EXAMINATION OVERSIGHT (E) TASK FORCE

Draft: 12/10/09

Examination Oversight (E) Task Force
San Francisco, CA
December 6, 2009

The Examination Oversight (E) Task Force met in San Francisco, CA, Dec. 6, 2009. The following Task Force members participated: Mary Jo Hudson, Chair, represented by Bill Harrington (OH); Ken Ross, Vice Chair, represented by Dan Schaefer (MI); Jim L. Ridling represented by Richard Ford (AL); Jay Bradford represented by Mel Anderson (AR); Steve Poizner represented by Al Bottalico (CA); Thomas R. Sullivan represented by William Arfanis (CT); Gennet Purcell represented by Kevin Brown (DC); Karen Weldin-Stewart represented by Linda Sizemore (DE); Susan E. Voss represented by Jim Armstrong (IA); William W. Deal represented by Georgia Siehl (ID); Michael T. McRaith represented by Jim Hanson (IL); Carol Cutter represented by Connie Ridinger (IN); Sharon P. Clark represented by David Hurt (KY); Ralph S. Tyler, III, represented by Les Schott (MD); Mila Kofman represented by Kendra Godbout (ME); Glenn Wilson represented by Jaki Gardner (MN); John M. Huff represented by Fred Heese (MO); Wayne Goodwin represented by Jeff Trendel (NC); Ann Frohman represented by Jim Nixon (NE); Roger A. Sevigny represented by Tom Burke (NH); Neil N. Jasey represented by Bob Kasinow (NJ); Kim Holland represented by John McCarter (OK); Teresa Miller represented by Russell Latham (OR); Joel Ario represented by Steve Johnson (PA); Joseph Torti, III represented by Jack Broccoli (RI); Leslie A. Newman represented by Larry Knight (TN); Alfred W. Gross represented by Doug Stolte (VA); Paulette Thabault represented by Ken McGuckin (VT); Mike Kreidler represented by Patrick McNaughton (WA); and Sean Dilweg represented by Roger Peterson (WI).

1. Adoption of Examination Repositories

Mr. Bottalico stated that the risk-focused examination process asks examiners to identify key activities and develop related risk statements based upon an understanding of the company being examined and a review of company and auditor-prepared process documentation. However, based upon feedback received from numerous examiners requesting a reference tool of common risks to be reviewed during an examination, the examination repository project was initiated. Work on this project balanced between providing useful examples of common solvency risks without developing a document that could be seen as a checklist of tests to be performed. The newly created exam repositories assist the examiner in identifying the risks that are often inherent within some of the more standard key activities of a typical insurance company. Only the most common risks have been included in the exam repositories to allow more flexibility and customization in identifying risks relevant to each company. Included with the list of risks are examples of control best practices, tests of controls, and examples of how an examiner may choose to perform detail tests for each risk. The repositories are presented as optional tools that are not intended to establish a minimum or maximum level of documentation and testing to be performed on an examination. The project of creating the exam repositories has now been completed, resulting in 18 total repositories being prepared for use in financial examinations. Each of the new exam repositories has been publicly exposed, reviewed in detail by regulators, and adopted by the Financial Examiners Handbook (E) Technical Group. An example repository related to underwriting, along with an introduction explaining how the repositories are meant to be used, was reviewed by the Task Force (Attachment One). On a motion from Mr. Bottalico, seconded by Mr. McNaughton, the examination repositories were adopted for inclusion in the NAIC *Financial Condition Examiners Handbook*.

2. Discuss Current Economic Crisis Issues

Mr. Harrington stated that the Task Force received a referral from the Financial Condition (E) Committee in February 2009 asking the Task Force to address certain recommendations received from the Credit Default Swap (E) Working Group. The Task Force was asked to review each of the items in the referral pertaining to its groups, develop a plan for addressing the items and report on its progress in addressing the issues to the Financial Condition (E) Committee on a regular basis. Mr. Harrington asked Mr. Peterson to report on the progress of the Task Force in addressing issues related to financial analysis and Mr. Bottalico to report on issues related to financial examinations.

Mr. Peterson stated that during 2009, the Financial Analysis Research and Development (E) Working Group made additions to confidential financial analysis solvency tools available to state insurance regulators. Enhancements addressed topics including guaranteed interest contracts, variable annuities with guarantees, securities lending, permitted practices, and peer analysis. In addition, the Financial Analysis Handbook (E) Working Group made enhancements to the *Financial Analysis Handbook*. A detailed discussion was added to the Level 1 Reference Guide of the Handbook regarding non-routine analysis considerations for events or situations outside of the normal course of business that may have a material impact on the overall financial condition of an insurer. The discussion highlights, for example, investment procedures, stress testing, liquidity considerations, securities lending, ratings, and catastrophes. Other enhancements were made to holding company procedures

related to communication and permitted practice indicators. Both of these groups will consider any future recommendations from the Invested Assets (E) Working Group in this area, when received.

Mr. Bottalico stated that the Financial Examiners Handbook (E) Technical Group has undertaken a project to respond to the recommendations included in the referral. As a result, a listing of concerns related to current economic conditions was created and discussed to determine whether guidance should be added to the *Financial Condition Examiners Handbook* or to a newly proposed exam risk alert to address the issues. The exam risk alert would consist of temporary guidance for examiners to utilize based on current issues. All of the items that the Technical Group determined were appropriate for inclusion in the Handbook were completed and adopted by the Technical Group on its Nov. 19 conference call. The Technical Group plans to continue work in this area in 2010 to develop an exam risk alert that can be utilized by examiners in performing Dec. 31, 2009, examinations.

3. Discuss Model #385 Survey Results

Mr. Harrington stated that in September 2008, the NAIC membership adopted revisions to the *Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition* (#385). These revisions provide additional standards to determine whether the continued operation of any insurer might be deemed to be hazardous to its policyholders, creditors or the general public. In addition, the revisions give the commissioner additional authority to issue an order requiring companies deemed to be in hazardous financial condition to take corrective action. As requested by the Executive (EX) Committee, a survey is updated quarterly to track the states' progress in adopting the revisions. Bruce Jenson (NAIC) presented the results of the survey, stating that five states have adopted the revisions, 23 states plan to adopt the revisions, nine states plan to adopt the revisions with minor changes, two states do not plan to adopt the revisions, 10 states are undecided, and two states did not provide a response. Of the states that plan to adopt the revisions or adopt with minor changes, four plan to complete the adoption in 2009, 16 in 2010, five in 2011, and seven do not yet have a timeline for adoption. No states have indicated that problems are anticipated in adopting the model revisions. NAIC staff will continue to update this survey on a quarterly basis, and the results will be discussed at each national meeting.

4. Adoption of Working Group Reports

Mr. Harrington asked the Task Force to review the written reports of the Analyst Team System Oversight (E) Working Group, Financial Analysis Handbook (E) Working Group (Attachment Two), Financial Examiners Coordination (E) Working Group (Attachment Three) and Financial Examiners Handbook (E) Technical Group (Attachment Four) that were included in the materials. On a motion from Mr. Johnson, seconded by Mr. Ford, the Task Force adopted the reports of its working groups.

Having no further business, the Examination Oversight (E) Task Force adjourned.

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SECTION 3—EXAMINATION REPOSITORIES

BACKGROUND

The examination (exam) repositories in this section were created to assist examiners in identifying the most common risks that are often inherent within different key activities of a typical insurance company. These repositories were created at a high-level to reduce the risk of examiners using them as checklists. The intent of the repositories is to provide a tool to assist examiners in determining what risks may be relevant to a typical insurance company, not to provide an all-inclusive listing of potential risks, nor to provide a minimum baseline of what risks are required to be identified on all exams. The repositories are fluid documents and, as such, will be modified and updated with relevant risks and exam procedures as deemed necessary; however, it is expected that the reliance on these documents will decrease as the examiners experience level on Risk-Focused exams increases. Only the most common risks have been included in these exam repositories to allow more flexibility and customization in identifying risks within key activities of the insurer. Included with the identified risks are examples of control best practices, tests of controls, and examples of how an examiner may choose to test the details of each identified risk.

Identified Risks

The identified risks provided within the exam repositories are not designed to be an all-inclusive list and may not apply to all insurance companies that are under examination. The examiner's understanding of the insurer obtained in Phase 1 should be utilized to determine which risks included in this exam repository are applicable to the insurer. The insurer will likely have additional risks associated with the different key activities that have not been included within the exam repositories. The examiner must determine what additional risks not included in this exam repositories should be examined as part of the review of the insurer's processes.

Control Best Practices

The control best practices provided within the exam repositories are the most common ways in which insurers mitigate the specific risks identified. These best practices are common for a typical insurance company, but may not apply to each individual insurer. Each insurer has its own controls in place to mitigate the identified risks, which may or may not correspond to the control best practice identified within the exam repositories. It is possible that the insurer has adequate controls in place, even if the control does not match the control best practices listed in the exam repositories.

Possible Tests of Controls

The possible tests of controls in the exam repositories are not designed to be an all-inclusive list; nor are they intended to be a list of procedures required to be performed on all examinations, as some of the procedures may not apply to the insurer under examination. If the insurer's controls do not match the control best practices, the examiner should not use the possible tests of controls provided within the exam repository. In this case, the examiner needs to develop alternative tests of controls based on how the insurer mitigates the identified risk. If the examiner intends to place reliance on the control, the examiner is required to assess its design and operating effectiveness regardless of whether the insurer's control matches the best practice provided.

Possible Detail Test Procedures

The additional detail tests provided within the exam repositories are not designed to be an all-inclusive list nor are they intended to be a list of procedures which are required to be performed on all examinations, as some of the procedures may not apply to the insurer under examination. In some circumstances, the examiner will need to develop additional detail test procedures beyond what is included within the exam repository. In all cases, examiners should conduct detail tests, where necessary, based on the assessed residual risk for each risk identified.

Both the possible control tests and detail tests listed are simply suggestions as to what the examiner may be able to perform to test the risk identified. Some of the tests listed in the detail test column are attribute tests and are

denoted with an asterisk (*). The detail tests so noted may be used as control tests; however, they are included in the detail test column because the tests would generally require more time and detail testwork than those control tests listed in the Possible Tests of Controls column. In general, most of these tests are not testing dollar amounts, but rather are testing attributes. As such, when performing these tests as detail tests examiners should use the Test of Controls Sampling Worksheet (included as part of Exhibit O) but may consider using a lower Tolerable Rate than what is listed on the worksheet, and thus a larger sample size, if placing a great deal of reliance on the detail procedure.

Use of a Specialist

The examiner should consider seeking the assistance of an actuary and/or other specialists in performing his/her review related to certain key activities. In particular, the performance of reserving calculations and rate calculations lend themselves to being tested and reviewed by a credentialed actuary.

EXAMINATION REPOSITORY –UNDERWRITING

Annual Statement Blank Line Items

There are no line items directly related to the underwriting process; however, policies underwritten and rate calculations may impact line items associated with the premiums exam repository.

Relevant Statements of Statutory Accounting Principles (SSAPs)

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

No. 6 Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due from Agents and Brokers (All lines)
No. 51 Life Contracts (Life)
No. 53 Property & Casualty Contracts - Premiums (P&C)
No. 54 Individual and Group Accident & Health Contracts (Health)
No. 65 Property & Casualty Contracts (P&C)

Sub Activity	Identified Risk	Branded Risk	Exam Asrt.	Control Best Practices	Possible Test of Controls	Possible Detail Tests
Other Than Financial Reporting Risks						
n/a	The insurer is not complying with or monitoring the overall underwriting strategy.	ST PR/UW OP	Other	The insurer has a well defined underwriting strategy that indicates the types and lines of business (coverages), geographical areasand other rating classes acceptable to the organization that are approved by the Board of Directors. The underwriting department has established and documented goals in accordance with the insurer's overall underwriting strategy. The insurer produces periodic reports outlining key underwriting results (including loss ratios), which are reviewed by senior management.	Review Board Minutes or other evidence of Board involvement in the approval of the insurer's underwriting strategy. Review the insurer's underwriting strategy to determine whether types of business (coverages) and geographical areas (rating classes) have been outlined as acceptable to the insurer. Review the underwriting department's goals for compatibility with the insurer's overall underwriting strategy. Review documentation of reports generated and evidence of senior management review.	Review the insurer's underwriting strategy for appropriateness. Review the information provided within underwriting reports reviewed by management for accuracy and appropriateness. Review historical underwriting and profitability results and determine whether the underwriting strategy has been properly adjusted in accordance with historical results.
n/a	The insurer has not established and maintained	ST PR/UW	Other	The insurer has established and documented risk exposure limits by geography,	Review documentation of risk exposure limits and evidence of senior management	Utilize audit software to review the insurer's risk exposures (e.g. for P&C

Sub Activity	Identified Risk	Branded Risk	Exam Asrt.	Control Best Practices	Possible Test of Controls	Possible Detail Tests
	appropriate risk exposure limits.			other rating classes and line of business (coverages), which have been reviewed and approved by senior management. The insurer utilizes a fully-staffed, well qualified underwriting function that has experience in all lines of business (coverages) and geographic locations (rating classes) served by the insurer. The insurer utilizes data models to track compliance with exposure limits established by the insurer.	review/approval. Review the credentials, background and responsibilities of the insurer's underwriting function (internal or external). Test the operating effectiveness of the insurer's controls to track compliance with the exposure limits by reviewing modeling data.	companies summarize policies by zip code, industry code, policy size, etc. For Life and Health companies summarize by risk class, age, medical codes, etc.) for compliance with insurer limits. If the insurer has not identified risk exposure limits, test the risk exposures for appropriateness by considering applicable industry standards and comparison to peer groups.
n/a	The insurer has not established appropriate underwriting and pricing guidelines resulting in inadequate or excessive base premium rates.	ST PR/UW	Other	The insurer has developed comprehensive underwriting and pricing guidelines that have been approved by senior management. The insurer utilizes a fully-staffed, well qualified pricing actuarial function that has experience in all lines of business (coverages) and geographic locations (rating classes) served by the insurer.	Review documentation of underwriting and pricing guidelines and evidence of senior management review/approval. Review the credentials, background and responsibilities of the insurer's pricing actuarial department for appropriateness.	Review the underwriting and pricing guidelines established by the insurer for appropriateness. Perform analytical procedures to review the insurer's profitability and history of indicated rates versus selected/filed rates to evaluate the sufficiency of premium rates.

Sub Activity	Identified Risk	Branded Risk	Exam Asrt.	Control Best Practices	Possible Test of Controls	Possible Detail Tests
				The pricing actuarial function has an established process to calculate base premium rates based on historical loss results, trends, Principal Advisory Organizations (ISO, LIMRA, etc.) and/or other appropriate factors (including costs of reinsurance) and the calculation is subject to a peer review process. If the insurer lacks sufficient data to be statistically credible, rates have been based on or benchmarked against data provided by advisory organizations.	Perform a walkthrough to gain an understanding of the rate calculation process, and obtain evidence of a peer review of base premium rate calculations and possibly get input from line personnel. Review and test the insurer's controls over utilization of data provided by advisory organizations to set premium rates.	If rates have been subject to insurance department approval, consider whether reliance can be placed on this work. If deemed necessary, utilize the department or an independent actuary to perform a review or independent calculation of base premium rates. Compare base premium rates utilized by the insurer to industry averages and advisory organization recommendations for reasonableness.
n/a	The insurer does not effectively oversee its Managing General Agents (MGAs) to ensure that appropriate underwriting standards are practiced.	OP RP	Other	The insurer has developed comprehensive underwriting and pricing guidelines that have been approved by senior management and communicated to the MGAs. The insurer monitors the	Review documentation of underwriting and pricing guidelines and evidence of senior management review/approval as well as evidence of communication and training provided to the MGAs. Review documentation that	Perform analytical procedures to review the underwriting results of significant MGAs to determine whether underwriting guidelines are followed. If deemed necessary, perform

Sub Activity	Identified Risk	Branded Risk	Exam Asrt.	Control Best Practices	Possible Test of Controls	Possible Detail Tests
				underwriting results of its MGAs through a regular review of relevant ratios. The insurer performs regular audits of its MGAs to determine whether insurer underwriting standards are being consistently followed.	provides evidence of regular review of MGA underwriting results by the insurer. Review audit reports and other documentation to determine whether the insurer provides sufficient oversight of its MGAs.	a site visit to examine the underwriting function at the MGA.
n/a	Policies are underwritten that do not comply with insurer guidelines and authorization levels.	OP	Other	The insurer utilizes a fully-staffed, well qualified underwriting function that has experience in all lines of business (coverages), geographic locations and other rating classes served by the insurer. The insurer provides initial and ongoing training programs to qualify its underwriting staff to follow the insurer guidelines established. Underwriters are restricted in the type and amount of policies that they underwrite by authority levels built into the system. The insurer has established a QA process to review new	Review the credentials, background and responsibilities, of the insurer's underwriting function (internal and/or external). Review documentation outlining the insurer's training of underwriting staff. Review system documentation indicating underwriting authority levels in place. Reperform, on a sample basis, testing of policies reviewed by the QA function for proper	Test a sample of new policies underwritten to determine whether the final underwriting decision was made by someone at an appropriate authority level.* Test a sample of new policies underwritten for compliance with appropriate underwriting guidelines.*

Sub Activity	Identified Risk	Branded Risk	Exam Asrt.	Control Best Practices	Possible Test of Controls	Possible Detail Tests
				policies underwritten for compliance with underwriting guidelines on a sample basis. The insurer designates an individual to be responsible for tracking and maintaining licenses for all jurisdictions in which it transacts business.	implementation of the insurer's underwriting guidelines. Review the insurer's process for tracking and maintaining licenses to write business.	Review certificates of authority for states and jurisdictions where the insurer is licensed to write business as of the examination date.
Financial Reporting Risks						
Data Accumulation & Protection	Application data are not properly and completely entered into the system.	OP	AC CO	The insurer's system contains edit checks that require application information to be complete and reasonable before being entered into the system. The insurer has a QA process in place that tests new application data entered into the system on a sample basis.	In conjunction with the testing performed through the Premium Repository, test the operating effectiveness of edit checks through reperformance and observation. In conjunction with the testing performed through the Premium Repository, reperform, on a sample basis, QA testing of the application data entered into the system.	Trace a of records from the application or report of the agent to the database and from the database to the application or report of the agent; verify and validate individual determinants such as effective date, term and expiration date of the coverage, contract or identification number, premium amount, and negative amounts.*
	In-force data is not appropriately restricted and protected to maintain accurate and complete data.	OP	AC CO	The insurer maintains logical access controls including password protection and active directories to properly restrict access to in-force data.	Test the operating effectiveness of logical access controls by reviewing documentation relating to requests for access and by attempting to have unauthorized individuals	Select a sample of in force policy data at the examination as-of date for accuracy and completeness testing.*

Sub Activity	Identified Risk	Branded Risk	Exam Asrt.	Control Best Practices	Possible Test of Controls	Possible Detail Tests
					access the in-force data.	
	Rates and rate changes are not properly loaded into the computer system.	OP LQ	AC	The insurer has documented processes and procedures to accurately load the appropriate actuarially calculated rates into its premium system including a supervisory review of rates loaded.	Test the operating effectiveness over rate loading controls by reviewing documentation indicating an approval of rates loaded into system.	Select a sample of rates loaded in the system for comparison to base premium rates calculated by the pricing actuarial unit.*
Underwriting Process	Policies are not priced in accordance with insurer guidelines.	OP	AC	The insurer utilizes a fully-staffed, well qualified underwriting function that has experience in all lines of business and geographic locations served by the insurer. The insurer provides initial and ongoing training programs to qualify its underwriting staff to follow the insurer pricing guidelines established. The insurer has established a QA process to review new policies underwritten for compliance with pricing guidelines on a sample basis.	Review the credentials, background and responsibilities, of the insurer's underwriting function (internal or external). Review documentation outlining the insurer's training of underwriting staff. Test a sample of policies reviewed by the QA function for proper implementation of the insurer's pricing guidelines.	Test a sample of new policies underwritten for appropriate pricing.*
	Endorsements, cancellations or other policy changes are	OP RP	AC	The insurer has established policies and procedures for making accurate, timely	Perform a walkthrough to gain an understanding of the insurer's process to make	Test a sample of changes made to in force policies during the year by reviewing

Sub Activity	Identified Risk	Branded Risk	Exam Asrt.	Control Best Practices	Possible Test of Controls	Possible Detail Tests
	not timely and accurately recorded.			changes to policies. The insurer has established a QA process to review changes to policies to ensure compliance with insurer policies and procedures on a sample basis.	changes to in force policies. Test a sample of changes to policies reviewed by the QA function for proper implementation of the insurer's policies and procedures.	supporting documentation.*
Compliance	Rates and forms do not comply with state standards and are not properly approved by the state.	OP LG	CM	The insurer has established policies and procedures for submitting rates and forms in compliance with state standards. The insurer's compliance officer (or other similar function) reviews and monitors the process to file rates and forms with the state.	Perform a walkthrough to gain an understanding of the insurer's process to file rates and forms. Review documentation indicating a review of rates and forms by a compliance officer and gain an understanding of the process for filing the rates and forms.	Take a sample of selected lines of business (coverages) to determine whether rates and forms were approved by the appropriate states.*

Draft: 11/4/09

Financial Analysis Handbook (E) Working Group
E-mail Vote
November 2, 2009

The Financial Analysis Handbook (E) Working Group of the Examination Oversight (E) Task Force conducted an e-mail vote Nov. 2, 2009. The following Working Group members participated: Roger Peterson, Chair (WI); Sheila Travis (AL); Kurt Regner (AZ); Neil Miller (MD); Judy Weaver (MI); Thomas Burke (NH); Russell Jones (NJ); Dennis Fernez (NY); Annette Boyce (OR); Steve Johnson (PA); and Jack Broccoli (RI).

1. Adopt the 2009 Health Edition of the NAIC *Financial Analysis Handbook*

On the Oct. 13 Working Group call, the Working Group voted to release additional edits to the Actuarial Opinion chapter of the 2009 health edition of the *Financial Analysis Handbook* for a comment period of 10 days ending Oct. 29. One comment letter was received from America's Health Insurance Plans recommending nonsubstantive grammatical and formatting edits. (Attachment Two-A)

An e-mail vote was conducted Nov. 2. A motion was made by Mr. Regner to adopt the revisions to the 2009 health edition of the *Financial Analysis Handbook* (Attachment Two-A1), which were discussed on previous conference calls. The motion was seconded by Ms. Weaver and passed unanimously.

Having no further business, the Financial Analysis Handbook (E) Working Group adjourned.

