

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS¹

IMF FINANCIAL SECTOR ASSESSMENT PROGRAM

SELF ASSESSMENT OF IAIS INSURANCE CORE PRINCIPLES²

AUGUST 2009

¹ This self assessment has been prepared by the NAIC for purposes of the IMF's FSAP of the United States and is non-binding, informal and summary in nature. The responses contained herein do not constitute the rules, regulations, interpretations or statements of the NAIC's state insurance regulator members.

² For further information concerning the self-assessment, please contact Ray Spudeck, Florida Office of Insurance Regulation at ray.spudeck@flor.com, or George Brady, National Association of Insurance Commissioners at gbrady@naic.org.

Financial Sector Assessment Program

NAIC Self-Assessment

August 26, 2009

Introduction

The insurance market in the United States is truly unique in the world. In aggregate premium dollar numbers, the U.S. market is number one on a list of the largest jurisdictions in the world based on 2008 data – and actually larger than numbers 2 through 6 combined. However, it is also true that much of the U.S. market is quite localized. There are far more firms writing insurance in the U.S. than in any other economy, and while there are some dominant firms, overall market concentration is less pronounced than in most other economies.

There are, at last count, 7,498 domestic insurers in the U.S. (14.2% life, 34.5% property/casualty, 10.3% health, 1.4% fraternal, 1.2% title, 3.5% risk retention groups, and 34.9% other risk bearing entities.) The vast majority of the business these companies write is in the U.S. - only 6.5% of premium for the U.S. domestic industry is written outside of the U.S. Some of these firms write only a few lines of business, while others are comprehensive providers. Many provide geographic specialization, some write nationally.

There is also a wide variation in market size and complexity across the states. Three individual U.S. states rank in the top 10 jurisdictions worldwide as to premium volume and nine states rank in the top 25. This variation in size and complexity, while not necessarily amenable to a one-size-fits-all approach to regulation, has allowed the U.S. state-based system of regulation to develop and implement best practice tools for a wide variety of insurance firms appropriate for their position in the market.

Logically, this unique market structure has led to the evolution of a similarly unique system of regulatory oversight and supervision. The current state-based system of regulation in the U.S. has been successfully providing sound, cooperative regulation and policyholder protections for 138 years. Indeed, one of the first projects of the newly created National Association of Insurance Commissioners (NAIC) in 1871 was to provide for the consistent valuation of assets for companies writing in more than one state jurisdiction.

As the insurance market has developed and as insurance contracts and some risk bearing organizational structures have become more complex, the state-based system of insurance regulation has continued to evolve in a coordinated, collaborative manner using the NAIC committee structure and processes to ensure the consistent application of best practices across the market. From the codification of uniform financial reporting and the uniform application of risk based capital solvency oversight, to the rigorous peer review process of the NAIC Financial Regulation Standards and Accreditation Program, the collaborative solvency oversight process embodied in the work of the NAIC Financial Analysis Working Group (FAWG), and the lead state supervisory process for multistate companies and groups, the system of state-based insurance regulation continues to develop and implement the tools and regulatory processes necessary to ensure that the promise of the insurance contract to the policyholder will be met. The record speaks for itself.

Information sharing among regulators¹ is a fundamental benefit of the insurance regulatory community that gathers as the NAIC. For well over a decade, the NAIC's FAWG has functioned as a form of peer review

¹ “Regulate” and “supervise” are used interchangeably throughout the Self Assessment to refer to functions performed by the Commissioner and staff of state insurance departments.

and has provided a forum for state insurance regulators to identify, discuss and monitor potentially troubled insurers that are of national significance to determine if appropriate action is being taken. FAWG also reviews and considers trends occurring within the industry to concentrate their efforts on more specific issues, such as a particular segment of the market, product, exposure or other problem that has the potential of impacting the solvency of the industry. In some cases these discussions lead to more focused discussions by specific states, as well as with other functional regulators or regulators of other insurers in other countries. Therefore, FAWG may be analogized to a supervisory college of U.S. insurance regulators to assist and advise appropriate regulatory strategies, methods and actions, as well as to support, encourage, promote and coordinate multi-state efforts in addressing solvency problems and monitoring wider insurance market trends.

The following Self Assessment provides the details of the procedures, processes and implementation of the resulting best practice regulatory standards in place in the U.S. state-based system, and notes how this system has been implemented. U.S. insurance regulators continue to develop and implement improved processes to meet market demands. As noted in the Self Assessment, initiatives relating to principles based reserving, reinsurance modernization, group solvency and other related issues are at the heart of the current priority project identified by the members of the NAIC as the Solvency Modernization Initiative.

The one element of the U.S. perspective on insurance regulation that remains unchanged is the philosophical focus on policyholder protection. The ultimate purpose of insurance regulation is to ensure that the promise conveyed by an insurance entity in its contract with an individual policyholder is a promise that will be honored. With that philosophy, the financial condition of the legal entity offering the contract is paramount; financial relationships between the legal entity and any affiliate organizations within a related group as well as its financial relationships with entities outside the group, while critical to the financial oversight process, are embodied in the focus on the financial condition of the legal entities that, at the end of the day, are the ones making the insurance promise.

IAIS Self-assessment Questionnaire

Introduction

This information applies to all Principles listed below.

Please complete this questionnaire as follows:

- Under each Principle, indicate the level of observance with each criterion (essential and advanced) in the column provided [O for *Observed*, LO for *Largely Observed*, PO for *Partly Observed*, NO for *Not Observed*, and NA for *Not Applicable*).
- The qualitative assessment should contain a discussion of the reasons underlying the assessment. The discussion should include
 - (i) Identifying relevant insurance laws, regulations, practices including supervisory tools and instruments, which apply to each criterion.
 - (ii) Institutional capacity of the supervisory authority to implement relevant rules and practices.
 - (iii) Any other information you consider relevant to the assessment.

Ideally, qualitative assessment should be made for each individual criterion. To facilitate future self-assessment exercises, one should also keep proper records of the workings that lead to the stated assessment.

Summary Self-Assessment: NAIC

Core Principle	Title	Level of Observance* (Please tick one for each Principle)				
		O	LO	PO	NO	NA
1	Conditions for effective insurance supervision	X				
2	Supervisory objectives	X				
3	Supervisory authority	X				
4	Supervisory process	X				
5	Supervisory cooperation and information sharing	X				
6	Licensing	X				
7	Suitability of persons	X				
8	Changes in control and portfolio transfers	X				
9	Corporate governance	X				
10	Internal control	X				
11	Market analysis	X				
12	Reporting to supervisors and off-site monitoring	X				
13	On-site inspection	X				
14	Preventive and corrective measures	X				
15	Enforcement or sanctions	X				
16	Winding-up and exit from the market	X				
17	Group-wide supervision	X				
18	Risk assessment and management	X				
19	Insurance activity	X				
20	Liabilities	X				
21	Investments	X				
22	Derivatives and similar commitments	X				
23	Capital adequacy and solvency	X				
24	Intermediaries	X				
25	Consumer protection	X				
26	Information, disclosure and transparency towards the market	X				
27	Fraud	X				
28	Anti-money laundering, combating the financing of terrorism (AML/CFT)	X				

*(O-Observed, LO-Largely Observed, PO-Partly Observed, NO-Not Observed, NA-Not Applicable)

ICP 1: Conditions for effective insurance supervision

Insurance supervision relies upon

- *a policy, institutional and legal framework for financial sector supervision*
- *a well developed and effective financial market infrastructure*
- *efficient financial markets.*

Financial sector policy framework:

The United States (U.S.) insurance regulatory framework is based upon years of development and revisions to state insurance department statutes, regulations, and regulatory tools. Many of these statutes, regulations and regulatory tools have originated through developments at the NAIC. The NAIC is an organization whose membership consists of the chief insurance regulatory officials of the individual states, the District of Columbia, and the five U.S. territories, and whose purpose is to assist state insurance regulators, individually and collectively, in serving the public interest and achieving insurance regulatory goals in a responsive, efficient and cost effective manner, consistent with the wishes of its members. The NAIC, and its members, have been improving state insurance regulation since the NAIC's formation in 1871.

The NAIC Financial Regulation Standards and Accreditation Program [hereinafter "the Accreditation Program"] sets forth the conditions for effective supervision, including specific statutes, regulations and regulatory tools. The core purpose of the Accreditation Program is to facilitate reliance by states on the core solvency regulation of the state in which an insurer is domiciled. [See Annex A for an Overview of the Accreditation Program.] A summary of the requirements can be found at:

http://www.naic.org/documents/committees_f_FRSA_pamphlet.pdf

The U.S. framework exceeds the requirements of ICP 1 in that the supervisory authorities are regularly reviewed for compliance with the published accreditation standards (similar to how U.S. supervisory authorities examine insurers to validate the effectiveness of internal controls, etc.).

Financial market infrastructure & efficient financial markets:

U.S. insurance regulators believe that one of the reasons the U.S. insurance marketplace has become the world's largest is because the general infrastructure of all business in the U.S. is well-established. This can largely be attributed to a reliable, effective, efficient and fair legal and judicial system where judgements are enforced, as well as high actuarial and auditing standards, both of which are utilized by U.S. insurance regulators. However, U.S. insurance regulators attribute most of the success for the U.S. insurance marketplace to the outstanding legal and regulatory framework that has been established by the states, and through the NAIC, with regard to appropriate and comprehensive legal, accounting and reporting frameworks, as well as regulatory tools which allow proper supervisory evaluation and action where appropriate. The current state-based system of regulation in the U.S. is legally defined by the McCarran Ferguson Act of 1945.

Much of this comprehensive legal and regulatory framework can be observed by reviewing the NAIC's model regulation service publication. This publication contains over 200 model laws and regulations, which have been created by regulators over the years in dealing with various regulatory issues. In addition to this, the 18 most important financial solvency related laws and regulations are those that are required in the Part A: Laws and Regulations Standards of the Accreditation Program. These standards include the use of the NAIC Accounting Practices and Procedures Manual which documents the codification of statutory accounting and disclosure requirements, independent auditor review requirements, and structured actuarial review criteria and methodologies, including public and confidential regulator-only disclosures.

Collectively, the above collection of statutes, regulations and regulatory tools set forth a well developed, efficient and effective financial market infrastructure.

For publicly traded entities, Generally Accepted Accounting Principles (GAAP) and Securities and Exchange Commission (SEC) disclosures and other requirements must also be provided and met.

In addition to the requirements set forth by the SEC, the Financial Accounting Standards Board (FASB) which establishes GAAP (*see* www.fasb.org), the NAIC and the states, professional organizations such as the American Academy of Actuaries and the American Institute of Certified Public Accountants provide technical and ethical standards for their respective practitioners to follow. (*See* www.actuary.org and www.aicpa.org respectively).

Regarding public access to information, the SEC maintains a publicly available EDGAR database (www.sec.gov) of its required annual and quarterly financial statements. Similarly, the NAIC maintains the Financial Data Repository (FDR) database for statutory annual and quarterly financial statements and supplements. The NAIC has a standardized template that insurers must use, along with consistent definitions of terms and inputs, allowing for a very high level of comparability for these statutory financial statements. The public is able to access the non-confidential filings included in the FDR database. In addition, information about insurer complaints is made available to the public through NAIC online tools, as is information on companies under regulatory action. Additional confidential information and filings is available only to supervisory authorities.

Assessment: Observed (O)

ICP 2: Supervisory Objectives

- *The principal objectives of insurance supervision are clearly defined.*

The U.S. insurance regulatory framework is designed to meet two principal objectives - the protection of the insurance consumer and maintenance of solvent insurance companies. The primary function of insurance regulation is to promote the welfare of the public by ensuring fair contracts at fairly administered prices from financially strong companies.

Each U.S. state, district and territory has established an executive branch department or division dedicated to the regulation of insurance. Laws enacted by the legislatures in each jurisdiction govern the conduct of the insurance industry within that jurisdiction, including the requirements to do business in a state (whether as a domestic or foreign insurer), solvency standards, licensing of insurance producers, and trade practice and market conduct requirements. The elected or appointed insurance commissioner, director, or superintendent in each state is charged with enforcing those laws and generally supervising the conduct of the business of insurance within the jurisdiction.²

Generally, state insurance departments are organized around two central areas of regulation - financial regulation and market regulation. Financial regulation encompasses licensing of companies, reporting and financial analysis, capital and surplus requirements, examinations of companies, regulation of reserves and investments, and insolvencies. Market regulation focuses on prevention of unfair trade practices (including unfair claims settlement practices), analysis and approval of policy rates and forms, producer licensing, prevention of unlicensed insurance activities, and consumer complaints and assistance.

Assessment: Observed (O)

² Throughout this self-assessment, the term “Commissioner” will be used for the elected or appointed chief regulatory official of each state, the District of Columbia, or territory.

ICP 3 Supervisory authority

The supervisory authority:

- *has adequate powers, legal protection and financial resources to exercise its functions and powers*
- *is operationally independent and accountable in the exercise of its functions and powers*
- *hires, trains and maintains sufficient staff with high professional standards*
- *treats confidential information appropriately.*

Legal framework & powers:

The state insurance departments have adequate powers, legal framework and financial resources to exercise their functions and powers. Each state has the power to supervise any entity which is transacting insurance as defined by the law; including insurers, reinsurers, captives, health maintenance organizations as well as insurance intermediaries. The comprehensive legal and regulatory framework set forth in state statutes gives each state the power to issue and enforce rules and other regulations and regulatory tools³ by administrative means, take the appropriate actions as and when required, and discharge its supervisory responsibilities effectively.

