FINANCIAL SECTOR ASSESSMENT PROGRAM

UNITED STATES OF AMERICA

IAIS INSURANCE CORE PRINCIPLES

DETAILED ASSESSMENT OF OBSERVANCE

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Contents Page

GLOSSARY

AAA	American Academy of Actuaries
ABCD	Actuarial Board for Counseling and Discipline
AICPA	American Institute of Certified Public Accountants
AML/CFT	Anti-Money Laundering/Combating the Financing of Terrorism
APPM	Accounting Practices and Procedures Manual
ASB	Actuarial Standards Board
ASI	Annual Statement Instruction
ASOP	Actuarial Standards of Practice
ACL RBC	Authorized Control Level Risk-Based Capital
CPA	Certified Public Accountant
ERISA	Employee Retirement Income Security Act
FAST	Financial Analysis Solvency Tools
GAAP	Generally Accepted Accounting Principles
GLBA	Gramm-Leach-Bliley Act
GWP	Gross Written Premium
FATF	Financial Action Task Force
FAWG	Financial Analysis Working Group
IAIS	International Association of Insurance Supervisors
ICP	Insurance Core Principle
IFRS	International Financial Reporting Standards
MoU	Memorandum of Understanding
NARAB	National Association of Registered Agents and Brokers
NICB	National Insurance Crime Bureau
NIPR	National Insurance Producer Registry
PCAOB	Public Company Accounting Oversight Board
RBC	Risk-Based Capital
RIRS	Regulatory Information Retrieval System
RRG	Risk Retention Groups
SAD	Special Activities Database
SAO	Statement of Actuarial Opinion
SAP	Statutory Accounting Principles
SMI	Solvency Modernization Initiative
SSAP	Statements of Statutory Accounting Principles
SVO	Securities Valuation Office
TAC	Total Adjusted Capital
TALF	Term Asset-Backed Securities Loan Facility
TARP	Troubled Asset Relief Program
TRIA	Terrorism Risk Insurance Act

I. Executive Summary, Key Findings, and Recommendations

1. **Insurance regulation in the United States, which is mostly carried out by states, is generally thorough and effective, although there are areas where significant development is needed**. Strong regulation contributed to the overall resilience of the insurance sector during the financial crisis. There is generally a high level of observance of the Insurance Core Principles. Aspects of regulatory work such as data collection and analysis in relation to individual insurance companies are world-leading. There are mechanisms to ensure individual states implement solvency requirements effectively. However, there is a need for development of the policy framework in relation to insurance and financial stability and international issues; and for extensive reform to the laws governing state insurance departments, including on appointment and dismissal of commissioners, to secure the independence of regulatory work. The approach to supervision of groups needs significant development.

A. Introduction

2. **This assessment of the U.S.'s compliance with International Association of Insurance Supervisors (IAIS) Insurance Core Principles (ICP) was carried out as part of the 2010 U.S.A., Financial Sector Assessment Program (FSAP)**. The assessment was carried out by Tom Karp, insurance expert and a former Executive General Manager, Australian Prudential Regulatory Authority, and Ian Tower, Monetary and Capital Markets Department, IMF.

3. **While insurance regulation is principally a responsibility of the states, the assessment addresses national compliance with the ICPs**. Regulatory responsibility is shared by 50 states, the District of Columbia and the five U.S. territories. Although certain departments of the U.S. government maintain an interest in insurance, for example in relation to external trade (where states have no authority) and anti-money laundering, federal authorities have limited regulatory powers over the insurance sector. This assessment addresses insurance regulation nationally and does not assess individual state authorities.

B. Information and Methodology Used for Assessment

4. **The assessment was based on information available in November 2009 at the time of an FSAP mission**. The National Association of Insurance Commissioners (NAIC) contributed a self-assessment and further information in response to requests before and during the mission. Documentation, including relevant laws and regulations,[1] was supplied. The assessment has been informed by discussions with regulators and market participants. The assessors met with staff from the NAIC and with selected insurance commissioners[2] and

[1] The model laws of the National Association of Insurance Commissioners were the main documentary resource for this assessment but the assessors have also referred to select individual state laws.

[2] The term 'insurance commissioner' is used throughout this report to refer to the most senior official responsible for insurance regulation in each state, district, or territory. Actual titles vary.

their staffs; with government, insurance companies and intermediaries; and with industry and actuarial bodies. The assessors are grateful for the full cooperation extended by all.

5. **The assessment was based on the 2003 version of the IAIS Insurance Core Principles and Methodology**. It took into account relevant IAIS standards and guidance in addition to the ICPs. The assessment of ICP 28 (anti-money laundering, combating the financing of terrorism (AML/CFT)) has been informed by the assessment carried out in 2006, of U.S. compliance with the Financial Action Task Force (FATF) AML/CFT standards, using the 2004 Methodology.

6. **The approach to this assessment reflects the large market size and state-based system of insurance regulation**. As the assessment addresses national compliance and the assessors were not able to hold discussions or review material from more than a few state authorities, reliance has been placed on discussions with:

- NAIC staff on regulatory practices across the states, based on an NAIC self-assessment which addresses compliance with the ICPs for the United States as a whole; and on the processes and procedures used by the NAIC (i.e., the commissioners of insurance acting collectively and the staff of the association) in their support for state regulators (see paragraphs 20 to 21); and

- A selection of insurance commissioners and their staff in the states of Illinois, Iowa, New York, and West Virginia. While discussions in all these states were wide-ranging, they paid particular attention respectively to life insurance supervision, the property and casualty sector (including brokers), coordination with foreign regulators, and challenges faced by smaller states.

- The assessors also met with officials from the U.S. Department of the Treasury to discuss their overview of the system in the context of evolving plans for the reform of U.S. regulation in response to the financial and economic crisis.[3]

7. **Findings from these discussions (and documents made available to the assessors) have been used to inform the overall assessment of observance of the ICPs in the United States**. The well-developed procedures of the NAIC have made it possible to take a view, in particular for financial regulation, of the degree of uniformity, in extent and quality of regulation, across the states. Nonetheless, the assessors note that their conclusions are subject to unavoidable limitations on their ability to verify practices across the country (particularly in the implementation of regulatory requirements) that result from a state-based system with over 50 separate authorities.

[3] In particular, the mission discussed the proposals set out in the document "Financial Regulatory Reform: A New Foundation," U.S. Department of the Treasury, June 2009.