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Memorandum

October 27, 2009

To: Roger Peterson, Chair Financial Analysis Handbook Working Group
Jane Koenigsman, Staff to FAHWG

Re: Exposed Draft Changes to Health Financial Analysis Handbook

These comments are being submitted on behalf of America's Health Insurance Plans (AHIP). AHIP is the nation's trade association representing nearly 1,300 member companies providing health, long-term care, dental, disability and supplemental coverage to more than 200 million Americans. We appreciate the opportunity to provide additional comments to the Financial Analysis Handbook Working Group (FAHWG) regarding the proposed changes to the review of the health blank actuarial opinion. The FAHWG exposed the recent revisions to the health blank actuarial opinion for comment during its call on October 13, 2009. We note that the exposure draft included many changes that AHIP had recommended in our letter of September 29, 2009. We appreciate your willingness to consider our comments. The following are, we believe, editorial changes consistent with the decisions made during the last conference call.

Page 1 - The paragraph that begins "Section 3 provides…" in the third line should recognize that the Table for this section has two boxes so it should read "...section provides boxes to be checked if there is revised wording or if any of the actuary's work as detailed in the Actuarial Memorandum, deviates from Actuarial Standards of Practice."

Page 2 and 3 - references to the items in Scope should use capital letters in the lettering since the Opinion Instructions for the health blank use capitals. Also on Page 3, in the paragraph that begins "Actuarial reserves and liabilities" the parenthetical should read: "(items 1a & 1b are specifically referenced in item D in the list above)."

Page 4 - in the bottom paragraph last sentence, the word 'opinion' should be capitalized.

Page 5, Procedure #8 - the second and third sentence should be revised into three sentences to deal with how "certain items" will be dealt with for 2009. They would read: The *Annual Financial Statement Instructions* list certain items to be included in the Opinion paragraph, A through H. Certain other items have been included as separate lines in the past. For 2009, these items would be included within item #H.

Page 7 the numbering in 7 should follow that used in the Opinion Instructions - i.e. A through H.

Page 8 the numbering in 8 should follow that used in the Opinion Instructions - i.e. A through F.

Sincerely,

William C. Weller
Consultant to AHIP

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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.

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

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

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.

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- Phase 3 – Identify and Evaluate Risk Mitigation Strategies/Controls—These strategies/controls include management oversight, policies and procedures, risk measurement, control monitoring, and compliance with laws.
- Phase 4 – Determine Residual Risk—Once this risk is determined, the examiner can determine where to focus resources most effectively.
- Phase 5 – Establish/Conduct 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.

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.

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.

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

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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 (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.

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.

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Additional Reference Sources

1. *Financial Condition Examiners Handbook*, NAIC.

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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 ~~complied~~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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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?

   ~~d~~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.

   ~~e~~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.

   ~~f~~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.

   ~~g~~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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~~h~~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 ~~26~~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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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. ~~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	☐

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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V. Supplemental Procedures – A. Audited Financial Report

Audit Committee

16. Effective January 1, 2010, every insurer is required to have designated an Audit Committee, a percentage of whose members~~which~~ 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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III. Analysts Reference Guide – C.1. Audited Financial Reports

Audit Committee

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

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 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. ~~2.~~ Annual Financial Reporting Model Regulation ~~Model Rule (Regulation) Requiring Audited Financial Reports~~, *Model Laws, Regulations and Guidelines*, NAIC.
3. *Accounting Practices and Procedures Manual*, NAIC

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V. Supplemental Procedures – D. Holding Company Analysis

3. Review the insurer's General Interrogatories, Part 1, #8.1 thru #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

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III. Analyst Reference Guide – C4. Holding Company Analysis

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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IV. Level 2 Procedures – B.6. Risk-Based Capital

2. Did the insurer fail the RBC Trend Test? If yes, discuss the plans to address the RBC Trend Test failure.

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III. Analyst Reference Guide – B.6. Risk-Based 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 percent (the Trend Test level) and has a combined ratio greater than 105 percent may trigger an action level.

~~*Procedure #2* determines for the analyst whether the health entity failed the RBC Trend Test. 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.~~

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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 Opinion is other than unqualified. Generally the analyst can focus on the following four steps to comprise 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 indicates 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 the 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 which 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 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 is 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 to opine on the items identified in Section 5. This is a key section to review for deviations from prescribed language which 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 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),

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

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 repeated from 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).
    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.

The 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 of $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 have specifically stated the reason(s) for such an opinion in the Opinion section and/or Relevant Comments section of the Opinion. If the actuary is unable to form an opinion, the actuary should have issued 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.

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.

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 that have been included 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, #112, 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 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 the asset adequacy analysis requirement, 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; and

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
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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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 (or a committee of the board). 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 for 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?

    Per Annual Statement Instructions:

    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.

An example of an item included in (h) above is the retrospective premium asset (Page 2, Line 13.3)

If any of the above are no, what item(s) are missing?

8. Does the Opinion state, "In my opinion, the amounts carried in the balance sheet on account of the items identified above:

   A. Are calculated 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."

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?

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.

V. Supplemental Procedures – B. Statement of Actuarial Opinion

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 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.

Summary and Conclusion

Health Financial Analysis Handbook – Annual 2009 / Quarterly 2010

V. Supplemental Procedures – B. Statement of Actuarial Opinion

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 for 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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Draft: 10/30/09

Financial Analysis Handbook (E) Working Group
Conference Call
October 13, 2009

The Financial Analysis Handbook (E) Working Group of the Examination Oversight (E) Task Force met via conference call Oct. 13, 2009. The following Working Group members participated: Roger Peterson, Chair (WI); Sheila Travis (AL); Kurt Regner (AZ); Ann Tang (CA); Sean O'Donnell (DC); Jim Hanson (IL); Neil Miller (MD); Judy Weaver (MI); Thomas Burke (NH); Russell Jones (NJ); Michael Sheiowitz (NY); Russell Latham (OR); Will Smith (PA); and Jack Broccoli (RI). Also participating were: Steve Ostlund (AL); Alan Furan (OH); and Kashik Patel (PA).

1. Discuss Comments Received on Draft Revisions to the 2009 Edition of the *Financial Analysis Handbook*

Jane Koenigsman (NAIC) summarized the draft revisions to the 2009 edition of the *Financial Analysis Handbook* (the Handbook) that were released for a 30-day comment period ending Sept. 29. Three comment letters were received.

Mr. Peterson summarized the comments from Connecticut (Attachment Two-B1). With no objection to Connecticut's recommended edit to the Level 1 reference guide, the Working Group accepted the recommendation.

Mr. Peterson summarized the comments from Ohio (Attachment Two-B2). With no objections to Ohio's recommended edits to the Health Actuarial Opinion chapter, the Working Group accepted the recommendations.

Bill Weller (Omega Squared Inc., representing America's Health Insurance Plans (AHIP) summarized AHIP's comments (Attachment Two-B3). He suggested a slight wording change to the reference guide regarding the addition of the health RBC trend test. With no objection to this edit, the Working Group accepted the recommendation.

Mr. Weller said he would work with NAIC staff on certain grammatical edits. Mr. Peterson agreed that non-substantive grammatical edits can be made.

Mr. Weller said that with regard to the overview paragraph in the reference guide for the Actuarial Opinion chapter that discusses section one of the Opinion and qualified actuaries, as well as procedure 3-a in the supplemental procedures, AHIP's concern is that the Opinion instructions that were adopted by the NAIC in September 2009 provide for requirements that companies would not have known about prior to completing the annual Opinion, particularly with respect to notifying the commissioner, providing a letter in the event of the replacement of the appointed actuary and getting a responsive letter from the prior actuary. AHIP does not disagree that all of those are useful. AHIP had suggested in the letter a statement that this requirement is only effective for changes that occur on or after Dec. 31 to deal with the instruction issue. He said he discussed this issue with Mr. Ostlund, chair of Accident and Health Working Group, and stated Mr. Ostlund was uncomfortable with that specific statement, but was more agreeable to adding something at the end of the paragraph. Mr. Weller suggested a statement such as, "Because these instructions were adopted by the NAIC in late 2009, the timing requirements in the instructions should not be rigorously applied to the 2009 Opinion." In essence, he said, the company should not be held responsible for not having notified a commissioner about a change in the actuary that occurred earlier in the year, when the instructions were not adopted until September 2009. Mr. Peterson asked if the responsibility to notify the commissioner has been in the instructions in general for a number of years or whether it is the time frame that is new. Mr. Weller said the time frame is definitely new. He said he does not believe that the health opinion instructions had the notification requirement prior to this change in the instructions. In addition, Mr. Weller said, there were situations where a life company was filing the health blank and the requirements with respect to how the actuary could become the appointed actuary for a life company were different than those that were in the these instructions. For example, in a life company, the Actuarial Opinion and Memorandum Regulation (#822) provides that the actuary may be appointed by an executive designated by the board of directors, other than the actuary themselves. A company that was not aware of this change until December 2009 might not have even submitted a letter with respect to replacement and might not do so until it is discovered that this was supposed to be done, perhaps not until 2010.

Mr. Peterson said he has a difficult time supporting such language as "rigorous enforcement." He said it is up to each state to determine the level of enforcement in a particular situation. Making note that these requirements are recently added and that it is reasonable to take that fact into consideration when looking at compliance with this standard, Mr. Peterson said this is the kind of addition that makes sense to add.

Mr. Weller said AHIP's concern is that a company or actuary not be held responsible for not having done something that they were not required to do during the time period because of an instruction that was adopted later in the year. There was not a true effective date for those requirements other than, presumably, Dec. 31. The way it is written, it appears companies should have followed these for any change that occurred from the appointed actuary in 2008 to the filing of the Opinion for 2009. Mr. Peterson said he views those requirements as becoming effective when published. He said the Handbook could make some reference that these were recently published changes and that consideration should be given to any changes in actuary made prior to these published requirements.

Mr. Patel said that, in terms of informing the actuaries or insurance companies, perhaps AHIP could take a role in informing their members of this change in requirement. The *Annual Statement Instructions* are released to the industry in the fall, informing the insurance companies of new changes; therefore, Mr. Patel said, there is ample opportunity for the appointed actuaries to review and comply. Regarding the concern AHIP has with actions being taken, it is up to each state to determine the action to be taken — but, generally speaking, Mr. Patel said he does not believe the regulatory community would take a harsh action for a non-compliance issue such as this.

Mr. Furan said the American Academy of Actuaries (AAA) published a practice note regarding the changes to the Health Actuarial Opinion Instructions in September 2009. The practice note referenced the role of the appointed actuary and that some actuaries may need to be reappointed for this year. There has been notification sent via e-mail from the AAA.

Mr. Weller said there has been an effort on the part of the actuarial community, AHIP and the Blue Cross and Blue Shield Association to inform their respective members that these changes were coming. This was done before NAIC Executive (EX) Committee/Plenary adopted the changes, on the basis that the industry did not expect any change from what was approved by the various groups up through Financial Condition Committee. AHIP would just like some kind of statement in the Handbook that indicates this information; i.e., that the notification and letter requirements are valuable and should be done for 2009, but recognizing that the timeliness is likely to not be consistent with the instructions because the instructions were adopted late in 2009.

Ms. Weaver said the Handbook could indicate it that it was adopted or published in September 2009, which might impact the timeliness of the notification. She said she does not want to include language that tells the states what they should or should not do. Mr. Latham agreed with the suggestion.

Mr. Peterson instructed NAIC staff to draft an appropriate statement based on Ms. Weaver's and his comments. The statement would be included in the reference guide and the supplemental procedures chapter.

Mr. Weller said that with regard to the overview paragraph in the reference guide for the Actuarial Opinion chapter that discusses Section 3 Table of Key Indicators, the second sentence that pertains to "Relevant Comments" should be edited to state that the "indicator provides boxes" instead of "section provides comments". AHIP's concern is that the Table of Key Indicators does not provide comments. Mr. Latham agreed with the change. Mr. Peterson said the change would be accepted as suggested by AHIP.

Mr. Weller said that with regard to the overview paragraph in the reference guide for the Actuarial Opinion chapter that discusses the Scope Section, AHIP suggests adding the statement, "Where the actuary determines that no liability exists, the value of $0.00 should be entered. Lines should not be deleted." Mr. Ostlund said he agrees that regulators do expect zeros, not blanks, and this is a good clarification. Mr. Peterson said the change would be accepted as suggested by AHIP.

Mr. Weller said with regard to the overview paragraph in the reference guide for the Actuarial Opinion chapter that discusses procedures #9, #10 and #11, AHIP suggests two options. Option one is to delete the section. Option two is to edit the sentence stating, "For the small number of health entities that are subject to the actuarial memorandum requirements…" to "For the small number of health entities that are subject to the asset adequacy analysis requirement…" and keep the section. Mr. Ostlund said he agreed with the suggestion to change the wording and keep the section. Mr. Peterson said he agreed with changing the language and keeping the section and that the Working Group would accept this change as suggested by AHIP.

Mr. Weller said with regard the Actuarial Opinion supplemental procedures chapter, he suggests wording for procedure #1 to address the Table of Key Indicators. Mr. Ostlund said this was not an actuarial issue, but a question of what the analyst should do. He said it was implied that the analyst would look at the Table of Key Indicators. He also stated that the Working Group should consider whether it is appropriate to include AHIP's suggested statements that instruct the analyst that "prescribed language needs less review" or "sampling of these sections may be appropriate." Mr. Peterson instructed NAIC staff to develop draft language on this issue. Mr. Peterson said the Handbook does not need to direct exactly what actions to take but, at a minimum, should point the analyst to review the Table. Ms. Weaver said the Handbook should be giving the analyst guidance as to what to look for, but the Handbook should not instruct as to what regulatory action to take.

Mr. Weller said with regard to the sentence after procedures #6h of the Actuarial Opinion supplemental procedures chapter that states, "An example of an item included in (h) above is the retrospective premium asset (Page 2, Line 13.3)", AHIP suggests removing that statement, as it refers to an asset when the procedure is referring to actuarial reserves and liabilities. AHIP is concerned with having an asset as an example. Mr. Ostlund said the retrospective premium asset is a negative liability that the Accident and Health Working Group wanted to capture. When the balance of the account is negative it is reported on the asset page, and if it is positive it is reported as a liability. He said next year, the Accident and Health Working Group expects this issue will be clarified in the actual statement, but for this year, analysts should look to see that the Opinion covers this account. Mr. Weller said he does not have a problem if the actuary includes other items. An item that may be included is the retrospective premium asset. It should be clear it is not a requirement for the Opinion. The Opinion should not be rejected because it does not address an asset item. He stated that he understands that a lot of actuaries include this item, but it is not a requirement that it be in the 2009 Opinion. He suggested a wording change to, "An example of an item that may be included in (h) above is the retrospective premium asset (Page 2, Line 13.3)." Mr. Peterson asked if there are conditions where the Opinion is required to address retrospective premium. Mr. Weller said that regulatory actuaries, in cases where there is a material retrospective premium asset, would want to talk to the appointed actuary to make sure that it was addressed on a basis that is consistent with the calculation of the rest of the Opinion items. If the value of the retrospective premium is zero, there is no requirement that the actuary confirm that the zero value is correct. Mr. Peterson asked if it would be more appropriate to include the phrase "when material." He stated that use of the term "may" is vague and not helpful to the analyst. Mr. Ostlund said the Accident and Health Working Group intended the current language to be the language as opposed to the "may" suggestion. He stated that if the retrospective premium was a zero value, the actuary should look to see that the value should be zero. Mr. Furan said that he has given two presentations to the AAA and, each time, he has said the retrospective premium asset is expected to be included in item (h) of the Opinion. On behalf of the Accident and Health Working Group, Mr. Ostlund suggested that AHIP's recommendation on this issue be rejected. Mr. Peterson agreed and said the language would be retained as-is.

Mr. Weller said with regard to procedures #7g and #8 of the Actuarial Opinion supplemental procedures, these are separate items in the Opinion. He suggested that these be separate procedures that retain wording consistent with the prescribed wording in the Opinion. The wording in the parenthetical could be retained. Mr. Ostlund said this is a grammatical change that NAIC staff can address. Mr. Peterson agreed that it was a grammatical issue and instructed NAIC staff to make appropriate changes.

Mr. Weller said with regard to the summary and conclusion paragraph in the Actuarial Opinion supplemental procedures, he suggests an additional statement to this paragraph to address the Table of Key Indicators where the actuary has not used the prescribed wording. Mr. Peterson said an edit can be made that is consistent with the edits NAIC staff has been instructed to draft to the body of the text, as previously discussed.

A motion was made by Mr. Latham to release for comment the additional revisions NAIC staff has been instructed to make to the health edition's Actuarial Opinion chapter as discussed on this call. The motion was seconded by Ms. Weaver and unanimously adopted. The exposure draft will be released Oct. 15 for a period of 10 days. Comments are due by Oct. 29.

2. Adopt the 2009 Life/A&H and Property/Casualty Editions of the *Financial Analysis Handbook*

A motion was made by Mr. Latham to adopt the revisions to the life/A&H and property/casualty editions of the Handbook (Attachment Two-B4). The motion was seconded by Ms. Weaver and unanimously adopted.

Having no further business, the Financial Analysis Handbook (E) Working Group adjourned.

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To: Financial Analysis Handbook Working Group

From: Connecticut Department

Date: September 29, 2009

Re: Financial Analysis Handbook Exposure Draft Comments

III. Analysis Reference Guide – A. Level 1 Procedures

Discussion of Non-Routine Analysis

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

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To: Financial Analysis Handbook Working Group
From: Alan Furan, OH DOI
Date: 9/18/09
RE: FAH Exposure Draft Comments

These may be more of the nature of minor grammatical and formatting tweaks to the wording as opposed to actual comments about the exposure draft.

All page numbers refer to the exposure document at
http://www.naic.org/documents/committees_e_examover_fahwg_2009_fah.pdf

1. Could the last paragraph on page 18 that rolls over to page 19 be indented or numbered in some manner to better show that it is associated with the paragraph above it? As it is now it could be confused as a new requirement and not a part of procedures 9, 10 and 11.

2. Question 2 on page 20 asks if the company notified the commissioner within 5 days and Question 3 also asks the same thing. It doesn't appear that the last part of question 2 is needed, the question could end after the word "rendered".

3. Question 5 on page 20 refers to "listing and summaries of policies in force" but the opinion was changed to refer to "data". I recommend changing "listing and summaries of policies in force" to "data".

4. If you read Question 7a on page 21 with the introduction, it essentially says that the **amounts** are in accordance with accepted actuarial standards. I recommend changing 7a to read

   Are calculated in accordance with …

   Actuarial standards apply to the way the amounts are calculated, not the amounts themselves.

Thank you for the opportunity to make these comments.

Alan R Furan, FSA, MAAA
Health Actuary, Office of Product Regulation and Actuarial Services
Ohio Department of Insurance
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Memorandum

September 29, 2009

To: Roger Peterson, Chair Financial Analysis Handbook Working Group
Jane Koenigsman, Staff to FAHWG

Re: Exposed Draft Changes to Health Financial Analysis Handbook

The Accident & Health Working Group (AHWG) proposed changes to the Health Financial Analysis Handbook to address the new Health Actuarial Opinion Instructions (HAOI) for the NAIC Health Blank. The Financial Analysis Handbook Working Group (FAHWG) exposed those changes for comment during its call on August 27, 2009. The following are some general comments that America's Health Insurance Plans (AHIP) made to the AHWG which have not yet been discussed by either working group. Given that these comments were not discussed at the AHWG, we also offer language in support of AHIP's proposed changes for consideration by the FAHWG. The proposed changes are intended to insure that the wording in the Handbook matches the prescribed wording in the HAOI. The rationale behind our suggestions is as follows.

AHIP is the nation's trade association representing nearly 1,300 member companies providing health, long-term care, dental, disability and supplemental coverage to more than 200 million Americans.

Changes in the Appointed Actuary Effective for 2009

The HAOI requires carriers to notify their state of domicile within 10 days of making a change in the appointed actuary. This is an appropriate requirement for reporting years 2010 and later as a prospective notification. For changes that have already been made, or that will be made prior to CY 2010, however, we suggest that a retrospective reporting requirement is inappropriate. Therefore, we recommend that that the Handbook note that the notification is only required if the change involves the appointment of a new actuary on or after December 31, 2009.

References to the Actuarial Memorandum

It appears that all references to the Actuarial memorandum in the Handbook are intended to apply to the memorandum required for life insurers that file using the Health blank (see comments on Procedures #9, #10 and #11 on pages 5 and 6 of III. Analysts Reference Guide – C.2. Statement of Actuarial Opinion as well as pages 3 and 4 of V. Supplemental Procedures – B. Statement of Actuarial Opinion).

This language could be retained to the extent the NAIC wishes to have these life insurers complete a separate actuarial memorandum based on the Actuarial Opinion and Memorandum Regulation. However, the language, as drafted is totally inconsistent with the anticipated components of the Actuarial Memorandum required by section 1B. of the HAOI. As such, our proposal is to eliminate the language totally in section 3 but retain the language already existing in section 5 that starts "If an asset adequacy analysis is not required…" on page 3 as it is a clear separation (dealing only with life insurance companies filing the Health blank).

References to Items No Longer Mentioned in HAOI

The exposed draft retains language dealing with "Additional Optional Items" that are no longer a separate aspect of the revised HAOI. Given the new focus on the use of prescribed language, we recommend that there be nothing in the Handbook that suggests the analyst should be looking for additional optional items (see page 3 of V. Supplemental Procedures – B. Statement of Actuarial Opinion) until these issues have been discussed by the AHWG which has a subgroup addressing this issue. That subgroup has made no recommendations at this time.

Lack of Reference to the Table of Key Indicators

We have included draft language to note the need to review the Table of Key Indicators. While we would have wished this language be developed jointly with the AHWG, that was not possible within the time constraints of your exposure period.

Changes Related to Health RBC Trend Test

We believe that the proposed change relating to the RBC Trend Test could be clearer if the wording were changed as follows:

> Reference Guide Text:
> *Procedure #2* determines for the analyst whether the health entity failed the RBC Trend Test. A health entity that falls ~~within or~~ below **an RBC Ratio of 300% (**the trend test level) **and** has a combined ratio greater than 105 percent may trigger an action level.

We appreciate the opportunity to provide these comments.