The Accreditation Program ensures that the states have the necessary laws in place to properly and appropriately regulate the financial solvency of its multi-state domestic insurers. Currently, 49 states and the District of Columbia are accredited. In order to be accredited, a state must have in place various requirements via statute, regulation or administrative practice to provide it with adequate regulatory power to regulate its domestic insurers. These requirements relate to 18 different topics such as examination authority, corrective action and risk limitation. [See ICP 1 (above) and Annex 1]

Independence and accountability:

The state insurance departments, and more specifically the Commissioner and their offices, are granted authority under state statute and regulation by the applicable state legislative body to take various actions which collectively implement the function and powers of the state insurance department. The state insurance department is independent from the applicable state legislative body. The Commissioner is either elected by the general population, or serves at the pleasure of the state governor, who is also independent from the state legislative body. The Commissioner is generally the only employee within the state insurance department whose position is either elected or appointed. Further, the structure and policies of the NAIC foster mutual accountability among the Commissioners.

Although sources of funding vary among the states, the most common method used by insurance departments is a “dedicated funding system” whereby specific amounts are placed in a separate fund established for the insurance department through the state budgetary process. A “quasi-dedicated” funding system is similar, except that the balance at the end of the year returns to the state’s general fund, rather than being carried over to the next fiscal year. In a “general revenue” funding system, all revenue generated by the state insurance department is placed into the state’s general fund. The state legislature then allocates an amount to the insurance department in the normal budgetary process.

³ These tools include, but are not limited to, risk based capital and the various reports produced and provided to the state insurance departments as a result of the various requirements set forth in statutes and regulations.

Insurance departments generate considerable revenues for their respective states. Revenues are based primarily on taxes (premium, retaliatory, franchise and income-based); fees (filing, examination, licensing); and fines and penalties.

Financial resources, human resource and legal protection:

As verified under the Accreditation Program, each state must make an appropriate allocation of its available resources to effectively address its regulatory priorities. This requires the state to hire, train and maintain sufficient staff with high professional standards. This also requires the state to consider the need to hire external specialists for oversight of more complex insurers or areas. Part C of the Accreditation Program specifically addresses the issue of financial and human resources. The three standards in this area address professional development, minimum educational and experience requirements, and the ability to attract and retain qualified personnel. This area is reviewed during an accreditation review to ensure that these standards are being complied with.

(See http://www.naic.org/documents/committees_f_FRSA_pamphlet.pdf for more details)

Confidentiality:

The comprehensive legal and regulatory framework as set forth in statutes, regulations and other regulatory tools gives each state the power to gather and protect confidential information. For example, all states have adopted the *NAIC Model Law on Examinations (Model #390)*, which sets forth these powers as they pertain to most of the financial information that is obtained by states in their function of monitoring the financial condition of insurers. The Accreditation Program also requires that the state insurance department have the regulatory authority to maintain the confidentiality of the information received from these other parties. In this regard, State insurance departments are required to have a documented policy to cooperate and share confidential information with officials of any state, federal agency or foreign country and the NAIC, as long as the other party has the authority and agrees to maintain the confidentiality of the information.

Assessment: Observed (O)

ICP 4 Supervisory process

- *The supervisory authority conducts its functions in a transparent and accountable manner.*

Supervisory process:

Open government is the cornerstone of both U.S. federal and state governmental frameworks. To ensure effective rule, the business of and administration by the government must be open to public scrutiny and oversight. All statutes, rules and regulations that are adopted by U.S. governmental bodies are subject to open, public discussion within the legislative body as well as from members of the public. Laws must be adopted by majority vote in the legislative bodies - with ample opportunity for discussion and receipt of public comment.

Insurance regulators are either elected individually or appointed by elected officials. Regardless of how they come to office, the insurance regulator is accountable to the public for their work in office. All laws, regulations and rules operated under or issued by a state insurance regulator go through a public approval process, either at the legislative or administrative level. Following the Administrative Procedures Acts in place in each jurisdiction, insurance regulators publish their proposed rules or regulation, accept public comments and may hold a public hearing prior to implementation or adoption.

Regulatory actions taken by state regulators are matters of public record and are subject to administrative appeals processes and judicial review where appropriate.

NAIC model laws and regulations are also developed through an open process. Once adopted by the NAIC, members take the model rules or regulation to their state legislative bodies for implementation and adoption - again under an open, legislative process or go through an open administrative process at the insurance department level. The goal of the development of NAIC model laws and regulation is to promote uniformity amongst the states but allow the states to implement individually.

The NAIC has an extensive website for use by regulators, industry, policyholders and others. This website contains a wealth of information on the role of the NAIC, the various Committees, Task Forces and Working Groups within the NAIC and various topics currently being addressed by the NAIC and its member states. The website contains a link to each state and jurisdiction's website. The Commissioner's role, objectives and activities are publically available through these individual department websites.

State insurance regulators are subject to the continuous oversight of both the state governor and the state legislative body. This ranges from issue by issue oversight to full program, service and budgetary review on a regular basis. These insurance regulatory entities regularly report to both their governor and legislative body on their supervisory activities, programs & progress in relation to their specified duties.

Assessment: Observed (O)

ICP 5: Supervisory cooperation and information sharing

- *The supervisory authority cooperates and shares information with other relevant supervisors subject to confidentiality requirements.*

Generally, regulatory information in the U.S. is publicly available unless a specific law calls for confidential treatment. State insurance laws based on NAIC models generally call for confidential treatment of examination and analysis material, as well as certain financial reporting information. Communication and coordination among supervisors has always been an important component of U.S. state based insurance regulation. One of the requirements of the Accreditation Program is that states should allow for the sharing of otherwise confidential documents with the regulatory officials of any state, federal agency or foreign countries, provided that the recipients are required under their law, to maintain confidentiality.

In order to facilitate regular information sharing among U.S. regulators, the NAIC developed and maintained a Master Information Sharing and Confidentiality Agreement (Master Information Sharing Agreement) for its members. The Master Information Sharing Agreement has now been entered into by and between the fifty states, the District of Columbia, Puerto Rico and Guam. The purpose of the agreement is to facilitate the ongoing sharing of confidential regulatory information and to satisfy the requirement in many states that the party receiving confidential information agree in writing to keep such information confidential. The Master Information Sharing Agreement is used to regularly share financial and market conduct examination and analysis material and has been used to support the sharing of information on issues such as broker compensation and disaster reporting. The NAIC FAWG adds another layer of communication and coordination to this framework (please see the description below).

With regard to sharing information with supervisors outside the U.S., the NAIC and European Union (EU) supervisors designed a model information sharing agreement, which has been used as the basis for states entering into agreements with regulators in many jurisdictions, including non-EU jurisdictions. There are many U.S. memoranda of understanding (MoUs) on information sharing in place between insurance regulatory officials. For example, insurance regulatory information sharing agreements exist between: Iowa-Netherlands, California-Germany, Nebraska-Germany, New York-UK, New York-Germany, New York-Taiwan, New York-China, New Jersey-Germany, Florida-Germany and Florida-UK.

The NAIC also engages in regular dialogues with insurance regulators from around the world and has 10 MoUs on Regulatory Cooperation in place, with Brazil, Hong Kong, Russia, Korea, Egypt, China, Iraq, ASSAL (Association of Latin American Insurance Supervisors), Vietnam, and Thailand. The purpose of these MoUs is to help signatory countries' insurance supervisors maintain efficient, fair, safe and stable insurance markets for the benefit and protection of policyholders, by providing a framework for co-operation, increased mutual understanding, and the exchange of information and technical assistance to the extent permitted by applicable laws, regulations and requirements. These MoUs on Regulatory Cooperation also call for engagement in consultations, as appropriate, on mutually agreeable approaches designed to enhance the integrity and efficiency of respective insurance markets and the exercise of insurance market supervisory functions.

Further to this function, the NAIC initiated the International Internship Program in 2004 – since it began, the program has had 91 participants from non-U.S. supervisory authorities participate in the 6-week program, with 23 states having hosted interns to date. In addition, a number of state regulators have participated in international consultations and training sessions to educate insurance and regulatory staff of

other countries worldwide through the coordination of NAIC and often with support from the U.S. Agency for International Development (USAID).

U.S. state insurance regulators have also participated and will continue to participate in supervisory colleges for insurance related entities around the world including, for example, ING, Zurich, Aegon, Swiss Re, AIG, XL Insurance, and Allianz. Further, several U.S. state insurance regulators have also convened an international supervisory college for Berkshire Hathaway. The first meeting of this supervisory college took place in April 2009 and the core members of this college include various U.S. states (Delaware, Maryland and Nebraska) and several non-U.S. supervisory authorities (Australia, Germany and the UK), with the first in-person meeting of this college anticipated to occur in the Spring of 2010.

Many state insurance departments have entered into confidentiality agreements for information exchange with federal agencies and as stated above memoranda of understanding with foreign countries to allow this type of important communication to occur. An example where this type of activity occurs at the NAIC level is the Joint NAIC/Federal Banking and Thrift Regulatory Agencies Forum. On a quarterly basis, NAIC Staff and state insurance regulators meet in a confidential session with Federal banking and thrift regulatory agencies to discuss topics of interest in the insurance and banking industries. Such discussions include the following general topics: 1) a market update on recent industry financial trends per insurer type, 2) legislative developments, and 3) areas of interest with NAIC Committees, Task Forces and Working Groups. These quarterly meetings provide valuable resource contact throughout the year to facilitate and serve as the foundation for other specific regulator requests and information flow that might need to occur.

Financial Analysis Working Group (FAWG)

For over a decade state insurance financial regulators have shared information and ideas by informal means through FAWG under the Financial Condition (E) Committee. FAWG creates a peer review environment for state insurance regulators to:

- 1) Analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled and determine if appropriate action is being taken.
- 2) Interact with domiciliary regulators and lead states to assist and advise as to what may be the most appropriate regulatory strategies, methods, and action(s).
- 3) Support, encourage, promote and coordinate multi-state efforts in addressing solvency problems, including identifying adverse industry trends.

FAWG meets on a routine basis in confidential sessions with the intent of adding further strength to the states' financial monitoring system. Although the insurers typically identified by FAWG have already been identified by the respective states as being potentially troubled, FAWG enhances the states' process by sharing ideas, experience and strategies on how to assist the state of domicile. This often occurs when the state of domicile shares information with FAWG on how the state and/or the insurer are addressing a particular issue. In addition, the discussions that take place between FAWG and the state of domicile are open to the other states where the insurer is licensed which, again, will allow different perspectives to be shared. The activities of FAWG are not limited to individual insurers. FAWG also reviews and considers trends occurring within the industry to concentrate their efforts on more specific issues, such as a particular segment of the market, product, exposure or other problem that has the potential of impacting the solvency of the industry. In some cases, these discussions lead to more focused discussions by specific states, as well as the Working Group's encouragement of the domiciliary regulator(s) to facilitate discussions with other functional regulators or regulators of other insurers in other countries.

Assessment: Observed (O)

ICP 6: Licensing

- *An insurer must be licensed before it can operate within a jurisdiction. The requirements for licensing are clear, objective and public.*

Assessment:

Individual states have statutes that require a company to be licensed before operating in its jurisdiction. To create a national uniform application, the Uniform Certificate of Authority Application (UCAA) was created by the NAIC and all states are accepting the UCAA. The application can be used for all lines of insurance except the Health Maintenance Organization (HMO). A company may need additional authorizations beyond receiving a Certificate of Authority to actually operate a business in some states. These additional state licensing requirements are based on either statutory or state specific requirements developed by the individual state. Specific state licensing requirements are generally available on state web sites or can be readily ascertained by contacting the state insurance department. Each state should be contacted before commencing insurance business to ensure all state requirements have been met.

The lines of business that are permitted to be licensed in a state are defined in each state's statutes. The UCAA application is the most universal licensing form currently being used by the majority of the states; the application information can be used as a basis for all general company licensing requirements in the United States.

The following forms shall be included with a UCAA application: an original executed application form identifying all lines of insurance the applicant is requesting authority to transact and is currently licensed to transact and is transacting in all jurisdictions.

The UCAA application includes a business profile of the applicant. Any other management offices that exercise control over insurance operations in any state in which an applicant is applying for admission must also be included. Additional charts should be provided to depict any operation that is delegated to an affiliate or third party, and any situation where resources are pooled among affiliates.

The plan of operation portion of the business profile presents, in detail, the product lines currently sold and planned by the applicant, the applicant's marketing plan, a description of the applicant's current and expected competition (both regionally and nationally), and a discussion of how each state in which admission has been requested fits into that plan. A verification form and brief questionnaire should accompany the applicant's plan of operation.

The UCAA also requires that the applicant show it meets each state's statutory minimum paid-in capital and surplus requirements. The level of surplus required is determined after considering the applicant's product line, operating record and financial condition. Compliance with the statutorily prescribed minimum surplus requirement may not be sufficient for all applicants.

The UCAA application shall include a copy of the applicant's most recent Annual Statement. A copy of the applicant's actuarial opinion certification must also be included.

The UCAA application includes an audited report, performed by a Certified Public Accountant (CPA) who is not an employee of the applicant. The application shall include the applicant's most recent Report of Examination from the insurance supervisor. If the applicant, its parent or its ultimate holding company, is not publicly traded, the application will also need to include a copy of the applicant's most recent consolidated financial statements, prepared in accordance with U.S. GAAP.

The UCAA application requires the applicant to submit an NAIC Management Discussion Analysis and a Risk-Based Capital Report. Applicants who are members of a holding company system will need to include a comprehensive debt-to-equity ratio statement. A summary of the applicant's reinsurance program, listing all reinsurance agreements and providing a basic explanation of each agreement shall also be included with the application.

The NAIC recently adopted accreditation standards related to company licensing, which will become effective January 1, 2012. The standards relate to a state insurance department's review of an application for initial licensure. The standards will be used to verify that license applications are reviewed in a timely manner and that the insurance department has sufficient, qualified staff to perform this review. Further, the standards require that the state have appropriate and sufficient procedures to perform this review, including an analysis of many of the items discussed above.

