield calculations and the risk exposure in loan-backed securities as required by SSAP No. 43R, *Revised Loan-backed and Structured Securities*. Section (E) focuses on the 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. 91R, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*. Section (F) focuses on the 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. 40, *Real Estate Investments*. Section (G) focuses on 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, *Accounting for Low Income Housing Tax Credit Property Investments*. All seven sections of this Note include significant parts, but each part of each section simply

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requires additional details. 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.

The information provided in section (A) of this Note can be helpful in quantifying the insurer's investment in mortgage loans, including mezzanine real estate loans, and assessing the impact of impaired loans. The analyst should use the information provided in this section to 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.

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, 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 investment in impaired mortgage loans for which there is no related allowance for credit losses.

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.

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.

The information provided in section (B) of this Note can be helpful in quantifying the insurer's investment in loans determined to be impaired. The analyst should use the information provided in this section to determine whether the insurer has recorded the investment in loans recognized as impaired as prescribed by SSAP No. 36.

The analyst should consider the information disclosed in this section to evaluate the insurer's investment in loans impaired and the terms agreed upon for debt restructuring. The analyst should note 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 they can maximize recovery of the loan.

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 note 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

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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.

The analyst should consider the information provided in section (D) to gain an understanding of the insurer's assumptions in determining prepayment of loan-backed securities. The information should help the analyst determine how closely the insurer followed the principles of valuation and prepayment assumptions 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 impaired securities (fair value is less than cost or amortized cost) for with 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 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.

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. 91R, 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 note 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. Per SSAP No. 91R, if the insurer has accepted collateral that is permitted by contract or custom to sell or repledge, regardless of whether the transaction is "on-balance sheet" or "off-balance sheet", the insurer should disclose certain information 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 aggregate fair value of all reinvested collateral. This allows the analyst to compare 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.

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The information provided in section (F) of this Note can be helpful in quantifying the insurer's investment in real estate determined to be impaired. The analyst should use the information provided in this section to determine whether the insurer has recorded the investment in real estate recognized as impaired as prescribed by SSAP No. 40. 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. 40.

The analyst should consider the information disclosed in this section to evaluate the insurer's investment in real estate impaired. 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 and the planned expenditures and recorded obligations for improvements.

The analyst should use the information provided in section (G) 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 percent of total admitted assets. In addition, the insurer is required to disclose any recognized impairments and the nature of any write-downs or reclassifications made during the year.

Note 6—Joint Ventures, Partnerships and Limited Liability Companies

This Note focuses on investments in joint ventures, partnerships, and limited liability companies and is split into two primary sections. Section (A) requires the insurer to disclose various information about investments in joint ventures, partnerships, and limited liability companies that exceed 10 percent of the admitted assets of the insurer. Section (B) requires the insurer to disclose specific information on the above types of investments that have become impaired.

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 their individual 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, i.e., 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 of these types of investments that are held by the insurer, 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.

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Note 7—Investment Income

This Note is split into two primary sections. Section (A) focuses on the insurer's basis for nonadmitting due and accrued investment income as required as a result of SSAP No. 34, *Investment Income Due and Accrued* and SSAP No. 99, *Accounting for Certain Securities Subsequent to an Other-Than-Temporary Impairment.* Section (B) discloses the amount the insurer nonadmits upon determining collectibility of due and accrued investment income. The information provided in both sections is helpful to the analyst in reviewing the financial statements and related exhibits and schedules for real estate, mortgage loans, and long-term bonds.

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 as a 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 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 collectibility of the remaining investment income due. The analyst should review SSAP No. 99 and SSAP No. 5, *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 uncollectible and should be written off and charged against investment income. Interest can be accrued on mortgage loans in default if interest is deemed collectible. But if interest is deemed uncollectible, 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 collectible, all accrued interest should be reported as a nonadmitted asset.