C. Institutional and Market Structure—Overview

8. **The U.S. insurance market is the largest in the world**. There were 7,948 licensed insurance companies at the end of 2008. Total premium volume in 2008 of US$1.24 trillion accounted for 29 percent of the global market (Japan and the United Kingdom were second and third largest with 11 percent and 10 percent shares respectively). On insurance density measures (premiums per capita), the United States ranked ninth at US$4,078 in 2008 and thirteenth on insurance penetration (premiums as a percentage of GDP) at 8.7 percent.[4] There are three main sectors—life, property and casualty (divided between personal and commercial lines), and health insurance. Key specialist insurance lines (i.e., those which must be written in separate companies) are: financial guaranty (bond insurance—the "monoline insurers"); mortgage insurance; and title insurance. The sector also includes captive insurance companies and Risk Retention Groups (RRGs). Total employment in insurance companies was 1.6 million at the end of 2008.

9. **Most U.S. insurers write primary insurance on U.S. risks**. The U.S. market is characterized by:

- low market concentration in most sectors, indicating a high degree of competition, which has been supported by provisions allowing certain risks, mostly in commercial lines, that are hard to insure ("excess and surplus lines") to be written free of some of the general regulatory requirements and coverage by guaranty funds, provided that cover has previously been sought by an agent but cannot be obtained in the regulated ("admitted") market;

- limited private sector capacity in certain "hard to insure" risks, particularly those related to severe weather, natural catastrophes, and some classes of medical risks, which has led to the creation of certain "residual market" mechanisms, such as joint underwriting arrangements and programs provided directly by state or federal government; at federal level, these cover, in particular, terrorism losses (TRIA), flood risk and crop loss; and, at state level, mainly workers compensation or property risks in areas exposed to natural catastrophes and reinsurance for hurricane losses (the Florida Hurricane Catastrophe Fund);

- limited international insurance business (so most business written by U.S. insurers is in relation to U.S. risks) and a relatively small reinsurance capacity—58 percent of all premium ceded to reinsurers by U.S. insurers is to markets in Europe and Bermuda (85 percent, if premium ceded to offshore affiliates of U.S. companies is included); and

[4] All data from Swiss Re: World Insurance in 2008.

- relatively few cross-sector groups offering insurance as well as other financial services: while the 1999 Gramm-Leach-Bliley Act (GLBA) reformed the regulatory framework to accommodate cross-sector groups, there are only 17 groups headed by a bank holding company regulated by the Federal Reserve (because they offer insurance and banking), while 42 contain a thrift regulated by the Office of Thrift Supervision.

10. **Distribution of insurance products is mainly through agents and brokers**. Intermediaries distributing insurance in the United States are generally referred to as "producers." They may act as agents of one or more insurance companies (captive agents or independent agents) or as brokers—i.e., acting on behalf of the customer. Banks may also distribute insurance products but have limited market share.

Recent performance

11. **Overall, the insurance sector, and the property and casualty companies in particular, has been resilient through the financial crisis**. Capital and surplus, the key measure of the buffer available in case insurance company reserves prove inadequate to ensure that policyholder claims can be paid, has fallen by 6.7 percent in life and 8.5 percent in property and casualty between end-2007 and mid-2009. Companies whose capital adequacy, measured by the regulators' risk-based capital (RBC) requirements, fell to regulatory intervention levels[5] accounted for only 3 percent of the total in 2008. While there have been several firms placed in receivership, only one company has been subject to receivership for causes and with a timing directly related to the financial crisis.[6] The property and casualty sector suffered from investment market falls, but losses from natural catastrophes so far in 2009 have not been as high as in some recent years. As Table 1 shows, while absolute dollar amounts of capital have fallen, so has the required risk-based capital, leading to capital coverage ratios in the sectors falling more slowly. Actual capital in each of the sectors is many times greater than required RBC levels and, on average, about two to three times the capital levels at which regulatory intervention would occur.

12. **However, there have also been significant stresses in the insurance sector in the last two years**. Writers of financial guaranty business (the monoline insurers) lost the previously high ratings on which much of their business depended after serious losses on business related to impaired structured finance products. The American International Group (AIG) was supported by the federal authorities after major losses at its capital markets affiliate. Two other insurance groups with federally regulated banking or thrift subsidiaries were granted federal government capital support under the Troubled Asset Relief Program (TARP) (others had applied for funds). Insurers also benefited from Federal Reserve

[5] The basis for calculating capital adequacy—Risk-Based Capital (RBC)—is described and assessed under ICP 23 in Table 4 (the detailed assessment) and the system of control levels (triggers for intervention) is described and assessed under ICP 14.

[6] See the assessment of ICP 16 for an account of receivership and other enforcement powers.

programs, particularly the Term Asset-Backed Securities Loan Facility (TALF) that supported liquidity in the markets in which they had invested.

Table 1. United States: U.S. Insurance Companies—Capital Adequacy

Year End	2008	2007	2006	2005	2004
Life					
Total adjusted capital (US$ billions)	337.9	382.6	363.5	344.4	340.2
RBC requirement (US$ billions)	44.6	47.7	44.8	42.3	43.9
Industry aggregate RBC ratio (TAC as % of RBC)	758%	802%	811%	814%	775%
Median RBC ratio of insurers (TAC as % of RBC)	910%	1009%	996%	975%	940%
Number of companies in action levels	23	13	13	11	17
Percentage of companies in action levels	2.7%	1.5%	1.4%	1.1%	1.7%
Property and Casualty					
Total adjusted capital (US$ billions)	578.9	640.7	599.3	523.8	484.8
RBC requirement (US$ billions)	96.8	102.7	98.6	94.2	93.6
Industry aggregate RBC ratio (TAC as % of RBC)	598%	624%	608%	556%	518%
Median RBC ratio of insurers (TAC as % of RBC)	992%	977%	935%	877%	828%
Number of companies in action levels	79	71	75	86	108
Percentage of companies in action levels	3.0%	2.7%	2.9%	3.4%	4.3%
Health					
Total adjusted capital (US$ billions)	75.2	79.9	72.2	61.6	46.8
RBC requirement (US$ billions)	12.7	12.2	10.9	9.6	8.1
Industry aggregate RBC ratio (TAC as % of RBC)	592%	655%	662%	642%	578%
Median RBC ratio of insurers (TAC as % of RBC)	545%	589%	582%	574%	548%

13. **Life insurance has been particularly affected**. In addition to large unrealized investment losses, some companies experienced downward pressure on regulatory capital ratios that raised concerns over possible widespread ratings downgrades. Regulators were approached for relief and firms were granted some individual modification ("permitted practices"). The strains were related to recent strong growth in non-traditional savings products such as variable annuities (Box 1), many of which contain generous guarantees. Life insurers were also affected by the illiquidity in asset markets, including pressures in securities lending (cash collateral had been reinvested by some firms in illiquid instruments, causing liquidity strains when the collateral was recalled). New business volumes have been falling sharply.