Sincerely,

William C. Weller
Consultant to AHIP

c/c: Steve Ostland, Chair, Accident & Health Working Group

Alan Furan, Chair, HAOI Subgroup of AHWG
John Engelhardt, NAIC staff to AHWG
Randi Reichel, AHIP Consultant
Shari Westerfield, BCBSA
Joe Zolecki, BCBSA

Health Checklist Subgroup
6/4/09

Health Financial Analysis Handbook – Annual 2008 / Quarterly 2009

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 comprise 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 ~~opinion~~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. This requiremernt is only effective for changes that occur on or after December 31, 2009. Requirements are also provided regarding a responsive letter from the prior actuary addressing agreement or disagreement to reasons for replacement provided by the company. 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 indicates 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~~ Opinion is unqualified, qualified, adverse, or inconclusive.

Section 3 provides the 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. For the Relevant Comments section, this table provides ~~revised wording was~~ an indicator that is used ~~or whether~~when any of the actuary's work as detailed in the Actuarial Memorandum ~~includes wording which~~ deviates from Actuarial Standards of Practice, as provided in such standards. The Table of Key Indicators also provides whether the ~~opinion~~Opinions 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 ~~the~~any person upon whom the actuary relied for data used in the reserve analysis. A statement from the person relied on is 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 which opine on the items identified in Section 5. This is a key section to review for deviations from prescribed language which form the basis for whether the ~~opinion~~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~~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~~Opinion. It is expected that adequate explanation of this determination be provided in the ~~opinion~~Opinion.

Section 10 of the ~~opinion~~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 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:

1. Claims unpaid (Page 3, Line 1),

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

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

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

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

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

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

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

8. 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 8 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 repeated from 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).

    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.

The ~~Opinion~~ Scope section, discussed above as~~for~~ Section 5 of the annual statement ~~opinion~~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~~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~~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 ~~opinion~~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 have specifically stated the reason(s) for such an opinion in the Opinion section and/or Relevant Comments section of the Opinion. If the actuary is unable to form an opinion, the actuary should have issued 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 ~~opinion~~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~~Opinion should be performed to identify if any extraordinary item is detailed in the ~~opinion~~Opinion. The primary goal of the Level 1 Procedures is to determine if a Opinion was received and available for later review. And if so, was it an ~~opinion~~Opinion which was unqualified, qualified, adverse, or inconclusive.

Discussion of Supplemental Procedures

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.

Health Financial Analysis Handbook – Annual 2008 / Quarterly 2009

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

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:

Procedures #1, #2, #3,and #4 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 #5 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 #6 assists the analyst in determining if the health entity's actuary has covered the required reserves.

Procedure #7 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 #8 and in particular that the ~~opinion~~Opinion states that the reserves meet the requirements of the state of domicile. ~~While t~~The *Annual Financial Statement Instructions* list certain items to include in the ~~opinion~~Opinion paragraph, (1~~a~~) through (8~~g~~) and prescribed, certain other items ~~such as (h) and (i)~~ may have been~~also be~~ included in the past. For 2009, these should be included within item (8). 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 #8 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 #9, #10, and #11* 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 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; and~~

~~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.
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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Health Checklist Subgroup
6/4/09

Health Financial Analysis Handbook – Annual 2008 / Quarterly 2009

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 (or a committee of the board). For purposes of the health actuarial ~~o~~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. ~~1.~~ Does the Opinion include a completed Table of Key Indicators? For each section of the Opinion, there should be one and only one box checked. While sections where the actuary has used prescribed language need less review, a review of a sampling of these sections may be appropriate. Where additional wording has been added or non-prescribed wording is noted, review of all differences should be completed. It may be necessary to review these findings with an actuary to fully understand the impact of the differences.

2. Does the Opinion state the actuary's qualifications and affiliation?

3. ***{Renumber balance of section.}***

2. 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 and did the company notify the commissioner of this within five (5) business days of the appointment?

3. 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? These requirments apply on if the change occurred on or after December 31, 2009.

   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 for 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?

4. Do the reserve amounts included in the ~~a~~Actuarial ~~o~~Opinion agree with the amounts per the Annual Financial Statement?

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 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?

6. ~~Although t~~The Health Annual Statement Instructions list (a) through (h) as prescribed items~~, certain other actuarial items, such as (i) through (iv), may also be included~~. If the following items are included in the Annual Financial Statement and required by the Annual Statement Instructions, does the ~~o~~Opinion cover the following in the scope and opinion of amounts?

   Per Annual Statement Instructions:

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 .

Note: Section 3 and section 5 should use consistent numbering/lettering for these items.

An 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?

7. Does the ~~a~~Actuarial ~~o~~Opinion state that the actuarial amounts are carried on the balance sheet and does the Opinion include the following:

~~(Annual Statement Instructions specifically refer to at least the items below in (a) through (g); however, other items such as (h) and (i) may be included by some health entities):~~

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 t~~The Underwriting and Investment Exhibit – Part 2B was reviewed for reasonableness and consistency with the applicable Actuarial Standards of Practice. ~~?~~

(In particular, ~~item (g)~~this should be prepared consistent with Actuarial Standard of Practice No. 5, "Incurred Health and Disability Claims", section 3.6, "Follow-Up Studies.")

~~(Annual Statement Instructions specifically refer to at least the items above in (a) through (g); however, items (h) and (i) below must be included by managed care health entities)~~

~~Additional Optional Items:~~

~~h. If the opinion is for a managed care health plan does it state that the actuary has knowledge of all capitated risk arrangements?~~

~~i. If the opinion is for a managed care health plan, does it indicate whether the actuary has evaluated the financial position of the provider entities?~~

~~8.~~ ~~Does the actuarial opinion state that the a~~Actuarial methods, considerations and analyses used in forming *the actuary's opinion* conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which~~ose~~ standards form the basis of this statement of ~~actuarial~~ opinion.~~?~~

If an asset adequacy analysis was not required, do not proceed with the procedures for asset adequacy analysis (# 9, 10, & 11) and skip to the Summary and Conclusion.

9. If the ~~o~~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?

10. If the ~~o~~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.

11. 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 ~~a~~Actuarial ~~o~~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.

Summary and Conclusion

Note any section where the Table of Key Indicators notes that the actuary has not used the prescribed wording. Summarize any pertinent comments by the qualified actuary. Provide conclusions as to whether or not the non-prescribed wording (either additional wording or different wording) in the Opinion reduces the value thereof.
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~~for 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

Health Financial Analysis Handbook – Annual 2008 / Quarterly 2009

V. Supplemental Procedures – B. Statement of Actuarial Opinion

- ☐ 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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Suite Five Hundred
Washington, DC 20004

202.778.3200
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Memorandum

July 9, 2009

To: Steve Ostland, Chair Accident & Health Working Group
John Engelhardt, NAIC Staff to AHWG

Re: Exposed Draft Changes to Health Financial Analysis Handbook

The Accident & Health Working Group exposed proposed changes to the Health Financial Analysis Handbook to address the new Health Actuarial Opinion Instructions (HAOI) for the NAIC Health Blank. The following are some general comments that America's Health Insurance Plans (AHIP) wishes to make. In addition, attached is a copy of the two documents with AHIP proposed additional changes to match more closely the wording in the instructions. Many are intended to insure that the wording in the Handbook matches the prescribed wording in the HAOI. Places where we would expect further discussion on one of the issues below are identified in the attached drafts with ***See Letter* at the start and *]*** at the end.

Changes in the Appointed Actuary Effective for 2009

The HAOI requires the notification of the state of domicile within 10 days of the change in the appointed actuary. This appears an appropriate requirement for 2010 and later as the effective date of the revised instructions will always be prior to any such change in the appointed actuary. For changes prior to 2010, the effective date of the requirement is not stated. The effective date of the Blanks change is "Annual 2009" but this may be of little use with respect changes that have already occurred or that will occur prior to year-end 2009.

We recommend that that the Handbook note that for 2008 and prior opinions, there is no notification requirement, that for 2009 the notification is only required if the change involves the appointment of a new actuary on or after December 31, 2009. Assuming that this is acceptable, it would make sense to alert companies of this transition position. AHIP would be willing to assist in this effort.

References to the Actuarial Memorandum

It appears that all references to the Actuarial memorandum are intended to apply to the memorandum required for life insurers that file using the Health blank (see comments on Procedures #9, #10 and #11 on pages 5 and 6 of III. Analysts Reference Guide – C.2. Statement of Actuarial Opinion as well as pages 3 and 4 of V. Supplemental Procedures – B. Statement of Actuarial Opinion).

This language may need to be retained to the extent the NAIC wishes to have these life insurers complete a separate actuarial memorandum based on the Actuarial Opinion and Memorandum Regulation. However, the language is totally inconsistent with the anticipated components of the Actuarial Memorandum required by section 1B. of the HAOI. AHIP offers our assistance in addressing this issue as well.

References to Items No Longer Mentioned in HAOI

The exposed draft retains language dealing with "Additional Optional Items" that are no longer a separate aspect of the revised HAOI. Given the new focus on the use of prescribed language, we recommend that there be nothing in the Handbook that suggests the analyst should be looking for additional optional items (see page 3 of V. Supplemental Procedures – B. Statement of Actuarial Opinion) until these issues have been discussed by the AHWG.

We appreciate the opportunity to provide these comments.

Sincerely,

William C. Weller
Consultant to AHIP

c/c: Randi Reichel, AHIP Consultant
Shari Westerfield, BCBSA

Health Checklist Subgroup
6/4/09

Health Financial Analysis Handbook – Annual 2008 / Quarterly 2009

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 comprise 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 ~~opinion~~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. 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 indicates 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~~Opinion is unqualified, qualified, adverse, or inconclusive.

Section 3 provides the 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. For the Relevant Comments section, this table provides ~~revised wording was~~was an indicator that is used ~~or whether~~when any of the actuary's work as detailed in the Actuarial Memorandum ~~includes wording which~~ deviates from Actuarial Standards of Practice, as provided in such standards. The Table of Key Indicators also provides whether the ~~opinion~~ 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 ~~the~~any person upon whom the actuary relied for data used in the reserve analysis. A statement from the person relied on is 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 which opine on the items identified in Section 5. This is a key section to review for deviations from prescribed language which form the basis for whether the ~~opinion~~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~~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~~Opinion. It is expected that adequate explanation of this determination be provided in the ~~opinion~~Opinion.

Section 10 of the ~~opinion~~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 Liabilites 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 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:

1. Claims unpaid (Page 3, Line 1),

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

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

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

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

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

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

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

8. 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 8 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 repeated from 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).

    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.

The ~~Opinion~~ Scope section, discussed above as~~for~~ Section 5 of the annual statement ~~opinion~~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~~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~~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 ~~opinion~~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 have specifically stated the reason(s) for such an opinion in the Opinion section and/or Relevant Comments section of the Opinion. If the actuary is unable to form an opinion, the actuary should have issued 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 ~~opinion~~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~~Opinion should be performed to identify if any extraordinary item is detailed in the ~~opinion~~Opinion. The primary goal of the Level 1 Procedures is to determine if a Opinion was received and available for later review. And if so, was it an ~~opinion~~Opinion which was unqualified, qualified, adverse, or inconclusive.

Discussion of Supplemental Procedures

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.

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:

Procedures #1, #2, #3,and #4 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 #5 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 #6 assists the analyst in determining if the health entity's actuary has covered the required reserves.

Procedure #7 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 #8 and in particular that the ~~opinion~~Opinion states that the reserves meet the requirements of the state of domicile. ***[See letter: While the *Annual Financial Statement Instructions* list certain items to include in the ~~opinion~~Opinion paragraph, (a) through (g), certain other items such as (h) and (i) may also be included.] *** 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 #8 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.

***[See letter *Procedures #9, #10, and #11* 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 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~~Opinion but were not subject to such analysis for the current ~~opinion~~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; and

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.
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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Health Checklist Subgroup
6/4/09

Health Financial Analysis Handbook – Annual 2008 / Quarterly 2009

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 (or a committee of the board). For purposes of the health actuarial ~~o~~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 state the actuary's qualifications and affiliation?
Note: Nothing in this document discusses the review of the Table of Key Indicators and whether or not, if the Table says that the prescribed language was used that this in fact the case. Nor does it address how to deal with situations where the Table indicates that alternative language or additional language is included in the Opinion.

2. 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 and did the company notify the commissioner of this within five (5) business days of the appointment?

3. ***[See letter 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?
   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 for 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?]***

4. Do the reserve amounts included in the ~~a~~Actuarial ~~o~~Opinion agree with the amounts per the Annual Financial Statement?

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 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?

6. ***[See letter Although the Health Annual Statement Instructions list (a) through (h), certain other actuarial items, such as (i) through (iv), may also be included.]*** If the following items are included in the Annual Financial Statement and required by the Annual Statement Instructions, does the ~~o~~Opinion cover the following in the scope and opinion of amounts?

   Per Annual Statement Instructions:

   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 .

An 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?

7. Does the ~~a~~Actuarial ~~o~~Opinion state that the actuarial amounts carried on the balance sheet and include the following:

[See letter – this should be deleted* (Annual Statement Instructions specifically refer to at least the items below in (a) through (g); however, other items such as (h) and (i) may be included by some health entities)]:

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 t~~The Underwriting and Investment Exhibit – Part 2B was reviewed for reasonableness and consistency with the applicable Actuarial Standards of Practice. ~~?~~

(In particular, ~~item (g)~~this should be prepared consistent with Actuarial Standard of Practice No. 5, "Incurred Health and Disability Claims", section 3.6, "Follow-Up Studies.")

***[See letter – this should be deleted* (Annual Statement Instructions specifically refer to at least the items above in (a) through (g); however, items (h) and (i) below must be included by managed care health entities)

Additional Optional Items:

h. If the opinion is for a managed care health plan does it state that the actuary has knowledge of all capitated risk arrangements?

i. If the opinion is for a managed care health plan, does it indicate whether the actuary has evaluated the financial position of the provider entities?*]****

~~8. Does the actuarial opinion state that the a~~Actuarial methods, considerations and analyses used in forming *the actuary's opinion* conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which~~ose~~ standards form the basis of this statement of ~~actuarial~~ opinion.~~?~~

***[See letter* **If an asset adequacy analysis was not required, do not proceed with the procedures for asset adequacy analysis (# 9, 10, & 11) and skip to the Summary and Conclusion.**

9. If the ~~o~~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?

10. If the ~~o~~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.

11. 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 ~~a~~Actuarial ~~o~~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.*/***

Summary and Conclusion

Note: This section should certainly refer to the Table of Key Indicators. As such, it needs to be rewritten.

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~~for 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.

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V. Supplemental Procedures – B. Statement of Actuarial Opinion

☐ Other (explain)

Analyst _____ Date _____

Comments as a result of supervisory review.

Reviewer _____ Date _____

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III. Level 1 Analyst Reference Guide

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 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 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).

III. Level 1 Analyst Reference Guide

- 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

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~~ied~~ with ~~any~~ 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 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?

IV. Level 1 Annual Procedures

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?

   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?

   ~~e.~~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.

   ~~f~~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.

   ~~g~~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.

   ~~h~~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-

IV. Level 1 Annual Procedures

grade and non-investment-grade bonds, and between publicly traded and privately placed securities.

~~i~~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.

~~j~~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.

IV. Level 1 Annual Procedures

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.

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.

IV. Level 1 Annual Procedures

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.

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.

IV. Level 1 Annual Procedures

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
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

Develop and document an overall summary and conclusion based on the analysis findings within Level 1, 2, 3, and Supplemental Procedures. 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.

IV. Level 1 Annual Procedures

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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V. Supplemental Procedures – A. Audited Financial Report

Audit Committee

16. Effective January 1, 2010, every insurer is required to have designated an Audit Committee, a percentage of whose members~~which~~ 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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III. Analysts Reference Guide – C.1. Audited Financial Reports

Audit Committee

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

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 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. ~~2.~~ Annual Financial Reporting Model Regulation ~~Model Rule (Regulation) Requiring Audited Financial Reports~~, *Model Laws, Regulations and Guidelines*, NAIC.
3. *Accounting Practices and Procedures Manual*, NAIC

Financial Analysis Handbook – Annual 2009 / Quarterly 2010

V. Supplemental Procedures – D. Holding Company Analysis

3. Review the insurer's General Interrogatories, Part 1, #8.1 thru #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

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III. Analyst Reference Guide – C4. Holding Company Analysis

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.

III. Analysts Reference Guide – A. 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, monitoring internal/external changes relating to all aspects of the society, 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 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 NAIC Annual Scoring System Report, IRIS ratios, Analyst Team Validated Level, and RBC results, and the information included in the NAIC 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.

III. Analysts Reference Guide – A. 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.

III. Analysts Reference Guide – A. Level 1 Procedures for Fraternal Societies

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 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 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 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.

- 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; 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 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. 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 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.

III. Analysts Reference Guide – A. Level 1 Procedures for Fraternal Societies

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 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 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.

III. Analysts Reference Guide – A. Level 1 Procedures for Fraternal Societies

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.

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.

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 condisered 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.

Additional Reference Sources

1. *Financial Condition Examiners Handbook*, NAIC.

IV. 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?

IV. Level 1 Annual Procedures for Fraternal Societies

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, 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.

IV. 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 and 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 nondiversified 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?

IV. Level 1 Annual Procedures for Fraternal Societies

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 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.

IV. Level 1 Annual Procedures for Fraternal Societies

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 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

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 1st 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 1st 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

IV. Level 1 Annual Procedures for Fraternal Societies

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 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

Develop and document an overall summary and conclusion based on the analysis findings within Level 1, 2, 3, and Supplemental Procedures. 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.

VI.A. 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 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.

VI.A. 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 issued by the society 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.

VI.A. Level 1 Quarterly Procedures for Fraternal Societies

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.

VI.A. 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

B. Perform Supplemental Procedures:

VI.A. Level 1 Quarterly Procedures for Fraternal Societies

- ❑ 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

Develop and document an overall summary and conclusion based on the analysis findings within Level 1, 2 and 3 Procedures. 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.

Draft: 11/24/09

Financial Examiners Coordination (E) Working Group
Conference Call
November 19, 2009

The Financial Examiners Coordination (E) Working Group of the Examination Oversight (E) Task Force met via conference call Nov. 19, 2009. The following Working Group members participated: Dave DelBiondo, Co-Chair (PA); Connie Ridinger, Co-Chair (IN); Jim Hattaway (AL); Al Bottalico (CA); Robert Lamberjack (MI); Peter Foley (MN); Fred Heese (MO); Bill Harrington (OH); and Patrick McNaughton (WA).

1. Minutes from Previous Conference Call

Mike Sindel (NAIC) stated that the Working Group held a conference call Oct. 7 to receive an update from the Regulator Issues (E) Subgroup and referrals from the industry subgroups.

On a motion from Mr. Hattaway, seconded by Mr. Lamberjack, the Working Group adopted the minutes from the conference call (Attachment Four-A).

2. Status Report from the Regulator Issues (E) Subgroup

Mr. Bottalico stated that the Regulator Issues (E) Subgroup has held two conference calls this quarter. The Subgroup discussed the association (zone) exam concept on the first call held Oct. 14 and proposed recommendations to the Financial Examiners Handbook (E) Technical Group for consideration. On the second call, the Subgroup continued its work on revising the lead state framework that is currently in the Handbook by reviewing the referrals received from the industry subgroups. The members of the Subgroup discussed the feedback regarding how industry would define a coordinated group exam. Mr. Bottalico added that it will take several more calls to work through all the feedback received. Mr. Sindel explained how the industry input was being considered by the Working Group and the Subgroup.

On a motion from Ms. Ridinger, seconded by Mr. Harrington, the Working Group received the report from the Subgroup.

3. Guidance on Coordination and Scheduling Group Examinations

Mr. DelBiondo stated that the Working Group is seeking feedback related to the guidance that was developed by NAIC staff, including the process discussed in the guidance. The process places more of the initial responsibility on how a holding company group should be scheduled and coordinated for financial exam purposes. He asked whether there were additional topics that should be included in the guidance that were not currently incorporated. Mr. Sindel mentioned that the framework that the Regulator Issues (E) Subgroup is working on would provide the general guidance on the process of how examinations within a holding company group would be scheduled and coordinated. The document that this Working Group is considering would be supplemental to that guidance and would be a document that the regulators would give to an employee of the holding company group that has the knowledge of the general workings of the group. The holding group would then provide input to the regulator, including supporting documentation, of how the group may be coordinated for financial examination purposes. This document provides some information the group may consider when providing its recommendations, but the listing is not all-inclusive. Mr. Sindel stated that the input from the holding group is critical to the coordination of these exams because company personnel have the expertise regarding information of each unique group. This information may include key systems and processes, corporate governance, risk management and computer systems.

Mr. Heese asked if the lead state would be the regulator contacting the holding company group. Mr. Sindel said that is what he anticipates. Mr. Lamberjack asked if the document was going to be a "living" document. Mr. Sindel stated that staff proposes that it would be a document in the Handbook and therefore published annually, but could be adjusted based on the holding company group and ultimately modified in the publication if necessary. Susan Lee (ING) asked if the document would be sent to the holding company even if the holding company was not an insurer. Mr. Sindel responded that the document would be distributed to whoever the regulators feel has the appropriate knowledge of the group to recommend how it should be coordinated. The person may be at the holding company level or could be someone at a major insurance subsidiary.

Mr. DelBiondo added that the document was created to be general so that it could be used for each holding company group. He mentioned that the regulators will be highly dependent on the companies to provide information on how they see the structure of their groups initially to begin coordinating these exams. Mr. Bottalico stated that there are differences between companies that write different lines of business that will need to be considered when this general guidance is implemented, but the guidance should be written at a high level so it is universal to coordinating financial exams of all types of companies. Mr. Sindel explained that the first two questions answered by the industry subgroups are being used by the Regulator Issues (E) Subgroup to help them develop the coordination framework, while the third question is what the Working Group used to develop the exhibit discussed here.

Larry Lentini (INS Services) proposed some changes that the Working Group agreed to. Bill Sergeant (State Farm) asked if any of this information would be duplicative of what insurers are already required to report and file with the NAIC. Mr. Sindel responded that the goal is not to require duplicative reporting, and regulators and insurers should try to utilize what is already required if possible.

Having no further business, the Financial Examiners Coordination (E) Working Group adjourned.

W:\Dec09\TF\Examo\Attachment Four- FECWG 11-19-09.doc

Draft: 10/27/09

Financial Examiners Coordination (E) Working Group
Conference Call
October 7, 2009

The Financial Examiners Coordination (E) Working Group of the Examination Oversight (E) Task Force met via conference call Oct. 7, 2009. The following Working Group members participated: Dave DelBiondo, Co-Chair (PA); Connie Ridinger, Co-Chair (IN); Jim Hattaway (AL); Al Bottalico (CA); Bill Arfanis (CT); Robert Lamberjack (MI); Peter Foley (MN); and Patrick McNaughton (WA).