Note 8—Derivative Instruments

This Note contains separate information and accounting requirements based on the date of the derivative instrument transaction. For those derivative transactions entered into or modified on or after January 1, 2003, SSAP No. 86, *Accounting for Derivative Instruments and Hedging Activities*, will provide guidance for this Note. For derivative transactions prior to January 1, 2003, SSAP No. 31, *Derivative Instruments*, will apply. Alternatively, an insurer may choose to apply SSAP No. 86 to all derivatives to which the insurer was a party as of January 1, 2003. In either case, the insurer is to disclose the transition approach that is being used.

<u>Disclosure Guidance for Derivative Transactions Occurring Prior to January 1, 2003</u>
This Note contains four sections. Section (A) focuses on 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. 31. The discussion provided in section (A) of this Note can be helpful in determining the insurer's risk

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exposure associated with its derivative investments. Section (B) focuses on the insurer's objectives for holding or issuing derivative financial instruments and is also required under SSAP No. 31. The information provided in section (B) of this Note is useful in understanding the insurer's investment stategy in regards to its use of deriviative instuments. Section (C) focuses on how each category of derivative instruments are reported in the financial statements and is also required by SSAP No. 31. The information provided in section (C) is helpful to the analyst in reviewing the financial statements and, more specifically, the related schedules for derivatives and exhibits for investment income from derivatives and gains and losses on derivatives. Section (D) focuses on the unrealized gains and losses resulting from derivatives that no longer qualify for hedge accounting. The information provided in section (D) also assists the analyst in evaluating the portion of the unrealized gains or losses on derivatives that represents derivatives that no longer qualify for hedge accounting.

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 might fluctuate significantly, resulting in significant gains and losses.

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. 31 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 or liabilities or future cash flows for which the derivative transactions were entered into or issued to hedge against. See section III Analyst Reference Guide, B1 Investments—Primer on Derivatives for further discussion of derivative instruments.

The analyst should consider the information disclosed in section (C) in conjunction with information provided 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. 31 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 percent of net investment income or if the insurer is experiencing capital losses on derivative instruments of more than 10 percent of capital and surplus. In cases where the insurer's total derivative instruments represent more than 10 percent of capital and surplus, special attention should also be given to this Note. See section IV Annual Procedures, B1—Investments, procedure #9 for specific guidance in evaluating the materiality of an insurer's risk to derivatives.

<u>Disclosure Guidance for Derivative Transactions Occurring After January 1, 2003</u>
This Note contains six sections. Section (A) focuses on 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. The discussion provided in section (A) of this Note can be helpful in determining the insurer's risk exposure associated with its derivative investments. Section (B) focuses on the insurer's objectives for holding or issuing derivative financial instruments and is also required under SSAP No. 86. The information provided in section (B) of this Note is useful in understanding the insurer's investment strategy in regards to its use of deriviative instuments. Section (C) focuses on how each category of

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derivative instrument is reported in the financial statements and is also required by SSAP No. 86. The information provided in section (C) is helpful to the analyst in reviewing the financial statements and, more specifically, the related schedules, for derivatives and exhibits for investment income from derivatives and gains and losses on derivatives. The information provided in sections (D) and (E) assist the analyst in evaluating the portion of the unrealized gains or losses on derivatives that represents derivatives excluded from the assessment of hedge effectiveness or no longer qualifying for hedge accounting. The information in section (F) provides details about derivatives accounted for as cash flow hedges of a forecasted transaction.

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.

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. See section III Analyst Reference Guide, B1 Investments—Primer on Derivatives for further discussion of derivative instruments.

The analyst should consider the information disclosed in section (C) in conjunction with information provided 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 percent of net investment income or if the insurer is experiencing capital losses on derivative instruments of more than 10 percent of capital and surplus. In cases where the insurer's total derivative instruments represent more than 10 percent of capital and surplus, special attention should also be given to this Note. See section IV Annual Procedures, B1—Investments, procedure #9 for specific guidance in evaluating the materiality of an insurer's risk to derivatives.

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 and liabilities 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. 10R, *Income Taxes-Revised, A Temporary Replacement of SSAP No. 10,* simply requires the recognition of the tax consequences of that transaction or event in the financial statements. Note that SSAP No. 10R is only effective for annual periods ending December 31, 2009 and interim and annual periods of 2010.