Box 1. Variable Annuities

Variable annuities products are investment-linked products with some form(s) of guarantee (accumulation, income, death or withdrawal) which are sold by life insurers into the retirement and investment market. In the United States, the most common guarantee offered is that on withdrawal. The customer's initial capital paid into such a product is invested in a sub-account at the customer's discretion. The customer can withdraw guaranteed periodic amounts up to the amount of the initial capital. The product terminates once the initial capital has been withdrawn with any remaining funds in the sub-account returned to the customer at maturity. So the sub-account value fluctuates with movements in the underlying assets and decreases with withdrawals.

The product therefore effectively combines an annuity, in the form of guaranteed periodic withdrawals, with a call option on the underlying residual sub-account at maturity. So, while the customer who owns the sub-account carries much of the investment risk, the insurer is carrying the risk that the sub-account will not be adequate to fund the guaranteed withdrawal amounts**.**

The NAIC has been developing its approach to the treatment of such products with complex guarantees in its capital adequacy requirements. In 2000, an internal models based approach was added to the previously factor-based capital approach to capture interest rate risk. This was refined in 2005 to capture equity risk.

These changes have automatically been applied by all states, as the NAIC risk-based capital system is referenced in all state laws. Work is currently under way further to refine the reserving requirements for such products. Over the last few years, and especially since the financial crisis, insurers have reduced their writing of such products and scaled back the types and levels of guarantees offered.

14. **While pressures have eased, there remain challenges**. The recovery in many markets since March 2009 has brought relief to the insurance sector. However, risks remain.

- Life companies in particular remain significantly exposed to possible further problems if economic downturn continues. Their commercial property exposure is high, both in loans and investments, as is exposure to banks. A prolonged low interest rate environment would exacerbate strains. However, as life companies have shifted to savings products, their insurance risks (mortality and longevity) have become less significant.

- Health insurers are subject to significant uncertainty arising from the proposed federal government reforms to health insurance.

- Property and casualty risks are more dispersed. While the United States is exposed to major natural catastrophes, their impact is regional; and while some companies are heavily exposed to particular events, national companies have diversified risks and the largest catastrophe risks are carried by reinsurers outside the United States.

Regulatory arrangements

15. **Insurance is a predominantly state-regulated activity in the United States**. While the foundation for state responsibility goes back to 1851, a key event was the legislative reaction to a Supreme Court decision in 1944. The court declared that insurance was interstate commerce and, hence, under the U.S. constitution, subject to federal regulation,

16. **There are also some federal government responsibilities**. While state regulation has not been substantially challenged since 1945, the federal government has enacted various measures affecting insurance. The 1974 Employee Retirement Income Security Act (ERISA) imposed federal reporting requirements and enforcement powers for employer-sponsored retirement plans and other related benefits. The Gramm-Leach-Bliley Act of 1999 preserved state regulation by reaffirming the McCarran-Ferguson Act, but pressed the states to achieve licensing reciprocity in insurance intermediary licensing or accede to federal intervention. The 2002 U.S.A. PATRIOT Act extended aspects of the Federal Bank Secrecy Act to insurance and gave examination powers in relation to anti-money laundering and certain specified insurance business to federal authorities.

17. **States carry out insurance regulatory functions within the state administration**. The insurance departments or similar units within state administrations carry out licensing and oversight work for insurance companies and intermediaries under powers set out in state legislation and in accordance with state budgets. A commissioner heads the department and exercises all formal powers. Some commissioners are elected, but most are appointed by the state governor. While arrangements vary among states, funding is usually raised from the insurance markets via fees and levies. (Fees are usually for specific activities, such as licensing and examinations, and are generally paid directly to the insurance department. Levies usually form part of state government revenue and are either dedicated to funding the insurance department or flow to general revenue with insurance department budgets subject to normal state budgeting processes). Insurance departments also collect premium taxes for the states, a significant part of state governments' total revenues.

18. **Businesses must obtain a license in each state where they are writing risks**. An insurance company is said to be "domiciled" in the state that issued its primary license; it is "domestic" in that state. Once licensed in one state, it may seek licenses in other states as a "foreign" insurer. An insurer incorporated in a foreign country is called an "alien" insurer in the U.S. states in which it is licensed. "Multistate companies" (the vast majority by premium income) are those that write business in more than one state. The extent of mutual recognition (known as reciprocity) varies by state and requirement, but financial regulation is mostly carried out by the state where the insurer is domiciled.

19. **State insurance departments carry out both financial and market conduct regulation**. States set reserving and capital requirements—the rules and associated reporting frameworks are complex and details are set out in an appendix to this assessment. States carry out financial analysis and onsite examinations—which are required by law every five years at minimum (or three years in some states). Most states have some review or approval authority over policy forms and, in the case of property and casualty insurers, they also often regulate premium rates. In respect to rates, the objective is to ensure that they are

not inadequate, excessive, or unfairly discriminatory. Departments also respond directly to consumers' complaints and requests for information. They license and oversee insurance intermediaries. States have extensive powers to enforce their financial and market conduct requirements.