Assessment: Observed (O)

ICP 7 Suitability of persons

- *The significant owners, board members, senior management, auditors and actuaries of an insurer are fit and proper to fulfill their roles. This requires that they possess the appropriate integrity, competency, experience and qualifications.*

The suitability of persons principle that significant owners, board members, senior management, auditors and actuaries of an insurer are fit and proper to fulfill their roles and that they possess the appropriate integrity, competency, experience and qualifications is maintained through a number of model laws, regulations and practices in U.S. insurance regulation. The primary processes to ensure the suitability of persons include the company licensing, off-site monitoring and on-site inspection processes.

As part of the license application process for companies, a business character report must be submitted for all officers, directors, key managerial personnel and individuals with a 10 percent or more beneficial ownership in the applicant and the applicant's ultimate controlling parent. Regardless of their source, the report must verify employment, education and military service for the past (10) years. Further, litigation, criminal, Uniform Commercial Code and bankruptcy records must be searched for the past seven (7) years. Typically, at least one business character reference must be obtained for each individual, such as from an attorney, partner or other business associate familiar with the business dealings of the individual. The newly adopted accreditation standards require that the state insurance department review biographical affidavits and perform an assessment of the quality and experience of the ultimate controlling person, proposed officers and directors, appointed actuary and appointed accountant. Some states require additional information including fingerprints and/or biographical affidavits in the license application. States require various degrees of experience to fulfill state seasoning requirements before an insurer can be licensed to conduct business. Time periods may be reduced for special exceptions or if an applicant demonstrates sufficient business experience.

On an ongoing basis, through the reporting and off-site monitoring process, insurers are required to report changes in officers, directors and key managerial personnel. After such changes are reported, supervisors may then request biographical affidavits for newly appointed officers, directors and other key management personnel. Change in the control of an insurance company is subject to a separate supervisory approval process performed during the off-site monitoring process as required by the *NAIC Insurance Holding Company System Regulatory Act (Models #440 and #450)*. Adoption of these two models is required under the Accreditation Program. These models outline requirements whereby the characteristics of the potential acquiring person or entity is evaluated for compliance with fit and proper requirements. The acquiring individual/entity is required to complete the Acquisition of Control Form (Form A) requiring background information of each applicant. The applicants are then reviewed for compliance with suitability requirements before the proposed acquisition is approved by the domestic supervisor.

As part of the on-site inspection process conducted at least once every five years, the suitability of the board of directors, management, auditors and actuaries are assessed. This assessment focuses on the independence, experience and background and ethics of these individuals and functions. A key aspect of the assessment is interviewing individuals to determine suitability. The examination team documents its understanding and assessment of key individuals/functions and considers the impact of this assessment throughout the remainder of the examination process. If deficiencies in the suitability of individuals are identified, the examination team makes recommendations for improvements to the insurer and adjusts its ongoing solvency monitoring of the insurer accordingly. Through increasing reporting requirements, increasing the frequency of examinations, and other means, the regulator can provide a strong incentive for the insurer to make changes in those areas where unsuitable individuals are identified. In addition, in situations where an insurer is deemed to be in a hazardous financial condition, the insurer can be ordered to

correct the situation as outlined in the *NAIC Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition (Model #385)*. Adoption of this model is required under the Accreditation Program. Through this regulation, if an unsuitable person is identified at an insurer, the regulator can make a case to show that the insurer is in a hazardous financial condition and order the insurer to correct this corporate governance deficiency in a manner deemed appropriate by the insurance commissioner.

In addition to the above, the *NAIC Annual Financial Reporting Model Regulation (Model #205)* requires an annual audit of an insurer's financial statements by an independent certified public accountant. Adoption of this model is required under the Accreditation Program. This model outlines independence requirements for the external auditor, prohibits auditors who have committed specific violations from performing insurance company audits and requires the auditor to submit a letter of qualifications indicating their knowledge and experience in the industry to the supervisor on an annual basis. In addition to requirements contained within the model, certified public accountants are subject to their own standards of professional conduct, qualifications and education as required by the American Institute of Certified Public Accountants and each state's board of accountancy.

In support of both the off-site monitoring and the on-site inspection process, requirements as to the integrity, competency, qualifications and experience of the company's appointed actuary are included in the *NAIC Actuarial Opinion and Memorandum Regulation (Model #822)* for Life Insurers and in the *NAIC Annual Statement Instructions for Property & Casualty Insurers*. Adoption of these two items is required under the Accreditation Program. This guidance requires insurers to utilize an appointed actuary who is a member in good standing with either the American Academy of Actuaries or the Casualty Actuarial Society, each of which outline their own standards of professional conduct as well as qualification and education requirements. In addition, the guidance prohibits actuaries who have committed specific violations from acting as the appointed actuary.

Assessment: Observed (O)

ICP 8: Changes in control and portfolio transfers

The supervisory authority approves or rejects proposals to acquire significant ownership or any other interest in an insurer that results in that person, directly or indirectly, alone or with an associate, exercising control over the insurer.

- *The supervisory authority approves the portfolio transfer or merger of insurance business.*

Changes in Control

All states and the District of Columbia have adopted substantially similar language found within the NAIC *Insurance Holding Company System Regulatory Act (Model #440)* (“the Holding Company Act”) and its related Regulation (Model #450) regarding change of control for any licensed insurer. These models are required for accreditation purposes. The Holding Company Act clearly defines “control” and requires potential controlling owners to receive regulatory approval for changes in control (Form A). It specifies minimum financial and non-financial requirements for resources and requires that background information on applicants be provided. In addition, there are requirements to ensure adequate competition and to make sure that policyholders are not adversely impacted, by changes in control. Within the Holding Company Act, regulators have clear criteria for denying a change in control. More specifically, the Holding Company Act provides that regulators can deny an application for change of control, for any of the following:

(a) After the change of control, the domestic insurer referred would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(b) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in the state or tend to create a monopoly;

(c) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;

(d) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(e) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

(f) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

The Holding Company Act requires annual filings regarding the holding company system and detailing intercompany contract terms and relationships (Forms B&C). The Accreditation Program requires that the state insurance department adequately and timely analyze these filings. In addition, virtually all intercompany contracts must be filed with the state insurance department for review. The state insurance department must also be informed of major transactions, including material changes to reinsurance contracts. The following transactions require notification: major transactions and investments, major changes in reinsurance, management agreements, and requests for extra-ordinary dividends.

The NAIC recently adopted accreditation standards related to change in control and these standards will become effective January 1, 2012. The standards relate to a state insurance department’s review of the Form A filing. The standards will require that the filing be reviewed in a timely manner and that the department have sufficient, qualified staff to perform this review. Further, the standards require that the state have appropriate and sufficient procedures to perform this review, including an analysis of many of

the items discussed above. It also requires use of the Form A database, which is a communication tool on these filings used by the state insurance department to collect and organize information.

Portfolio transfer

U.S. insurance regulators possess authority to review portfolio transfers through several statutory sources. The Holding Company Act requires that the domestic state insurance department must be notified of major transactions with affiliated entities, which would include material portfolio transfers between related parties. Assumption reinsurance and bulk reinsurance statutes establish thresholds by which material transfers of all or most of an insurer's business, either in total or within a specific line of business, are subject to review and approval. In some cases, such transfers may be subject to approval by non-domestic state regulators. Also, state laws concerning the cancellation and non-renewal of an entire book of business or specific line of business may require the insurer to provide notice and/or seek approval from state regulators for transfers of business. Insurers are also required to provide notice to their policyholders of such transfers. Finally, the NAIC *Disclosure of Material Transactions Act* (Model #285) requires insurers to report to its domestic regulator other significant asset and reinsurance transactions that otherwise may not have been subject to approval. These approval and notification requirements may prompt additional inquiry and assessment by regulators and possibly disapproval of such transactions.

Assessment: Observed (O)

ICP 9: Corporate governance

- *The corporate governance framework recognizes and protects rights of all interested parties. The supervisory authority requires compliance with all applicable corporate governance standards.*

The Core Principle states that the relevant supervisory authority should require “compliance with all applicable corporate governance standards.” The principle also recognizes that the Board of Directors (Board) is the focal point of the corporate governance system and many of the established criteria relate to activities of the Board and not directly to the oversight of the insurance supervisor. U.S. insurance supervisors have interpreted this principle to require oversight by the supervisory authority as to whether the Board and management are complying with the specific criteria set forth.

Criteria regarding corporate governance issues are dispersed throughout state insurance and commercial codes through statute, regulation and administrative orders. In general, the U.S. insurance supervisory approach for corporate governance of insurers is based upon a proportionality principle. Under this principle, larger and more complex entities are subject to more stringent requirements in the application of corporate governance standards. For example, for publicly traded companies, many of the supervisory corporate governance criteria are set and enforced by the Securities and Exchange Commission (SEC). Some of the significant requirements of the SEC for publicly traded insurers include expertise and independence requirements for the audit committee as well as requirements to maintain effective internal controls over financial reporting. Many of these SEC requirements have recently been adopted for use in insurance regulation through revisions to the NAIC *Annual Financial Reporting Model Regulation (Model #205)*. These revisions will require an independent audit committee to be established for each insurer exceeding an annual premium threshold, in accordance with our proportionality principle. In addition, the revisions include standards for the conduct of insurers in connection with the preparation of required reports. The revisions to the model are scheduled to go into effect January 1, 2010. Adoption of this model is required under the Accreditation Program.

U.S. insurance supervisors have extensive requirements for governance over all related party transactions. These requirements are embedded within the NAIC’s *Insurance Holding Company System Regulatory Act (Model #440)*. This act includes requirements related to 1) acquisition of control of an insurer; 2) disclosures regarding the holding company structure and any new agreements with affiliates; and 3) prior notice of transactions. In addition to governance requirements, U.S. insurance regulators also impose special accounting rules on transactions with affiliates in order to address the abuse that can occur with these types of arrangements, and require prior approval by regulators of material and, for certain transaction types, all related party transactions. Adoption of this model is also required under the Accreditation Program.

U.S. insurance supervisors review compliance with many of the corporate governance criteria at the licensing stage for new insurers and producers, in requiring and reviewing annual statements, in conducting periodic financial and market condition reviews, in approving mergers or other changes of control involving domestic insurers, and in applying solvency oversight. As discussed in more detail in response to ICP 6 (Licensing), the Uniform Certificate of Authority Application (UCAA) created by the NAIC as a national uniform licensing application, includes, among other items, a business character report, a business profile, a plan of operation, indication of compliance with a state’s minimum paid-in capital and surplus requirements, and a company’s Annual Statement and most recent financial examination report. A business character report must be submitted for all officers, directors, key managerial personnel and individuals with a 10 percent or more beneficial interest in the applicant or its parent. The business profile includes a depiction of the applicant’s organization and a detailed plan of operation.

Additional requirements for disclosures to be included in the annual statements are placed on insurers to determine if the board and management are maintaining the appropriate ethical standards and properly managing conflicts of interest. Through this manner, insurers are required to explain if the senior officers of the company are not subject to a code of ethics that includes:

- Honest and ethical conduct, including a adequate management of actual or apparent conflict of interest between personal and professional relationships;
- Full, fair, accurate, timely and understandable disclosure in the periodic reports filed by the reporting entity;
- Compliance with applicable government laws, rules and regulations;
- Prompt internal reporting of violations to an appropriate person identified in the code; and,
- Accountability for adherence to the code.

U.S. insurance regulators also require any insurer to disclose in its financial statements that the company has procedures for disclosure of any conflict of interest. These disclosures are regularly reviewed and considered through the off-site monitoring process, along with any significant changes in the business character reports or business profile filed by the insurer.

Another way that U.S. insurance supervisors address many of the corporate governance criteria is through conducting on-site inspections. The NAIC *Financial Condition Examiners Handbook* (Examiners Handbook) recognizes corporate governance assessment as a critical step in planning an effective financial examination. In order to complete an examination under the risk-focused surveillance approach, examiners must consider and evaluate the insurer's corporate governance and established risk management processes. By understanding the corporate governance structure the examiner will obtain information on the quality of guidance and oversight provided by the Board and the effectiveness of management. This information will enhance the examiner's consideration of current and prospective risk areas and assist with the appropriate determination of the detailed examination procedures that should be performed.

An assessment of the corporate governance provided by the Board may be determined through discussions with the Board and through gaining an understanding of the Board's oversight role. Some of the areas outlined in the Examiners Handbook to be considered in the assessment of the Board include:

- Membership criteria and terms;
- Knowledge and experience of directors;
- Independence from management;
- Extent of monitoring and oversight of management activities;
- Sufficiency of Board committees, in subject matter and membership;
- Oversight in determining the compensation of executive officers and the appointment and termination of those individuals;
- Sufficiency and timeliness of information provided to the Board; and
- The Board's role in establishing the appropriate "tone at the top" including the development and enforcement of a code of conduct.

Additionally, an assessment of the corporate governance provided by senior management may be determined through discussions with management and by reviewing the organizational structure, assignment of authority and adherence to internal controls in place at the company. Some of the areas outlined in the Examiners Handbook to be considered in the assessment of senior management include:

- Knowledge and experience of management;
- Turnover in key management positions;
- The nature of business risks accepted and the company's risk assessment processes;

- Access to adequate financial and operating information to identify trends or variations from budgets;
- Attitudes and actions towards financial reporting and internal controls; and
- Management's role in developing, communicating and enforcing a code of conduct.

At the conclusion of the corporate governance assessment performed during the inspection, 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. If deficiencies in the corporate governance practices of the company are identified, the examination team makes recommendations for improvements to the insurer and adjusts its ongoing solvency monitoring of the insurer accordingly. In situations where an insurer is deemed to be in a hazardous financial condition, the insurer can be ordered to correct the situation as outlined in the NAIC *Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition (Model #385)*.