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Deferred tax liabilities (DTLs) represent temporary differences that will result in future taxable amounts. Deferred tax assets (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." The easiest way to understand the concept of a temporary difference is to review an example of one.

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 IRS requires that an insurer set up what is known as a Proxy DAC (deferred policy acquisition expense) asset.

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 accident and health, 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.

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 percent—IRS percentage). The insurer will amortize this asset (for tax purposes) over the next 10 years, resulting in annual amortization of $710 thousand. However, in the current year, the insurer will only be allowed to amortize $355 thousand, 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 percent), because this is the amount that taxes will be reduced in the

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future as a result of the temporary difference. This is just one example of how temporary differences are calculated under SSAP No. 10R 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 Differences
Property/Casualty 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 percent of the annual change in unearned premiums in income. This temporary difference 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.

All Insurance Companies
Accrued Market Discount: For statutory purposes, SSAP No. 26, *Bonds, excluding Loan-Backed and Structured Securities* 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 paragraph 14 of SSAP No. 10R 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.

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Balance Sheet Approach
As noted in the above example, SSAP No. 10R 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 *Statement of Financial Accounting Standards 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 2010 to perform this calculation. However, SSAP No. 10R does use some conservatism that requires the insurer to determine what will reverse in the next year.

Limitations
As noted above, SSAP No. 10R does add a layer of conservatism to the recognition of DTAs in an insurer's financial statements. It does this by limiting the amount of DTAs that can be admitted in the financial statements of an insurer. In all cases, SSAP No. 10R limits the amount of net DTAs that an insurer can carry to 10 percent and if the insurer meets certain criteria in paragraph 10 of SSAP No. 10R, it limits the DTA to 15 percent of capital and surplus. In addition, the SSAP further limits the amount of DTAs that an insurer can hold to the amount of DTAs that will reverse within one year, three years, or during a timeframe corresponding with IRS tax loss carryback provisions. This limitation is consistent with the overall definition of an admitted asset. See SSAP No. 10R for 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. A new line has not been created for deferred tax assets or deferred tax liabilities; those amounts should be reported with current federal income taxes receivable/payable as indicated in the *Annual Statement Instructions*. In addition, the DTA and DTL, even though they are calculated on a gross basis, 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.

Disclosure
The disclosure requirements of SSAP No. 10R are rather extensive, and are broken down into six parts. Section (A) of this Note requires that the insurer disclose the financial components (assets, liabilities, and surplus impact) of the deferred taxes. Section (B) of this Note requires that the insurer disclose any DTLs that are not required to be reported as a liability in connection with paragraph 31 of FASB 109. Section (C) of this Note requires the insurer to disclose the significant components of its current income taxes incurred. Section (D) of this Note requires an insurer to disclose the types and amount of temporary differences that affect the insurer's effective tax rate. Section (E) of this Note requires the insurer to disclose certain information on operating loss and tax credit carryforwards. Section (F) of this Note requires the insurer to disclose certain information on consolidated tax returns, if applicable.

The analyst should use the information required in section (A) of this Note to determine the overall impact that SSAP No. 10R has had on the financial position of the insurer. The first section requires the insurer to report its gross, adjusted gross, admitted and nonadmitted DTAs by tax character, total DTLs by tax character, total nonadmitted DTAs and overall surplus impact. SSAP No. 10R also requires the disclosure of certain information resulting from the application of SSAP No. 10R 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 total adjusted capital in the RBC calculation; and the increased amount of DTAs, admitted assets and surplus. As indicated above, this accounting is consistent with the concept of recognition. However, as also indicated

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above, there are limitations put on the amount of DTAs that an insurer can admit. Despite these limitations, the number of insurers that may report an increase in capital and surplus as a result of this statement may outnumber the number of insurers that report a decrease. Because a 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 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 (See the Internal Revenue Code for further discussion) account.

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 judgement 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. 10R prohibits the use of anticipated tax rates in its application.

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.

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.

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. 10R to its financial statements regardless of a consolidated tax return being prepared. SSAP No. 10R allows the allocation of taxes between affiliated entities that file a consolidated tax return, but the basic requirements of SSAP No. 10R 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.