20. **The NAIC plays an important coordinating role for state regulators**. The NAIC is the vehicle through which the state insurance commissioners act as a group. The commissioners have established a not-for-profit organization to assist them in respect of their regulatory responsibilities, by centralizing some functions to achieve economies and greater uniformity, to pool resources and to obtain and share expertise. The objective is to enable the states to develop regulation in ways they could not achieve by acting individually. The NAIC itself employs some 430 staff, which compares with nearly 12,000 employed by the states. Key functions of the NAIC, in relation to this assessment, are:

- processes and procedures to develop and agree model laws and regulations, which now total over 200. States contribute to the development of these laws via NAIC working groups. While states are not obliged to implement model laws and regulations in state law, the process creates an expectation that state legislation will broadly mirror the requirements agreed by commissioners at NAIC meetings. In practice, states often implement the models with variations, which are particularly significant in market conduct and producer licensing;

- the Financial Regulation Standards and Accreditation Program (referred to in this report as "the accreditation program"). This is an extensive process aimed at ensuring that states meet certain minimum standards in respect to financial regulation. It covers, in relation to financial issues, laws and regulations (including 18 of the NAIC model laws) and key provisions on accounting and solvency; regulatory practices, including offsite and onsite supervision; and organizational and staffing practices. Standards on insurance company licensing will be added in 2012. In order to achieve and retain accreditation, states undergo a detailed review by independent examiners (many are accountants or retired senior regulators) once every five years; interim annual reviews are also required. Final decisions on accreditation are taken by a committee of commissioners. All 50 states and the District of Columbia are accredited. Formally, the effect of accreditation is to enable states to accept examinations undertaken by the domestic state rather than carrying out their own, although individual states may still impose additional standards on "foreign" companies (i.e., accreditation does not guarantee reciprocity). There are also reputational implications; and

- the centralized process of financial analysis operated through the mechanism of the NAIC's Financial Analysis Working Group (FAWG). This is a group of 18 senior financial experts who meet to discuss reports from NAIC staff covering all "nationally significant companies" (around 1,600 companies representing 85 percent of the market) based on annual and quarterly statements and other information. The

objective is to challenge domestic state regulators, who retain responsibility for any action, on their analysis of companies and their regulatory response. A similar process is being developed for market conduct regulation.

State regulators, through the NAIC, maintain a number of databases covering financial information (most companies submit statements direct to the NAIC), data on producers, etc.

21. **As they are the most likely to be fully and effectively implemented by states, this assessment highlights measures subject to accreditation program**. The assessors have relied heavily on the accreditation program, because it is widely seen as assuring that minimum standards are met in all accredited states. In assessing statewide compliance with other NAIC model laws and other measures, the assessment distinguishes between those implemented in most, many and some states. However, as mentioned above, states have not been assessed individually and there is therefore a degree of uncertainty about the assessment of compliance across the country in these cases.

22. **State regulators, through NAIC coordination mechanisms, have been taking initiatives to modernize key aspects of their approach, although progress has been mixed**. In addition to continuing development of their requirements, state regulators have been engaged since 2000 on a broad-based regulatory modernization plan. This includes shifting from predominantly compliance/audit examinations of insurers to more forward-looking assessments of risk. This important change will be formally part of the accreditation program from January 1, 2010. Many of the objectives of the wider modernization plan have been met, but others, such as those relating to greater uniformity in producer licensing, have not been fully met.

23. **The mixed progress reflects structural features of the regulatory framework**:

- In a state-based system, state administrations and legislatures are not bound to implement NAIC model laws and regulations; while local variations are often appropriate given the varying market conditions, it can be hard to achieve uniformity where it is necessary or desirable (in particular to reflect the essentially national reach of many large insurance companies and some intermediaries).

- While the NAIC processes appear to be thorough and to deliver appropriate change, the need to involve many stakeholders and achieve consensus significantly slows the delivery of change, except where it is particularly urgent.

- Regulatory requirements are heavily rules-based, which, while it has advantages in making requirements clear and comprehensive, increases the time required to make regulatory changes; the heavy use of rules also risks creating a tendency for regulators to engage in micro-management of insurers as each issue or problem that arises is addressed by adding even more rules.

24. **A major new review, the Solvency Modernization Initiative (SMI), is now under way**. In 2008, the NAIC launched the SMI as a review of financial requirements. This will include a study of solvency regimes and developments in other countries and the EU. The

aim is to deliver a framework consistent with best practices and, if possible, more closely aligned with regimes in other countries and with accounting standards. The SMI is wide-ranging, covering:

- capital requirements, including reviewing the design and calibration of current requirements and considering whether to require regulatory reporting of companies' economic capital levels and information about the development of the companies' target capital;

- international accounting, particularly the implications of the joint project on insurance contract accounting of the U.S. Financial Accounting Standards Board (FASB) and International Accounting Standards Board (IASB); insurance regulators are required to review all changes to GAAP accounting and to determine what changes should be made to their own system of statutory accounting;

- insurance valuation, including a project to move toward more principles-based reserving in life insurance; and consideration of making capital requirements reflect individual company risk characteristics more;

- reinsurance—implementing a modernization framework developed in 2008, once pending federal legislation is in place; a new Reinsurance Supervision Review Department will be charged with assessing non-U.S. regulatory regimes under a mutual recognition framework; and

- group solvency issues—considering potential revisions to the current approach to supervision of groups, the use and potential improvement of supervisory colleges with regulators from around the world, and group-wide supervision requirements, which may include group-wide capital requirements.

Consideration will also be given to the development of corporate governance principles for insurance companies and the establishment of risk management requirements. These are all major initiatives that have the potential to transform U.S. insurance regulation in the future.

25. **Other reforms will address issues highlighted by the financial crisis, and insurance will be included in the scope of future system wide regulatory reforms**. Reforms are pending to the requirements applying to bond insurers (monolines) and to securities lending, to take account of crisis events. Action has already been taken and more is under consideration to reduce the former reliance on ratings of the major credit rating agencies. Congress and the administration are working on regulatory reform in response to the crisis and proposals to date include certain reforms affecting insurance regulation. The details of these wider reforms were under discussion at the time of this assessment.

Guaranty funds (policyholder compensation arrangements)

26. **Insurance policyholders are protected against the insolvency of insurance companies by guaranty associations in each state**. All U.S. insurance companies are required to be members of associations covering life and health insurance and, through

separate organizations, property and casualty. These associations are established by state laws (there are NAIC models). Payments are triggered by the insolvency of an insurer, although, in practice, associations seek to obtain continuity of coverage by transferring policies to other companies. Laws differ on the extent of coverage and maximum amount payable per policyholder. Associations rely on assessments of other insurers writing the same class of business, i.e., they are not pre-funded. State laws set limits on assessment—typically, for life insurance, 2 percent of each insurer's prior year premium income in the state per year.

D. Main Findings

27. **Insurance regulation in the United States is generally thorough and effective, although there are areas where development is needed**. Strong regulation contributed to the overall resilience of the insurance sector during the financial crisis. Insurance regulators are responding to lessons from the crisis. In relation to compliance with the Insurance Core Principles:

- The preconditions for effective insurance supervision are generally met—reflecting the highly developed legal and institutional framework within which it operates and the scale and liquidity of U.S. financial markets; but there is a need for development of the policy framework in relation to insurance and financial stability and international issues.