Assessment: Observed (O)

ICP 10: Internal control

- *The supervisory authority requires insurers to have in place internal controls that are adequate for the nature and scale of the business. The oversight and reporting systems allow the board and management to monitor and control the operations.*

Internal control standards and requirements are dispersed throughout state insurance codes through statutes, regulations and administrative orders. In addition, for publicly traded companies, many of the standards relating to internal controls over financial reporting are set and enforced by the Securities and Exchange Commission (SEC). SEC rules require management and the external auditor to report on the adequacy of the company's internal control over financial reporting. The report must contain an assessment, as of the end of the company's most recent fiscal year, of the effectiveness of the internal control structure and procedures of the issuer for financial reporting. A similar requirement has recently been adopted for use in insurance regulation through revisions to the *NAIC Annual Financial Reporting Model Regulation (Model #205)*, which is required under the Accreditation Program. These revisions will require companies exceeding an annual premium threshold to complete Management's Report of Internal Controls over Financial Reporting attesting to the adequacy of internal controls. Similar to the SEC requirements, the attestation should be based upon documentation and testing of the company's internal controls, through diligent inquiry. However, unlike the SEC rules, this report will not be subject to a separate attestation by the company's external auditor. The revisions to the model are scheduled to go into effect January 1, 2010.

In addition to SEC rules for public companies and similar regulatory requirements for all insurers exceeding an annual premium threshold, all insurance entities are required to receive an annual audit in accordance with the *Annual Financial Reporting Model Regulation (Model #205)*. An important aspect of each audit, as required by the American Institute of Certified Public Accountants, is to understand and assess an entity's internal controls. When material weaknesses in an insurer's internal control processes are identified during an audit, this model regulation requires the weaknesses to be reported to the insurance supervisor for further review.

In addition to requiring annual statutory audits, the on-site inspection process is critical in evaluating the internal control processes in place. The *NAIC Financial Condition Examiners Handbook* (the "Examiners Handbook") states that risk mitigation strategies/controls are generally based on five overarching principles, which are applicable to all critical activities of an insurer. Compliance with the Examiners Handbook is required under the Accreditation Program. These principles include:

1. An active board and senior management oversight;
2. Adequate risk management, monitoring and management information systems;
3. Adequate and clear policies, authorization limits and procedures;
4. Comprehensive internal controls; and
5. Processes to assure compliance with laws and regulations.

An evaluation of board and senior management oversight is conducted through the examination process as covered in our responses to ICP 7 and ICP 9. The process to review the company's risk management practices is evaluated through the examination processes as covered in ICP 18. The other principles (3-5 above) of effective internal controls are also evaluated in accordance with the risk-focused examination process. This process requires the supervisor to identify and assess all significant inherent risks faced by the insurer, whether they relate to financial reporting issues or to business and operational issues. After risks have been identified, the examiner is required to identify and assess the internal control processes that can mitigate each identified risk. Controls are assessed by considering both their design and operating effectiveness. When weaknesses in the company's internal controls are identified during the assessment

process, the company is asked to make corrections to its processes and the supervisor adjusts its ongoing solvency monitoring of the insurer accordingly. Through increasing reporting requirements, increasing the frequency of examinations, and other means, the regulator can provide a strong incentive for the insurer to improve internal control weaknesses. In situations where an insurer is deemed to be in a hazardous financial condition, the insurer can be ordered to correct the situation as outlined in the NAIC *Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition (Model #385)*, which is a required model under the Accreditation Program.

Assessment: Observed (O)

ICP 11: Market analysis

- *Making use of all available sources, the supervisory authority monitors and analyses all factors that may have an impact on insurers and insurance markets. It draws conclusions and takes action as appropriate.*

U.S. state insurance regulators oversee the financial soundness of all individual insurers within their authority. However, in doing so, state insurance regulators consider not only the potential impact of insolvency on consumers, but also the impact on the insurance marketplace for consumers. This is particularly true for certain types of coverage, such as auto, home, health, where excess lines are not always available. This is one of the reasons that some states require rates to be approved, so that in those cases where the market requires a more delicate balance, the state can impact that through its approval of rates.

The review of market conditions and assessment of market exposure is completed regularly through various reports, publications (public and non-public), and automated financial regulatory tools. For example, in the U.S., state insurance regulators receive quarterly information on the amount of premium written and losses in their state by all insurers. The majority of this information is readily accessible from the NAIC FDR database, and the NAIC has created many automated market reports available to regulators to assist in this analysis. These regulator only reports allow the user to select from a variety of criteria needed to look at a specific perspective on the market. For example, these reports return key market share and financial data for each line of business, Key data includes details on market share, cumulative market share, and financial data such as loss ratios and losses incurred. The market share reports are available on an insurer and group basis. There are also reports to provide key financial and market data for a particular state and includes details on premiums written, key financial indicators, confirmed complaints, regulatory actions, and other relevant areas to assess state market share. From a qualitative perspective, data is collected at the NAIC within several databases, such as complaints, regulatory actions, special activities, rating agency actions, etc. These databases allow various reports and analysis to be generated. For example, the complaints report details closed complaints by company code or state. In addition, a complaint trend report lists complaints by month for the past three years or lists complaints by year for the past five years with a count of the number of complaint records in the database for this entity based on the criteria selected, showing the percentage change (+ or -) as the time period changes. The regulatory action reports provide a history of actions taken by states including details on the reason for the action, date of action, and the regulator who took the action.

The quarterly statement filed by all insurers allows further analysis as to the number of insurers and reinsurers in a particular market, any new insurers or any insurers existing in the market. In addition, the NAIC database also contains detailed information on every component of the balance sheet, the income statement, the investment mix and product mix. This information is supplemented annually with more specific product breakout information. However, many states will utilize “data calls” when additional information is needed on an even more granular level (e.g. disaster reporting).

In addition to all of the above, the NAIC Insurance Analysis & Information Department utilizes the NAIC database to perform quarterly analysis on the information submitted to the NAIC. As a result of this, industry reports are produced shortly after the financial statement date and distributed to the Chief Financial Regulators in each of the states. These summarize the operating performance of each of the major insurance sectors. In addition, other market analysis is performed by NAIC staff as needed to identify more long-term trends that may be of interest to regulators (e.g. trends with certain lines of business, accumulation of certain assets, use of debt, etc.), which is provided to the FAWG. FAWG considers the significance of such information and, if material, will distribute such information to the Chief Financial Regulators.

Any insurance regulator is also able to subscribe to investment and capital market information as supplied by the NAIC's Security Valuation Office on a daily, weekly, monthly and quarterly basis. Additionally, the NAIC Research Department also performs in depth analysis on each of the major insurance sectors and publishes such information on a periodic basis. These detailed reports from the Research Department are available to regulators as well as the general public. For example, public reports are available for quick reference to identify the largest writers per premium volume by line of business. These reports allow for monitoring increases and decreases in market share and overall level of market concentration. The reports are available for each business type and provide details on a state and countrywide basis and include data by line of business for Property/Casualty detailing the top 10 groups by state and the largest 125 groups countrywide; the Life and Fraternal reports include the largest 125 groups for life insurance, annuity considerations and total premiums written; and the Accident & Health reports include the largest 125 groups for total A&H premiums written. These reports are updated annually. A Statistical Compilation report provides aggregate annual statement data for property/casualty, life/health insurance companies, all HMOs and companies that write accident and health insurance and file annual statements with the NAIC. The report includes annual statement financial data, state and countrywide insurance data, and selected data elements from company and combined statements.

The NAIC also publicly produces various market condition reports to assess particular lines of business such as medical malpractice, Credit Life and Credit Accident and Health Insurance, and Long-Term Care. The Medical Malpractice Insurance Report studies the market conditions and is based on a review of historical data collected and compiled by the NAIC, as well as a review of other medical malpractice studies. It was conducted with the objective of reviewing regulatory and legislative solutions to be considered in response to a market crisis. The Credit Life and Credit Accident and Health Insurance Experience Report includes industry-wide data for more than 500 individual insurers. The report details earned premiums, incurred losses, loss ratios and market share information for each type of insurance for a period of two years. The Long-Term Care Experience Reports contain countrywide company-specific experience for all forms combined, with the experience segmented by duration; and countrywide company-specific experience displayed on a form-by-form basis.

Lastly, the NAIC receives reports from other U.S. regulators, IAIS members, other international regulators and various resources (e.g. Bloomberg, Rating Agencies, etc.) to assess the global market place, including the banking sector, insurance sector and capital markets.

Assessment: Observed (O)

ICP 12: Reporting to supervisors and off-site monitoring

- *The supervisory authority receives necessary information to conduct effective off-site monitoring and to evaluate the condition of each insurer as well as the insurance market.*

All 50 states and the District of Columbia maintain statutes, regulations or practices that require the submission of annual and quarterly financial information, including an actuarial and audit opinion, as well as other various supplements. All 50 states and the District of Columbia maintain statutes, regulations or practices that require companies to file with the insurance department the appropriate NAIC annual statement blank which should be prepared in accordance with the NAIC's instructions handbook and follow those accounting procedures and practices prescribed by the *NAIC Accounting Practices and Procedures Manual*. This includes a requirement that management attest to the accuracy of the statement in accordance with these manuals. The results of these financial figures are used by regulators, along with other information (including required reporting on material transactions as defined by law), to determine the appropriate steps for ongoing monitoring of the financial condition of the insurer. Many states include as part of such monitoring steps the procedures outlined in the *NAIC Financial Analysis Handbook*.

Note, both the reporting requirements, as well as the analysis procedures used by states to monitor the financial condition of insurers, are updated continuously through the NAICs Blanks Working Group and Financial Analysis Handbook Working Groups respectively.

All state insurance regulators have the authority to require insurers to complete and submit to the regulator financial statements on a more regular basis (e.g. monthly) where more periodic monitoring is appropriate. All regulators also require that an annual filing of the financial statements of the ultimate controlling individual/corporation be submitted to the regulators. Additionally, specific statements of statutory accounting principles require the value of any subsidiary to be audited. The form of this audit can vary depending upon the business conducted by that subsidiary, and therefore can either be based upon statutory accounting, generally accepted accounting principles, or tax accounting. All 50 states and the District of Columbia require securities owned by insurance companies be valued in accordance with those standards promulgated by the NAIC's Securities Valuation Office. All 50 states and the District of Columbia prescribe minimum standards for the establishment of liabilities and reserves resulting from insurance contracts issued by an insurer; including life reserves, active life reserves and unearned premium reserves, and liabilities for claims and losses unpaid and incurred but not reported claims. Additionally, the NAIC's *Standard Valuation Law (Model #820)* and *Actuarial Opinion and Memorandum Regulation (Model #822)* or substantially similar provisions are in place.

All states and the District of Columbia strive to maintain Financial Analysis regulatory practices and procedures in accordance with those outlined by Part B of the Accreditation Program. Review of a state insurance department's financial analysis (or off-site monitoring) process is a key component within the accreditation standards. There are eight broad standards pertaining to financial analysis and numerous specific guidelines with which a state insurance department must comply. If a state insurance department is accredited, one may be assured that the state insurance department is in substantial compliance with these standards and guidelines.

Assessment: Observed (O)

ICP 13: On-site inspection

- *The supervisory authority carries out on-site inspections to examine the business of an insurer and its compliance with legislation and supervisory requirements.*

The NAIC *Model Law on Examinations (Model #390)*, as enacted in each state, authorizes the supervisor to conduct on-site examinations whenever it is deemed necessary and the supervisor is given the flexibility to decide the scope of such an examination. The objective of this model law is to direct department resources to companies having or likely to have financial difficulty; however, all companies are required to be examined once every five years, although the scope and extent of that exam will be based on the particular attributes of the company to be examined. In scheduling and determining the nature, scope and frequency of the examinations, the supervisor considers criteria as set forth in the *Financial Condition Examiners Handbook* (Examiners Handbook) adopted by the NAIC. As part of the Accreditation Program, the NAIC confirms that state insurance departments are performing full-scope examinations of all multi-state domestic companies no less frequently than once every five years. In addition, during on-site accreditation reviews, the accreditation review team assesses the state's compliance with the various requirements in the Examiners Handbook.

For purposes of completing an examination of a company under the model, the supervisor is granted the authority to investigate any person, or the business of any person, in so far as the examination or investigation is, in the sole discretion of the supervisor, necessary or material to the examination of the company. In addition, the model law requires that every company or person from whom information is sought (internal or external), shall provide to the examiners timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The officers, directors, employees and agents of the company or person must facilitate the examination and aid in the examination so far as it is in their power to do so. In addition to the authority granted by the *Model Law on Examinations (Model #390)*, the *NAIC Insurance Holding Company Regulatory Act (Model #440)*, as enacted in each state, grants the supervisor additional authority to order insurance holding companies and affiliates to produce such records, books, or other information necessary to ascertain the financial condition of an insurer. Adoption of this model is required under the Accreditation Program.

The *Model Law on Examinations (Model #390)* further requires that at the conclusion of the on-site examination, an examination report comprised of findings of fact as well as the conclusions and recommendations of the supervisor is issued within sixty (60) days of the completion of the examination. The report is then transmitted to the company to allow the company a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report. Within thirty (30) days of the end of the period allowed for the receipt of written submissions or rebuttals, the supervisor shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's work papers and enter an order adopting the examination and requiring the company to cure any violations identified within the report. The company is then required to correct any violations, with such corrections subject to review of the supervisors. As part of the Accreditation Program, states are to adopt examination reports timely and send them to the other state insurance departments in which the insurer is licensed or transacts business.

For less material findings identified during the examination, the Examiners Handbook outlines a process to utilize a separate management letter to communicate non-material findings to the company. The company's response and efforts to correct these issues are then tracked and followed up on by the supervisor. The Examiners Handbook also provides additional guidance to be followed by supervisors in calling and

conducting on-site financial condition examinations. The Examiners Handbook is reviewed and updated on an annual basis to support the needs of supervisors in conducting on-site financial condition examinations.

There is also an association examination system which 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.