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. 10R.

The analyst should also determine if the insurer has appropriately limited the DTA to 10 percent of capital and surplus. Under SSAP No. 10R, if the insurer is subject to RBC requirements and meets the

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requirements outlined in SSAP No. 10R paragraph 10, the insurer may elect to admit a higher amount of adjusted gross DTAs up to a limit of 15 percent of capital and surplus.

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 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 and Affiliates

As discussed in SSAP No. 25, *Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties*, related party transactions are subject to abuse because reporting entities might be induced to enter transactions that might not reflect economic realities or might not be fair and reasonable to the insurer or its policyholders. As such, related party transactions require specialized accounting rules and increased regulatory scrutiny. Because of this, the purpose of this Note is to provide detailed information regarding all types of affiliates and affiliated transactions. It is broken up into eleven different sections that provide specific information on an insurer's affiliated relationships or transactions. The accounting guidance for affiliates is addressed in SSAP No. 25. SSAP No. 25 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.

The analyst should use the information in this Note to gain an understanding of the effects of the related party transactions on the financial statement and determine whether concerns exist regarding affiliated transactions. The analyst should evaluate amounts owed by a related party to determine if there may be a significant collectibility 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 important to evaluate the effect of any guarantees or affiliated undertakings 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.

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

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group or the holding company alone (e.g., 10-K filing), to understand the amount of debt 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 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.

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.

In cases where the insurer and other enterprises are under common ownership or control relationships exist, the analyst should evaluate the risk that the operating results or financial position of the insurer may pose. The risks may be significantly different than those that would have existed if the enterprises were autonomous. Unusual agreements or affiliated transactions 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.

Note 11—Debt

This note contains two sections. The first section (A) requires disclosure of information related to all other debt, including capital notes. The accounting guidance is 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, and debt terms, covenants, and any violations. The section (B) requires disclosure of information related to agreements with the Federal Home Loan Bank (FHLB).

For the first section (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 percent of capital and surplus, special attention should be given. For all debt, the analyst will want to verify 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 of the insurer for additional funding. Another important area to review is repayment conditions, restrictions, or covenants. In particular, the analyst needs to be aware if there are 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.

For the second section (B) the analyst should review the 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 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.

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

This Note contains six sections. Section (A) requires the insurer to disclose details of employer-sponsored defined benefit plans and is required by SSAP No. 89, *Accounting for Pensions, A Replacement of SSAP No. 8*, SSAP No. 11, *Postemployment Benefits and Compensated Absences*, and SSAP No. 14, *Postretirement Benefits Other Than Pensions*. Section (B) focuses on the details of defined contribution plans and other postretirement benefit plans and is required by SSAP No. 89 and SSAP No. 14. Section (C) focuses on multi-employer plans and is required by SSAP No. 89 and SSAP No. 14. Section (D) discusses parent or holding company sponsored plans and is required by SSAP No. 89, SSAP No. 11 and SSAP No. 14. Section (E) discusses postemployment benefits and compensated absences that do not meet the conditions for accrual as a liability and is required by SSAP No. 11. Section (F) focuses on the impact the Medicare Modernization Act has on postretirement benefits as discussed in SSAP No. 14 and INT 04-17.

Section (A) of this Note provides significant disclosure regarding the insurer's employer sponsored defined benefit plans. As discussed in SSAP No. 89, 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.

As defined in SSAP No. 89, a defined contribution plan defines the amount of the employer's contributions to the plan and its allocation to plan participants. Less disclosure is required for this type of pension plan. In section (B), the insurer is required to disclose the cost recognized for the defined contribution plan separately from the amount of cost recognized for defined benefit plans. Also, they must disclose a description of significant changes to the plan. The analyst should evaluate the plan disclosures to determine the impact to the financial statements.

Section (C) of this Note focuses on multi-employer plans. It is similar to section (B) in regard to the type of disclosure required. 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.

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 provided in section (D) of this Note 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.

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 in section (E) to determine if there is concern regarding a potential impact to the financial statements.

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Section (F) 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. 14, such as a reduction in the net postretirement benefit, amortization, reduction in current period service cost or interest cost, or any other significant changes.