- There is a need for institutional reform in the laws governing state insurance departments, including on appointment and dismissal of commissioners, the budgetary framework and remuneration policies, in order to secure the independence of regulatory work.

- While insurance regulation is carried out openly and transparently, there is a need for measures (including providing free access to more information and documents about the NAIC's model laws and their implementation) to foster improved stakeholder understanding of the state-based regulatory approach.

- There is a comprehensive set of requirements and processes for insurance company licensing, but some gaps in the requirements relating to suitability of persons with reliance on supervisory work to identify concerns and take action where necessary.

- Requirements in relation to governance, internal controls, and risk management are limited and should be extended, but departments are focusing closely on these issues in the risk-focused examination process currently being rolled out.

- NAIC data collection and analysis capabilities are world-leading, although the absence of complete group-wide consolidated data for insurance groups and broader financial conglomerate groups hinders the ability of supervisors to analyse and monitor market-wide events of importance for the stability of insurance markets.

- Financial examinations (i.e., onsite supervision) are generally thorough and well documented. Examinations also appear to identify the important issues. The rollout of

a risk-focused examination approach is requiring major changes from examiners and implementation needs to be closely monitored by the NAIC.

- The approach in relation to enforcement is comprehensive and applied by regulators in practice as necessary; there is no explicit authority for supervisors to fine individual directors or senior managers of insurers, or to bar them from acting in responsible capacities in the future.

- The approach to supervision of groups needs significant development. The U.S. supervisors do not currently make a comprehensive and consistent assessment of the financial condition of the whole group of which a licensed insurance company is a member. Risk-focused examinations are not yet generally focusing on group issues; and supervisory colleges are not meeting for all U.S.-based international groups.

- The liability reserving methods and bases generally lead to conservative estimates and, in combination with capital requirements, provide a sizable buffer against adverse experience. However, for general transparency and for international comparison, consideration should be given to specifying a target safety level for reserving and an associated target safety level for capital.

- While producer (i.e., intermediary) regulation is less uniform than it is for insurance companies, states have in place the core requirements—licensing, examinations and powers to take action in case of producer misconduct. There is a need to extend broker trust fund arrangements across states, to develop a uniform approach to the regulation of major brokers and to complete the current work on a consistent approach to the regulation of commission disclosure.

- Consumer protection work is moving to a more proactive approach to market conduct of insurers. This transition has further to go, particularly in respect of the ability of departments to identify and respond quickly to wider market issues. As with producer licensing, there is a lack of uniformity across states in the market conduct area. However, core consumer protection requirements are apparently in place in most states.

- Requirements on fraud, including making insurance fraud a crime, are in place across states, and the capacity of departments to address fraud-related issues is increasing as market conduct exams are undertaken and the availability of fraud data increases.

- The authorities have only recently brought relevant insurance business within the scope of federal anti-money laundering regulatory requirements. There were significant gaps in the framework when the most recent FATF work was undertaken in 2006. The need to increase resources available for examinations and the effectiveness of cooperation between state and federal regulators, are being addressed through discussions on new procedures and information sharing arrangements.

Table 2. Summary of Observance of the Insurance Core Principles

Insurance Core Principle	Grading	Comments
ICP 1– Conditions for effective insurance supervision	LO	The preconditions for effective insurance supervision are generally met—reflecting the highly developed legal and institutional framework within which it operates and the scale and liquidity of U.S. financial markets. But there is a need for some development of the policy framework in relation to insurance and financial stability and to international issues. Whereas insurance regulation is state-based, the broader regulatory and financial sector policy framework falls to federal authorities. On international insurance regulatory issues, there is a mismatch between the authority reserved to the federal government to enter into international agreements and that of the states to regulate the insurance sector, taking account of such agreements.
ICP 2 – Supervisory objectives	LO	The objectives of departments are generally not established explicitly by law. They reflect the evolution of their roles and responsibilities over the years, the risks and challenges in insurance business in different states and the political preferences of state legislatures. There are differences in the ways individual departments view their objectives, which may hamper moves toward greater uniformity of state regulation. There is also some scope for conflict of objectives. There is a need to balance objectives of achieving financial safety and soundness and consumer protection with the desirability of fostering market efficiency and competitiveness.
ICP 3 – Supervisory authority	PO	The vesting of regulatory powers in the commissioner in principle ensures that departments are operationally independent. However, the ability of the governor in most states to dismiss commissioners at any time, and without a public statement of reasons, exposes departments to potential political influences. Elected commissioners may be subject to the pressures of the electoral cycle. In addition, departments are dependent on state legislatures in respect of principal legislation and for budgetary resources, which cannot always be allocated according to the departments' own priorities. Departments are exposed to budgetary cuts during economic downtowns, when workloads tend to rise (although income from examination work charged to companies can mitigate such pressures). The use of statewide remuneration policies constrain departments' ability to hire specialist skills and can result in extensive and (for companies being examined) costly reliance on external experts.
ICP 4 – Supervisory process	LO	Insurance regulation is carried out openly and transparently, with clear accountability to the state administration and legislature and rights of appeal (and judicial review), which balance the need for due process with the importance of regulators being able to act swiftly and decisively where necessary to achieve regulatory objectives. But there is a need for measures (including providing free access to more information and documents about the NAIC's model laws and their implementation) to foster improved stakeholder understanding of the state-based regulatory approach.
ICP 5 – Supervisory cooperation and information sharing	LO	Although the main focus of information exchange with other regulators has traditionally been on cooperation with other insurance departments, regulators are able to share information with relevant federal authorities and with regulators abroad. There is a need to continue developing the