In addition to the *Model Law on Examinations (Model #390)* and the Examiners Handbook, another standard that assists supervisors in performing on-site examinations is the NAIC *Annual Financial Reporting Model Regulation (Model #205)*. Adoption of this model is required under the Accreditation Program. The purpose of this regulation, as enacted in each state, is to improve the supervisor's surveillance of the financial condition of insurers by requiring an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants. By requiring an annual audit, the supervisor receives evidence as to the financial solvency of its companies through additional on-site inspection performed by independent auditors. The work of the independent auditors is required by the model to be made available for review by insurance department examiners, including any communications related to the audit between the auditor and the company. In addition, the auditor's annual report is reviewed during the off-site inspection process. The Accreditation Program includes standards and guidelines to ensure that the state insurance department is adequately reviewing this filing in a timely manner.

Assessment: Observed (O)

ICP 14: Preventive and corrective measures

- *The supervisory authority takes preventive and corrective measures that are timely, suitable and necessary to achieve the objectives of insurance supervision.*

In terms of capital triggers, states have both fixed and variable capital requirements, the latter of which is referred to as risk-based capital. [See also response to ICP 23] All 50 states and the District of Columbia have the *Risk-based Capital (RBC) for Insurers Model Act (Model #312)* or provisions substantially similar in state laws or regulations that also allow regulators to take preventive and corrective measures. This model is required for accreditation purposes. If an insurer were to trend towards or exceed the thresholds outlined by these requirements, then the state could invoke various corrective measures, including requiring an action plan be filed, taking control of the insurer, and/or issuing various preventive orders (e.g. cease and desist new writings, etc.). All 50 states and the District of Columbia have state laws that contain the NAIC's *Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition (Model #385)* or a substantially similar provision which authorizes the state insurance department to order a company to take necessary corrective action or cease and desist certain practices which, if not corrected, could place the company in hazardous financial condition.

The accreditation standards require that states adopt this model. Under this statute, there are numerous qualitative and quantitative triggers to suggest that a particular company is acting in a condition that is hazardous to the policyholder. This includes but is not limited to: 1) Adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinions, reports or summaries; 2) Whether the insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the insurer, when considered in light of the assets held by the insurer with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts; (3) Any other finding determined by the state insurance commissioner to be hazardous to the insurer's policyholders, creditors or general public.

All 50 states and the District of Columbia have state laws setting forth a receivership scheme that can provide for protective measures for insurers prior to an insolvency and if found to be insolvent. The Accreditation Program requires that accredited states have a receivership scheme included in their statute.

The NAIC *Administrative Supervision Model Act (Model #558)* provides the states with the authority to place insurance companies under immediate administrative supervision if the state insurance commissioner determines the company to be in a hazardous financial condition.

The NAIC *Insurance Department Resources Report*, a survey of NAIC member jurisdictions conducted annually, shows that hundreds of actions to suspend or revoke authority to issue policies or take other actions are issued annually. The Report also discloses Formal Hearings from Company Disciplinary actions.

Assessment: Observed (O)

ICP 15: Enforcement or sanctions

- *The supervisory authority enforces corrective action and, where needed, imposes sanctions based on clear and objective criteria that are publicly disclosed.*

The NAIC Accreditation Program requires that a state's law contain *the NAIC Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in a Hazardous Financial Condition (Model #385)* or a substantially similar provision that authorizes a department of insurance to order a company to take necessary corrective action or cease and desist certain practices which, if not corrected, could place the company in a hazardous financial condition. Section 3 of the Model identifies a broad range of specific standards that may be considered by the state insurance commissioner to determine whether the continued operation of any licensed insurers might be hazardous to its policyholders or the general public.

The NAIC *Administrative Supervision Model Act (Model #558)* provides the states with the authority to place insurance companies under immediate administrative supervision if the state insurance commissioner determines the company to be in a hazardous financial condition.

The NAIC *Insurer Receivership Model Act (Model #555)* provides the states with the authority to place companies into receivership if there has been non-compliance with any orders of the state insurance commissioner among the many grounds for receivership.

The NAIC *Insurance Department Resources Report*, a survey of NAIC member jurisdictions conducted annually, shows that hundreds of actions to suspend or revoke authority to issue policies or take other actions are issued annually. This report also shows the numbers and claims volume of run-offs, supervisions, conservation/rehabilitations, and liquidations.

Both model #385 and #555 mentioned above are required for accreditation purposes.

Assessment: Observed (O)

ICP 16: Winding-up and exit from the market

- *The legal and regulatory framework defines a range of options for the orderly exit of insurers from the marketplace. It defines insolvency and establishes the criteria and procedure for dealing with insolvency. In the event of winding-up proceedings, the legal framework gives priority to the protection of policyholders.*

The NAIC Accreditation Program requires that a state's law should set forth a receivership scheme for the administration, by the insurance commissioner, of insurance companies found to be insolvent as set forth in the NAIC's *Insurers Receivership Model Act (Model #555)*. Every state has adopted a version of the NAIC's model regarding receivership of insurers. The first model was adopted in 1936. It has been substantially updated many times over the last 69 years. Since not all states have continuously updated their adoptions of this model, many states have older versions of the model. Some of the older versions are not as clear as the more modern versions regarding the procedures for dealing with the insurer in receivership.

All of these versions give some priority to the provision of benefits to policyholders or the payments of claims arising under policies. Much of this priority is afforded through guaranty associations that generally cover certain consumer type policies to ensure that the policies are transferred to a solvent insurer (Life & Health) or that claims are paid in full (Property & Casualty). The guaranty associations then step into the shoes of the policyholders they have supported in asserting their claims against the estate of the insolvent insurer. In the U.S., unlike most other jurisdictions, third party claimants may be able to assert claims directly against the estate of an insolvent insurer (despite any lack of privity of contract) on the basis that the insureds were required to obtain coverage for the protection of these, at the time, unidentified third party beneficiaries of the contract.

If state intervention and receivership proceedings do not fully address concerns, state guaranty associations have been established to protect policyholders, claimants and beneficiaries against financial losses due to insurer insolvencies. Fundamentally, the purpose of an insolvency guaranty law/association is to cover an insolvent insurer's financial obligations, within statutory limits, to policy owners, annuitants, beneficiaries and third-party claimants on as timely basis as possible.

The Accreditation Program requires that accredited states have a regulatory framework in place such as that maintained in the NAIC guaranty fund model acts.

Assessment: Observed (O)

ICP 17: Group-wide supervision

- *The supervisory authority supervises its insurers on a solo and a group-wide basis.*

All U.S. regulators require insurers' completion of the NAIC Annual Statement, which requires among other things, a detailed organization chart (Schedule Y) to be included in the insurers filings. All U.S. regulators also require insurers' completion of the NAIC Quarterly Statement, which requires among other things, any changes in the organization chart from the prior year-end. The Annual Statement Schedule Y include includes a dollar summary of various types of transactions within the holding company system. The NAIC's Annual and Quarterly statement also requires disclosure of whether an insurer is affiliated with one or more banks, thrifts or securities firms (i.e. financial conglomerate/financial holding company).

The *NAIC Framework for Insurance Holding Company Analysis* was incorporated into the *NAIC Financial Analysis Handbook (Financial Analysis Handbook)* to assist analysts with performing analysis on holding companies. The Financial Analysis Handbook contains an Analyst Reference Guide and Supplemental Procedures specifically discussing holding company analysis, including Form A, Form B, Form D, Form E and Extraordinary Dividend/Distributions to assist state insurance departments in performing analysis on a Holding Company.

Form A, B, D, E and Extraordinary Dividend/Distribution are transaction specific and are not part of the regular annual/quarterly analysis process. The review of these transactions may vary as some states may have regulations that differ from these Forms. See detail below:

Form A—Statement of Acquisition of Control of or Merger with a Domestic Insurer

The NAIC *Insurance Holding Company System Regulatory Act* (the Holding Company Act) (Model #440) outlines specific filing requirements for persons wishing to acquire control of or merge with a domestic insurer. All 50 states and District of Columbia have laws substantially similar to the NAIC Model Insurance Holding Company System Regulatory Act (Model #440) as adoption of this model is required for accreditation. Form A is filed with the domestic state of each insurer in the group. The domestic state or lead state communicates the filing with all impacted states. Individual state statutes and regulations may or may not impose other time limitations on the review period and federal law sets out the time period for review of any transactions with depository institutions. The newly-adopted accreditation standards will require that the filing be reviewed in a timely manner and that the Department have sufficient, qualified staff to perform this review. Further, the standards require that the state have appropriate and sufficient procedures to perform this review, including an analysis of many of the items discussed above. It also requires use of the Form A database, which is a communication tool on these filings used by the state insurance department to collect and organize information.

Form B—Insurance Holding Company System Annual Registration Statement

The Holding Company Act (Model #440) is the model that defines insurance holding companies and the related registration, disclosure, and approval requirements. Form B is the insurance holding company system annual registration statement which allows state regulators to identify and evaluate the relationships within holding companies that impact insurers. The Holding Company Act (Model #440) requires every insurer that is a member of an insurance holding company system to register by filing a Form B within 15 days after it becomes subject to registration and annually thereafter. Any non-domiciliary state may require any insurer that is a member of a holding company system and authorized to do business in the state, and is not subject to registration in its state of domicile, to furnish a copy of the registration statement. An insurance holding company system consists of two or more affiliated persons or entities, one or more of which is an insurer. An affiliate is an entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another entity. Control is presumed to exist

when an entity or person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities. The Accreditation Program requires adequate and timely analysis of these filings by the insurance departments.

Form D—Prior Notice of a Transaction

The Holding Company Act (Model #440) requires each insurer to give notice of certain affiliate transactions. These transactions are reviewed to determine if they are fair and reasonable to the interests of the insurer. Form D must be filed with the domestic state. Material transactions include but are not limited to sales, purchases, exchanges, loans, extensions of credit, guarantees, investments, reinsurance, management agreements, service agreements and cost-sharing agreements. The transaction is considered material if, for non-life insurers, it is the lesser of 3 percent of the insurer's admitted assets or 25 percent of policyholder's surplus; and for life insurers, 3 percent of the insurer's admitted assets, each as of the most recent prior to December 31st. Some states have stricter definitions of materiality in their holding company regulations. Holding company regulations require that affiliated transactions be fair and reasonable to the interests of the insurer.

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

The Holding Company Act (Model #440) requires that any domestic insurer, together with any person controlling a domestic insurer, or proposing a merger or acquisition, file a Form E or other required pre-acquisition notification form. The insurer may also be required to file documents with the Federal Trade Commission under the Hart-Scott-Rodino Act. The period for review and action on proposed affiliations for transactions falling under the GLBA is limited to 60 days prior to the effective date of the transaction. Under Section 104(c)(2) of the GLBA, states have a 60-day period preceding the effective date of the acquisition, change, or continuation of control in which to collect information and take action. It may not be mandatory for some states to approve or disapprove the Form E or other required information. These states may only have a certain period of time that an insurer's license to do business in the state is denied or a cease and desist order is put into effect.

Extraordinary Dividend/Distribution

The Holding Company Act (Model #440) requires that any domestic insurer planning to pay any extraordinary dividend or make any other extraordinary distribution to its shareholders receive proper prior regulatory approval. The insurer may be required to wait 30 days after the state insurance commissioner has received notice of the declaration and has not, within that period, disapproved the payment or until the state insurance commissioner has approved the payment within the 30-day period. Each state has its own definition of what constitutes "extraordinary".

Additionally, the Financial Analysis Handbook discusses the role of the lead state to assist states in coordinating regulatory activities in their review of insurance groups. The timely action requirements imposed by the GLBA increase the importance of designating a lead state(s). The concept of a lead state is not intended to relinquish the authority of any state, but to facilitate efficiencies when one or more states coordinate the regulatory process of all states involved. A Lead State Summary Report is available to regulators to disclose, which state(s) are the lead for insurance holding company groups.

Based on recent events and changes in the global market place, the Group Solvency Issues (EX) Working Group was created and charged to identify any necessary changes to the Holding Company Model Act (Model #440) resulting from a study of the current model's limitations evident in the U.S. regulatory system during the current economic crisis and/or from international initiatives related to group-wide supervision. The working group will also study the need to develop group-wide regulatory requirements, including the need for group-wide capital adequacy requirements, enhanced group-wide reporting, and

consideration of non-regulated entities. In addition, the working group will recommend courses of action to improve cross-border communication and coordination (both internationally and across U.S. state borders) among supervisors, including supervisors of other financial sectors where appropriate.

Assessment: Observed (O)

ICP 18: Risk assessment and management

- *The supervisory authority requires insurers to recognize the range of risks that they face and to assess and manage them effectively.*

U.S. insurance regulators do not explicitly require insurers to have comprehensive risk management policies and systems in place; however, the insurer's risks and their systems to measure and manage those risks are reviewed through the on-site inspection process. Comprehensive on-site financial examinations are required in the U.S. no less frequently than once every 5 years as outlined in the *NAIC Model Law on Examinations (Model #390)*. Supervisors also have the authority to examine companies whenever it is deemed necessary. Through this process, the examination team reviews tools and reports utilized by the insurer to measure and manage risks and conducts in-depth interviews with top management and the board of directors that include risk management as a significant topic. The methods to review a company's risk assessment processes are outlined in the *NAIC Financial Condition Examiners Handbook*. Review of an insurer's risk assessment processes is a required element of an examination under the NAIC Accreditation Program. If deficiencies in the risk management function are noted, recommendations for improvements are made by the supervisor to the insurer. In situations where an insurer is deemed to be in a hazardous financial condition, the insurer can be ordered to, among other things, correct corporate governance practice deficiencies, and adopt and utilize the governance practices recommended by the supervisor as outlined in the *NAIC Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition (Model #385)*. Both Model #385 and #390 are required for accreditation purposes.

