INTRODUCTION

Insurance regulation is conducted at an individual state level. Each insurance company has a domiciliary or home state. This is the state in which the company has its corporate charter. This state is the primary regulator of the company.

The mission of state insurance departments is to protect consumers and maintain a healthy industry. This mission is accomplished through a focus on financial solvency of companies and market conduct activities. (The term 'market conduct' is comparable to the OTS term 'compliance'.)

Insurance departments have authority to conduct examinations of any insurance company doing business in the state regardless of where the company is domiciled. Often states work together to conduct examinations of multi-state companies.

State insurance department reports are public information in many states. OTS has entered into information sharing agreements with many states to obtain access to examination reports. Your regional functional regulation coordinator can assist you in obtaining these reports.

Insurance department examination reports (both financial and market conduct) should be requested from the domiciliary state. You should evaluate these reports to determine any potential impact on the holding company or thrift.

STATE STRUCTURE

Companies must be licensed in each state in which they want to sell their products. Most large companies are licensed in each of the lower 48 states and the District of Columbia and often Alaska and Hawaii. (Because Alaska and Hawaii present unique geographic challenges some companies choose not to do business there.) Each state in which a company is licensed also has authority to regulate the company for activities within that state.

Most insurance holding companies own multiple insurance companies. They may all be domiciled in the same state or they may each be domiciled in a different state. In addition, each company may be licensed to do business in a variety of states.

In addition to chartering (domiciliary state) and licensing, states regulate other insurance activities as well. Policy forms, endorsements[1], riders[2] and rates (property/casualty insurance) are subject to regulation as well.

DEPARTMENT STRUCTURE

Most state insurance departments operate as a separate department within state government. In some states, regulation of all financial services has been centralized in one department. In those states the same department or agency regulates insurance, banking and securities with separate sections specializing in each. The departments in Vermont and New Jersey are two states that operate this way.

State insurance departments vary in size from less than 30 to over 1,000 employees. As a result, functions are handled differently from state to state. However, there are several common functions that are performed by all departments:

- Financial condition examinations
- Market conduct examinations
- Financial analysis
- Company licensing and admissions
- Consumer affairs
- Enforcement

[1] Endorsements are forms used to change a standard property/casualty policy to reflect the needs of the policyholder.

[2] Riders are forms used to change a standard life insurance policy to reflect the needs of the policyholder.

- Policy and forms analysis
- Rate filings
- Agent licensing
- Legal

In some smaller states, the same people may perform several functions, such as financial condition examinations and financial analysis. In other, larger states, employee responsibilities are more specialized.

Insurance companies receive the most structured and intensive regulation. In addition to financial and market conduct activity, policy forms, rates and advertising are subject to regulatory oversight.

Pure reinsurers receive significantly less oversight because they do not deal with the general public. These companies deal only with other insurance companies. Both the reinsurer and its insurance company customer are considered to be knowledgeable and less in need of protection.

Due to the large number of agents and brokers, regulation is handled in a different way. All states require licensing after successful completion of an examination. Most states also require continuing education in order to renew licenses.

Although state insurance departments have the authority to conduct financial and market conduct exams of agents at any time, they do not happen on a regular schedule. Most regulation for this group centers on the investigation of consumer complaints. A high frequency of serious complaints or severity of a given complaint may result in either a financial or market conduct examination.

Financial examinations occur every three to five years depending on state law. Most states do not have a specific requirement for the frequency of market conduct examinations. In small states, market conduct examinations are done through complaint investigation.

Insurance regulation historically varied greatly from state to state. During the last decade efforts have been made to strengthen and standardize insurance regulation and procedures from state to state. The passage of Gramm-Leach-Bliley in 1999 increased states efforts in these areas.

State insurance departments are funded in a variety of ways. Insurance department sources of revenues are premium taxes, audit fees, filing fees and licensing fees. In some states, the department receives revenues with the balance in excess of the budget forwarded to the state general fund. In other states, the state treasury receives insurance department revenue, with the department receiving its fund allocation. In general, less than ten percent of the revenue collected by the department is spent on insurance regulation.