1. Status Report from the Regulator Issues Subgroup

Mike Sindel (NAIC) mentioned that the Subgroup held two conference calls in the past quarter. On the first call, held July 23, the Subgroup discussed several items related to the lead state concept to coordinating financial examinations and asked NAIC staff to begin developing a revised framework based on the Subgroup's deliberations. On the second call, held Aug. 31, the Subgroup reviewed the framework and made some revisions. The Subgroup delayed additional work on this framework until information is received from the industry subgroup memos regarding the definition of a coordinated financial exam and characteristics that may make coordinating exams of holding company groups difficult. The Subgroup began discussions about the zone exam concept and how it relates to the Exam Tracking System (ETS). The Subgroup requested that NAIC staff prepare a memorandum detailing the issues with the existing concept and potential solutions. This memo will be discussed by the Subgroup on its next conference call scheduled for Oct. 14. Mr. Sindel mentioned that all guidance prepared by the Subgroup will be referred to the Financial Examiners Coordination (E) Working Group for consideration and exposure when completed.

On a motion from Mr. McNaughton, seconded by Mr. Hattaway, the Working Group received the report from the Subgroup.

2. Referrals from the Industry Subgroups

Ms. Ridinger stated that each of the three industry coordination subgroups met several times to receive feedback from industry representatives on the topic of coordinated financial examinations. As a result of the feedback received, each subgroup developed a memorandum that has been referred to the Working Group for consideration. Mr. McNaughton presented the referral from the Health Coordination Subgroup (Attachment Four-A) and Mr. Sindel presented the referrals from the Life Coordination Subgroup (Attachment Four-B) and the P&C Coordination Subgroup (Attachment Four-C).

Ms. Ridinger suggested that the results from the first two questions in each of the subgroup referrals be referred to the Regulator Issues Subgroup to assist with the development of Financial Condition Examiners Handbook guidance on coordinating holding company groups in relation to financial exams. She stated that she would like to use the information for the third question to develop a questionnaire that examiners can send to companies to help schedule holding company group exams. This document would be sent out well in advance of the exam to allow time for the insurer to complete it. This would also allow the examiners time to coordinate the exam based on the results. Depending on the attributes of each of the companies in a group, the examiners will determine the best way to coordinate the exams and schedule them accordingly. Ms. Ridinger asked NAIC staff to begin developing the questionnaire using the information received from the industry subgroup to present back to the Working Group on its next conference call.

Having no further business, the Financial Examiners Coordination (E) Working Group adjourned.

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Summary of Feedback Received
(Health Companies)

As discussed during the conference call on Aug. 5, 2009, a request of the Health Coordination Subgroup was sent to interested parties to obtain information that can be utilized to improve the coordination of financial examinations and make them more efficient for insurers and regulators. The responses received have been summarized for presentation in this document.

1. How would you define a coordinated financial exam? Do you have any specific expectations from a coordinated financial exam? Please explain.

   Most respondents indicated an expectation that a coordinated examination includes a concerted effort to utilize the work performed by others. The coordinated examination should attempt to be a comprehensive and simultaneous examination of each of a holding company's affiliated insurance legal entities, which may be domiciled in multiple states. The lead state should have a system and tool in place to share examination schedules to ensure that examinations are conducted efficiently and timely. The lead state should familiarize itself with the structure of the company (that is, whether it is a holding company, part of a holding company, or single state); the internal operations of the company (that is, whether it has consolidated operations with parent/sister/subsidiary companies and what those operations are); and whether those consolidated operations have been examined by other states. The lead state should coordinate C-level interviews to minimize the impact that personal interviews have on senior management of both the legal entity and the holding company. One respondent mentioned that interviews should begin at the legal-entity level and that C-level individuals of companies within the holding company system should only be interviewed if there is a demonstrable need to do so. When interviews with holding company personnel are deemed necessary, the interviews should be performed by the lead state and shared with all other states. The examiners should, whenever possible, conduct the interviews by telephone or during regularly scheduled board/committee meetings.

   Further, most respondents indicated, that all examining states should make a consistent effort to utilize the work already performed by other states, the external audit firms and the internal audit department whenever possible to avoid duplication of efforts. All examining states should provide adequate oversight of the work of its staff and consultants. This includes adequate review of other state examiners' work papers before reliance is placed on that work. The examining states should ensure that the scope and extent of planned testing is well established before the start of the examination to avoid placing undue burden on the Company.

   One respondent indicated information that is common throughout the enterprise should be housed by one state (perhaps the domiciliary state of the largest company) and incorporated as part of the examination documents by all examining states.

   Another respondent indicated that in an ideal situation, a coordinated exam would place all examination responsibilities on one state. The other domestic states should have some input in the planning process, but would not need to be onsite at the company. The other domestic states could then rely on the work that is performed by the lead state and perform an independent review of the work papers. Those states could then adopt the examination as their own. Proper planning up front should address any individual state's concerns and provide adequate testing to include any work that is necessary on a company-by-company basis.

2. What are some characteristics or traits of the health companies in your holding company group that may make coordinating exams difficult? Please explain.

   Respondents indicated that variations in assets, size, direct written premiums and product offerings of various legal entities within a holding company system can create challenges. Health companies, particularly those with health maintenance organizations (HMOs) within their family of companies will be more likely than other types of insurers to have many single-state entities as opposed to multi-state licensed legal entities within their structure. This can represent a challenge to state examiners, particularly where not all companies are integrated into the parent holding company system. The broad range in the size and complexity of these companies, including several different domiciliary states utilizing various exam schedules, can make coordination more difficult.

3. Please list the types of information you would expect to provide to a financial examiner to assist them in coordinating the companies in your holding company group and making the exam(s) more efficient. In other words, what company characteristics would you consider if you had to determine how to coordinate the exams for the companies in your holding company group? Please provide as many as possible and explain.

   The following responses were received suggesting information that would be useful for regulators in determining the coordination of a holding company examination. There were a number of suggestions that examiners already receive that are important in conducting coordinated exams but were not included in the listing below as the information was not necessarily beneficial in determining how to coordinated exams. This information included items such as Form B and 10K information. The responses have been summarized to avoid duplication of suggestions.

   - Provide a diagram of the corporate structure and relationship between the holding company and the various insurance legal entities
   - Provide a description of Sarbanes-Oxley scope, entity level controls and the significant processes evaluated by management along with results of management's most recent evaluation of internal control over financial reporting
   - Provide an overview of the common management lines of authority for company operations to facilitate more effective and focused interviews with company management
   - An overview of our shared services and centralized functions that are in place across the legal entities.
   - Provide a listing by name of all administration systems, including locations and names of experts who manage them, with those systems that are common to multiple entities identified as such
   - Provide information regarding IT systems and system controls that are utilized or similar for multiple or all companies in a group
   - Provide access to the company's independent certified public accountants (CPAs) to ascertain their audit approach to the company's holding company system and its various regulated subsidiaries
   - Provide management's risk assessment of the legal entity under review to help state examiners to determine the entity's risk exposures
   - Provide Model Audit Rule documentation if applicable to demonstrate that the legal entity has documented internal controls around the statutory financial reporting process
   - Documentation of the internal audit program and a listing of the internal audits performed during the period under review.

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Summary of Feedback Received
(Life Companies)

As discussed during the conference call on Aug. 3, 2009, a request of the Life Coordination Subgroup was sent to interested parties to obtain information that can be utilized to improve the coordination of financial examinations and make them more efficient for insurers and regulators. The responses received have been summarized for presentation in this document.

1. How would you define a coordinated financial exam? Do you have any specific expectations from a coordinated financial exam? Please explain.

   Most respondents indicated an expectation that examinations of all entities within a holding company group should always be coordinated unless there is a valid, documented reason not to coordinate. The coordinated examination should be a comprehensive and simultaneous examination of each of a holding company's affiliated insurance legal entities, which may be domiciled in multiple states. The coordinated examination should be planned well in advance of the start of fieldwork in order to gather the necessary information on shared processes and systems throughout the group to adequately plan the work to be performed. There should be a collaborative communication plan amongst all states, with the lead state assuming primary responsibility for communicating with the company. There would be defined responsibilities amongst the participating states, with clearly defined decision making authority being held by the lead state. Processes performed at the enterprise level (e.g. corporate governance, IT systems, etc.) should be reviewed and maintained by a lead state and incorporated into the examination workpapers by all examining states. All examining states should use common processes and information requests to obtain the needed planning information.

   Further, most respondents indicated, that for other common functional activities that impact multiple insurance entities (e.g. claim processing, investing), responsibilities for examining the processes in these areas should be divided up amongst the participating states to avoid redundancy. The results of this review should be shared through a centralized repository so that all impacted states could have access to the work performed and place reliance on the controls/processes reviewed and resulting conclusions/assessments. States that cannot participate in the onsite examination should have remote access to review examination workpapers in real time. The results of this type of coordinated examination would benefit both the industry and insurance departments. Utilizing examiner resources from multiple departments should lead to better allocation of those resources thus providing cost savings to both companies and insurance departments.

   Some respondents indicated that as the products offered in their companies differ, that coordinated exams would not provide significant efficiencies. However, their expectation would still be that the timing/scheduling of examinations would be coordinated amongst the states and that those processes performed at the enterprise level would still be subject to review by one lead state (e.g. corporate governance).

   Other respondents indicated an expectation that all the insurance entities within a holding company group would be examined at one time by a single state regulator, with no direct involvement by other domestic states. The other states of domicile should then rely on the work performed by the lead state.

   One respondent recommended that, in order to facilitate coordinated examinations and align examination scheduling, a one-time exemption of the mandatory 5 year examination period should be granted to allow states the ability to get on the same examination schedules as the other domestic states.

2. What are some characteristics or traits of the life companies in your holding company group that may make coordinating exams difficult? Please explain.

   Most respondents indicated that multiple entities within their groups are domiciled in multiple states with varying examination cycles. In addition, most respondents indicated that common systems and applications are typically used by each business product offered by the holding company, and that the products are often distributed across multiple entities. Since company control documentation and testing, as well as external auditor work, may be organized by business product and not by legal entity, this can complicate the examination process if examiners are strictly focused on a legal entity review.

Some respondents indicated that although most of their entities share common systems and applications, there are individual entities within the group that offer unique products and do not share systems and applications with the rest of the group.

Other respondents indicated that business processes vary significantly from entity to entity throughout the group, which make it difficult to gain efficiencies from a coordinated exam.

Other respondents indicated a difficulty in that the parent holding company is not an insurance entity, which complicates a review of corporate governance.

3. Please list the types of information you would expect to provide to a financial examiner to assist them in coordinating the companies in your holding company group and making the exam(s) more efficient. In other words, what company characteristics would you consider if you had to determine how to coordinate the exams for the companies in your holding company group? Please provide as many as possible and explain.

   The following responses were received suggesting information that would be useful for regulators in determining the coordination of a holding company examination. The responses have been summarized to avoid duplication of suggestions.

   - Provide a diagram of the corporate structure and relationship between the holding company and the various insurance legal entities, with any significant changes since the last examination prominently notated
   - Provide a listing of all legal entities and their state of domicile
   - Provide the primary location of books and records for each legal entity
   - Provide company organization charts and directors' names for each legal entity
   - Provide a business overview write-up including financial plans and management's concerns and risks for each legal entity
   - Provide the types and respective premium volume of products within each legal entity
   - Provide a listing by name of all administration systems, including locations and names of experts who manage them, with those systems that are common to multiple entities identified as such
   - Provide an overview of the "mutual service" departments (e.g. IT, accounting, investments, executive, etc.) servicing multiple companies within the group.
   - Provide a description of Sarbanes-Oxley scope, entity level controls and the significant processes evaluated by management along with results of management's most recent evaluation of internal control over financial reporting
   - Provide an overview of the common management lines of authority for company operations to facilitate more effective and focused interviews with company management.
   - Provide a description of unique product offerings for any of the life affiliates.
   - Provide an overview of Model Audit Rule documentation, including a description of the "Group of Insurers" determined for purposes of Model compliance.

Summary of Feedback Received
(P&C Companies)

As discussed during the conference call on Aug. 4, 2009, a request of the P&C Coordination Subgroup was sent to interested parties to obtain information that can be utilized to improve the coordination of financial examinations and make them more efficient for insurers and regulators. The responses received have been summarized for presentation in this document.

1. How would you define a coordinated financial exam? Do you have any specific expectations from a coordinated financial exam? Please explain.

   The majority of respondents indicated that the coordinated examination should be planned well in advance of the start of fieldwork in order to gather the necessary information on shared processes and systems throughout the group to adequately plan the work to be performed. There should be a collaborative communication plan amongst all states, with the lead state assuming primary responsibility for communicating with the company. There would be defined responsibilities amongst the participating states, with clearly defined decision making authority being held by the lead state. Processes performed at the enterprise level (e.g. corporate governance, IT systems, etc.) should be reviewed and maintained by a lead state and incorporated into the examination workpapers by all examining states.

   Many respondents indicated that all examining states should use common processes and information requests (including questionnaires) to obtain the needed planning information. A recommendation was made that NAIC staff work with states that are utilizing different information requests to build the additional questions or information they would like to receive into the existing planning questionnaire found in the Examiners Handbook. All information requests and planning for the coordinated examination (including logistical requirements) should be communicated to company personnel well in advance of on-site examination activities. Interviews with executives at the holding company level should be performed by the lead state and utilized by all other states to prevent duplication of work. In addition, the lead state should coordinate interviews with executives at all other levels to ensure that individuals are not interviewed by multiple states during an examination cycle. The lead state should also be the primary reviewer of auditor workpapers.

   Many respondents also indicated that utilizing examiner resources from multiple departments should lead to better allocation of those resources thus providing cost savings to both companies and insurance departments. The group of examiners from different states should start and finish work at the same time to reduce inefficiencies. One respondent recommended that examiners perform work offsite and share the work performed by utilizing technology whenever possible. The lead state should provide a reasonable notice of the on-site start date and allow for proper advance preparation of company personnel.

   Other respondents indicated an expectation that all the insurance entities within a holding company group would be examined at one time by a single state regulator, with no direct involvement by other domestic states. The other states of domicile should then rely on the work performed by the lead state. One respondent mentioned that upon the completion of the exam, the states should issue one comprehensive report.

   One respondent recommended that, in order to facilitate coordinated examinations and align examination scheduling, a one-time exemption of the mandatory 5 year examination period should be granted to allow states the ability to get on the same examination schedules as the other domestic states. One respondent also mentioned that a coordinated exam should always be performed at the holding group level unless there is a valid documented reason not to.

2. What are some characteristics or traits of the property and casualty companies in your holding company group that may make coordinating exams difficult? Please explain.

   Most respondents indicated that multiple entities within their groups are domiciled in multiple states with varying examination cycles. Although some respondents indicated that they utilize common systems and applications, other respondents mentioned varying processes as well as different operating divisions, locations, and products. Some of the unique operating concerns include the market in which companies operate, the method(s) of distribution, the types of business conducted, and systems may not be similar in some cases.

   One respondent indicated intercompany pooling arrangements as a unique consideration for exam coordination.

3. Please list the types of information you would expect to provide to a financial examiner to assist them in coordinating the companies in your holding company group and making the exam(s) more efficient. In other words, what company characteristics would you consider if you had to determine how to coordinate the exams for the companies in your holding company group? Please provide as many as possible and explain.

   The following responses were received suggesting information that would be useful for regulators in determining the coordination of a holding company examination. The responses have been summarized to avoid duplication of suggestions.

   - Provide information on similarities and differences of operations including markets, distribution channels, risk management
   - Provide overview of "mutual service" departments or business units that service multiple companies within the group (e.g. IT, accounting, investments, executive, etc.)
   - Provide information on the common management lines of authority (including board of directors) for company operations including corporate governance charts (functional charts)
   - Provide a breakdown of IT systems and applications/processes used by the companies including flowcharts
   - Provide internal control framework for companies in group
   - Provide an explanation as to whether a coordinated exam makes sense given the unique characteristics of a particular group
   - Provide a comprehensive overview of key functional activities and how such activities are managed
   - Provide breakdown of direct written premium by company and line of business
   - Provide information on significant agreements and transactions with affiliates

   One respondent indicated that critical pieces of information necessary to coordinate include a completed Exam Planning Questionnaire (with necessary attachments/exhibits), combined and individual Annual Statements, and Statutory Audit Reports with notes to the financials. Another respondent added that consistency in the questionnaires provided by examiners is critical to coordination.

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Draft: 11/23/09

Financial Examiners Handbook (E) Technical Group
Conference Call
November 19, 2009

The Financial Examiners Handbook (E) Technical Group of the Examination Oversight (E) Task Force met via conference call Nov. 19, 2009. The following Technical Group members participated: Al Bottalico, Chair (CA); Jim Hattaway (AL); Bill Arfanis (CT); Kevin Brown (DC); Connie Ridinger (IN); Donald Crawley (MD); Jim Nixon (NE); John Marshall (NV); Bill Harrington (OH); Greg Lathrop (OR); Dave DelBiondo (PA); Pat McNaughton (WA); and Fred Thornton (WI). Also participating was: David Smith (VA).

1. Exposures from Fall Conference Call

Mr. Bottalico discussed several items that were previously exposed on the Technical Group's last conference call, including exhibits on letters of representation, prospective risk assessment and exam interviews. The exposures also included additional detailed guidance on these topics and the reorganization of the *Financial Condition Examiners Handbook*. No comments were received on any of the exposed items during the exposure period.

On a motion from Ms. Ridinger, seconded by Mr. Hattaway, the guidance was adopted by the Technical Group for inclusion in the 2010 Handbook (Attachment Four-A).

2. Examination Repositories

Mr. Bottalico stated that the project to create the examination repositories has concluded and has resulted in 18 total repositories. He added that regulators, interested parties and NAIC staff have expended a considerable amount of time and resources to create these tools for examiners. He thanked all of the people that helped create or revise these repositories and noted that the tools will be beneficial to examiners when conducting exams.

Mr. Bottalico mentioned that each of the repositories has been publicly exposed and has had a detailed review performed by at least three member states of the Technical Group. He added that the Technical Group plans to review and update these repositories on an ongoing basis.

On a motion from Mr. Harrington, seconded by Mr. Marshall, the Technical Group adopted the examination repositories for inclusion in the 2010 Handbook and agreed to place the existing repositories online as reference materials for examiners.

3. Examination Repositories Introduction

Mr. Bottalico stated that during the detailed review of the examination repositories, regulators requested an overall introduction to the exam repositories that would provide information including why the repositories were created, how to use them and what kind of information is incorporated into them. He added that some of the tests in the Possible Detail Tests column are attribute tests and have asterisks next to them because they could be used as detail tests in Phase 5 or control tests in Phase 3. He explained that these tests have been placed in the detail tests column because they will generally require more time and effort to complete than other direct control tests that have been placed within the Possible Tests of Controls column.

On a motion from Mr. Hattaway, seconded by Mr. Harrington, the introduction for the examination repositories was adopted by the Technical Group for inclusion in the 2010 Handbook.

4. Guidance on Documentation of Internal Controls

The Technical Group received a referral from the Risk Assessment Implementation Subgroup regarding guidance on the documentation of internal controls. Mr. Bottalico mentioned that examiners were having a hard time understanding what was required to be documented regarding internal controls. The guidance stated that documentation of the controls was not necessary if they were not already documented; it did, however, require that an understanding of the internal controls be obtained and documented by the examiner. The feedback received from a survey conducted by the Subgroup was that examiners were still having a hard time determining the definition of an understanding of controls and how that pertains to documentation in exam work papers.

As a result, the Subgroup developed additional guidance to help clarify the expectations related to documenting an understanding of controls. Mr. Bottalico stated that the key focus of the guidance developed stated, "In situations where control information is not documented or readily available, examiners should not create documentation of the controls themselves, but rather, document their understanding of controls. This understanding may consist of only a few simple sentences describing how the company mitigates each identified risk. If, after prudent inquiry, the examiner is unable to ascertain what controls exist at an identified risk level, the examiner should provide a brief narrative describing the general controls that exist for each sub-activity (or, if not possible, each key activity)."

On a motion from Mr. Harrington, seconded by Ms. Ridinger, the guidance on documenting internal controls was adopted by the Technical Group for inclusion in the 2010 Handbook (Attachment Four-B).

5. Guidance on Review of Subsequent Events

The Risk Assessment Implementation Subgroup also referred to the Technical Group guidance regarding the review of subsequent events. This guidance discusses the types of subsequent events and how the examiner should account for those events, including whether a footnote in the exam report or an exam adjustment is necessary.

On a motion from Mr. Marshall, seconded by Mr. McNaughton, the guidance on reviewing subsequent events was adopted by the Technical Group for inclusion in the 2010 Handbook (Attachment Four-C).

6. Economic Crisis Update and Revisions to Exhibit M

Mr. Bottalico stated that the Technical Group held a conference call in August to discuss a referral received regarding the current economic crisis. The referral asked the Technical Group to determine whether any guidance should be added to the Handbook with regard to the crisis. As a result, a listing of topics was created, and the Technical Group decided if guidance should be added to the Handbook or to an Exam Alert for each topic. The Exam Risk Alert would be temporary guidance for examiners to utilize based on current issues. All the topics that the Technical Group wanted to add to the Handbook have been drafted into the Handbook. Some of these items include risks that were added to various exam repositories and prospective risks that were added to Exhibit V for situations where prospective risks don't relate directly to a specific key activity. Mike Sindel (NAIC) added that staff plans to develop the Exam Risk Alert next but had previously focused on items that would be included in the Handbook due to the publication deadline.

One of the topics discussed in the economic crisis conversation was enterprise risk management (ERM). Therefore, staff proposed guidance for inclusion into the Handbook. In summary, Exhibit M discussed ERM and how it is a part of the corporate governance of a company and should be addressed by the examiners. It provides some items to consider, such as risk tolerances and how management identifies, assesses and mitigates risks.

Mr. Smith proposed that the discussion of an assessment being made on the effectiveness of the insurer's risk management function be changed to a review of the function. Since this is an area that examiners may not have addressed in the past, he wanted to make sure that examiners are comfortable with understanding and reviewing the risk management function before they provide an assessment on it. Mr. Harrington agreed with these recommended changes.

On a motion from Mr. Harrington, seconded by Mr. Lathrop, revisions to Exhibit M were adopted, as amended, by the Technical Group for inclusion in the 2010 Handbook (Attachment Four-D).