		network of MoUs. All state insurance departments should ensure laws are updated to enable them to protect information received from foreign regulators.
ICP 6 – Licensing	O	While approaches in individual departments vary, the core requirements adopted by all states represent a comprehensive set of requirements and processes for insurance company licensing. The extension of the accreditation process to licensing standards in 2012 should nonetheless provide assurance that the core licensing requirements continue to be complied with in practice by state departments.
ICP 7 – Suitability of persons	LO	Departments take a view on all significant owners, Board members, senior management, auditors, and actuaries and take appropriate action where concerns arise. However, the approach is based on assessment of the fitness and propriety of key functionaries at the point of application for a license, and on an ongoing basis through the examination process, rather than the approval of individuals (which is the approach taken in some other countries). There are gaps in the specific requirements—companies do not have to notify departments of concerns about the fitness and propriety of key individuals and departments cannot disallow functionaries from holding two positions that could result in material conflict.
ICP 8 – Changes in control and portfolio transfers	O	There are extensive requirements and related reporting governing changes in control and portfolio transfers.
ICP 9 – Corporate governance	LO	Corporate governance standards for publicly-traded U.S. companies, including insurers, are set and enforced by the SEC, while requirements for all insurance companies will be introduced from January 2010. Departments have been increasing their focus on governance issues, mainly as a more risk-based approach to examinations has started to be implemented. Examinations had previously focused more on financial condition and related controls, while corporate governance has historically received less attention. The new examination approach is still being rolled out but the risk-based approach becomes part of the accreditation standards in 2010.
ICP 10 – Internal controls	LO	Other than controls relating to financial reporting, departments have few requirements relating to internal controls on insurers at present. For publicly-traded companies, the Sarbanes-Oxley provisions provide a general framework of detailed control requirements and testing of controls. From January 1, 2010, much of this framework will be extended to all insurers, with the exception of smaller companies, but these requirements will take time to implement in full. Departments are increasingly looking to ensure sound internal controls at insurers via the risk-based examination process, but this approach is still being implemented.
ICP 11 – Market analysis	LO	The absence of complete group-wide consolidated data for insurance groups and broader financial conglomerates hinders the ability of supervisors to analyze and monitor market-wide events of importance for the stability of insurance markets. The lack of analysis of developments outside the U.S. markets, given that it relies so heavily on offshore reinsurers, needs to be addressed. Otherwise, the NAIC data sources and analysis capabilities are world-leading. They should be more used in international supervisory college discussions to better understand U.S. insurer exposures in a group and to encourage insurance regulators in other

		jurisdictions to develop similar capabilities.
ICP 12 – Reporting to supervisors and off-site monitoring	LO	The NAIC data collection and analysis capabilities in relation to authorized insurance companies are world-leading. The affiliate transaction requirements provide a strong means of identifying and controlling intra-group dealings and exposures. However, there are no formal reporting requirements for complete group-wide consolidated data for insurance groups and broader financial conglomerate groups which would allow insurance regulatory style financial condition assessment.
ICP 13 – On-site inspection	O	Financial examinations are generally thorough and well documented. Examinations also appear to identify the important issues. The rollout of a risk-focused examination approach will require examiners to make more qualitative judgments about insurer risks and controls, including scoring them for inclusion in the risk matrix. Effective implementation will not be easy because of the changes it demands of examiners. The NAIC might consider undertaking an assessment of the implementation of the risk-focused examination approach in the near future (e.g., in the course of 2012).
ICP 14 – Preventive and corrective measures	O	The structure of prompt corrective action triggers and required actions is thorough and is rigorously applied. While it could not, and should not, prevent insurers ever failing, it does lead to reduced insurer shortfalls in any failure (guaranty fund data suggests most shortfalls are in the 5–15 percent of liabilities range). It also provides clear messages to the insurers of the consequences of their reducing capital levels.
ICP 15 – Enforcement or sanctions	LO	There is no clear authority for the supervisory authority to fine individual directors or senior managers of insurers or to bar them from acting in responsible capacities in the future.
ICP 16 –Winding-up or exit from the market	O	There is a strong focus by the supervisory authorities on ensuring individual policyholder obligations are met. Customer complaints handling facilities in supervisory authorities, readily available information on the progress of insurer receiverships and a network of insurer guaranty funds provide a high level of policyholder protection. The arrangements for insurer wind-up and exit from the market are clear, have worked effectively and in conjunction with guaranty fund arrangements provide strong protection against policyholder loss if an insurer fails.
ICP 17 – Group-wide supervision	PO	The U.S. approach is focused on securing the financial soundness of individual insurance companies. While this has not been unusual among insurance regulators internationally, many have been supplementing their strong solo company focus with financial and other requirements and more supervisory focus applied at group level and U.S. supervisors should do the same. They do not currently make an assessment of the financial condition of the whole group of which a licensed insurance company is a member. Risk-focused examinations are not yet generally focusing on group issues; and supervisory colleges are not meeting for all U.S.-based international groups.
ICP 18 – Risk assessment and management	LO	While the desired outcomes for this ICP are essentially achieved in practice owing to comprehensive examination of insurers, it is increasingly important that the risk management function of insurers is of high quality

		and given significant focus and influence within insurers. There is no requirement that an insurer have in place comprehensive risk management policies and systems capable of promptly identifying, measuring, assessing, reporting, and controlling their risks.
ICP 19 – Insurance activity	LO	The relevant laws or regulations do not explicitly provide that an insurer must have in place strategic underwriting and pricing policies approved and reviewed regularly by the Board. Boards are not required to set the strategic limits on these core insurance functions within which management should operate. There is a risk that the prior notification requirement may lead to undue 'prior approving' of many reinsurance transactions, which could be an ineffective use of supervisory resources.
ICP 20 – Liabilities	O	The liability reserving methods and bases generally lead to conservative estimates, which is in line with the conservative, book value nature of statutory insurance accounting in the United States Elements of the reserving methods adopted involve stochastic modeling or scenario analysis techniques to estimate the reserves required under moderate adverse conditions. However, there is currently no particular or specified safety level which is targeted for reserving – or capital. For general transparency and for international comparison, it is recommended that consideration be given to specifying a target safety level for reserving and an associated target safety level for capital. This should also assist in keeping margins for conservatism in reserves more similar across insurance classes and assist with peer comparisons of reserving.
ICP 21 – Investments	O	The regulatory requirements for investments are robust and likely to have contributed to the limited number of major investment problems for insurers in the financial crisis. As insurers move to a more principles-based approach, it will be important to ensure that all aspects of investment risk, especially asset/liability mismatching risks, are well covered in the reserving and capital requirements.
ICP 22 – Derivatives and similar commitments	O	The requirements relating to derivatives use in insurers are robust and sensible in that they allow derivatives to be used for purposes which would enhance an insurer's investment management and returns without exposing it to undue risk of losses. There are no requirements on derivatives use at a holding company level outside the licensed insurer (but this is not required by the ICPs).
ICP 23 –Capital adequacy and solvency	LO	There are no requirements to address inflation of capital through multiple gearing (i.e., holding company debt raisings injected as equity into insurance subsidiaries). These should be included in the law, regulation or rules. Insurance company reserves are determined conservatively and the regulatory capital is then required in addition. The combination of reserving and capital provides a sizable buffer against adverse experience. In the absence of a specified safety level which is targeted for reserving plus capital, it is difficult to determine the level of adversity that the combination of reserves and capital can cover, but it appears to be commensurate with or higher than in many other insurance jurisdictions.
ICP 24 – Intermediaries	LO	While producer (i.e., intermediary) regulation is much less uniform than it is for insurance companies, most states have at least the core requirements