Note 13—Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

This Note is split into 13 separate sections and covers several key areas of an insurer's overall capitalization. The first area is capital and surplus and includes items #1–#10. 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 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 approved by the insurance department.

The second area of this Note requires the insurer to disclose certain information on surplus notes. The analyst should use the information required in item #11 of the Note to obtain a greater understanding of the insurer's surplus note obligations. Using the information required, 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. Other areas the analyst should review and consider when there are any new surplus notes include verifying the proper accounting for the notes and any associated interest; the payment schedule for repayment and if the insurer will be able to meet this schedule; the type and quality of assets received in the transaction; and if the notes were issued to a parent or affiliates. If the notes were issued to an affiliate, the analyst should consider reviewing the affiliate's financial statements to verify the notes are appropriately reported by the other entity.

The third and final area covered in this Note is quasi-reorganization. The analyst should use the information required in items #12 and #13 of the Note to obtain an understanding of any quasi-reorganizations that may have occurred during the most recent period. 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). Item #13 of the Note requires disclosure of the dates and amounts of any dividends paid, whether ordinary or extraordinary, that were involved in the quasi-reorganization.

Note 14—Contingencies

This Note is split into five sections: contingent commitments, assessments, gain contingencies, claims related extra contractual obligation and bad faith losses stemming from lawsuits, and all other contingencies. The accounting guidance for contingencies is addressed in SSAP No. 5, *Liabilities, Contingencies and Impairments of Assets*, and for specific items, in SSAP No. 35 *Guaranty Fund and*

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Other Assessments; SSAP No. 97, *Investments in Subsidiary, Controlled and Affiliated Entities, A Replacement of SSAP No. 88;* SSAP No. 55, *Unpaid Claims, Losses and Loss Adjustment* Expenses; and SSAP No. 48, *Joint Ventures, Partnerships and Limited Liability Companies*.

Contingencies are defined in SSAP No. 5 as an existing condition, situation, or set of circumstances involving uncertainty as to a possible loss or gain to an enterprise that will ultimately be resolved when one or more future event(s) occur or fail to occur.

As discussed in SSAP No. 5, 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.

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.

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. 35 for specific statutory reporting guidance and required disclosure in this Note.

Per SSAP No. 5, gain contingencies are not to be recognized in a reporting 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.

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.

Note 15—Leases

This Note is split into two primary sections. Section (A) focuses on the disclosure of items related to lessee arrangements. Section (B) focuses on the disclosure of items related to lessor business activities. Both sections of this Note include two or three parts, but each part of each section simply requires additional details regarding the breakdown and disclosure of the lessee's or lessor's arrangements.

The accounting guidance for leases is in SSAP No. 22*, Leases*. A lease is defined by SSAP No. 22 as an agreement conveying the right to use property, plant, or equipment usually for a stated period of time. Under SSAP No. 22, 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

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(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.

Per SSAP No. 22, 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. 22, 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, increase 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.

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. 22, 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 note property-type asset concentrations and examine the lessor's current and future profitability reliance on its rental income.

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.

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

This Note contains four parts, each of which is required by SSAP No. 27, *Disclosure of Information about Financial Instruments with Off-Balance-Sheet Risk, Financial Instruments with Concentrations of Credit Risk and Disclosures about Fair Value of Financial Instruments*. Part (1) summarizes the face

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amount of financial instruments with off-balance sheet risk by class of financial instrument. Part (2) discusses the credit risk, market risk, cash requirements of the instrument and the accounting policies related to the instrument. Part (3) discloses the amount of accounting loss the entity would incur in a situation where there was non-performance of the contract terms of the financial instrument and the related collateral or other security supporting the financial instrument. 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.

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. 5. 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 to Financial Statements.

In the first part 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. The analyst should use the second part of this Note 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.

The analyst should use the third part 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. The fourth part of this Note 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.