7. Referral from the Risk Retention Group (E) Task Force

Mr. Bottalico stated that the Technical Group received a referral from the Risk Retention Group (E) Task Force that proposed additional guidance for the Handbook related to risk retention groups. The Task Force recently discussed whether exams on risk retention groups are association (zone) exams. Based on the Liability Risk Retention Act, it was determined that exams over risk retention groups are not association exams because non-domestic states are not specifically allowed to participate in these exams. A domestic regulator could invite or allow another state to participate but is not required to do so. The Task Force also proposed some minor changes to the e-mail notification sent from the Exam Tracking System when an exam is called. The changes explain that the e-mail is strictly a notification for RRG exams and not an invitation to participate. These changes represent guidance for better communication and notification to other states and are not actual changes to the exam process.

On a motion from Mr. Hattaway, seconded by Mr. McNaughton, the Technical Group adopted these changes into the Handbook and the Exam Tracking System e-mail notification (Attachment Four-E).

Having no further business, the Financial Examiners Handbook (E) Technical Group adjourned.

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EXHIBIT T -
SAMPLE LETTER OF REPRESENTATION

An illustrative management representation letter for the property and casualty, mortgage guaranty, title company, health, and life, accident and health entities is presented in Exhibit T. The sample letter~~s~~ incorporate~~s~~ a representation~~s~~ that should ordinarily be obtained by the examiner as well as clauses for specific issues. The management representation letter should be modified by the regulator to meet the circumstances of the particular examination and the nature of the company being examined. Some clauses for specific issues in particular lines of business have been provided with the relevant line of business shown in parentheses at the end of the clause. An electronic copy of each letter of representation (based on line of business) can be found online.

Modifications or special representations relating to management's knowledge or intent should be obtained when the examiner believes that they are necessary to complement other examination procedures or when corroborating evidential matter is limited. It would be unusual to obtain a representation letter that did not include some special representations to cover individual company circumstances.

Certain representations may be limited to matters that may have a material effect on the statutory financial statements, as indicated in the illustrative letter. It is preferable for management to specify the agreed-on materiality limits in the representation letter. Illustrative language for this materiality purpose is included in the sample letter. When evaluating the materiality threshold to be included in the letter, the examiner should consider the nature of the company under examination and the extent of detail desired in management's representations. In no event shall the materiality threshold included in the letter exceed planning materiality levels as this level relates to the examiner's overall perspective of the financial statements rather than a particular account balance or cycle. The illustrative letter also contains qualitative criterion of materiality, which is required in all representation letters.

(~~Property & Casualty -~~On Company Letterhead)

Date (date should agree with report of examination)

Name of Examiner
Examiner-In-Charge
(Name of State) Department of Insurance
Address
City, State Zip Code

We are providing this letter in connection with your examination of the statutory financial statements of *(Name of Insurance Company, Title Company or Mortgage Guaranty*) as of (*Month, Date, Year*) and for the period from (*Month, Date, Year*) to (*Month, Date, Year*). We are responsible for the ~~preparation~~ fair presentation of the statutory ~~financial~~ statements of financial position, results of operations, and changes in statutory financial position in conformity with the accounting practices prescribed or permitted by the (Name of State) Department of Insurance.

Certain representations in this letter are described as being limited to those matters that are material. Solely for the purpose of preparing this letter, the term "material," when used in this letter, means any item or group of similar items involving potential amounts of more than $_____. These amounts are not intended to represent the materiality threshold for financial reporting and disclosure purposes. Notwithstanding this, an item is considered material, regardless of size, if it involves an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would have been changed or influenced by the omission or misstatement.

We confirm, to the best of our knowledge and belief, the following representations made to you during the examination.

1. The corporate governance practices and policies the company has in place are adequate and appropriate in relation to the size and complexity of the company and the systems and processes used are adequate and appropriate to address risk inherent within the company.

2. We have made available to you all:

- Statutory financial records and related data; ~~and~~
- Minutes of meetings of stockholders/policyholders (if a mutual company), directors and committees, or summaries of actions of recent meetings for which minutes have not yet been prepared; ~~.~~
- Access to individuals within the company to whom you requested access to gain examination evidence; and
- Risk assessment documentation.

3~~2~~. There have been no:

- Fraud or other irregularities involving management or employees who have significant roles in the internal control structure;

- Fraud or other irregularities involving other employees that have or may have a material effect on the statutory financial statements;

- Fraud or other irregularities involving agents, MGAs, third party administrators, independent contractors, holding companies or other individuals or parties that have or may have a material ~~impact~~effect on the statutory financial position of the Company; or

- Communications from regulatory agencies concerning noncompliance with, or deficiencies in, statutory financial reporting practices. (P & C, Life, A & H, Mortgage Guaranty, Title)

- Communications from regulatory agencies concerning noncompliance with, or deficiencies in, statutory financial reporting practices. This includes those related to Medicare and Medicaid antifraud and abuse statutes. (Health)

4~~3~~. We have no plans or intentions that may materially affect the carrying value or classification of assets and liabilities.

5~~4~~. The financial statements are free of material ~~and intentional immaterial~~ misstatements.

6~~5~~. The following have been properly recorded or disclosed in the statutory financial statements:

- Any related party transactions and related amounts receivable or payable, including sales, purchases, loans, transfers, leasing arrangements, and guarantees.

- All liabilities, both actual and contingent.

- Guarantees, whether written or oral, under which the Company is contingently liable.

- Capital stock, repurchase options or agreements on capital stock reserved for options, warrants, conversions, or other requirements (N/A for mutual companies).

- Arrangements with financial institutions involving compensating balances or other arrangements involving restrictions on cash balances and line-of-credit or similar arrangements.

- Significant estimates and material concentrations known to management that are required to be disclosed in accordance with SSAP No. 1, *Disclosure of Accounting Policies, Risks & Uncertainties, and Other Disclosures*.

- The amount of credit risk and extent, nature, and terms of financial instruments with off-balance-sheet risk to be disclosed in accordance with SSAP No. 27.

- Agreements to repurchase assets previously sold.

7~~6~~. We confirm the completeness of the information provided regarding the identification of related parties.

8~~7~~. There are no violations or possible violations of laws or regulations whose effects should be considered for disclosure in the statutory financial statements or as a basis for recording a loss contingency. (P & C, Life, A & H, Mortgage Guaranty, Title)

8. There are no violations or possible violations of laws or regulations whose effects should be considered for disclosure in the statutory financial statements or as a basis for recording a loss contingency. This includes those related to Medicare and Medicaid antifraud and abuse statutes, including but not limited to the Medicare and Medicaid Anti-Kickback Statutes, Limitations on Certain Physical Referrals (the Stark law),

and the False Claims Act, in any jurisdiction, whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements. (Health)

9~~8~~. Billings to third-party payors comply in all material respects with diagnostic and procedure coding guidelines (for example ICD-9-CM and CPT-4) and laws and regulations (including those dealing with Medicare and Medicaid antifraud and abuse), and billings reflect only charges for goods and services that were medically necessary; properly approved by regulatory bodies (i.e., Food and Drug Administration), if required and properly rendered. (Health)

10. Contingent Liabilities:

- There are no other liabilities or gain or loss contingencies that are required to be accrued or disclosed by SSAP No. 5.

- There is no litigation against the Company that is considered material in relation to the statutory financial position of the Company. For purposes of this section, the Company has excluded litigation for which the only amounts sought relate to benefits within the normal terms of coverage under contracts of insurance issued by the Company, and which are otherwise considered in the actuarial determination of the Company's unpaid claim reserves.

- *In the occurrence of a contingent liability noted by management the following should be included in the management representation letter*: Except for the contingent liability disclosed in Note X of the financial statements, there are no contingent liabilities ~~which~~that require disclosure in the financial statements or notes thereto.

- *(If applicable)* The … litigation by XYZ Company has been settled for the total sum of XXX that has been properly reflected in the financial statements. No other claims in connection with ~~this~~ litigation have been or are expected to be received.

9~~1~~1. Adequate provision has been made for adjustments and losses in collection of receivables.

1~~0~~2. Provision has been made for estimated retroactive adjustments by third-party payors under reimbursement agreements.

13~~1~~. The Company is in compliance with bond indentures or other debt instruments.

14~~2~~. Pending changes in the organizational structure, financing arrangements, or other matters that could have a material effect on the financial statements of the Company are properly disclosed.

15~~3~~. The Company has properly classified all assets as admitted or nonadmitted in accordance with SSAP No. 4.

16~~4~~. The Company has free and clear title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged except as disclosed in the annual statement.

17~~5~~. We have reviewed long-lived assets and certain identifiable intangibles whenever changes in circumstances have indicated that the carrying amount of these assets might not be recoverable and have recorded the adjustment in accordance with SSAP No. 5.

18~~6~~. Deferred tax assets and liabilities as reported in the financial statements comply and have been valued in accordance with SSAP No. 10, *Income Taxes*.

19~~7~~. The Company has properly disclosed and recorded any premium deficiency reserves in accordance with SSAP No. 53. (P & C)

20~~18~~. Investments are appropriately recorded and valued as follows:

- Bonds – are recorded and disclosed in accordance with SSAP No. 26 and interpretations thereof.
- Preferred stocks – are recorded and disclosed in accordance with SSAP No. 32 and interpretations thereof.
- Common stocks – are recorded and disclosed in accordance with SSAP No. 30 and interpretations thereof. Common stock of subsidiaries and affiliated or controlled companies are recorded and disclosed in accordance with SSAP No. 46 and interpretations thereof.
- Short-term investments – are recorded and disclosed in accordance with SSAP No. 2 and interpretations thereof.
- Mortgage loans and collateral loans – are recorded and disclosed in accordance with SSAPs No. 37 &~~and No.~~ 21 and interpretations thereof.
- Real estate – is recorded and disclosed in accordance with SSAP No. 40 and interpretations thereof.
- Policy loans – are recorded and disclosed in accordance with SSAP No. 49 and interpretations thereof. (Life, A & H)
- Health Care Delivery Assets – are recorded and disclosed in accordance with SSAP No. 73. (Health)
- Derivatives – are recorded and disclosed in accordance with SSAP~~'~~s No. 31 & 86 and interpretations thereof.

21~~19~~. We have made you aware of all derivative risks that the company is subject to that are not disclosed on Schedule DB of the Annual Statement.

22~~0~~. Accident and Health Premiums Due and Unpaid – Premiums are recognized and reported in accordance with SSAP No. 54. Uncollected premiums are reported in accordance with SSAP No. 6. (Health)

23. Adequate consideration has been given to, and appropriate provision made for, estimated adjustments to revenue, such as for denied claims and changes to diagnosis-related group (DRG) assignments. (Health)

24. All peer review organizations, fiscal intermediary, and third-party payor reports and information have been made available. (Health)

25. Cost reports filed with third parties: (Life, A & H, Health)

- All required Medicare, Medicaid, and similar reports have been properly filed.
- Management is responsible for accuracy and propriety of all cost records filed.
- All costs reflected on such reports are appropriate and allowable under applicable reimbursement rules and regulations and are patient-related and properly allocated to applicable payors.
- The reimbursement methodologies and principles employed are in accordance with applicable rules and regulations.

- Adequate consideration has been given to, and appropriate provision made for, audit adjustments by intermediaries, third-party payors, or other regulatory agencies.

- All items required to be disclosed, including disputed costs that are being claimed to establish a basis for subsequent appeal, have been fully disclosed in the cost report.

- Recorded third-party settlements include differences between filed (and to be filed) cost reports and calculated settlements, which are necessary based on historical experience or new or ambiguous regulations that may be subject to differing interpretations.

26. The Company's liabilities for unpaid losses and loss adjustment expenses are based upon and recorded at management's best estimate in accordance with SSAP No. 55. (P & C, Mortgage Guaranty)

26~~1~~. The Company has properly disclosed and recorded policy reserves in accordance with SSAP's No. 51, 52, 54 and 59. The Company's liabilities for unpaid claims and claim adjustment expenses are based upon and recorded at management's best extimate in accordance with SSAP No. 55. (Life, A & H)

26. The Company's liabilities for unpaid claims and claim adjustment expenses are based upon and recorded at management's best estimate in accordance with SSAP No. 55. (Health, Title)

27. Agents' balances or uncollected premiums have been recorded and disclosed in accordance with SSAP No. 6. (P & C, Mortgage Guaranty, Title)

2~~7~~8. The Company has properly disclosed and recorded separate account transactions in accordance with SSAP No. 56. (Life, A & H)

29. The Company's actuary has certified as to the propriety of the basis and amounts at which the deferred and uncollected premiums, the reserve for life policies and contracts (including deposit-like contracts; SSAP No. 52), and the reserve for accident and health policies are stated. (Life, A & H)

29. The Company's actuary has certified to the propriety of the basis and amounts at which the claim reserves and all actuarial liabilities are stated at (*Month, Date, Year).* (Health)

30. The Company has computed the asset valuation reserve and interest maintenance reserve in accordance with methods prescribed by the Annual Statement Instructions of the National Association of Insurance Commissioners. (Life, A & H)

30. The Company has recorded individual and group accident and health reserves in accordance with SSAP No. 54. (Health)

30. The Statutory Contingency Reserve and applicable supplementary reserve has been properly recorded and disclosed in accordance with SSAP No. 58. (Mortgage Guaranty)

30. The Statutory Premium Reserve and applicable supplemental reserve has been properly recorded and disclosed in accordance with SSAP No. 57. (Title)

31. Title plants have been recorded and disclosed in accordance with SSAP No. 57. (Title)

32. Utilization data has been properly determined and included in the statutory financial statement. (Health)

33. Covered liabilities are properly stated in the statutory financial statement and are determined as health care services covered through "hold harmless" clauses in the provider contracts which state that providers will not bill enrollees even though the provided has not been paid by the HMO. (Health)

34. The Company is in compliance with contractual agreements, grants, and donor restrictions. (Health)

35. There were no material commitments for construction or acquisition of property, plant and equipment, or to acquire other noncurrent assets, such as investments or intangibles.

~~23.~~ *In the event of a material commitment, replace this clause ~~#22~~ with the following*: Other than the commitment described in Note *X* of the financial statements, there are no material commitments for construction, or acquisition of property, plant and equipment, or to acquire other noncurrent assets, such as investments or intangibles which require disclosure in the financial statements.

36~~24~~. We have complied with all aspects of contractual agreements that would have a material effect on the statutory financial statement in the event of noncompliance.

37~~25~~. There are no material transactions that have not been properly recorded in the accounting records underlying the statutory financial statements.

38~~26~~. All required returns and statutory reporting requirements have been filed on a timely basis with the appropriate regulatory bodies.

39~~27~~. All material reinsurance transactions have been recorded and disclosed in accordance with SSAP No. 62. (P & C, Mortgage Guaranty, Title)

39. All material reinsurance transactions have been recorded and disclosed in accordance with SSAP No. 61. (Life, A & H, Health)

~~28~~40. The Company has properly disclosed and recorded all changes in accounting principles in accordance with SSAP No. 3.

~~29~~41. The Company has recorded and disclosed subsequent events in accordance with SSAP No. 9.

~~30.~~ *In the event of a subsequent event, the following should replace this clause ~~#29~~ in the Management Representations Letter:* Other than …~~,~~ described in Note X to the financial statements, there have been no events subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

~~31~~42. The Company is not aware of the employment of or a business relationship with a "prohibited person" as defined in The Violent Crime Control and Law Enforcement Act of 1994: United States Code, Section 1033 (e)(1)(A).

43~~32~~. Note *X* to the financial statements discloses all of the matters of which we are aware that are relevant to the Company's ability to continue as a going concern, including significant conditions and events, and management's plans.

44~~33~~. We agree with the findings of specialists in evaluating the (describe the assertion) and have adequately considered the qualifications of the specialists in determining the amounts and disclosures used in the financial statements and underlying accounting records. We did not give or cause any instructions to be given to specialists with respect to the values or amounts derived in an attempt to bias their work.

45~~34~~. The valuation of securities is consistent with the methods allowed under the Purposes and Procedures Manual of the NAIC Securities Valuation Office and what is required under the NAIC Accounting Practices and Procedures Manual.

~~34~~65. The Company has recorded and disclosed defined benefit plans and defined contribution plans in accordance with SSAP No. 89.

~~34~~76. The Company has recorded and disclosed postretirement benefits other than pensions in accordance with SSAP No. 14.

~~*Note: The following representations may not apply to all examinations, particularly smaller companies with less sophisticated information systems environments.*~~

~~34~~87. Regarding the corporate Information Systems (IS) function, we have made available to you all information and documentation responsive to your review of the IS function; and we have, to the best of our knowledge and belief, answered all questions and inquires fully and accurately.

49~~38~~. Except as already disclosed to you, the corporate IS function has established and maintains adequate policies, procedures and guidelines concerning systems security, systems back up, systems design, change controls, testing of systems changes, configuration of transaction controls, documentation and error or exception reporting.

50~~39~~. All corporate IS policies, ~~and~~ guidelines and systems that could have a material impact on the financial ~~statements~~ solvency of the company are monitored and have been complied with; and, no breaches that could have a material impact on the financial ~~statements~~solvency of the company, whether perpetrated by external or internal parties, are known to have occurred. (If incorrect, describe fully.)

~~4~~510. There were no significant deficiencies or material weaknesses with new systems, system modifications or new site locations implemented during the period that could have a material impact on the financial ~~statements~~solvency of the company.

~~4~~521. None of the Company's third party service providers, upon which the Company relies, has known problems which would be likely to threaten the reliability of the Company's information systems and/or the systems' internal controls, or which could have a material impact on the Company's financial ~~statements~~solvency.

We understand that your examination was made in accordance with standards established by the (Name of State) Department of Insurance, and procedures established by *the National Association of Insurance Commissioners*, and accordingly included such tests of the accounting records and such other procedures as considered necessary under the circumstances.

Name of Insurance Company, Title Company or Mortgage Guaranty

_____ _____

Chief Executive Officer Date

_____ _____

Chief Financial Officer Date

EXHIBIT V – PROSPECTIVE RISK ASSESSMENT

The concept of risk on a risk-focused examination encompasses not only risks as of the examination date, but risks which extend or commence during the time which the examination was conducted, and risks which are anticipated to arise or extend past the point of examination completion. As such, consideration of 'prospective risks' (including moderate or high residual risks existing at the balance sheet date that will impact future operations, risks anticipated to arise due to assessments of company management and/or operations or risks associated with future business plans of the company) is an intrinsic element of a risk-focused examination and should occur throughout all phases of the examination process.

This exhibit has been included as a guide for examiners to utilize in documenting their consideration of prospective risks that are overarching and relate to more than one specific key-activity of the company. Additionally, this exhibit includes example categories~~examples~~ of general prospective risks~~circumstances~~ that impact insurers~~have previously been associated with troubled insurance company situations~~.

In completing this exhibit and documenting the examiner's consideration of prospective risks throughout the examination process, the examiner should conduct an evaluation, and if possible, examination procedures on the noted prospective insolvency risks to assess the degree of risk present and recommend future monitoring. Throughout the examination process and at the conclusion of the exam, the examiner should communicate with the department's financial analysts to keep them informed of the identified prospective risks and examiner assessments.

Consideration of Prospective Risks – Risks Identified During Phases of Risk-Focused Examination:

As discussed throughout the Handbook guidance, the consideration of prospective risks should occur throughout each phase of the examination process. During Phase 1 of the examination, the examination team should have completed a high level review of the company to ensure that any solvency concerns, including those that commenced or extended after the examination date or those that are anticipated to commence or extend beyond the examination completion date are considered and addressed during the course of the examination. If the examiner identifies a prospective risk that relates to one specific key-activity of the company, this prospective risk should be documented in the corresponding risk matrix for that key-activity and treated the same as all other identified risks. However, if the examiner identifies a prospective risk that does not relate to a specific key-activity identified, or relates to more than one key-activity identified, the examiner should utilize this exhibit to document the process to consider these prospective risks.

For the prospective risks to be documented in this exhibit, the process to consider these prospective risks should generally reflect~~mirror~~ the risk-focused examination phases. Similar to~~ of key activities/sub-activities. Within~~ Phase 2 of the examination, the examiner~~insurer~~ should identify ~~assess the~~ inherent risks that may result in significant ~~of the~~ prospective solvency risks to the company. As outlined ~~concerns. With~~in Phase 3, the examiner should evaluate the impact of existing risk mitigation strategies to assess whether the potential solvency risk is reduced through current internal controls and~~company~~ operations of the company. Following this evaluation, the examiner should assess ~~. In Phase 4 an assessment of~~ the residual risk that remains ~~risks~~ for each of the general prospective risks identified in the exhibit. Finally, the examiner should perform examination~~should be completed to aid the examiner in determining the extent of~~ procedures (if possible) to evaluate~~necessary within Phase 5 to ensure appropriate consideration of the potential solvency concerns during~~ the prospective risk further or determine steps for ongoing monitoring and/or making recommendations to~~course of~~ the company as outlined in Phases 5-7~~examination~~.

Examiners may use the following worksheet to ~~should~~ document the prospective risks identified and the impact of existing risk mitigation strategies to assess the extent that the prospective risks identified are mitigated through current company operations. (It is presumed that those items noted with moderate or high residual risks would often be considered prospective risks that may impact future company operations.)