U.S. insurance regulators also have numerous other laws and regulations that are designed to manage the maximum amount of risk to the policyholders of that insurer. These requirements include, but are not limited to Risk-Based Capital, investment limitations, reserving standards, actuarial opinions associated with the reserving standards, and specific limitations (10% of capital and surplus) on any single insured risk. In addition, many insurer transactions require regulatory approval, which allow regulators an opportunity to discuss and make inquiry regarding insurer operations during the review and approval process. Many of these requirements are necessary elements on the Accreditation Program.

Assessment: Observed (O)

ICP 19: Insurance activity

- *Since insurance is a risk taking activity, the supervisory authority requires insurers to evaluate and manage the risks that they underwrite, in particular through reinsurance, and to have the tools to establish an adequate level of premiums.*

Insurance Activity:

The process in the United States for considering the risk that the insurer is undertaking begins with the licensing of the insurer. All companies that wish to engage in the practice of insurance, as defined by state statute, must submit an application for a certificate of authority to conduct business in that state. The application must include information on the insurer's proposed management team and proposed board, business plan and projected financial information on the insurer, and other relevant information. (Several aspects of the licensure process are included in the recently adopted accreditation standards as discussed in Principle 6 and below.) See the following for further detail.

http://www.naic.org/industry_ucaa_primary.htm#section1

Other information on the insurer's proposed business plan would typically be submitted with the application. The level of detail within the business plan would be expected to be commensurate with the complexity and amount of risk proposed to be undertaken by the insurer. The plan would be expected to address the risk limitation requirements and the minimum capital and surplus requirements for both the first year of operations as well as the near term. The regulator will consider the overall ability for the plan to succeed based upon the assumptions and factors, as well as the ability to mitigate risks and initial capital requirements through the use of reinsurance, in determining if a license should be granted. The newly adopted company licensing accreditation standards require that the state review the applicant's business and strategic plans, pro forma financial projections, proposed reinsurance program, investment policy, financing arrangements, and related party agreements.

If the insurer is granted a license, the insurer will begin to be monitored just as any other insurer is monitored. More specifically, the financial analysis department will perform quarterly reviews of the insurer's financial statements (and related available information) to determine how the company is performing against its projected plan. The NAIC *Financial Analysis Handbook* sets forth the standards for the analysis that most states conduct on their insurers on a quarterly and annual basis. The department typically uses the analysis department to help educate the insurer on what its expectations are with respect to certain items, and in doing so, develops a line of communication with management. Review of a state insurance department's financial analysis process is a key component within the accreditation standards. There are eight broad standards pertaining to financial analysis and numerous specific guidelines with which a state insurance department must comply. If a state insurance department is accredited, one may be assured that the state insurance department is in substantial compliance with these standards and guidelines.

In the mean time, as products are developed by the insurer, they will be subject to the state's ratemaking and policy form requirements. In most cases, these reviews are focused on making sure that the price charged the consumer is not excessive. However, in the process of reviewing the methodology and assumptions used by the insurer, it's not uncommon for the regulator to determine that the prices are not sufficient, particularly with certain types of products. Although all states do not require insurers to file for approval of rates, a policy form does typically have to be approved. This review allows the state to become comfortable with the risk the insurer is considering taking on, or at least better understand the risks before they play a large part of the insurer's operations.

After the insurance operations of a start up company have developed, or the introduction of a particular product becomes more widespread, the regulator typically would consider an examination of the insurer in accordance with its authority under the *NAIC's Model Examination Law* (Model #390), and the procedures set forth in the *NAIC Financial Condition Examiners Handbook*. In accordance with a risk-focused approach, the regulator would design the examination to focus on those risks that are of the highest concern to the regulator with respect to the company. One of the primary risks that are focused on during an examination is the insurers underwriting, and more specifically the related pricing and reserving risk. For property and casualty companies, much of this risk is reviewed annually with the review by the states of Insurance Expense Exhibits. For life companies, much of this risk is reviewed in connection with the annual asset/liability matching performed by the insurer in completion of the confidential actuarial memorandum available to the state of domicile.

Similar to the financial analysis process, review of a state insurance department's financial examination process is a critical aspect of the accreditation standards. There are nine broad standards pertaining to financial examination and numerous specific guidelines with which a state insurance department must comply. If a state insurance department is accredited, one may be assured that the state insurance department is in substantial compliance with these standards and guidelines.

Assessment: Observed (O)

ICP 20: Liabilities

- *The supervisory authority requires insurers to comply with standards for establishing adequate technical provisions and other liabilities, and making allowance for reinsurance recoverables. The supervisory authority has both the authority and the ability to assess the adequacy of the technical provisions and to require that these provisions be increased, if necessary.*

Assessment:

The *NAIC Standard Valuation Law (Model #820)* is the primary authority for determining adequacy of reserve liabilities for life and accident and health insurance companies. Reserve requirements for property and casualty insurers are outlined in the *NAIC Accounting Practices and Procedures Manual*. Adoption of the *NAIC Standard Valuation Law (Model #820)* and the *NAIC Accounting Practices and Procedures Manual* are both requirements of the Accreditation Program.

Section 4 of the *NAIC Standard Valuation Law (Model #820)* provides the requirements for the minimum standard for valuation of all policies and contracts issued by life and accident and health insurance companies. Statutory requirements for life insurance reserves are very conservative. Reserve requirements for property and casualty insurers are outlined in the *NAIC Accounting Practices and Procedures Manual* and in actuarial standards of practice.

Accounting definitions of liabilities are detailed in the *NAIC Accounting Practices and Procedures Manual*. Internal controls are analyzed during the financial examination process and during annual reviews by independent Certified Public Accountants.

As specified in the *NAIC Standard Valuation Law (Model #820)* and the *NAIC Actuarial Opinion and Memorandum Regulation (Model #822)*, life and accident and health insurance companies are required to annually file an actuarial opinion and memorandum setting forth an opinion relating to adequacy of reserves and related actuarial items held in support of policies and contracts. Section 2 of the *Standard Valuation Law (Model #820)* requires the respective supervisors to annually value reserve liabilities in accordance with the standards outlined within that law. The *NAIC Annual Statement Instructions for Property and Casualty Insurers* require an annual actuarial opinion relating to adequacy of loss and loss adjustment expense reserves, in addition, the *Property and Casualty Actuarial Opinion Model Law* requires the filing of the annual actuarial opinion summary. The adoption of the *NAIC Standard Valuation Law (Model #822)*, *Actuarial Opinion and Memorandum Regulation* and *NAIC Annual Statement Instructions* are all requirements of the Accreditation Program.

Part 2 of the *NAIC Financial Condition Examiners Handbook* includes examination procedures to be performed by examiners. Sections C and D of Part 2 include specific procedures to be performed in determining adequacy of life and accident and health and property and casualty reserves and liabilities. Adoption of and compliance with the *NAIC Financial Condition Examiners Handbook* is a requirement of the Accreditation Program. In addition, there is on-going off-site monitoring through the financial analysis processes. Reserves are required to be increased when found not to be sufficient.

In summary annual filings of the company, actuaries opine on whether the insurance reserves (technical provisions) are reasonable and meet actuarial standards of practice for the profession. In addition, independent auditors provide annual attestation on the financial statements and insurance department financial analysts provide quarterly monitoring. In addition, financial examinations review reserves and have the ability to require the company to increase reserves, if determined insufficient.

The NAIC *Accounting Practices and Procedures Manual* along with the NAIC *Annual Statement Instructions* detail reinsurance accounting requirements. Extensive details about reinsurance are included in Schedule F of the Annual Statement. The NAIC *Credit for Reinsurance Model Law (Model #785)* and the NAIC *Life and Health Reinsurance Agreements Model Regulation (Model #791)* outline the requirements that must be met in order for ceding insurers to take credit on their financial statements for reserves ceded to an assuming reinsurer. Adoption of Model #785 and Model #791 is a requirement of the Accreditation Program.

For liabilities, some stress testing is included in asset adequacy analysis for life insurance. For property/casualty insurance, the policy liabilities are reported at ultimate value and not discounted, so there is conservatism. Actuarial standards of practice for property and casualty actuarial reserving require the use of multiple loss scenarios. Risk based capital calculations on an individual company basis are required to be filed annually. Three formulas for risk based capital are updated and monitored on an annual basis. Risk-based capital is a method of measuring a minimum amount of capital appropriate for a company to support its overall business operations in consideration of its size and risk profile. The risk based capital analysis begins with reported financial data based upon the accounting requirements that apply to the insurer. A company's risk-based capital is calculated by applying factors to various asset, premium, claim, expense and reserve items. The factor is higher for those items with greater underlying risk and lower for less risky items. The adequacy of a company's actual capital can then be measured by a comparison to its risk-based capital as determined by the formula. Risk-based capital standards will be used by regulators to set in motion appropriate regulatory actions for insurers that show indications of weak or deteriorating conditions. It also provides an additional standard for minimum capital requirements that companies should meet to avoid being placed in rehabilitation or liquidation. Adoption of the *NAIC Risk-Based Capital for Insurers Model Act (Model #312)*, NAIC Actuarial Opinion and Memorandum Model Regulation (Model #822), NAIC Annual Statement Instructions, and *NAIC Accounting Practices and Procedures Manuals* is required under the Accreditation Program. The Accreditation Program also requires that accredited states value securities in accordance with standards promulgated by the NAIC Securities Valuation Office (SVO).

Assessment: Observed (O)

ICP 21: Investments

- *The supervisory authority requires insurers to comply with standards on investment activities. These standards include requirements on investment policy, asset mix, valuation, diversification, asset-liability matching, and risk management.*

Investment Policy, Asset Mix, Diversification, Asset-Liability Matching

The United States (U.S.) insurance regulatory framework is based upon years of development and improvements. The Accreditation Program requires all states to have a statute or regulation that requires a diversified investment portfolio for all domestic insurers both as to type and issues, and includes a requirement for liquidity. Many of these standards are summarized in the NAIC's two versions of its Investment of Insurers Model Act. The two versions present two different approaches that can be used to require a diversified investment portfolio. The Defined Limits version (*Model #280*) places restrictions on the amount that may be held in particular types of financial assets (e.g. limits on equities, noninvestment grade bonds, etc) as a means to achieve diversity. The Defined Standards Version utilizes a more principle-based approach to achieve diversity by requiring the board of directors to establish and monitor an investment policy that meets the specified criteria of the model.

The Investments of Insurers Model Acts do not have specific requirements in terms of asset and liability matching, but the *NAIC's Actuarial Opinion and Memorandum Model Regulation (Model #822)* outlines the various interest rate scenarios to be considered by the valuation actuary in performing the asset adequacy analysis. The adoption of the NAIC Actuarial Opinion and Memorandum Model Regulation is a requirement of the Accreditation Program.

Valuation:

The Defined Limits version of the NAIC Investments of Insurers Model Act (*Model #280*) provides that investments shall be valued in accordance with the valuation standards of the NAIC, including the *NAIC Purposes and Procedures of the Securities Valuation Office*, the *NAIC Valuation of Securities Manual*, the *NAIC Accounting Practices and Procedures Manual*, the *NAIC Annual Statement Instructions*, or any successor or valuation procedures officially adopted by the NAIC. In addition, the Accreditation Program (Law and Regulation Standard A.5., Valuation of Investments) requires the state to statutorily mandate that securities owned by insurance companies be valued in accordance with those standards promulgated by the NAIC Securities Valuation Office, and other invested assets be valued in accordance with the procedures promulgated by the NAIC Financial Condition (E) Committee.

Risk Management:

The process to review the company's risk management practices is evaluated through the examination process as covered in ICP 18. As discussed therein, U.S. insurance regulators do not explicitly require insurers to have comprehensive risk management policies and systems in place; however, the insurer's risks and their systems to measure and manage those risks are reviewed through the on-site inspection process. Through this process, the examination team reviews tools and reports utilized by the insurer to measure and manage risks and conducts in-depth interviews with top management and the board of directors that include risk management as a significant topic. The methods to review a company's risk assessment processes are outlined in the *NAIC Financial Condition Examiners Handbook*. The *Examiners Handbook* contemplates that management should have a process in place that ensures compliance with company policies and regulatory requirements; including compliance with investment objectives and dollar limits set by the company policy.

The *Examiners Handbook* requires the supervisor to identify and assess all significant inherent risks faced by the insurer, whether they relate to financial reporting issues or to business and operational issues. After risks have been identified, the examiner is required to identify and assess the internal control processes that mitigate each identified risk. Controls are assessed by considering both their design and operating effectiveness. When weaknesses in the company's internal controls are identified during the assessment process, the company is asked

to make corrections to its processes. The *Examiners Handbook* also requires the supervisor to determine if the investment policies are correlated to the nature of the products developed, their markets and distribution channels. As noted previously, adoption and compliance with the Examiners Handbook are required elements under the Accreditation Program.

The financial statements contain extensive investment schedules, which detail every individual investment owned, sold and purchased during the reporting period. These schedules can be accessed electronically and there are extensive regulator tools which allow analysis on a macro and a targeted basis. For example if a large issuer of corporate debt defaults, regulators can quickly determine which companies are invested in the issuer and the extent of the investments. This detailed reporting allows detailed analysis on the assets of individual insurers and on a market wide basis. This allows analysis on many different characteristics of the investment portfolio, including credit quality, asset type, maturity distribution, concentration of risk etc.

In addition to the laws and regulations regarding insurer investments, the NAIC has:

- Concentrated investment analytical expertise at the NAIC Securities Valuations Office (SVO) for use by all state regulators;
- Developed financial reporting requirements that require insurers to report each investment they own on an annual basis as well as detailed disclosure of acquisition and dispositions on an interim quarterly basis;
- Directed the SVO to opine on asset classification issues for reporting and solvency purposes;
- Directed the SVO to maintain a designation process so admitted assets can be categorized as to risk for appropriate RBC treatment;
- Directed the SVO to maintain a forward looking analysis of developments in the financial markets that could significantly impact insurer portfolios, such as CDOs RMBS, Enron, etc; and
- Directed the SVO to review for appropriateness the filings from insurers creating replicated/synthetic asset transactions.