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

This Note is split into three primary sections. Section (A) focuses on the transfer of receivables reported as sales and represents a new disclosure that is required as a result of SSAP No. 42, *Sale of Premium Receivables*. Section (B) focuses on the transfer and servicing of other financial assets and represents a new disclosure that is required as a result of SSAP No. 91R. Section (C) is also required by SSAP No. 91R but pertains only to wash sales. The third section, unlike most of the Notes, is actually required to be included in the quarterly statement, if applicable.

Section (A) of this Note 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 the information required in section (A) 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

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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, *Disclosure of Information about Financial Instruments with Off-Balance-Sheet Risk, Financial Instruments with Concentrations of Credit Risk and Disclosures about Fair Value of Financial Instruments.*

Section (B) of this Note is broken up into six different areas. The first part of section (B) of this Note requires an insurer to disclose certain information regarding the valuation of certain assets transferred. The analyst should use the information required in this part of the Note to evaluate the reasonableness of the information recorded by the insurer. The second part requires an insurer to disclose 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 the information required in this part of the Note to help understand the types of investing and financing contracts the insurer uses to maximize profits and liquidity. The third part requires an insurer to disclose certain information regarding servicing assets and liabilities recorded in the financial statements. The analyst should use the information required in this part of the Note to help understand the materiality of the servicing process in relation to the insurance operations. The analyst should also use the information required in this part of the Note, as well as other economic events, to evaluate if certain circumstances have occurred within the insurer or the marketplace that indicate that a liability should be recorded. The fourth part requires an insurer to disclose certain information regarding securitized financial assets in which the transfer is accounted for as a sale. The analyst should use the information required in this part of the Note to understand the insurer's accounting policies for initially measuring the interests that continue to be held by the transferor, if any, and the methodology used in determining the fair value of the underlying assets and of the interest in the securitization. The fifth part requires an insurer to disclose certain information regarding the subsequent measurement of interests and fair market valuation. 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 the information required in this part of the Note to evaluate the possible impact of adverse outcomes highlighted in the sensitivity analysis or stress test. The sixth part of section (B) requires an insurer to disclose any transfers of receivables with recourse.

Section (C) of this Note requires an insurer to disclose certain information regarding its use of "wash sales" as defined in SSAP No. 91R. The analyst should use the information required in this part of the Note to help understand the purpose and types of various financial contracts the insurer uses.

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

This Note is split into three primary sections. The first section focuses on the profitability of uninsured and partially insured accident and health (A&H) plans under administrative services only (ASO) contracts. The second section focuses on the profitability of uninsured and partially insured A&H plans for the reporting entities of administrative service contract (ASC) plans. The third section focuses on the profitability of Medicare or similarly structured cost-based reimbursement contracts. All three sections of this Note of the *Annual Statement Instructions* include four or five parts, but each part of each section simply requires additional details regarding the breakdown of the uninsured or partially insured plan's expenses, fee income, and gain or loss.

The accounting guidance for health entities that operate uninsured plans and partially insured plans is in SSAP No. 47, *Uninsured Plans*. An uninsured A&H plan may be either an ASO plan or an ASC plan.

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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.

This Note should also be used by the analyst 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.

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 percent of surplus. This Note is required by SSAP No. 53, *Property Casualty Contracts-Premiums* and SSAP No. 54, *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 volume of business written or to facilitate entry into new lines of business or geographical locations (see Analyst Reference Guide, B8 for a detailed explanation).

The analyst should use the information in this Note 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.

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

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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.

Note 20—Other Items

This Note is split into seven primary sections. Each section is individually unique and is required by various SSAPs, INTs, and other sources. Some of the items are included in this Note on a temporary basis. Because of these reasons, the guidance on this Note is limited to an identification of the items and does not include a discussion of how to use the data.

Section (A) focuses on extraordinary items and is required by SSAP No. 24. Section (B) focuses on troubled debt restructuring for debtors and is required by SSAP No. 36. Section (C) focuses on disclosures of other miscellaneous amounts not recorded in the financial statements that represent assets pledged to others as collateral in accordance with SSAP No. 1. Section (D) focuses on the disclosure requirements of possibly uncollectible assets and is required by SSAP No. 6, *Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers,* and SSAP No. 47. Section (E) focuses on disclosures for business interruption insurance recoveries, including information related to the nature and aggregate amount of losses and recoveries recognized due to business interruption. Section (F) focuses on disclosures for state transferable tax credits. Section (G) focuses on disclosures for subprime mortgage related risk exposure and related risk management practices. The analyst may need to reference the *AP&P Manual* for further guidance on each particular section.