Prospective Risk Identified	Risk Mitigation Strategies	Prospective Residual Risk Assessment	Examination Procedure and/ or Communication with Analysts
Prospective Risk 1 (Example) – In order to improve the company's market share, the company is currently implementing a plan to extend their auto insurance operations into five new states. ~~Example 1 – Company management does not enforce a code of conduct and the attitude of top management was apathetic towards the establishment of effective internal controls.~~	*The company has established a focus group to assess the impacts of the expansion as well as to assess and monitor the surplus necessary to accept this new business. ~~No risk mitigation strategies to address this concern were identified~~*	*Moderate – The company appears to be addressing key concerns of the planned expansion with the establishment of a focus group. However, this process cannot fully reduce the high inherent risk of expanding operations into several new territories. ~~High – Although the company appears to be solvent at this time, the attitude of top management presents a situation in which increased monitoring would be required to ensure continued stability.~~*	*Risk was communicated to ~~Due to the lack of an appropriate 'tone at the top', the examiner will exercise additional conservatism in completing the risk-focused examination. The examiner notified the~~ financial analysts ~~of this concern~~ on 5/30/XX. ~~Analysts were~~ and requested ~~to specifically evaluate the increased premiums and related surplus levels. In addition, analysts plan to follow-up with the company on its progress in extending its business.~~additional monitoring of this insurer. It is recommended that future examinations of this insurer occur no less than every 3 years.*
Prospective Risk 2:~~Example 2 – In order to improve the company's market share, the company is currently implementing a plan to extend their auto insurance operations into five new states.~~	*~~The company has established a focus group to assess the extent of increased premiums expected from this expansion as well as assess and monitor the surplus requirements needed to accept this new business~~*	*~~Low – The company appears to be addressing key concerns of the planned expansion with the establishment of a focus group.~~*	*~~Risk was communicated to financial analysts on 5/30/XX. Analysts were requested to specifically evaluate the increased premiums and related surplus levels. In addition, analysts plan to follow-up with the company on its progress in extending its business.~~*
Prospective Risk 3:			
Prospective Risk 4:			
Prospective Risk 5:			

Consideration of Prospective Risks – Common Areas~~Causes~~ of Concern~~Insurer Insolvencies~~:

The prospective risk categories provided within this exhibit are not designed to be an all-inclusive list and may not apply to all insurance companies that are under examination. The examiner's understanding of the company obtained in Phase 1 should be utilized to determine whether risks in these categories may be applicable to the company. The company will likely face additional prospective risks that do not fit within the categories in this exhibit~~The NAIC *Troubled Insurance Company Handbook* (TIC Handbook), which is maintained by the Financial Analysis (E) Working Group, discusses some of the more typical circumstances that have been associated with previously identified troubled insurance companies situations. A Troubled Company is broadly defined by the TIC Handbook as an insurance company that either is or is moving toward a financial position that subjects its policyholders, claimants, and other creditors to greater-than-normal financial risk, including the possibility that the company may not maintain compliance with the applicable statutory minimum capital and/or surplus requirements~~.

Prospective Risk Category	Comments
Merger and Acquisition Activity	If applicable, review the company's process to identify and perform due diligence on potential acquisitions. In addition, it may be appropriate to review the company's process to integrate acquired entities and business into its systems.
Product Development	If applicable, review and assess the company's process to identify, develop, price and market new products in accordance with the company's strategy and business needs.
Legal & Regulatory Changes	If applicable, review how the company identifies, monitors and addresses changes to the legal and regulatory environment it operates within.
HR/Personnel Risks	If applicable, review and assess the company's HR processes to identify, mitigate and monitor risks related to hiring, managing, retaining and terminating personnel in accordance with company needs.
Strategic Planning	If applicable, review and assess the company's processes for strategic planning to determine whether the company regularly analyzes its strengths and weaknesses as well as opportunities and threats on an ongoing basis. In addition, it may be appropriate to review the company's process to update its overall business plan on a regular basis.
Compensation Structure	If applicable, review the company's process for developing, monitoring and adjusting its compensation structure to ensure that employees are appropriately compensated without creating an incentive to misrepresent financial results.
Rating Agency Downgrade	If applicable, review the company's process to monitor and prepare for potential adverse changes in its credit ratings. If a future rating agency downgrade is deemed likely, consider whether the company is adequately prepared to handle the results of such a downgrade.
Costs of Capital	If applicable, review the company's access and ability to obtain capital, reinsurance and letters of credit, if necessary, to meet funding and risk diversification needs.

E. Part 5: Consideration of Prospective Risks for Indications of Solvency Concerns

In addition to conducting an examination to verify the current status of the company's solvency condition, the risk assessment surveillance cycle requires examiners to prospectively consider the company's financial condition by assessing whether the company's current processes provide indications of future solvency concerns. In conducting examinations based on the risk-focused surveillance framework, the examiner should give consideration to the business processes and management controls that often are considered retrospectively after financial issues indicate that a company has potential financial solvency issues. In addition to assessing business risks, other elements that would commonly be assessed for prospective solvency risks include consideration of the company's asset/liability matching approach, process for establishing loss reserves, pricing and underwriting and reinsurance arrangements. Among other things, these assessments should include consideration of the company's rate of growth and whether the liquidity of assets would create future concerns about the company's financial solvency.

As discussed in the preamble, this enhanced approach will allow the examiner to review risks that existed at the examination "as of" date and will be positioned to assess risks that extend or commence during the time the examination was conducted and risks which are anticipated to arise or extend past the point of examination completion. How the examiner addresses the prospective risk noted during the examination depends on the nature of the prospective risk itself. ~~Consider the following chart for clarification:~~

~~Impact on Financial Statements (F/S) currently under Examination~~	~~Type of Risk~~	~~How Addressed by Examiner~~
~~Impact to the current financial statement or to financial statements up to the date of the completion of the examination.~~	~~oSpecific risks that are known as of the balance sheet date that would have an impact on financial statements.~~ ~~oSpecific items that the company entered into or risks that expanded after the balance sheet date that impact the financial statements:~~ ~~➢Subsequent event~~ ~~➢Footnote disclosure~~	~~Follow risk-focused examination approach. Documentation in:~~ ~~➢Risk Assessment Matrix under the Financial Reporting Risk section~~ ~~➢Completion of Exhibit P "Review of Events Subsequent to B/S Date"~~
~~No impact to current financial statement or financial statements up to the date of completion of the examination.~~	~~oSpecific Items that the company entered into after the balance sheet date which requires monitoring:~~ ~~➢New line of business~~ ~~➢Entering into state~~ ~~oEnterprise Risk – Company processes that provide indications of solvency concerns~~ ~~➢Business process~~ ~~➢Corporate governance~~	~~Activity should be monitored and detail procedures may be required as part of the examination and the conclusions should be provided to financial analysts and used for supervisory plan. Documentation in:~~ ~~➢Risk Assessment Matrix under the Risks Other Than Financial Reporting section~~

	~~➢Controls or lack of certain controls~~	

~~Preliminary examples of risks that an examiner may want to consider in assessing prospective solvency concerns have been included within Exhibit O.~~

By the end of Phase 1 of the examination, the examination team should have completed a high level review of the insurer to identify any solvency concerns that commenced or extended after the examination date, or that are anticipated to commence or extend beyond the examination completion date. This should ensure that all potential solvency concerns are considered and addressed during the course of the exam. If the examiner identifies a prospective risk that relates to one specific key-activity of the company, this prospective risk should be documented in the corresponding risk matrix (or similar document) for that key-activity and treated the same as all other identified risks. As such, examples of risks that an examiner may want to consider in assessing prospective solvency concerns related to common key activities have been included within the examination repositories. However, if the examiner identifies a prospective risk that does not relate to a specific key-activity identified, or relates to more than one key-activity identified, the examiner should utilize Exhibit V to document the process to consider these prospective risks. ~~The examiner should also utilize the risk matrix (or similar documentation) for documenting risks identified other than financial reporting risks. These risks may require detail examination procedures to be performed and/or be monitored and provided to the financial analysts and used for the supervisory plan. (The Risk Assessment Matrix illustrates the method the examiner should utilize in documenting and assessing the business and prospective risks within a company.)~~

~~As the examination team analyzes the current information on the company, knowledge of the various risks will assist in identifying the key functional activities to focus on during the examination.~~

EXHIBIT Y – EXAMINATION INTERVIEWS

Overview

Interviews are a useful examination tool to gather information about key activities, risks, and risk mitigation strategies. Employees can also provide information on fraudulent activity within the company. It is critical for the examination team to understand and leverage the company's risk management program; that is how the company identifies, controls, monitors, evaluates and responds to its risks. The discipline and structure of risk management programs vary dramatically from company to company. Interviews should be performed in the early stages of the examination so that regulators can adjust their procedures accordingly. An examiner can perform alternate, additional, or fewer substantive and control tests as a result of interviews with the company.

Interviews should be conducted with key members within management of the company as well as members of the board of directors, audit committee, internal/external auditors and any other employees deemed necessary. These interviews can be used at the beginning of the examination or at any time during the examination as necessary. However, a basic understanding of the company is essential to obtain prior to conducting interviews. Examiners should consider the size and complexity of the organization in determining which individuals to interview. This interview process is a key step in the top down approach, beginning with senior management and then drilling down through the various levels of management to obtain a thorough understanding of the organization to assist in scoping the examination. In order to select the individuals to interview, the examiners should obtain an organizational chart from the company and compile a list of potential interviewees. Interviews of board members and senior company management should be conducted by examiners who possess the appropriate background and training.

Interviews should be performed in person if possible. This allows the interviewer to receive both verbal and nonverbal communication. The interviews should be kept confidential when possible; however, if a significant fraud or other pertinent issue was discovered through the interviews, the regulator has a duty to report the conflict to the appropriate officials.

The examiner should conduct the interview in a location where both parties are free to talk openly. The examiner should ask relevant questions with the most general questions posed first as building blocks for additional conversation. The examiner may want to consider alternating between open ended questions (i.e. Explain to me how this process works) vs. closed ended questions (i.e. How many claim processors do you have in your department?) to obtain the information. Open ended questions are generally better suited for explanation and processes while the closed ended questions are better suited to obtain concise information. The examiner should be prepared, listen carefully, and focus on the speaker's entire message as well as non-verbal expressions during the interview process.

Since information obtained from the interview serves as important evidence in the examination process, the examiner should develop techniques to plan, conduct, document, and consider interview information. Although interviews play a key role in gaining useful insight into company operations, interviews alone are not sufficient exam evidence and should be corroborated with other exam documentation to evaluate the accuracy of the information.

NOTE: The following template was prepared to assist examiners in obtaining a general knowledge of the company through the interview process. The examiner performing the interview should not rely exclusively on this template and should tailor questions based on knowledge of the company and the interviewee. Each section of the template is described below to assist the examiner in tailoring the template to the interviewee.

Instructions

Experience and Background – In this section, the examiner should determine the knowledge, education and practical experience the interviewee possesses. When obtaining background information on board/committee members, the examiner should consider whether the interviewee is independent of the company. If the examiner has obtained sufficient information from the interviewee's biography, questioning may not be necessary.

Duties and Responsibilities – In this section, the examiner should obtain information about what responsibilities the interviewee has within the organization including any potential conflicting duties. When interviewing board/committee members, the examiner should determine whether the interviewee demonstrates a proper understanding of how management establishes and monitors achievement of objectives. In addition, board members should be able to explain what company information they monitor on a continuing basis.

Reporting Structure – In the reporting section, the examiner should gain an understanding of the organizational structure and how the interviewee's department interrelates with other departments. Examiners should obtain information on who reports to the interviewee as well as whom the interviewee reports to, what information is being reported and reviewed and how often.

Ethics – In the ethics section, the examiner should obtain information explaining how ethics are communicated and expressed throughout the company. The examiner should also determine if the interviewee is aware of any fraudulent activities or allegations of fraudulent activities impacting the company. When interviewing board members, the examiner should determine whether the board is reviewing and enforcing the code of conduct on a continuing basis.

Risk Areas – In this section, the examiner should ask the interviewee to explain the risks inherent in his/her department or area of interest. Inquiring about risks will assist the examiner in completing Phase 2, Identify and Assess Inherent Risk in Activities. In addition to interviewing board members and upper management about risks inherent to the company, the examiner should also obtain information regarding types of external/environmental factors affecting the company.

Risk Mitigation Strategies – In this section, the examiner should ask the interviewee to explain how the company mitigates risks identified in the previous section. This information should include what controls are in place to prevent or detect those risks. Inquiring about risk mitigation strategies will assist the examiner in Phase 3, Identify and Evaluate Risk Mitigation Strategies (Controls).

Corporate Strategy – This section only pertains to board/committee members and upper management. The examiner should ask the interviewee to explain the corporate strategic initiatives of the company. In addition, the examiner should determine how the company prepares strategic plans for the future of the company and what competitive advantages/disadvantages exist within the company.

Other Topics – The examiner should obtain information regarding any other topics not previously discussed in this section. Some topics include significant turnover in his/her department, political or regulatory changes that may affect business and prospective risks.

Examination Interview Template

Interviewer: _____ ***Interviewee:*** _____

Date & Time: _____ ***Title/Position of Interviewee:*** _____

Experience and Background

_____

_____

Duties and Responsibilities

_____

_____

Reporting Structure

_____

_____

Ethics

_____

_____

Risk Areas

_____

_____

Risk Mitigation Strategies (Internal Controls)

_____

_____

Corporate Strategy

_____

_____

Other Topics

_____

_____

NOTE: The following lists of questions represent optional tools for examiners to use when conducting examination interviews. Lists have been created for several key positions of the company which are commonly interviewed during the examination process. Each list includes questions that have been customized based upon the company position that the examiners may consider asking during the interview. It is important to note that the

actual questions asked during the examination interview process should be at the discretion of the interviewer. **Not all questions included in the listing may be appropriate for each interview. In addition, the interviewer should ask questions not included in the listing according to the examiner's understanding of the company.**

Interview Questions for Board or Committee Members

Experience and Background

- How has your professional experience and background prepared you to serve on the Board of Directors for this company?

Duties and Responsibilities

- How often does the board/committee meet? Why is that sufficient?
- Briefly describe your duties and responsibilities, including what company information you monitor on a continuous basis.
- How does management establish objectives and how does the board of directors monitor achievement of those objectives?
- What role does the board of directors play in determining executive compensation?
- What areas are discussed and what type of decisions are made by the board/committee?
  - How does the board ensure that sufficient information is received to make informed decisions on behalf of the company?
- Does the board/committee review related party transactions?

Reporting Structure

- Describe the reporting structure of the company including who reports to the board/committee.
- Describe the interaction the board of directors has with the internal/external auditors. Shareholders. Senior Management.

Ethics

- Does the company have a code of conduct/ethics in place? Is it enforced? Approved?
- Explain the commitment to ethics by the board/committee and explain how the board/committee conveys that commitment to employees.
  - How does the board obtain an understanding of the "tone" throughout the organization?
- How does the company compare to others in terms of its position on ethics?
- Do you have any knowledge or suspicion of fraud within the company?

Risk Areas

- How does the board identify and monitor key risks faced by the company?
  - What are the key risks the board has identified?
  - What are the key prospective risks the company faces?
- Does the board review any type of stress testing?

Risk Mitigation Strategies (Internal Controls)

- How often does the board receive reports from management on the internal controls of the company?
  - What information is reported?

Corporate Strategy

- How is the board involved in significant corporate strategy decisions?
- Does the board approve an annual business plan?
- How does the board gain comfort with total exposures and the risk return trade-offs?
- Where is the company headed strategically? What type of plan is in place to implement this strategy? Has it been approved? How is it being monitored?

- Is the corporate strategy effectively communicated between senior management and the rest of the company?
- Explain any strengths or weaknesses of the company as well as opportunities or threats the company is facing and how the company is responding to each.

Other Topics

- Explain any significant turnover in senior management or on the board/committee.
- What type of succession planning does the company have in place?
- Based upon the current economic climate, are there any other competencies/skills that would be useful to the board?
- Is the current size of the board sufficient to fulfill necessary oversight responsibilities?
- How does the company monitor and assess financing needs as well as access to capital?

Interview Questions for the Chief Executive Officer

Experience and Background

- How has your professional experience and background prepared you to serve as the Chief Executive Officer for this company?

Duties and Responsibilities

- Briefly describe your duties and responsibilities.
- How does management establish objectives and how is the achievement of those objectives monitored?
- What role do you play in the hiring of senior management and determining executive compensation?
  - How is your compensation determined?
- How do you support the operations and administration of the board?

Reporting Structure

- Describe the reporting structure of the company including to whom you report as well as those reporting to you.
- Explain the function and reporting structure of your senior management team.
  - How often are you in contact with them?
- Describe your interaction with the board of directors.

Ethics

- Does the company have a code of conduct/ethics in place? Is it enforced? Approved?
- Explain management's commitment to ethics and explain how management conveys that commitment to employees.
  - How does management obtain an understanding of the "tone" throughout the organization?
- When establishing ethics, does the company evaluate what other companies have implemented? If yes, how does the company compare?
- Do you have any knowledge or suspicion of fraud within the company?

Risk Areas

- How are key risks faced by the company identified and monitored?
  - What are the key prospective risks the company faces?
  - How are these risks communicated to senior management and throughout the company?
- Describe any stress testing performed by the company.

Risk Mitigation Strategies (Internal Controls)

- What is the formal procedure for reporting on risk management to senior management and the board?
- Explain your commitment to the internal control structure?
- What is your company's plan for operating in crisis/disaster – business continuity?
- From a strategic perspective, how are risks addressed across all business units and entities?

Corporate Strategy

- Where is the company headed strategically? What type of plan is in place to implement this strategy? Has it been approved? How is it being monitored?
- What are your plans for retaining and growing business?
- Explain what tools or reports you utilize to make key business decisions.
- Explain any strengths or weaknesses of the company as well as opportunities or threats the company is facing and how the company is responding to each.
- What key measures do you assess to evaluate the company's performance and competitive position?

- If part of a Holding Company:
  - How does the holding company contribute to the company's strategy?
  - How might the holding company be impacted by the company's strategy?
- How often do you discuss corporate strategy with your direct reports?

Other Topics

- Explain any significant turnover in senior management or on the board/committee.
- What type of succession planning does the company have in place?
- How does the company monitor and assess financing needs as well as access to capital?

Interview Questions for the Chief Financial Officer/Controller

Experience and Background

- How has your professional experience and background prepared you to serve as Chief Financial Officer for this company?

Duties and Responsibilities

- Briefly describe your duties and responsibilities, including the preparation and information flow of financial reports.
- How does management establish objectives and how is the achievement of those objectives monitored?
- How is your performance evaluated? Is it based on the performance of the company?
- Describe your involvement in regulatory compliance.

Reporting Structure

- Describe the reporting structure of the company including to whom you report as well as those reporting to you.
- Describe your interaction with the board of directors. Internal/external auditors.
- How is financial information disclosed to the board/shareholders/creditors/others?

Ethics

- Does the company have a code of conduct/ethics in place? Is it enforced? Approved?
- Explain management's commitment to ethics and explain how management conveys that commitment to employees.
  - How does management obtain an understanding of the "tone" throughout the organization?
- When establishing ethics, does the company evaluate what other companies have implemented? If yes, how does the company compare
- Do you have any knowledge or suspicion of fraud within the company?
- Have you ever had to take a position on an accounting/reporting issue or make an adjustment to the financial statements that you were uncomfortable with or did not fully understand?

Risk Areas

- How are key risks faced by the company identified and monitored?
  - What are the key prospective risks the company faces?
  - How are these risks communicated to your senior management level team and throughout the company?
- What key risks do you monitor in your position?
  - What reports or other means do you utilize to evaluate the risks?
- Do you monitor risks relevant to specific components or divisions within the entity?

Risk Mitigation Strategies (Internal Controls)

- How often do you discuss with the audit committee/board of directors how the internal control system serves the company?
- How has the Model Audit Rule affected the company? Holding company?
- Briefly describe the key aspects of the financial reporting process, including validation of financial information, review and approval, and distribution.
- Describe some of the key management estimates (i.e. loss reserves, etc.) included within the company's financial reports and describe how they are performed, reviewed and approved.
- Describe the budgeting and planning process.
- Briefly describe the month/year-end close process including manual journal entries and approvals.

- What is the process for adopting/implementing accounting guidance?

Corporate Strategy

- Where is the company headed strategically? What type of plan is in place to implement this strategy? Has it been approved? How is it being monitored?
- What are your plans for retaining and growing business?
- Explain what tools or reports you utilize to make key business decisions.
- How do you identify and manage changes in business conditions?
- Explain any strengths or weaknesses of the company as well as opportunities or threats the company is facing and how the company is responding to each.
- What key measures do you assess to evaluate your company's performance and competitive position?
- If part of a Holding Company:
    - How does the holding company contribute to the company's strategy?
    - How might the holding company be impacted by the company's strategy?
- How often do you discuss corporate strategy with your direct reports?

Other Topics

- Explain any significant turnover in your department.
- How are related party transactions approved and recorded and how are related party transactions disclosed to shareholders?
- Is the accounting department adequately staffed?
- How does the company monitor and assess financing needs as well as access to capital?
- Explain the company's involvement in transactions that include derivative risks?
- Is the company subject to any derivative risks that are not disclosed within Schedule DB of the Annual Statement? If so, please explain.

Interview Questions for the Chief Operating Officer

Note: Several different functions/processes could report to the Chief Operating Officer. Some of these areas have questions outlined within this exhibit (e.g. Underwriter, Actuary, etc.) The examiner will likely need to tailor interview questions for other specific functions that are not included (e.g. Claims Handling, Sales & Marketing, Human Resources, etc.).

Experience and Background

- How has your professional experience and background prepared you to serve as the Chief Operating Officer for this company?

Duties and Responsibilities

- Briefly describe your duties and responsibilities.
- How does management establish objectives and how is the achievement of those objectives monitored?
- How is your performance evaluated? Is it based upon the performance of the company?
- Describe your involvement in regulatory compliance.
- Describe your involvement in the sales and marketing aspects of the company.

Reporting Structure

- Describe the reporting structure of the company including to whom you report as well as those reporting to you.
- Describe your interaction with the CEO and other senior management. Board of Directors.

Ethics

- Does your company have a code of conduct/ethics in place? Is it enforced? Approved?
- Explain management's commitment to ethics and explain how management conveys that commitment to employees.
- When establishing ethics, does the company evaluate what other companies have implemented? If yes, how does the company compare
- Do you have any knowledge or suspicion of fraud within the company?

Risk Areas

- How are key risks faced by the company identified and monitored?
  - What are the key prospective risks the company faces?
  - How are these risks communicated to senior management and throughout the company?
- What key risks do you monitor in your position?
  - What reports or other means do you utilize to evaluate the risks?
- Do you monitor risks relevant to specific components or divisions within the entity?

Risk Mitigation Strategies (Internal Controls)

- How often do you discuss with the audit committee/board of directors how the internal control system serves the company?
- How has the Model Audit Rule affected the company? Holding company?
- What internal controls are in place to mitigate risks in the processes you supervise?

Corporate Strategy

- Where is the company headed strategically? What type of plan is in place to implement this strategy? How does the strategy impact activities within your department?
- Explain strengths or weaknesses of the company as well as opportunities and threats the company is facing and how the company is responding to each.
- What are your plans for retaining and growing business?

- What key measures do you assess to evaluate your company's performance and competitive position?
- How often do you discuss corporate strategy with your direct reports?

Other Topics

- Explain any significant turnover in your department.
- How do you ensure that your department is adequately staffed?
- How often are claims reviews or audits performed and by whom? What are examples of items that would be reviewed during the audit?

Interview Questions for an Internal Auditor

Experience and Background

- How has your experience and background prepared you to serve as internal auditor for this company?

Duties and Responsibilities

- Briefly describe your duties and responsibilities.
- How is your performance evaluated? Is it based on the performance of the company?
- How much of your department's time is allocated to MAR, business process reviews, compliance?
- Do you perform any management or accounting functions?
- How are audit findings communicated to the company? The board/audit committee?
- Please describe any special projects and/or key initiatives.