Assessment: Observed (O)

ICP 22: Derivatives and similar commitments

- *The supervisory authority requires insurers to comply with standards on the use of derivatives and similar commitments. These standards address restrictions in their use and disclosure requirements, as well as internal controls and monitoring of the related positions.*

Assessment:

Section 18 and Section 31 of the NAIC Investment of Insurers Model Act (Defined Limits Version) (Model #280) outlines the conditions and restrictions in the use of derivatives and other off-balance sheet items, primarily for the purpose of limiting the insurer's risk exposure.

Section 4 of the *NAIC Investments of Insurers Model Act* (Defined Limits Version) (Model #280) outlines the requirements for investment policy and authorization by the board of directors. Section 5 of the NAIC Investments of Insurers Model Act (Defined Standards Version) (Model #283) also includes factors to be considered by the insurer in determining whether an investment portfolio or investment policy is prudent, including the exposure to various risks.

Section 4 of the recently updated *NAIC Derivative Instruments Model Regulation* (Model #282) includes guidelines and internal control procedures necessary to affect and maintain derivative transactions, which includes a system for determining whether a derivative instrument used for hedging has been effective. It also requires insurers to have a credit risk management system for over-the-counter derivative transactions that measure credit-risk exposure.

Section 4 of the NAIC Investments of Insurers Model Act (Defined Standards Version) (Model #283) requires the insurer to establish and implement internal controls and procedures to assure compliance with investment policies and procedures. In addition, Section 5 of the NAIC Derivative Instruments Model Regulation (Model #282) requires that written documentation explaining internal guidelines and controls governing derivatives transactions be submitted for approval by the state insurance supervisor. The supervisor has authority to disapprove the guidelines. The NAIC *Financial Condition Examiners Handbook* also includes examination procedures to ensure that the internal controls established in the area of derivative transactions exist and are working effectively. Adoption of the NAIC *Financial Condition Examiners Handbook* is a requirement of the NAIC Accreditation Program.

Statement of Statutory Accounting Principles No. 86 – *Derivative Instruments* requires mark to market accounting, generally, for any derivative instrument that is not in a highly effective hedging relationship. By virtue of requiring mark to market accounting, the insurer must have the capability to verify pricing of all derivatives carried at fair value. Such pricing is subject to annual independent CPA audits as well as verification by the insurance supervisor during on-site financial examinations of the insurer. In additions, even derivatives in an effective hedging relationship with certain assets that are not marked to market are required to provide current fair value information on a quarterly basis. The NAIC *Financial Condition Examiners Handbook* requires the examiner to verify compliance with SSAP No. 86 valuation guidance during a financial examination. SSAP No. 86 also requires extensive disclosures about derivatives, their use and the company's objectives in using derivatives and the context needed to understand them. This includes gains and losses and disclosures about the cash flow implication of derivative investments. There are also disclosures if an insurer writes derivatives and the possible impacts. If an insurer writes derivatives both the accounting guidance and model laws address that "covering assets" must be set aside for future obligations. SSAP No. 86 also requires that the amounts from writing derivatives are recognized as a deferred liability.

There are also extensive financial reporting requirements including the reporting of every individual derivative owned in annual statement investment schedule DB. Like the other investment schedules, every derivative investment owned, purchased and sold is listed.

The NAIC *Derivative Instruments Model Regulation (Model #282)* requires the insurer to establish written guidelines to require compliance with internal control procedures. As stated in Principle 10 above, the annual internal control letter from the independent CPA is required to report any significant deficiencies in the insurer's internal control environment and such controls are also subject to examination by the insurance supervisor.

Section 4 of the NAIC Investment of Insurers Model Act (Defined Limits Version) (Model #280) requires that, on no less than a quarterly basis, and more often if deemed appropriate, an insurer's board of directors shall receive and review a summary report on the insurer's investment portfolio, its investment activities and investment practices, in order to determine whether the investment activity of the insurer is consistent with its written investment policy. The board of directors may review and revise the written investment plan, as appropriate, on no less than a quarterly basis. While this provision applies to the insurer's entire investment portfolio, such information also includes the derivative activities of the insurer.

Section 4 of the *NAIC Derivative Instruments Model Regulation (Model #282)* requires the board of directors to determine whether the insurer has adequate professional personnel, technical expertise and systems to implement investment practices involving derivatives. Section 4 of the NAIC Investments of Insurers Model Act (Defined Limits Version) (Model #280) requires the board of directors to review and assess the insurer's technical investment and administrative capabilities and expertise before adopting a written investment policy concerning the overall investment strategy or investment practice.

The NAIC *Accounting Practices and Procedures Manual*, SSAP No. 86, paragraphs 53-54; require significant disclosures for all derivative contracts outstanding. Adoption of the NAIC *Accounting Practices and Procedures Manual* is a requirement of the NAIC Accreditation Program. In addition, the statutory financial statements require extensive individual derivative information in investment schedule DB.

Assessment: Observed (O)

ICP 23: Capital adequacy and solvency

- *The supervisory authority requires insurers to comply with the prescribed solvency regime. This regime includes capital adequacy requirements and requires suitable forms of capital that enable the insurer to absorb significant unforeseen losses.*

One of the methods state regulators use to monitor the solvency and capital adequacy of insurance companies is the risk-based capital (RBC) calculation. The RBC calculation is a standardized approach to measuring a minimum amount of capital appropriate for an individual insurance company to support its overall business operations in consideration of its size and own-risk profile. The RBC provides an elastic means of setting the capital requirement which reflects the degree of risk taken by the insurer as the primary determinant. The same RBC formulas specified by the NAIC are used by all of the states.

The risk-based capital calculation provides higher RBC charges for riskier assets or for riskier lines of business so more capital is needed. An additional RBC charge is added for a concentration of assets in a particular issuer. Some common risks identified in the RBC calculations include asset risk (including credit risk, interest rate risk and market risk), underwriting or insurance risk, and business risk.

The *NAIC Risk-Based Capital for Insurers Model Act* (Model #312) is a requirement within the NAIC Accreditation Program and has been implemented in a substantially similar form in all states. Along with the *NAIC Risk-Based Capital for Health Organizations Model Act* (Model #315), these model acts specify solvency control levels where the state would intervene and require corrective action or take control of the company based on the results of the RBC formula. The RBC Model Act also requires companies to file a plan with projections of future results if the company's reported capital falls below the highest solvency control level as calculated by the RBC formula or in certain cases if reported capital is trending downward toward the highest solvency control level.

Statutory accounting principles as defined in the NAIC Accounting Practices and Procedures Manual are the basis for suitable forms of capital. This includes the concept of non-admitted assets, which are assets held by insurers that are not able to be counted toward capital and surplus. The insurance regulatory scheme does not include different tiers of capital. However, surplus notes that meet specified regulatory requirements are hybrid instruments that are allowed as capital and surplus of an insurer. These statutory accounting principles are also the basis for the valuation of assets (including the admission, valuation and impairment of the assets) and the valuation of liabilities as reported in the NAIC statutory annual statement. Certain amounts reported in the statutory annual statement are then used as inputs for the RBC calculation.

Investment limitation laws limit the percentage of the company portfolio of assets the company can invest in for different classes of assets. If the investment limitations are exceeded for a class of assets such as common stock, the assets above the limit are non-admitted. There are significant reinsurance requirements that include the ability of reinsurers to pay. This includes statutory accounting requirements for taking a reserve credit for the reinsurance and collateral requirements for the reinsurer.

States maintain fixed minimum capital requirements related to incorporation and licensing within a particular state. These requirements are set at a level to protect policyholder interests. The NAIC Accreditation Program (Law and Regulation Standard A.2., Capital and Surplus Requirement) requires statutory authority requiring that insurers have and maintain a minimum level of capital and surplus to transact business. The state must also have the authority to require additional capital and surplus based upon the type, volume and nature of the insurance business transacted. These fixed minimum capital and surplus requirements fit together with the company specific RBC requirement so that an insurer must maintain capital and surplus in excess of both requirements.

Another component of the solvency framework involves the Financial Analysis (E) Working Group, which routinely analyzes nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled to determine if appropriate action is being taken. In addition, the NAIC has created numerous Financial Analysis Solvency Tools that are enhanced regularly to assist states in screening, prioritizing and analyzing insurers. These tools include both quantitative and qualitative analysis and are developed, maintained and improved by regulator working groups and NAIC staff.

Assessment: Observed (O)

ICP 24: Intermediaries

- *The supervisory authority sets requirements, directly or through the supervision of insurers, for the conduct of intermediaries.*

State insurance regulators have a very structured system for the licensing and monitoring of intermediaries, commonly referred to as producers in the United States. The *NAIC's Producer Licensing Model Act (Model #218)* provides the basis for this system, having been enacted into law in a substantial majority of the states.

All individuals who sell, solicit or negotiate insurance are required by law to be licensed. As part of this process, both the individual and the business entity through which the producer operates must be licensed. Resident applicants must pass a test to ensure a minimal level of competency. Tests are specific to the following lines of authority: (1) life; (2) accident and health or sickness; (3) property; (4) casualty; (5) variable life and variable annuity products; and (6) personal lines. A resident applicant must pass a test for each line of insurance he/she wishes to sell. Some state insurance regulators also require pre-licensing education before a resident applicant can sit for an examination. To ensure producers are of sound moral character, applicants are asked a series of background questions. Sixteen states fingerprint their applicants to identify any prior criminal activity. Once licensed, producers must satisfy ongoing continuing education requirements in their resident state. The standard is 24 hours of continuing education every two years, with 3 of the 24 hours in ethics.

In addition to obtaining a resident or home state license, producers must also obtain a license in each non-resident state where they wish to sell, solicit or negotiate insurance. In other words, an applicant will first obtain a resident or home state license in the state the applicant maintains his or her principal place of residence or principal place of business. Once a resident or home state license is obtained the producer may then expand into other states by obtaining a non-resident license.

State insurance regulators retain wide discretion as to what activities warrant the denial, imposition of sanctions for engaging in misconduct. In addition, a Federal law, 18 U.S.C. 1033, imposes a lifetime ban from the business of insurance for felons whose crime involves dishonesty or breach of trust. The only way such individual may engage or participate in the business of insurance, is to obtain a "written consent" of the appropriate insurance commissioner. These include suspension or revocation of both a resident and non-resident license as well as the levying of fines where appropriate. State insurance regulators may take action against a licensee for a variety of infractions. For instance, a license may be suspended or revoked when a producer has misappropriated a client's money; however, states do not generally require an intermediary to have a separate trust account for the deposit of clients' funds.

Insurance producers may work as independent producers, who represent multiple companies, or may work as captive producers and represent only one company. Forty-two states and the District of Columbia require producers to obtain formal appointments with the companies they represent. Insurance companies are then required to notify states of the appointment of each state in which the producer will be selling, soliciting or negotiating insurance of the appointment. Finally, producers generally disclose associations through the normal course of business as insurance consumers need to understand what company will be underwriting the risk.

All information about producers is centrally coordinated and stored in a national database called the State Producer Licensing Database (SPLD). The following information is maintained in the SPLD: (1) general demographic information relating to all producers, such as name and address(es); (2) license information, such as states licensed, license numbers, authorized lines and license status; (3) appointment information, such as company appointments, effective date, termination date and termination reason; and (4) regulatory actions (if taken).

Assessment: Observed (O)

ICP 25: Consumer protection

- *The supervisory authority sets minimum requirements for insurers and intermediaries in dealing with consumers in its jurisdiction, including foreign insurers selling products on a cross-border basis. The requirements include provision of timely, complete and relevant information to consumers both before a contract is entered into through to the point at which all obligations under a contract have been satisfied.*

Intermediaries - commonly referred to as “producers” in the U.S. - are prohibited by state law from using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business. Because of varying resources and structures of producers, state insurance regulators do not dictate what type of training or systems insurers and producers must have in place. Producers have a responsibility to provide appropriate disclosure concerning the products they sell and their potential impact on the consumer if purchased as well as to assess the needs of their clients. For the sale of annuities, insurers and producers are required to make reasonable efforts to obtain information concerning a consumer’s financial status, tax status, and investment objectives to make an appropriate recommendation to the consumer. Moreover, it is an unfair trade practice for an intermediary to misrepresent the benefits and conditions of a policy. Finally, insurers are also required to provide each consumer with a copy of their contract.

States uniformly require insurance claims to be settled in an equitable and fair manner. For example, any of the following acts constitute an “unfair claims practice” and are prohibited: (1) knowingly misrepresenting to claimants and insured’s relevant facts or policy provisions relating to coverage’s at issue; (2) failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies; (3) not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear; (4) refusing to pay claims without conducting a reasonable investigation; and (5) attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application.

The NAIC has adopted the *Insurance Information and Privacy Protection Model Act (Model #670)*, the *Privacy of Consumer Financial and Health Information Regulation (Model #672)* and the *Standards for Safeguarding Consumer Information Model Regulation (Model #673)*. The purpose of these models is to establish standards for the states to enact for the collection, use and disclosure of information gathered in connection with insurance transactions by insurance institutions, producers or insurance support organizations.

State insurance regulators track unlawful unauthorized insurance activity, issue warnings to the public to be wary of those engaged in these activities, and take enforcement action, such as cease and desist orders, to stop them. In addition, state insurance regulators, through the NAIC have conducted a national consumer educational campaign on fake insurance plans. States also maintain consumer information on their Web sites, develop consumer brochures, and conduct in-person consumer outreach. Most recently, the state insurance regulators, through the NAIC, have created a program entitled Insure U, which is specifically designed to provide consumers with the knowledge needed to make wise buying decisions - http://www.naic.org/index_consumer.htm.