Note 21—Events Subsequent

Subsequent events are required to be disclosed in the financial statements and/or Notes as a result of 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. This Note is split into two primary parts. The first part (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 subsequent events 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. The second part (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 subsequent events provide relevant information needed to evaluate the information in the financial statements. Type II events are only disclosed in the Notes to Financial Statements.

The analyst should use the information disclosed in Type I of this Note to determine what impact 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 affected the reported line item estimates. For these reasons, analysts should review Type I 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.

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The analyst should use the information disclosed in Type II of this Note to assess and quantify the impact that 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.

Note 22—Reinsurance

This Note is split into seven primary sections. Section (A) requires the insurer to report certain information on any individual unsecured reinsurance recoverables that exceed 3 percent of policyholders' surplus. Section (B) requires the insurer to report certain information on reinsurance recoverables in dispute. Section (C) requires the insurer to report certain information on reinsurance assumed and ceded commissions. Section (D) requires the insurer to report certain information on uncollectible reinsurance that was written off during the year. Section (E) requires the insurer to report certain information on commutation of reinsurance. Section (F) requires the insurer to report certain information on the use of retroactive reinsurance. Section (G) requires the insurer to report certain information on reinsurance accounted for as a deposit.

The analyst should use all of the information provided in this Note to 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. To assist in accomplishing this, the analyst may consult the following: the financial statements of the reinsurer; Analyst Team designations; regulatory and governmental filings (SEC and insurance department's Form B); rating agency reports; financial reports on the insurance industry; and other financial sources.

Under SSAP No. 61*, Life, Deposit-Type and Accident and Health Reinsurance*, Uncollectible Reinsurance, "The ceding and assuming companies must determine if reinsurance recoverables are collectible. If it is probable that reinsurance recoverables on paid or unpaid claims or benefit payments will be uncollectible, consistent with SSAP No. 5, these amounts shall be written off through a charge to the Statement of Income utilizing the same accounts which established the reinsurance recoverables."

In addition to using all of the information in this Note to obtain a greater understanding of the insurer's reinsurance program, the analyst should also consider using specific sections of the Note as follows.

The analyst should use the information provided in section (B) of this Note to determine if any disputed recoverables have been noted. If so, the analyst should issue an inquiry to the insurer to determine the

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steps being taken to recover the amount(s). The analyst might want to question the validity of the credit being taken for disputed items.

On the property/casualty side, the analyst should use the information provided in section (E) of this Note 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.

The analyst should use the information provided in section (F) of this Note 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. 62, *Property and Casualty Reinsurance,* Section 28).

The analyst should use the information provided in section (G) of this Note 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. 75, *Reinsurance Deposit Accounting—An Amendment to SSAP No. 62*, *Property and Casualty Reinsurance*, provides accounting guidance.

Note 23—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. 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.

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 analyst should review the Note to determine whether the reported amount is recorded in compliance with necessary statutory guidance. For property/casualty companies, the analyst should compare the admitted amount reported in the Note for accrued retrospective premiums to what is recorded on the balance sheet.

Note 24—Changes in Incurred Losses and Loss Adjustment Expense

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

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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 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 5–10 percent 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 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 25—Intercompany Pooling Arrangements

This Note requires an insurer to report certain information on reinsurance pooling arrangements with affiliated insurers. The analyst should use the information required in this Note to obtain a greater understanding of the insurer's pooling agreements. 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.

Note 26—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. 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 claimant. They come through arms-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

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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.

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.

Note 27—Health Care Receivables

This Note is divided into two primary sections. Section (A) requires disclosure on pharmaceutical rebate receivables. Section (B) requires the insurer to disclose 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, *Certain Health Care Receivables and Receivables under Government Insured Plans*. Exhibit C—Implementation Guide of SSAP No. 84 provides additional accounting guidance for the practical application of SSAP No. 84.