GUARANTY FUNDS

Unlike thrifts, insurance companies failures are not covered by any government funded (either federal or state) insurance program.

Insurance companies failures are paid for by the other insurance companies selling business in the state. The mechanism to collect the funds and handle insolvencies is the state guaranty fund. Separate funds exist in each state, one each for property/casualty and life/health insurance.

Guaranty funds step in to make up state mandated shortfalls that may occur in company failures. Typically, policyholders are notified of the date coverage will terminate and their need to find coverage elsewhere. Claims are paid in full, up to a certain dollar amount, depending on the state and type of policy. Most states have maximum amounts per policy that are covered by the funds.

Guaranty funds are not prefunded. Once a state places a company into receivership the guaranty fund steps in. The fund works with the court appointed receiver to determine an estimated shortfall.

Insurance companies who write the same types of insurance in the state are subject to assessment for the failure. Each company is billed in relation to the amount of business it writes in the state. For instance, if an auto insurer is taken into receiver-

ship, the insurance company writing the most automobile insurance in the state will be assessed the largest amount. Receiverships can take many years to resolve.

The Federal Insurance Deposit Corporation (FDIC) advertises the insurance it provides to depositors. State guaranty funds do not. In many states agents are prohibited from discussing the existence of guaranty funds during the sales process. State regulators do not want to encourage consumers to rely on the existence of the fund instead of making informed purchase decisions.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC)

The NAIC, formed in 1871 is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia, American Samoa, Guam, Puerto Rico and the Virgin Islands. The purpose of the NAIC is to assist state insurance regulators in their mission of adequately regulating the insurance industry. The organization focuses on issues that protect consumers and help maintain the financial stability of the insurance industry.

The NAIC is comprised of insurance commissioners and their staff as well as a paid staff of NAIC employees. The organization develops model laws, financial analysis tools, statutory accounting principles, market conduct regulations and examination programs and practices.

The NAIC conducts its work through an elaborate system of committees, working groups and task forces. Groups can be disbanded once objectives are accomplished and new groups are created as issues arise in the industry. At any point in time the NAIC has over 150 different groups in place.

The groups conduct their work through conference calls and meetings. The NAIC meets formally on a quarterly basis to report on its progress and agenda. Most meetings are open to the public.

NAIC MODEL LAWS

The development of model laws is a key contribution of the NAIC. A model law is a draft bill that may be submitted to state legislature. States may modify model laws to meet their specific needs. Model laws typically include input from many states providing the benefit of diverse practices and real world experiences. States have the option of whether or not to use the model laws. State legislatures must pass the law in order to make it effective in the state.

NAIC DATABASE

The NAIC maintains the largest database of insurer financial information in the world. Companies required to file statutory financial statements by the state are usually also required to file the statements with the NAIC. The information becomes part of a database that is used as a basis for examination preparation and financial analysis.

NAIC SOLVENCY AND MARKET CONDUCT PRODUCTS

The NAIC also provides the states with standard financial examination, market conduct, financial analysis and other programs and handbooks, all supported by automated tools and training programs.

Smaller insurance departments are able to use the NAIC manuals and automated tools as a complete system for examinations and analysis. Larger departments often modify the products to meet specific state requirements and staffing needs.

In addition, NAIC staff is available to consult on unusual or complex topics that arise during the course of regulatory activities.

ACCREDITATION PROGRAM

In 1990, the NAIC implemented the Accreditation Program. This program includes the baseline

standards for solvency regulation by state insurance departments. The goal of the program is to improve the quality of regulation. The program includes a mandatory full on-site examination and re-accreditation of the department every five years with interim annual reviews to assure compliance with standards. Departments with inadequate regulations or procedures may lose accreditation. A map showing the current accreditation status of each state is available on the NAIC website (www.naic.org).

Accreditation standards require that insurance departments have adequate statutory and administrative authority to regulate an insurer's corporate and financial affairs. The program also evaluates the adequacy of staff, both in quantity and quality. In addition, the administrative, organizational and personnel practices are reviewed to determine that the department has the organizational ability to be effective.