Reporting Structure

- Describe the reporting structure of the company including to whom you report as well as who reports to you.
- Describe your interaction with the board of directors/audit committee? External auditors? Senior Management?
- How do you monitor/follow up on audit findings? Are findings classified as to significance?

Ethics

- Does the company have a code of conduct/ethics in place? Is it enforced? Approved?
- Explain your commitment to ethics and explain how you convey that commitment to your employees.
- How does your company compare to others in terms of its position on ethics?
- Do you have any knowledge or suspicion of fraud within the company?

Risk Areas

- How are key risks faced by the company identified and monitored?
  - What are the key prospective risks the company faces?
  - How are these risks communicated to your senior management level team and throughout the company?
- What key risks do you monitor in your position?
  - What reports or other means do you utilize to evaluate the risks?
- Do you monitor risks relevant to specific components or divisions within the entity?
- How do you determine what audits to perform and the appropriate scope for those audits?

Risk Mitigation Strategies (Internal Controls)

- How does the internal audit department address the potential for override of internal controls?
- Do you discuss with the audit committee/board of directors how the internal control system serves the company? How often?
- How has the Model Audit Rule affected the company, if at all? Holding company? Internal audit department?
- Describe any internal control issues discussed during the most recent audits.
- Do you review the company's application of accounting guidance?

Corporate Strategy

- Explain strengths or weaknesses of the company as well as opportunities and threats the company is facing and how the company is responding to each.
- What key measures do you assess to evaluate your company's performance and competitive position?
- If part of a Holding Company:
    - How does the holding company contribute to the company's strategy?
    - How might the holding company be impacted by the company's strategy?
- How often do you discuss corporate strategy with your direct reports?

Other Topics

- Explain any significant turnover in your department?
- How do you ensure the internal audit department adequately staffed?
- How are internal audit members hired?
- Are any internal audit functions outsourced?
- Is the company involved in transactions that include derivative risks?
- Is the company subject to any derivative risks that are not disclosed within Schedule DB of the Annual Statement?

Interview Questions for Investment Management

Experience and Background

- How has your professional experience and background prepared you to manage the investments for this company?

Duties and Responsibilities

- Briefly describe your duties and responsibilities.
- How does management establish investment objectives and how is the achievement of those objectives monitored?
- Describe the governance structure over investments?
- Are there written investment guidelines that the company must follow?
  - Do you or others monitor them for compliance?

Reporting Structure

- Describe the organizational structure of the investment function?
- Describe the reporting structure of the company including to whom you report as well as those reporting to you.
- Describe your interaction with the Board of Directors and the CEO.
- What is the composition and role of the investment committee and is that committee independent from operational management?
  - How often do they meet?
  - What are their areas of concern?

Ethics

- Does the company have a code of conduct/ethics in place? Is it enforced? Approved?
- Explain management's commitment to ethics and explain how management conveys that commitment employees.
- Do you have any knowledge or suspicion of fraud within the company?

Risk Areas

- What is the company's risk tolerance for investments and how is that communicated?
- How does the company monitor risks related to investments (interest rate risk, credit risk, etc.)?
- How does the company review its risk/reward tradeoff?
- How does the company determine its asset allocation strategy?

Risk Mitigation Strategies (Internal Controls)

- What is the formal procedure for reporting on risk management to senior management and the board.
- What internal controls exist to ensure adherence to investment policies and procedures?
- How is performance and compliance gauged (both with statutory rules and internal investment policies)?
- Who monitors potential impairment issues?
  - How often?
- What controls and authorizations are in place to transfer money?
  - Are all employees with access to funds bonded?
- Are all transactions approved by senior management?
- How does the company monitor and determine the value for its Schedule BA investments?
- How are assets and liabilities matched at the company?

Corporate Strategy

- Where is the company headed strategically? What type of plan is in place to implement this strategy? How does the strategy impact activities within your department?
- Explain strengths or weaknesses of the company as well as opportunities and threats the company is facing and how the company is responding to each.
- Is the company-wide strategy clearly communicated to the rest of the company by senior management?
  - How does that impact your department goals/activities?
- Explain what tools or reports you utilize to make key business decisions.

Other Topics

- Explain the company's involvement in transactions that include derivative risks?
- Is the company subject to any derivative risks that are not disclosed within Schedule DB of the Annual Statement? If so, please explain.

Interview Questions for Internal Legal Counsel

Experience and Background

- How has your professional experience and background prepared you to serve as legal counsel for this company?

Duties and Responsibilities

- Briefly describe your duties and responsibilities.
- How do you identify any potential legal issues that may arise within the company?

Reporting Structure

- Describe the reporting structure of the company including to whom you report as well as who reports to you.

Ethics

- Does the company have a code of conduct/ethics in place? Is it enforced? Approved?
- Explain management's commitment to ethics and explain how management conveys that commitment to employees.
- Do you have any knowledge or suspicion of fraud within the company?

Risk Areas

- How are key legal and regulatory risks faced by the company identified and monitored?
  - What are the key prospective risks the company faces?
  - How are these risks communicated to your senior management level team and throughout the company?
- Explain any significant (use a pre-determined threshold) lawsuits/legal actions outstanding against the company?
- Are the number of lawsuits fluctuating or remaining constant?

Other Topics

- Has there been any turnover in your department?
- Describe your staff's experience.
- Are any legal functions outsourced? How are those functions monitored?

Interview Questions for Chief Risk Officer

Experience and Background

- How has your professional experience and background prepared you to serve as the Chief Risk Officer for this company?

Duties and Responsibilities

- Briefly describe your duties and responsibilities.
- How does your role/function relate to, or how is it integrated with SOX/MAR processes, internal audit, or other departments?
- Describe the major projects taking place and how you divide your departments time (i.e. what are the areas of focus)?
- Do you publish reports/findings?
  - Who do they go to?

Reporting Structure

- Describe the reporting structure of the company including to whom you report as well as who reports to you.
- Is there a board-level committee or other group that you report to?
  - Is that group independent from your area of management?
  - What is their role and how do you interact with them?
- Describe those who have been involved (your team, internal audit, operational areas, consultants, external auditors, etc.) and their roles in the MAR compliance process.
- Are there any financial ties to company profits within your compensation package?

Ethics

- Does the company have a code of conduct/ethics in place? Is it enforced? Approved?
- Explain management's commitment to ethics and explain how management conveys that commitment to employees.
- When establishing ethics, does the company evaluate what other companies have implemented? If yes, how does the company compare
- Do you have any knowledge or suspicion of fraud within the company?

Risk Areas

- How are key risks faced by the company identified and monitored?
  - What are the key prospective risks the company faces?
  - How are these risks communicated to your senior management level team and throughout the company?
- Do you monitor risks relevant to specific components or divisions within the entity?
- What key risks do you monitor in your position?
  - What reports or other means do you utilize to evaluate the risks?
- What is the company's plan for operating in crisis/disaster - business continuity?

Risk Mitigation Strategies (Internal Controls)

- What is the formal procedure for reporting on risk management to senior management and the board?
- What is your company's plan for operating in crisis/disaster – business continuity?
- From a strategic perspective, how are risks addressed across all business units and entities?
- How has the Model Audit Rule affected the company, if at all? Holding company? Internal audit department?

- Does the organization structure allow for proper segregation of duties?
- What internal controls exist to ensure adherence to company policies and procedures? Regulatory procedures?
- What procedures are in place to diversify risks?
- What strategies are used for managing the most significant risks facing the company?
- Are executive officers and management team members required to disclose personal business or family relationships with organizations your company invests in?
- Describe any compliance related training conducted by the organization?
  - Is the training required?
- Are quality reviews performed by internal auditors or other means within the company?
- How are goals set and performance evaluated?
  - How is that linked to responsibility and accountability?
  - How does all of that impact the divisional level?
- What is the nature and extent of incentive compensation throughout the company?
  - How are risks related to compensation identified, monitored, and mitigated?

Corporate Strategy

- Explain strengths or weaknesses of the company as well as opportunities and threats the company is facing and how the company is responding to each.

Other Topics

- Do you have an organizational-wide integrated risk management framework?
- Explain the company's involvement in transactions that include derivative risks?
- Is the company subject to any derivative risks that are not disclosed within Schedule DB of the Annual Statement? If so, please explain.

Interview Questions for Underwriting

Experience and Background

- How has your professional experience and background prepared you to serve as an underwriter for this company?

Duties and Responsibilities

- Briefly describe your duties and responsibilities.
- Describe the company's book of business.
  - Program business, treaty, facultative
  - Mix of property/liability
  - Mix of excess/quota share
- Are there written underwriting guidelines that the company must follow?
  - Do you or others monitor them for compliance?
  - Do you have a written best practices checklist which includes quality standards?
- How do you monitor regulatory compliance?
- How do you evaluate your staff?
- Describe how your underwriters' skill levels are developed?

Reporting Structure

- Describe the reporting structure of the Underwriting Department including to whom you report as well as those reporting to you.
- Is there an underwriting committee?
  - How is it organized and who are its members?
- Describe your interaction with the CFO/CEO/BOD?
  - Do you provide them with any specific reports?

Ethics

- Does the company have a code of conduct/ethics in place? Is it enforced? Approved?
- Explain management's commitment to ethics and explain how that commitment is conveyed to employees.
- Do you have any knowledge or suspicion of fraud within the company?
- Does the company require ethics training for underwriters and brokers?

Risk Areas

- How are key risks faced by the company identified and monitored?
  - What are the key prospective risks the company faces?
  - How are these risks communicated to your senior management level team and throughout the company?
- What key risks do you monitor in your position?
  - What reports or other means do you utilize to evaluate the risks?
- Describe the development and approval process for new products?
- What are the underwriting authorization levels.
- Which lines of business performed well/poorly in the past?
- What percent of your cases are automatically underwritten vs. manually underwritten?
- How do you determine if you are you underwriting the cases you should?
- Give a general description of product pricing.

Risk Mitigation Strategies (Internal Controls)

- How does the company ensure that correct contractual language and rates are used?

- What controls are in place to ensure underwriting guidelines are followed?
- How are brokers monitored to ensure compliance with underwriting standards?
- How often are underwriting audits performed and who performs them?
- How do you ensure that what is underwritten gets entered as premium correctly?
- How does the underwriting function fit into the overall corporate strategy?
- Do you have a documented procedure for following actual loss to expected loss ratios?
- What reports do you use to monitor underwriting activity?
- How is premium adequacy maintained?

Corporate Strategy

- Where is the company headed strategically? What type of plan is in place to implement this strategy? How does the strategy impact activities within your department?
- Explain strengths or weaknesses of the company as well as opportunities and threats the company is facing and how the company is responding to each.
- Explain what tools or reports you utilize to evaluate underwriting decisions.
- What key measures do you assess to evaluate the company's performance and competitive position.

Other Topics

- Explain any significant turnover in the underwriting department.
- Explain the distribution channels used by the company.
- What is the compensation/commission structure for each distribution channel?
- How do you ensure that your staff is handling an appropriate number of cases?

Interview Questions for the Chief Actuary

Experience and Background

- How has your professional experience and background prepared you to be the Chief Actuary for this company?

Duties and Responsibilities

- Briefly describe your duties and responsibilities.
- How does management establish objectives and how is the achievement of those objectives monitored?
- How is your performance evaluated? Is it based on the performance of the company?

Reporting Structure

- Describe the reporting structure of the actuarial function including to whom you report as well as those reporting to you.
- Is there a reserving committee?
  - How is it organized and who are its members?
  - How are differences resolved?
- Describe your interaction with the CFO/CEO/BOD?
  - Do you provide them with any specific reports?
- Do the Board/Audit Committee members demonstrate an understanding of the variability inherent in the reserves?

Ethics

- Does the company have a code of conduct/ethics in place? Is it enforced? Approved?
- Explain management's commitment to ethics and explain how that commitment is conveyed to employees.
- Do you have any knowledge or suspicion of fraud within the company?

Risk Areas

- How are key legal and regulatory risks faced by the company identified and monitored?
  - What are the key prospective risks the company faces?
  - How are these risks communicated to your senior management level team and throughout the company?
- Have there been changes in the appointed actuary in recent years, and, if so, how often have such changes occurred and why?
- What is the current reinsurance program? Describe any changes over the past 5 years?

Risk Mitigation Strategies (Internal Controls)

- What is the formal procedure for reporting on risk management to senior management and the board.
- What controls are in place to ensure reserving guidelines are followed?
- Who determines what reserves will be booked in the financial statements quarterly? Annually?
  - Does the company book to the actuary's point estimate, or is there a monitored gap?
- How often are full reserve analyses performed?
- Does the company book to the actuary's point estimate, or is there a monitored gap?
- Is the actuarial opinion signed by a company actuary or a consultant?
- Does the company use commercial software or "homegrown" spreadsheets? What controls are in place to check for errors?
- How are pricing and underwriting monitoring integrated into the reserving process?
- Is there a peer review of the reserving actuary's work and who performs it?

- How much reliance does the Appointed Actuary place on the work of others?

Corporate Strategy

- Give a general description of the company's reserving philosophy.
- Explain what tools or reports you utilize to evaluate actuarial decisions.

Other Topics

- What is the quality of the Actuarial Report with respect to completeness and clarity of documentation?

Phase 1: Part 2 Understanding the Corporate Governance Structure
(Pg 1-25 of 2009 Handbook)

Management
Interviews with senior management at the "C" level may be used at the beginning of the examination or at any time during the examination as necessary. "C" level management may include the CEO (Chief Executive Officer), CFO (Chief Financial Officer), COO (Chief Operating Officer), CIO (Chief Information Officer), CRO (Chief Risk Officer), Controller, Chief Actuary or other appropriate executive level management. Examiners should consider the size of the organization in determining which individual would provide the examiner with the most beneficial information regarding the company for the stage of the examination. This interview process is a key step in the top down approach, beginning with senior management and then drilling down through the various levels of management to obtain a thorough understanding of the organization to assist in scoping the examination. Topics of these high level interviews should include, but not be limited to (1) corporate strategic initiatives, (2) external/environmental factors of concern to management, (3) political/regulatory changes that may affect business, (4) competitive advantages/disadvantages, (5) management of key functional activities, and (6) how management establishes and monitors the achievement of objectives.

The examiners should consider which individuals should be interviewed and the sources of data to be evaluated to complete each planning step. In order to select the individuals to interview, the examiners should obtain an organizational chart from the company and compile a list of potential interviewees. Interviews should not be limited to the accounting department personnel. The interview list should also include managers of key functional business units (depending on the company structure, lines of business or revenue centers may be more appropriate). As all companies have different organizational structures, it is important that the interview schedule and the examination plan match the company. The examiner should form their objectives, or what they want to get out of the interview, prior to conducting the interview. In order to accomplish this the examiner should have a basic knowledge of the job function of the person that they are interviewing so that they can ask relevant questions and get the most information possible in one setting, as it is may be difficult to coordinate multiple contacts with a "C" level interviewee or a member of the board of directors. The information maintained in Exhibit Y - Examination Interviews provides some basic questions that an examiner may consider when performing "C" level interviews. Exhibit Y, however, does not provide examples for functional positions at the insurer (e.g. Claims Handling, Sales & Marketing, etc.). These functional interviews are typically best documented in a narrative format and may be done in conjunction with walkthroughs or other control documentation procedures. ~~For additional information on conducting examination interviews, see Exhibit Y - Examination Interviews.~~

Handbook Reorganization

Included for reference in this document are the **Original Table of Contents**, from the 2009 Handbook and the **Revised Table of Contents** which is being proposed for the 2010 Handbook.

It has been proposed that the information in the Handbook be reorganized in order to improve the flow and ease of use. This reorganization has been completed and rather than including the entire Handbook for exposure the Original Table of Contents and Revised Table of Contents have been provided for comparison. A quick overview of each of the changes within the reorganization is provided below.

Introduction
There were no changes to the introduction section itself; however, in the 2010 Handbook the Introduction will be broken out into its own section prior to the start of actual guidance in "Section 1" of the handbook.

Section 1 - General Examination Guidance
This is, in large part, Section 3 - "Examination Administration" from the 2009 Handbook. It was determined that most of the information in this section was information that the examiner should know prior to getting into the actual phases of the risk-focused examination.

Part 1 - Association Examinations - No changes

Part 2 - Scheduling Financial Condition Examinations - No changes

Part 3 - General Examination Considerations - Previously Section 3, Part 3 "Conducting Examinations" in Original Table of Contents.

Though some of the sub-letters have been relocated within Part 3 they remain the same with the exception of the following:

Letter C – Examination Sampling, has been added as a general exam consideration. The information contained in C has been taken from Section 5 of the 2009 Handbook without change. The worksheets included in the 2009 Section 5 have been included as Exhibit O for the 2010 Handbook.

Letter H – Comments and Grievance Procedure Regarding Compliance with Examination Standards, was moved from the 2009 table of contents Part 5 of Section 3.

Part 4 - Standard Examination Procedures - Formerly Letter B - General Examination Procedures under Part 3 - Conducting Examinations. The 2009 guidance had General Exam procedures

broken down into the sub bullets shown on the 2010 table of contents. This information was pulled out to highlight the importance of the standard procedures that need to be completed for each exam so it will be its own part within Section 1 for the 2010 Handbook.

All of the lettered sections within Part 4 are the same as those originally listed under that part on page 3-29 of the 2009 Handbook except for Reinsurance Review which has been moved down in the 2010 table of contents to be its own part, which is the next part (Part 5) under Section 1.

Part 5 - Reinsurance Review - Previously Section 6 of the 2009 TOC. The 2009 Reinsurance section gave a lot of background and basic reinsurance education. This format wasn't really consistent with the rest of the Handbook format so all of the extra educational pieces were removed and the relevant exam related information was maintained in this part. There were previously 11 sections under reinsurance and that has been condensed down to just four sections in the 2010 handbook. The eliminated, educational portions of the 2009 Reinsurance guidance will be maintained online for easy reference.

Part 6 - Reporting Examination Progress and Findings - No changes

Section 2 - Examination Phases
Previously Section 1 in the Original Table of Contents

Section 3 - Examination Repositories
Previously Section 4 in the Original Table of Contents - will include only the new exam repositories in 2010

Section 4 - Examination Exhibits
Previously Section 2 - will be at the end of the book to maintain logical order.

NOTE: The revised table of contents does not have page numbers. A numbering system change from the current system (i.e., 1-1, 1-2, 1-3, etc.) to a straight forward numbering system, (i.e. 1,2,3) will be implemented upon completion of the 2010 Handbook and page numbers will be added at that time.

INDEX OF CONTENTS

SECTION 2 — EXAMINATION PHASES

SECTION 3 — EXAMINATION REPOSITORIES

KEY ACTIVITIES RELATING TO:

SECTION 4 — EXAMINATION EXHIBITS

C. Consideration of Small/Medium-Sized Insurers

For many small-to-medium sized insurers, appropriate segregation of duties to mitigate identified inherent risks may not exist. This generally is due to the costs associated with employing a sufficient number of employees. Therefore, a small or medium sized company might achieve its control objectives in a different manner than a large insurer. For example, a small or medium sized entity may place more reliance on its control environment and monitoring procedures than specific control activities.

The extent of internal control documentation included in the workpapers is influenced by the nature, size, and complexity of the entity and its environment. There are many levels of documentation that may exist for an insurer's controls. For public companies there is typically extensive SOX documentation available. For large, non-public insurers, controls may be documented through management's assessment of internal controls as required by the Model Audit Rule (MAR). For those insurers who are not required to fully comply with SOX or MAR, an annual financial statement audit would still be required. Under the Statements of Auditing Standards (SAS), required by the AICPA, controls must be documented and reviewed by the external auditor during the financial statement audit. If the insurer does not fall under any of the above situations, they may still have internal controls documented by company personnel, internal auditors or others.

Although extensive documentation of insurer controls makes an exam more effective and efficient, unwritten policies and procedures may still be effective if they have been adequately communicated and implemented. Whether policies and procedures are written or not, they must be implemented thoughtfully, conscientiously, and consistently in order to be effective. Controls that are not documented may be tested in a similar manner as if the controls were documented. Examiners should not automatically default to performing only detail testing when documentation is not available. Regardless of the documentation available, the examiner should determine whether controls are in place and mitigating the identified risks. Examiners may still realize examination efficiencies through control testing even in situations where no, or limited, documentation is available. All of the aforementioned sources of documentation may be useful to examiners in documenting their understanding of controls; however, in situations where control information is not documented or readily available, examiners should not create documentation of the controls themselves, but rather, document their understanding of controls. This understanding may consist of only a few simple sentences describing how the company mitigates each identified risk.

If, after prudent inquiry, the examiner is unable to ascertain what controls exist at an identified risk level, the examiner should provide a brief narrative describing the general controls that exist for each sub-activity (or, if not possible, each key activity). Under these circumstances, control testing would not be required because obtaining sufficient evidence of risk mitigation would not be likely to reduce the inherent risk(s). As such, an overall control rating of weak should be assigned to the identified risk(s). The examiner would then include a reference to documentation that would support this assessment. The examiner should follow-up and report on any key controls noted during the examination that are determined to be deficient. When appropriate, comments should be included in the examination report, Insurer Profile Summary, supervisory plan and management letter for follow-up by the financial analysts and examiners.

After documenting an understanding of controls, there may be situations in which examiners determine that it would not be cost effective or efficient to perform control testing. Although the risk-focused approach provides examiners with the flexibility to make this determination, the examiner should still focus examination efforts on those areas perceived to have a higher degree of risk. For these situations, the examiner may eliminate control testing and assess an overall control rating of weak for the identified risk(s).

8. Review of Subsequent Events

Some events or transactions that occur after the balance sheet date may have an important bearing on the financial statements. If it is determined that a subsequent event is material to the financial statements the examiner should consider whether the condition existed: (1) at the balance sheet date, (2) after the balance sheet date but prior to the issuance of the financial statements or (3) after the balance sheet date and subsequent to the issuance of the financial statements.

For those subsequent events that provide additional evidence about conditions that existed at the balance sheet date that are not reflected by the values reported in the financial statements, an examination adjustment should be made by the examiner.

For those subsequent events that provide evidence about conditions that did not exist at the date of the balance sheet but developed prior to the issuance of the insurer's financial statements, a footnote disclosure is not required; however, if the undisclosed subsequent event could make the financial statements misleading, a description of the event and an estimate of the financial effect of the subsequent event should be disclosed in the footnotes to the examination report. The same treatment should be used for subsequent events where no evidence of the condition existed until after the insurer's financial statements were issued. No examination adjustments would be required in these situations since the condition did not exist at the balance sheet date. As long as the insurer used sound judgment at the time of the issuance of the financial statements regarding the subsequent event, that future condition should not be used to determine the values at the 'as of' date on the balance sheet.