Section (A)—Pharmaceutical Rebate Receivables

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. 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.

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Section (A) of the Note also contains a table, 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 following example.

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
12/31/2007	$150 (A)				
9/30/2007	130 (B)	$133 (C)	$62 (D)		
6/30/2007	142	143	138	$5	
3/31/2007	157	152	150	1	$1
12/31/2006	125	132	129	3	0
9/30/2006	123	129	125	1	0
6/30/2006	112	120	110	4	6
3/31/2006	110	118	118	0	0
12/31/2005	68	75	69	5	3
9/30/2005	60	59	58	1	0
6/30/2005	57	60	49	8	1
3/31/2005	45	50	48	1	1

This example assumes a financial statement date of 12/31/2007 and further assumes full implementation of SSAP No. 84 retroactive to 1/1/2005, 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 2007.

B. The $130 represents the company's best estimate of rebates to be received on drugs filled in the third quarter of 2007.

C. $133 is the actual amount of rebates determined for the third quarter of 2007, i.e., the amount billed to the pharmaceutical company or confirmed to the pharmacy benefit manager. This amount was billed by 11/30/2007. 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 11/30/2007, the $62 represents the actual rebates received by the company during December 2007. In subsequent disclosures, the company would "update" this to include amounts received in January and February of 2008.

The admitted asset balance for pharmacy rebates at 12/31/2007 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 3/31/07 (first

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quarter of 2007) 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).

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.

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 are not explained in the Note.

The Note was also designed to provide information on collectibility. If, in accordance with SSAP No. 5, it is probable the balance of a receivable is uncollectible, any uncollectible 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 collectibility 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 collectibility of pharmaceutical rebate receivables, and certain receivables should be written off if they are deemed to be uncollectible.

Section (B)—Risk-Sharing Receivables

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

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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.

The purpose of this disclosure is to show how an insurer's risk-share balances have changed over time (e.g., estimated and billed amounts), to show how much of the receivable is estimated amounts or subsequently billed amounts, and to provide information on collectibility. 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 collectibility of risk-sharing receivables, and that certain receivables should be written off if they are deemed to be uncollectible. Risk-sharing receivables from affiliated entities are included in this footnote and are reported as Health Care Receivables.

Note 28—Participating Policies

This Note requires the insurer to disclose information on participating contracts. The Note for participating policies is required by SSAP No. 51, *Life Contracts* (SSAP No. 51), and SSAP No. 54.

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 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 29—Premium Deficiency Reserves

This Note requires the insurer to disclose information on premium deficiency reserves. The Note for premium deficiency reserves is required by SSAP No. 53 and SSAP No. 54.

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 disclosure requires the insurer to provide the amount of that reserve and disclose if the reporting entity utilized anticipated investment income as a factor in the premium deficiency calculation. Premium deficiency reserves could impact the insurer's financial

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position; therefore, the analyst should review the disclosure to determine the extent of any impact on the insurer's financials.

Note 30—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 uncollectible.

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 ten percent 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 ten percent that are not anticipated to be collected should also be non-admitted.

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.

Note 31—Discounting of Liabilities for Unpaid Losses or Unpaid Loss Adjustment Expenses

This Note is split into three primary sections. Section (A) requires the insurer to report certain information on reserves that have been discounted using a tabular basis. Section (B) requires the insurer to report certain information on reserves that have been discounted using a non-tabular basis. Section (C) requires the insurer to report certain information if the insurer has made any changes in the assumptions used to discount its reserves. 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 property/casualty 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-

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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.

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 percent, 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 percent, 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.

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.

Note 32—Asbestos/Environmental Reserves

This Note is split into six different sections. Each section provides specific information on the insurer's asbestos and/or environmental (A&E) business. The accounting guidance and disclosure requirements for A&E Reserves are addressed in SSAP No. 65. This Note assists the analyst in determining whether unpaid losses and/or loss adjustment expenses (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.

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 incurred but not reported (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 percent 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.

Note 33—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. 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.

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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 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—34 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*.

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.

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