Accreditation standards include required financial examination procedures and practices, personnel standards and the adoption of certain model laws by the state legislature.

STATUTORY ACCOUNTING PRINCIPLES

Statutory Accounting Principles (SAP) are the accounting rules and methods required by state insurance departments for insurance companies. SAP differs greatly from Generally Accepted Accounting Principles (GAAP).

Differences Between SAP and GAAP

SAP is balance sheet oriented with the emphasis on valuation of assets and liabilities on a liquidation basis. This is quite different than GAAP that has an income statement focus and assumes a going concern and the matching of income with related expense.

SAP is less concerned with matching income and expense time periods and instead recognizes expenses more aggressively and income more conservatively.

SAP is intentionally more conservative than GAAP. It values assets at amounts that could be realized quickly and liabilities at amounts required to satisfy them as though they were immediately due and payable. Because of this sense of immediacy, SAP statements do not use the traditional current and long-term categories often seen on GAAP statements.

An asset under SAP is only an asset if it has been specifically identified in SAP as an asset. Any GAAP asset that is not recognized by SAP is considered a nonadmitted asset. Because total GAAP assets are reduced by the value of nonadmitted assets to reach SAP assets, policyholders' surplus (owners' equity in GAAP) is also reduced by an equal amount.

A nonadmitted asset is an item that does not meet the strict requirements of liquidity for SAP. Examples are, company office buildings, furniture, fixtures, supplies, prepaid expenses and uncollected premiums more than 90 days old. These items are nonadmitted for SAP because it would be difficult to convert them into cash in a short period of time without a loss in value.

SAP also differs from GAAP in its more strict rules for the financial statement recognition of reinsurance, deferred taxes and premium deficiencies.

Because companies are regulated individually by states, SAP is focused on an individual insurance company presentation of results. Unlike GAAP, the concept of consolidated statements does not exist. Combined statements for a group of property/casualty insurance companies can be prepared but may not be all inclusive of all entities in the organization. Combined statements are not prepared for other types of insurers.

The NAIC's role in SAP

SAP is promulgated by the NAIC and is published in its Accounting Practices and Procedures Manual. This manual is for sale to the public. Changes to SAP are typically adopted as of January 1 of the year.

SAP stands separate and apart from GAAP. It has not received Other Comprehensive Basis of Accounting (OCBOA) standing from the American Institute of Certified Public Accountants (AICPA).

A standing committee of the NAIC is charged with reviewing changes to GAAP to determine the applicability and impact on SAP. This is done to address new developments in the world of financial reporting but is not done with the intent that SAP be changed to match GAAP.

SAP statements are prepared on NAIC standard forms called blanks. Statements are prepared for the first three quarters and at year-end. All companies report based upon calendar quarters and a December 31 year-end. The year-end blank is much more detailed than the quarterly blank.

Statutory Financial Statements

SAP statements include a balance sheet, income statement and cash flow statement. In addition, a number of schedules present detailed information regarding investments, claims and reinsurance.

Each major insurance industry has its own specific blanks version. Separate versions exist for property/casualty, life/health, health maintenance organization, dental plans, fraternal organizations and title insurance.

Prescribed and Permitted Practices

The NAIC prescribes SAP. State insurance departments, as the regulatory authority, continue to have the ability to grant companies permission to deviate from SAP. State approved deviations from SAP are considered permitted practices. Companies must include in the Notes to the Financial Statement permitted practices and their impact.

State insurance departments grant a permitted practice for an individual company when prescribed SAP would result in financial reporting that would be inappropriate or misleading for the situation.

SUMMARY

The insurance industry is regulated primarily at the state level. The insurance regulators of the 50 states, the District and the 4 territories developed methods of communicating and coordinating activities through the NAIC and informal channels of communication. This cooperation and communication has resulted in a regulatory system and structure that is consistent in many ways while still providing states the ability to address local concerns.