Specific procedures related to the review of subsequent events can be found in~~The "~~ Exhibit P - Review of Events Subsequent to the Balance Sheet Date.~~" Checklist (Exhibit P) covers the procedures that should be used in all examinations.~~

EXHIBIT P -
REVIEW OF EVENTS SUBSEQUENT TO THE BALANCE SHEET DATE

Company_____Examination Date_____Approved by_____

Generally, the period of review of post-balance sheet events extends from the date of the balance sheet to the date of the examination report, which in most cases is the date of substantial completion of the fieldwork. It is usually not possible; however, to extend all procedures to the same date. If delivery of the examination report is unduly delayed, consideration should be given to extending the review to a later date.

The workpaper should contain specific information as to the scope of the investigation of subsequent events and the consideration given to each of them. Procedures related to subsequent events that extend into the subsequent period include, but are not necessarily limited to, the items described below.

	Performed By	Date
1. Scan cash receipt records for evidence of proceeds of loans, significant sales of productive assets or other unusual items. Amounts over $_____ Date through _____		
2. Scan cash disbursement records for unusual payments and payment of liabilities not recorded as of balance sheet date. Amounts over $_____ Date through _____		
3. Review general journal entries for entries that would have a material effect upon the financial statements as of the balance sheet date. Amounts over $_____ Date through _____		
4. Read minutes of meetings to directors, stockholders and important committees up to the report date. If minutes have not been prepared, obtain a written representation from the secretary about matters dealt with at such meetings. Review draft (if any) of proxy statement to be issued to shareholders for matters that may affect the financial statements.		
5. Read latest available interim financial statements. Compare them with the financial statements being reported on and obtain explanations for any unusual items noted as a result of the comparison. Amounts over $_____ Date through _____		

	Performed By	Date
6. Inquire of officers and other executives having responsibility for financial and accounting matters as to whether the interim statements have been prepared on the same basis as that used for the statements under examination. (Indicate identity of statements and periods covered.)		
7. Inquire of officers and other executives having responsibility for financial and accounting matters (limited where appropriate to major locations) as to: (Note: Indicate persons with whom discussions were held and date and attach memoranda or comments regarding significant matters discussed. Corporate office inquiries should extend to the report date.) a. Whether any substantial contingent liabilities or commitments existed at the balance sheet date or at the date of inquiry. b. Whether there were any significant changes in capital stock or debt to the date of inquiry. c. The current status of items in the financial statements being reported on was accounted for on the basis of tentative, preliminary or inconclusive data. d. Whether any other matters had occurred that would materially affect the financial statements or operations of the company. This includes appropriate inquiries as to subsequent events of material affiliates accounted for by the equity method. e. Whether the company is complying with the requirements set forth in SSAP No. 9 with regard to the treatment of subsequent events.		
8. If the above procedures produce responses that significantly affect the financial statements, they should be confirmed in writing. This may be done in the letter of representation.		

EXHIBIT M -
UNDERSTANDING THE CORPORATE GOVERNANCE STRUCTURE

The purpose of this exhibit is to assist the examiner in documenting the understanding and assessment of an insurer's board of directors, senior management, organizational structure and a review of the ~~management~~risk-management function. A favorable overall assessment of governance does not, by itself, serve to reduce the scope or extent of examination procedures; rather, specific governance controls need to be assessed for their adequacy of the management of specific risks, in conjunction with other controls designed to manage the same.

A. ASSESSING THE BOARD OF DIRECTORS

An assessment of the board of directors may be determined through discussions with the board of directors and through gaining an understanding of the board's oversight role. As a general guideline, the following areas should be considered in the assessment of the board of directors:

1. Are membership criteria and terms for the board of directors sufficient to enable the effective monitoring and oversight of management?

2. Does the board of directors effectively monitor and oversee management activities?

3. Is the board of directors sufficiently independent from management, such that, when necessary, difficult and probing questions are raised?

4. What is the frequency and timeliness with which meetings are held with chief financial and/or accounting officers, internal auditors and external auditors?

5. Is the information provided to the board of directors or committee members sufficient and timely enough to allow monitoring of management's objectives and strategies, the entity's financial position and operating results, and terms of significant agreements?

6. Is there a formal process through which the board of directors or audit committee is apprised of sensitive information, investigations and improper acts (e.g., travel expenses of senior officers, significant litigation, investigations of regulatory agencies, defalcations, embezzlement or misuse of corporate assets, violations of insider trading rules, political payments, illegal payments) sufficiently and in a timely manner?

An active and effective board of directors, or underlying committee, provides an important oversight function. In addition, because of management's ability to override system controls, the board of directors plays an important role in ensuring effective internal control, setting the "tone at the top" and setting other management standards that may affect the risk analysis for the company's activities. Key components include:

1. Independence from management, such that, when necessary, difficult and probing questions are raised. For example, consider whether:
    a. The board of directors constructively challenges management's planned decisions (e.g., strategic initiatives and major transactions) and probes for explanations of past results (e.g., budget variances).
    b. A board of directors that consists solely of an entity's officers and employees (e.g., a small corporation) questions and scrutinizes activities, presents alternative views and takes appropriate action if necessary.

2. The use of board committees, where warranted, by the need for more in-depth or directed attention to particular matters. For example, consider whether:
    a. Board committees exist.

b. They are sufficient, in subject matter and membership, to deal with important issues adequately.

3. The knowledge and experience of directors. For example, consider whether:
   a. Directors have sufficient knowledge, applicable industry experience and time to serve effectively.

4. The frequency and timeliness with which meetings are held with chief financial and/or accounting officers, internal auditors and external auditors. For example, consider whether:
   a. The audit committee meets privately with the chief accounting officer and internal and external auditors to discuss the reasonableness of the financial reporting process, system of internal control, significant comments and recommendations, and management's performance.
   b. The audit committee reviews the scope of activities of the internal and external auditors annually.

5. The sufficiency and timeliness with which information is provided to the board of directors or committee members, to allow monitoring of management's objectives and strategies, the entity's financial position and operating results, and terms of significant agreements. For example, consider whether:
   a. The board of directors regularly receives key information, such as financial statements, major marketing initiatives, significant contracts or negotiations.
   b. Directors believe they receive the proper information.

6. The oversight in determining the compensation of executive officers and head of internal audit, and the appointment and termination of those individuals. For example, consider whether:
   a. The compensation committee approves all management incentive plans tied to performance.
   b. The compensation committee, in joint consultation with the audit committee, deals with compensation and retention issues regarding the chief internal auditor.

7. The board's role in establishing the appropriate "tone at the top." For example, consider whether:
   a. The board and audit committee are involved sufficiently in evaluating the effectiveness of the "tone at the top."
   b. The board of directors takes steps to ensure an appropriate "tone."
   c. The board of directors specifically addresses management's adherence to the code of conduct.

8. The actions the board of directors or committee takes as a result of its findings, including special investigations as needed. For example, consider whether:
   a. The board of directors has issued directives to management detailing specific actions to be taken.
   b. The board of directors oversees and follows up as needed.

B. UNDERSTANDING THE ORGANIZATIONAL STRUCTURE

The organizational structure should not be so simple that it cannot adequately monitor the enterprise's activities nor so complex that it inhibits the necessary flow of information. Executives should fully understand their control responsibilities and possess the requisite experience and levels of knowledge commensurate with their positions. Key components include:

1. The appropriateness of the entity's organizational structure, and its ability to provide the necessary information flow to manage its activities. For example, consider whether:
   a. The organizational structure is appropriately centralized or decentralized, given the nature of the entity's operations.
   b. The structure facilitates the flow of information upstream, downstream and across all business activities.

2. The adequacy of the definition of key managers' responsibilities, and their understanding of these responsibilities. For example, consider whether:
    a. Responsibilities and expectations for the entity's business activities are communicated clearly to the executives in charge of those activities.

3. The adequacy of knowledge and experience of key managers in light of responsibilities. For example, consider whether:
    a. The executives in charge have the required knowledge, experience and training to perform their duties.

4. The appropriateness of reporting relationships. For example, consider whether:
    a. Established reporting relationships – formal or informal, direct or matrix – are effective, and they provide managers information appropriate to their responsibilities and authority.
    b. The management of the business activities has access to senior operating executives through clear communication channels.
    c. The internal audit function reports directly to the board of directors or to the audit committee.

5. The extent to which modifications to the organizational structure are made in light of changed conditions. For example, consider whether:
    a. Management periodically evaluates the entity's organizational structure in light of changes in the business or industry.

6. Sufficiency in the number of employees, particularly in management and supervisory capacities. For example, consider whether:
    a. Managers and supervisors have sufficient time to carry out their responsibilities effectively.
    b. Managers and supervisors work excessive overtime, and are fulfilling the responsibilities of more than one employee.

C. UNDERSTANDING THE ASSIGNMENT OF AUTHORITY AND RESPONSIBILITY

The assignment of responsibility, delegation of authority and establishment of related policies provides a basis for accountability and control, and set forth individuals' respective roles. Key components include:

1. The assignment of responsibility and delegation of authority to deal with organizational goals and objectives, operating functions and regulatory requirements, including responsibility for information systems and authorizations for changes. For example, consider whether:
    a. Authority and responsibility are assigned to employees throughout the entity.
    b. Responsibility for decisions is related to assignment of authority and responsibility.
    c. Proper information is considered in determining the level of authority and scope of responsibility assigned to an individual.

2. The appropriateness of control-related standards and procedures, including employee job descriptions. For example, consider whether:
    a. Job descriptions, for at least management and supervisory personnel, exist.
    b. The job descriptions, or other standards and procedures, contain specific references to control related responsibilities.

3. The appropriateness of staff size, particularly with respect to information systems and accounting functions, with the requisite skill levels relative to the size of the entity and nature and complexity of activities and systems. For example, consider whether:
    a. The entity has an adequate workforce – in numbers and experience – to carry out its mission.

4. The appropriateness of delegated authority in relation to assigned responsibilities. For example, consider whether:
    a. There is an appropriate balance between authority needed to "get the job done" and the involvement of senior personnel where needed.
    b. Employees at the appropriate level are empowered to correct problems or implement improvements, and empowerment is accompanied by appropriate levels of competence and clear boundaries of authority.

D. ASSESSING MANAGEMENT COMPETENCE

A quality assessment of the board of directors and management may be determined through discussions and observations of the governance processes. As a general guideline, the following areas should be included in the assessment of management competence.

1. How long has key management been with the company in their current positions, and what specific industry experience do they have?

2. Has there been significant turnover in management?

3. Have members of management ever been officers, directors, trustees, key employees or controlling stockholders of an insurance company which, while they occupied any such position or served in any such capacity with respect to it:

    a. Became insolvent or was placed in conservation;

    b. Was placed into supervision or rehabilitation;

    c. Was enjoined from or ordered to cease and desist from violating any securities or insurance law or regulation: or

    d. Suffered the suspension or revocation of its certificate of authority or license to do business in any state?

Management Performance Evaluation

1. Does management periodically review information to adequately assess the impact of changes in competition, technology, regulation, environment and general economic trends that may impact the company's business?

2. Does management have adequate financial and operating information to identify trends or variations from budgets that may impact the statutory financial statements?

3. Does management effectively analyze and investigate financial and operating information and trends such that significant adverse trends or misstatements in the Annual Statement could reasonably be expected to be identified and rectified on a timely basis?

4. Do management, supervisors and agents have appropriate knowledge and experience to capably and effectively administer management's policies and procedures?

5. Does the Company maintain effective controls to ensure potential short-term liquidity problems, long-term capital needs, and other significant fund management variations/needs are identified and rectified on a timely basis?

6. Do adequate physical safeguards exist over company assets and are all officers and their employees appropriately bonded (see Exhibit R for assistance)?

7. Does management have a positive attitude toward internal controls (including controls over the information systems)?

8. Does management have adequate financial and operating information to identify, on a timely basis, potential liabilities, commitments, and/or contingencies that may require recording and/or disclosure in the annual statement?

As an expansion of the sample evaluative guidance above, the philosophy and operating style of management will normally have a pervasive effect on an entity. These are intangibles, but one can look for positive and negative signs. Key components include:

1. The nature of business risks accepted, (e.g., whether management often enters into particularly high-risk ventures, or is extremely conservative in accepting risks). For example, consider whether:
    a. Management moves carefully, proceeding only after carefully analyzing the risks and potential benefits of a venture.

2. Personnel turnover in key functions, (e.g., operating, accounting, information systems, internal audit). For example, consider whether:
    a. There have been excessive turnover of management and supervisory personnel.
    b. Key personnel have quit unexpectedly or on short notice.
    c. There is a pattern to turnover (e.g., inability to retain key financial or internal audit executives) that may be an indicator of the emphasis that management places on control.

3. Management's attitude toward the information systems and accounting functions, and concerns about the reliability of financial reporting and safeguarding of assets. For example, consider whether:
    a. The accounting function is viewed as a necessary group of checks and balances, or as a vehicle for exercising control over the entity's various activities.
    b. The selection of accounting principles used in financial statements always results in the highest reported income.
    c. Operating unit accounting personnel also have the responsibility to report to or communicate with central financial officers.
    d. Valuable assets, including intellectual assets and information, are protected from unauthorized access or use.

4. Frequency of interaction between senior management and operating management, particularly when operating from geographically removed locations. For example, consider whether:
    a. Senior managers frequently visit subsidiary or divisional operations.
    b. Group or divisional management meetings are held frequently.

5. Attitudes and actions towards financial reporting, including disputes over application of accounting treatments (e.g., selection of conservative versus liberal accounting policies; whether accounting principles have been misapplied, important financial information not disclosed, or records manipulated or falsified). For example, consider whether:
    a. Management avoids obsessive focus on short-term reported results.
    b. Personnel do not submit inappropriate reports to meet targets.
    c. Managers do not ignore signs of inappropriate practices.
    d. Estimates do not stretch facts to the edge of reasonableness and beyond.

E. REVIEWING THE RISK MANAGEMENT FUNCTION

A review of the entity's risk management function should be conducted through discussions with senior management and the board of directors and through gaining an understanding of the risk management function including inspection of relevant risk management documentation. As a general guideline, the following areas should be considered in ~~assessing~~conducting a review of the risk management function:

1. What kind of risk-management culture is demonstrated throughout the organization? What does the culture indicate regarding the importance of risk- management to the organization?

2. How are risk tolerances and appetites defined and communicated throughout the organization?

3. How are existing risks identified, tracked, assessed and mitigated?

4. How are emerging and/or prospective risks identified, tracked, assessed and managed?

5. How does the organization use the risk information it gathers to determine its capital needs? Are internal models utilized and regularly updated to ensure appropriate risk-management decisions?

6. How are responsibilities for risk-management functions delegated and monitored within the organization?

7. What is the involvement of the Board of Directors in the risk management function of the organization?

An effective risk- management function is essential in providing effective corporate governance over financial solvency. During the latter phases of the risk-focused examination, the examiner will document a review of the entity's individual risk management functions within the system. However, during a review of the entity's corporate governance the examiner should document the review of the entity's risk management function as a whole, as well as its place and importance in the entity's corporate governance structure.

F. DOCUMENTATION

The examination team should document its understanding and assessment of the entity's governance, as well as its assessment on the related impact on the examination. This summary should include a description of any unique examination procedures, including special inquiries that are considered necessary to any significant risks identified as a result of the assessment.

The Risk Assessment Matrix, as the central documentation tool, should be utilized for the identification and assessment of risks. Documentation on the assessment of management is at the discretion of the examiner. For smaller, low-risk insurance companies, a memorandum may be sufficient documentation. For example, a memorandum could summarize the attributes and techniques supporting the examiner's overall evaluation, any resulting examination scope implications, and the approach used to validate the more significant attributes and techniques.

I. ASSOCIATION EXAMINATIONS

The association examination system is not intended to preempt states' legislative and regulatory authority in conducting financial examinations. The association examination system creates a vehicle for conducting financial examinations of multi-state licensed insurers. It allows a representative number of states to adequately plan and devote resources to the financial examination of multi-state licensed insurers. It also allows an independent perspective on examination issues by those participating in the financial examination.

The NAIC officially favors the association plan of examination for all companies licensed (or registered in the case of risk retention groups) in more than one zone or in more than three states in a single zone. Such examinations shall include verification of the payment of taxes by the company to the respective states in which it is licensed, in addition to determining the solvency of the company and the manner in which it conducts its affairs.

In order for these examinations to be accepted by other states, the NAIC Model Law on Examinations states that at least one accredited state participate in each association examination.

The NAIC has adopted the full use of the NAIC Examination Tracking System (ETS) for all examinations regardless of the number of states in which a company is licensed.

The NAIC has adopted the requirement for electronic data processing (EDP) assisted examinations on zone examinations when audit software is compatible with the insurer's hardware. The use of any examination tool, including audit software, is based on a conscious assessment of the risk involved in the reliance on data.

An EDP assisted examination is defined as the use of a software package that will facilitate the examination by providing the capability of direct retrieval of information from company electronic files to achieve:

a. Reliability of information accumulation;

b. Efficiency of information accumulation;

c. Flexibility of information accumulation (i.e., degree of selectivity or comprehensiveness desired); and

d. Expeditious and extensive analysis of data accumulations.

The NAIC has adopted the association plan of examination for rating, advisory, service or statistical organizations operating in more than one zone.

The NAIC has also adopted the association plan of examination for calling examinations of risk retention groups (RRGs), but only to the extent that the other states are notified of an upcoming examination. The Liability Risk Retention Act of 1986 neither requires nor prohibits non-domestic states to participate on examinations of RRGs. Therefore, the domestic state is required to notify the other states of an upcoming examination but is not required to invite the other states to participate on the examination. As a result, the zone coordinator has no necessary role or responsibilities for these exams.

The NAIC zone exam ination s ystem functions i n a ccordance with the policy adopted b y the NAIC and im plemented under the ju risdiction and supervision of the Financial Condition (E) Committee.

The Financial Condition (E) Committee has divided the country into four zones:

STATES BY ASSOCIATION EXAMINATION ZONES

NORTHEASTERN ZONE—ZONE I

Connecticut New Jersey
Delaware New York
District of Columbia Pennsylvania
Maine Rhode Island
Maryland Verm ont
Massachusetts
New Hampshire

SOUTHEASTERN ZONE—ZONE II

Alabama North Carolina
Arkansas Puerto Rico
Florida South Carolina
Georgia Tennessee
Kentucky Virginia
Louisiana West Virginia
Mississippi Virgin Islands

MIDWESTERN ZONE—ZONE III

Iowa Missouri
Illinois Nebraska
Indiana North Dakota
Kansas Ohio
Michigan Oklahoma
Minnesota South Dakota
Wisconsin

WESTERN ZONE—ZONE IV

Alaska Montana
American Samoa Nevada
Arizona New Mexico
California Oregon
Colorado Texas
Guam Utah
Hawaii Washington
Idaho Wyom ing

A. Criteria for Calling Association Examinations

On all association examinations where a company has annual direct premium writings totaling $15,000,000 or more in a zone, based upon the most recent annual statement, or where such writings in a zone are less than $15,000,000 but at least 30% of its aggregate writings are within a zone, such zone shall be invited to participate in the examination (all applicable companies except RRGs) or notified of the examination (RRGs). Although a zone may qualify for participation, the state representing the zone should have a material concern as it relates to the company's operations. The calling state has the authority to challenge zone participation if the zone representative does not have at least 10% of the insurer's annual premium in their respective state or does not have another valid regulatory reason for participation. The valid regulatory reason required for participation could be waived if a state within the zone, which has a valid regulatory reason, grants the participating state the authority to act on its behalf due to a lack of resources. The state representing the zone must receive this authority in writing and it must be presented to the zone secretary for acceptance.

On all examinations of rating, advisory, service or statistical organizations, where members and subscribers have annual direct premium writings totaling $100,000,000 or more in a zone, or where such writings in a zone are less than $100,000,000 but 15% of its writings are within a zone, such zone shall be invited to participate in such examination. Said zone participation shall not be waived by the zone chair without consent of the majority of states in the zone. In the event of such waiver, the examiners participating in such examination shall be considered as representing the states in that zone or zones.

In any other situation, regardless of the amount of premium writings within a zone, upon request of a majority of states within a zone, the zone chair shall designate an examiner to represent the zone in an examination.

Zone participation should focus on insurers and insurer functions that pose the greatest risk exposure. In an effort to reduce examination inefficiencies, a valid regulatory reason should be provided by the state requesting participation in the examination. Valid regulatory reasons for participation include, but are not limited to the following:

1. Material financial concerns exist with the insurer. A concern is "material" if, in light of surrounding circumstances, the magnitude of the item is such that it is probable that the judgment of a reasonable person relying on the statutory financial statement would have been changed or influenced by the inclusion or correction of the item;

2. The insurer is subject to a disproportionately high number of consumer complaints;

3. Specific concerns with potential fraud supported by appropriate documentation;

4. Premium volume, if the insurer writes a material amount of business in the state (at least 10% of the insurer's annual premium must be written in the state requesting to participate). A state that has either a material amount of premium volume or a large percentage of the outstanding loss and loss adjustment expense reserves should be presumed to have a justified interest to participate in the examination; or

5. The calling state requests help due to resource issues. In requesting help, cost should be considered, but is not required to be the ultimate factor in determining whether zone examiners, consultants or contract examiners should be utilized on the exam.

The zone secretary of the state calling the examination has the ability to decline zone participation in the absence of a valid regulatory reason.

EXAMINATION TRACKING SYSTEM E-MAIL
Tracked for Suggested Changes
Risk Retention Group (E) Task Force Subgroup

This notification is to inform the recipient that an examination of the above is being called. This email will automatically be sent to the Financial Chief Examiner.

Detail information, premium schedules, and jumpstart reports are available via I-Site for further financial analysis on the company(ies).

The calling state has indicated that the company has not been granted any permitted practices.

Traditional Life/Health and Property/Casualty Companies:
If the state would like to pursue further information or involvement in this examination(s), please contact the lead state's chief examiner.

If your state would like to participate on this exam, please submit your intent to participate within 10 days.

Risk Retention Groups:
This email is a notification that an examination on the above-referenced company will be performed in the near future. It is not intended to be an invitation to participate on the examination.

W:\Dec09\TF\Examo\Wg\feh\Attachment 4-E.pdf