In 2007, insurance regulators in the United States responded to 2,351,686 consumer inquiries and 371,444 consumer complaints against their insurers. In many instances, intervention by the regulators resulted in resolving complaints in favor of the consumers by, for example, paying of a claim or extending coverage under the terms of a policy.

Assessment: Observed (O)

ICP 26: Information, disclosure & transparency towards the market

- *The supervisory authority requires insurers to disclose relevant information on a timely basis in order to give stakeholders a clear view of their business activities and financial position and to facilitate the understanding of the risks to which they are exposed.*

Assessment

State regulators require Statutory Accounting Basis Financial Statements to be filed in the state and with the NAIC on at least an annual basis and quarterly statements are also required. These requirements are part of the Accreditation Program. Statutory Financial Statements contain the primary financial statements: balance sheet, income statement, statement of cash flows and notes to financial statements. These are filed with the NAIC electronically in a structured reporting format. Companies must provide extensive information related to assets held, and detailed information related to loss/claim reserves, expenses, investment income, capital gains (losses) and profitability by line of business. The Securities Exchange Commission (SEC) requires financial statements prepared on a GAAP basis for public companies, and these are geared more toward non-regulatory market participants. Statutory filings are explicitly for the benefit of the state insurance regulators. All above references to financial disclosures are in terms of statutory reporting.

Companies are also required to provide actuarial certifications and opinions on claim and related loss reserving liabilities and companies must file an annual Certified Public Accountant audited financial report and a Management Discussion and Analysis. The Statutory Financial Statements are required to be completed in accordance with the NAIC *Annual Statement Instructions, Accounting Practices and Procedures Manual* and *Securities Valuation Office Purposes and Procedures Manual*. As it relates to statistical reports, state regulators have the authority to make “data calls” of the industry at any time. The NAIC Accreditation Program (Law and Regulation Standard A.15., Filings with NAIC) requires the state to have statutory authority to require companies to file annual and quarterly financial statements with the NAIC. Adoption of the NAIC *Annual Statement Blank, NAIC Annual Statement Instructions* and *NAIC Accounting Practices and Procedures Manual* is required by the NAIC Accreditation Program.

Insurers must also complete the risk-based capital report, which assesses capital charges against various risk exposures in the insurer’s operations, investments, etc. This report is confidential for regulators; however summary information regarding the results of the report is included in the annual statement.

Comprehensive accounting guidance is specified in the NAIC *Accounting Practices and Procedures Manual*, with limited exceptions, which are explicitly disclosed.

As specified in the NAIC *Accounting Practices and Procedures Manual* and by state law, there is to be included or attached to Page 1 of the annual statement, the statement of a qualified actuary, entitled “Statement of Actuarial Opinion,” setting forth his or her opinion relating to loss and loss adjustment expense reserves. Requirements also exist as it relates to the company’s appointment of the qualified actuary and the content of the actuarial report and opinion.

Companies are required to file quarterly statements forty-five days after the end of the quarter and the annual statement on or before March 1st of the preceding calendar year, unless otherwise required. Generally, the President, Secretary and Treasurer of each company are required to sign the annual and quarterly statements on the Jurat page as it relates to the following statement:

“The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained,

annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions there from for the period ended, and have been completed in accordance with the NAIC *Annual Statement Instructions and Accounting Practices and Procedures* Manual except to the extent that: (1) state laws may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively.”

State regulators have the authority to request amendments to these quarterly statements.

Off-balance sheet items are disclosed in the General Interrogatories and the Notes to Financial Statements of the annual and quarterly statements.

The NAIC’s automated financial data repository and other systems provide state insurance departments with on-line access to financial and market data useful in financial solvency and market surveillance. State insurance departments are connected to the NAIC systems via a client/server network. This network, which was completed in 1995, provides easy access to databases, increased productivity, and improved integration of technology. The Accreditation Program (Regulatory Practices and Procedures, Part B.1.) requires insurance departments to maintain a financial analysis staff to adequately collect, analyze and monitor the financial condition of their domestic insurance companies on both an individual company basis and on a macro basis.

Companies are required to have an annual audit by an independent CPA and are required to file an audited financial report as a supplement to the annual statement on or before June 1 for the year ended December 31 immediately preceding. The Accreditation Program requires that the state adequately document its review and consideration of the CPA report. In addition to ongoing quarterly analysis, on-site financial examinations by state regulators range from every three to five years depending upon individual state statutes. The NAIC *Model Law on Examinations* states that the insurance supervisor shall at a minimum conduct an examination of every insurer licensed in the state not less frequently than once every five years. In scheduling and determining the nature, scope and frequency of the examinations, the insurance supervisor shall consider such matters as results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent CPA, and other criteria as set forth in the NAIC *Financial Condition Examiner’s Handbook*. Regulatory concerns may cause insurers to have either full or limited scope financial exams occurring more frequently. There is to be included or attached to Page 1 of the annual statement, the statement of a qualified actuary, entitled “Statement of Actuarial Opinion,” setting forth the actuary’s opinion relating to loss and loss adjustment expense reserves. Requirements also exist as it relates to the company’s appointment of the qualified actuary and the content of the actuarial report and opinion. The NAIC Accreditation Program (Regulatory Practices and Procedures, Part B.2.) requires insurance departments to maintain an examination division to perform on-site examinations on a periodic basis. Adoption of the NAIC Model Law on Examinations (*Model #390*) is a requirement of the NAIC Accreditation Program.

Assessment: Observed (O)

ICP 27: Fraud

- *The supervisory authority requires that insurers and intermediaries take the necessary measure to prevent, detect and remedy insurance fraud.*

State Antifraud Plan laws, regulations and bulletins require insurers to establish internal models for fraud prevention and reporting. Antifraud Plans detail the measures a carrier should take to prevent fraud and provide protocol when fraud is discovered. The insurer or intermediary's Antifraud Plan must be filed with the state insurance regulator.

Financial and market conduct examinations will reveal fraud. State insurance regulators regularly conduct examinations. Insurers understand that in order to continue conducting business in a state, they should demonstrate they are in compliance with all state laws, including antifraud laws.

States utilize the antifraud laws established through their state legislature to combat insurance fraud. Insurers are required to report external, internal and claims suspected fraud. The NAIC offers consumers and insurers the Online Fraud Reporting System (OFRS) in order to facilitate mandatory reporting. A report made in OFRS is delivered to all states the insurer does business in.

Many U.S. insurers and intermediaries dedicate specific staff to address internal and external fraud, commonly known as Special Investigation Units (SIU). State insurance regulators work closely with Sinus to assist in fraud investigations, as well as the prevention of fraud.

Regulators have statutory authority to share information regarding investigations, actions and examination results with other insurance regulators and law enforcement agencies. Insurance regulators may levy civil penalties or take civil action for unfair trade practices, which in many cases encompasses instances of fraud. Cases may also be referred for criminal prosecution. If an insurance regulator does not house an internal prosecutor, state or local prosecutors accept referred cases. Statutes provide state insurance regulators with all necessary means to address insurance fraud.

State insurance departments have established protocol and department personnel dedicated to investigating and often prosecuting insurance fraud referrals.

State regulators maintain excellent reporting and cooperative relationships with state and federal law enforcement agencies, SIUs, and independent antifraud associations. These relationships allow state regulators to better combat insurance fraud and work towards the reduction of insurance fraud. Through educational opportunities and outreach, state regulators encourage agencies, organizations and insurers to work cooperatively on investigations and suspected fraudulent activities.

Assessment: Observed (O)

ICP 28: Anti-money laundering, combating the financing of terrorism (AML/CFT)

- *The supervisory authority requires insurers and intermediaries, at a minimum those insurers and intermediaries offering life insurance products or other investment related insurance, to take effective measures to deter, detect and report money laundering and the financing of terrorism consistent with the Recommendations of the Financial Action Task Force on Money Laundering (FATF).*

The supervisory authority requires insurers and intermediaries, at a minimum those insurers and intermediaries offering life insurance products or other investment related insurance, to take effective measures to deter, detect and report money laundering and the financing of terrorism consistent with the Recommendations of the Financial Action Task Force on Money Laundering (FATF).

The Bank Secrecy Act (BSA) at 31 U.S.C. 5318(h) was adopted by the United States Congress in 1970 as a means to fight money laundering in the United States. However, it had limited application to certain businesses. In 2001, the U.S.A. Patriot Act amended the BSA to include all businesses defined as financial institutions. Effected insurers, including life insurance carriers and other investment related insurers, are now required to comply with the provisions of the BSA, in particular, the Anti-Money Laundering (AML) provisions. The Financial Crimes Enforcement Network (FinCEN) is responsible for the administration of the BSA and AML activities.

The BSA requires financial institutions to report transactions by businesses or individuals of \$10,000.00 or more. Additionally, the financial institutions are required to file Suspicious Activities Reports (SAR) under certain circumstances that can indicate or are common indications of fraudulent activities. In the case of insurance, life insurance proceeds commonly require these filings.

The *NAIC Financial Condition Examiners Handbook* recommends that regulators conducting exams notify appropriate federal regulators if an insurer is not in compliance with the required practice. State insurance regulators confirm insurance carriers Anti-Money Laundering practices during financial and market conduct examinations.

State insurance fraud bureaus have access to the Federal Bureau of Investigation Law Enforcement On-Line (LEO) website. This website contains training information related to a number of topics, including AML. Through LEO, the state insurance fraud bureaus facilitate inquiries regarding suspicious activities with life insurance policies in death or missing person cases.

State insurance fraud bureaus work closely with their federal governmental counterparts when suspected money laundering activities are discovered. Regular financial examinations and market conduct examinations will discover money laundering activities. Both state and federal regulators have the authority to cooperate and share information relating to AML investigations.

State and federal laws implement and comply with FATF recommendations. AML activities have been criminalized in the United States at both the state and federal levels. Businesses and individuals must take certain record-keeping measures related to AML activities. Effected organizations and individuals have specific reporting duties. The United States aggressively fights money-laundering and has the adequate and recommended protections.

Assessment: Observed (O)

ANNEX A

Overview of the NAIC Financial Regulation Standards and Accreditation Program

The NAIC Financial Regulation Standards and Accreditation Program (the “Accreditation Program”) was developed to ensure that the state insurance departments are complying with minimum, baseline standards in regulating the financial solvency of its domestic insurers. These minimum baseline standards were developed in 1989, and the NAIC adopted a formal certification program in 1990.

The objective of the Accreditation Program is to provide a process whereby solvency regulation of multi-state insurance companies can be enhanced and adequately monitored with emphasis on the following: 1) adequate solvency laws and regulations in each accredited state to protect insurance consumers; 2) effective and efficient financial analysis and examination processes in each accredited state; and 3) appropriate organizational and personnel practices. This ensures that accredited state insurance departments have the power and authority to effectively regulate financial solvency, and also have implemented this authority through continual analysis and periodic examinations.

As of May 2009, 50 insurance departments are accredited, thereby indicating that they have met these minimum, baseline standards. Moreover, since the program began, all 50 states and the District of Columbia have adopted laws and regulations designed to bring them closer to meeting the NAIC’s accreditation standards.

The accreditation standards are divided into the following main parts and subparts:

- Part A: Laws and Regulations
- Part B: Regulatory Practices and Procedures
 - Subpart B1: Financial Analysis (Off-site monitoring)
 - Subpart B2: Financial Examinations (On-site monitoring)
 - Subpart B3: Information Sharing and Procedures for Troubled Companies
- Part C: Organizational and Personnel Practices

The Part A accreditation standards include 18 different topics such as Examination Authority, Corrective Action and Reinsurance Ceded. Each of these topics has additional significant elements with which the state must demonstrate compliance via a law, regulation and/or administrative practice. Within the 18 standards, there are a total of 119 significant elements.

The eight Financial Analysis accreditation standards deal with topics such as sufficient qualified staff and resources, appropriate supervisory review, priority-based review, appropriate depth of review and documented analysis procedures. Included in the eight standards are a total of 35 guidelines. Collectively, these standards require that the state insurance department appropriately monitor the financial solvency of its multi-state domestic insurers in a timely manner and take appropriate action, when warranted.

The nine Financial Examination accreditation standards deal with topics such as sufficient qualified staff and resources, use of specialists, use of appropriate guidelines and procedures and examination reports. Included in the nine standards are a total of 47 guidelines. Collectively, these standards require that the state insurance department examine an insurer’s financial statements on a routine basis and in consistent and appropriate manner.

The Information Sharing accreditation standards require that the state insurance department have the authority to share confidential information with certain parties. The state should also have the authority to maintain the confidentiality of confidential information received from certain parties. The Procedures for Troubled Companies standards require that the state generally follow and observe the procedures set forth in the NAIC *Troubled Insurance Company Handbook*.

The Part C accreditation standards relate to areas such as professional development, minimum educational and experience requirements and retention of personnel.

As part of the accreditation process, an on-site review is conducted of the state insurance department, during which a team of approximately five independent consultants review financial analysis and financial examination files to assess compliance with the accreditation standards established under the Accreditation Program. In addition, NAIC Legal staff reviews the state's laws and regulations to ensure that they are in compliance with the 18 accreditation standards related to laws and regulations. The Financial Regulation Standards and Accreditation (F) Committee of the NAIC, consisting of regulators from across the country, considers the report of the review team and decides whether a state meets the requirements set forth in the standards.

Once accredited, the insurance departments are accredited for a period of five years, subject to interim annual reviews. For the interim annual review, the state insurance department must complete a comprehensive questionnaire (and attach any applicable documents) related to its laws/regulations and its financial analysis and examinations processes and procedures. This submission is required on an annual basis and is reviewed by NAIC staff to ensure continued compliance with the accreditation standards.

Further information may be obtained at http://www.naic.org/documents/committees_f_FRSA_pamphlet.pdf