		– licensing, requirements in relation to producer skills and expertise, and powers to undertake examinations and to take action in case of producer misconduct. The general legal framework provides safeguards for client money where intermediaries act as agents (and this has been tested in numerous cases). There is less uniformity on the safeguards applying to money held by brokers, but separate accounts with trust status are required in at least two states where large commercial lines brokers are domiciled.
ICP 25 – Consumer protection	O	Departments have been increasing the scope of their consumer protection work in recent years, moving away from a traditional focus on financial issues (and handling of consumer complaints) to a more proactive approach to market conduct of insurers. Established regulatory tools from the financial area, and the model of cooperation and challenge between state insurance departments, have been extended to market conduct. This transition has further to go, however, particularly in respect of the ability of the departments to identify and respond quickly to wider market issues as well as problems at individual companies. As with producer licensing, there is a marked lack of uniformity across states in the market conduct area. However, core consumer protection requirements are apparently in place in most states.
ICP 26 – Information, disclosure and transparency toward markets	O	While there are no regulatory requirements in relation to disclosure, full financial information, including the actuarial opinion and auditor's statement, are readily available to stakeholders. This reflects the relative ease of access and concentration of data that has resulted from financial statements being submitted directly to the NAIC. However, there is scope to improve the availability of information to policyholders without access to databases, ratings, etc, while the NAIC should also consider reviewing the benefits of developing a set of explicit disclosure requirements.
ICP 27 – Fraud	O	While approaches vary by state, core requirements (such as making insurance fraud a crime) are in place across states. The capacity of departments to address fraud-related issues is increasing as market conduct exams are undertaken and the availability of data on fraud improves with the development of databases. Remaining gaps in the framework—for example, where departments do not require an anti-fraud plan from insurance companies—should be addressed as soon as possible.
ICP 28 –Anti-money-laundering, combating the financing of terrorism	PO	The authorities have only recently brought relevant insurance business within the scope of anti-money laundering regulatory requirements. Implementing the approach has taken time. There were significant gaps in the framework when the most recent FATF work was undertaken in 2006. The Internal Revenue Service (IRS), as the examination authority in this area, is now carrying out examinations. As its resources available for this work are limited, it is cooperating with state insurance departments to make use of their expertise. However, the effectiveness of cooperation between state and federal regulators is limited pending the consideration of legal issues arising from their collaboration and agreement of new procedures and information sharing arrangements. Both the federal government and state insurance departments wish to increase information sharing of examination information. This work has been given a high priority by the federal and state agencies but no deadline as yet. (A factual update on developments since the 2006 FATF work is being undertaken separately as part of the FSAP work.)
Aggregate: Observed (O) – 11, largely observed (LO) – 14, partly observed (PO) – 3, not observed (NO) –zero, not applicable (N/A) – zero.		

E. Recommended Action Plan and Authorities' Response

Recommended action plan

Table 3. Recommended Action Plan to Improve Observance of the Insurance Core Principles

Principle	Recommended Action
ICP 1 – Conditions for effective insurance supervision	The authorities should (i) increase information-sharing and coordination between state regulators and federal authorities, including representation of state regulators in national bodies with responsibilities for system wide oversight and financial stability; (ii) agree policies and procedures for the regulation of systemically important institutions, markets and instruments, where assessed to exist in the insurance sector; and (iii) make new arrangements to increase the authority of federal authorities in relation to the implementation of international agreements.
ICP 2 – Supervisory objectives	Insurance departments, the NAIC and state legislatures should develop a clear, joint statement of the objectives of insurance regulation, taking into account good practice internationally, and align the objectives of individual state departments with these objectives. This work should address whether there are potential conflicts between existing objectives and how to manage them and the need to balance the objectives of achieving financial safety and soundness and consumer protection with the desirability of fostering market efficiency and competitiveness.
ICP 3 – Supervisory authority	The NAIC and state legislatures should make reforms including (i) providing for fixed terms to be standard for commissioner appointments, with dismissal mid-term to be possible only for prescribed causes and with publication of reasons; (ii) making departments fully self-funding, subject to continued accountability to and oversight by state legislatures, while allowing them greater flexibility to hire staff with specialist skills and reduce reliance on external experts; and (iii) extending the rule-making powers of departments to a wider range of technical issues (for example valuation and risk-based capital), and subject to appropriate consultation and requirements for due process.
	State laws should be changed, where this has not already been done, to extend the protection of information received from other government agencies to foreign agencies, which is essential to support the widest scope of information-sharing internationally. The NAIC and state legislatures should consider extending the protection of confidentiality, to the extent consistent with the wider legal environment, to all relevant information which is received by departments, rather than limiting protection according to the source of the information, as at present.

Principle	Recommended Action
ICP 4 – Supervisory process	To further improve the transparency of its work, the NAIC should: (i) make publicly available some information that is currently available only on payment of a fee or by subscription (for example the NAIC model laws and material on how states have adopted them); (ii) publish summary information on their assessment of states' compliance with accreditation standards (even if scores remain private); and (iii) commit to publication on a regular basis (maybe every two years) of their self-assessment of compliance with IAIS Insurance Core Principles. These measures would help to foster improved understanding of state regulation and the role of the NAIC. In addition, the NAIC could also consider developing its approach to regulatory impact analysis and making such work a routine part of its analysis of proposed new or changed requirements.
ICP 5 – Supervisory cooperation and information sharing	The states and NAIC should continue to develop the network of MoUs. As mentioned in connection with ICP3, all state insurance departments should ensure that laws are updated to enable them to protect information received from foreign regulators. This will ensure that overseas regulators are not deterred from sharing information freely.
ICP 7 – Suitability of persons	Specific requirements in relation to individuals' fitness and propriety should be adopted. Gaps in the requirements of departments should be filled—companies should have to notify the department of concerns about the fitness and propriety of key individuals and departments should be able to disallow functionaries from holding two positions that could result in material conflict.
ICP 9 – Corporate Governance	As examiners gain experience, the NAIC and/or departments should consider issuing more guidance on good and bad practices in corporate governance for insurers. This would help examiners and firms to develop a clearer expectation of what constitutes effective governance for insurance business, including for groups.
ICP 10 – Internal controls	As examiners gain experience, the NAIC and/or departments should consider the scope for issuing guidance on good and bad practices in internal control. They should also make it a formal requirement for insurers to have an internal audit function. Such a function is now widely considered as an important part of a good control framework—similarly to audit committees, where there are now extensive requirements of all but the smaller insurers.
ICP 11 – Market analysis	Regulators should collect more complete group-wide consolidated data for insurance groups and broader financial conglomerates. They should develop further their analysis of developments outside the U.S. markets.
ICP 12 – Reporting to supervisors and off-site monitoring	Collection of group-wide consolidated data for insurance groups and broader financial conglomerate groups should be introduced.
ICP 15 – Enforcement or sanctions	The insurance laws should be changed to provide the supervisory authority with powers to fine individual directors and senior managers of insurers, and to bar them from acting in responsible capacities in the future.

Principle	Recommended Action
ICP 17 –Group-wide supervision	U.S. supervisors should (i) include fuller assessment of the financial condition of the whole group of which a licensed insurance company is a member; this may involve quantitative techniques and practices in use internationally; (ii) extend the risk-focused approach to examinations of solo insurance companies to groups, again starting with U.S. groups—in effect extending the lead regulator and college of regulators arrangements already in widespread use for such groups within the framework developed by the NAIC; (iii) ensure that colleges of supervisors for the U.S. groups with major international operations are established and functioning effectively—and led by U.S. regulators with appropriate insurance expertise. It may also be desirable for insurance regulators to be given additional powers, such as clear authority to license insurance holding companies, apply insurance capital requirements to the consolidated insurance group and direct the insurance holding company to make changes at the group level to rectify any shortcomings.
ICP 18 –Risk assessment and management	The relevant laws, regulations or standards should be changed to include a requirement that an insurer have in place comprehensive risk management policies and systems capable of promptly identifying, measuring, assessing, reporting and controlling their risks.
ICP 19 – Insurance activity	The relevant laws or regulation should explicitly provide that an insurer must have in place strategic underwriting and pricing policies approved and reviewed regularly by the Board.
ICP 23 – Capital adequacy and solvency	For general transparency and for comparison, it is recommended that consideration be given to specifying a target safety level for reserving and an associated target safety level for capital. This should assist not only with peer comparisons of reserving and capital across insurers, but also comparisons against other insurance regimes internationally. Requirements to address inflation of capital through multiple gearing (i.e., holding company debt raisings injected as equity into insurance subsidiaries) should be included in the law, regulation or rules. Further development of stress testing could be considered, using the experience gained from exercises undertaken during the financial crisis.
ICP 24 – Intermediaries	Some strengthening of the approach to producer regulation is recommended: (i) to extend broker trust fund arrangements across states (where not already in place) to ensure that client funds are fully protected; (ii) to develop a uniform approach to the regulation of major brokers which reflects the important role which large brokers play in the commercial lines market; and (iii) to complete the current work on a consistent approach to the regulation of commission disclosure. In addition, producers should be required to make disclosures to customers of the status under which they are doing business, including which insurance companies have appointed them.
ICP 28 - Anti-money-laundering, combating the financing of terrorism	It is recommended that a timetable is set for the agreement and implementation of new arrangements between state insurance departments and federal authorities that will deliver greater resourcing of supervisory activities as well as necessary information exchange.

Authorities' Response to the Assessment

28. The U.S. authorities welcome the opportunity to take part in the U.S. FSAP and the IMF's assessment of a high level of observance of the IAIS Insurance Core Principles (ICPs). It has provided insurance regulators in the United States with a timely opportunity to undertake a comprehensive self-assessment of the U.S. insurance regulatory system against international standards, and has contributed to ongoing internal reviews and assessments of regulatory practices. In addition, the FSAP has served as a useful platform for providing an overview of the U.S. insurance regulatory system and its multi-jurisdictional structure. The authorities appreciate the recognition by the IMF of the strengths in the regulatory system including areas that the IMF itself has coined as "world leading."

29. As recognized by the Report, it is important to consider the U.S. assessment in context. The assessment of the U.S. supervisory framework was undertaken in the wake of a severe financial crisis, and movements toward significant changes in supervisory practices have gained momentum as a result of the financial crisis and circumstances emanating from the crisis, including with respect to group-wide supervision. The IMF's assessment of U.S. compliance with ICP 17, the group-wide supervision standard, goes beyond the scope of the current ICP assessment in that it assesses compliance with a group supervision structure, which is still under discussion and development in most jurisdictions and within the IAIS, where revision of the insurance ICPs that may reflect these changes may not be finalized until 2011.

30. Insurance regulators in the United States are working with regulators around the world on initiatives to enhance group supervision, and have in place inter-regulatory cooperation processes, such as the use of lead state supervisory structures and the Financial Analysis Working Group of the National Association of Insurance Commissioners (NAIC). In addition, the Report acknowledges the comprehensive review underway with the Solvency Modernization Initiative which takes into account international and cross-sectoral practices in the analysis of possible additions or modifications to current insurance regulatory practices.

31. U.S. authorities remain strongly committed to prudential regulatory independence and accountability, including continually striving to improve ways to effectively balance these two objectives. Transparent rulemaking with opportunity for stakeholder involvement, for example, has proven a particularly effective way to provide accountability and improve the regulatory environment, while respecting regulatory independence. As reflected in the assessment of ICP 3, the Supervisory Authority standard, the assessment appears to rely on structural characteristics while failing to fully recognize the effective operational independence of state insurance regulators. In practice, the U.S. multijurisdictional approach to insurance regulation holds regulators accountable to each other in a peer review process that includes on-going nation-wide monitoring through the NAIC, regular dialogue among all regulators, and the ability of states to question the actions of fellow state insurance regulators.

32. Within the assessment, there appear to be philosophical preferences for a principles-based, rather than rules-based, approach to regulation, yet assessment recommendations inconsistently apply those preferences by variously seeking more, as well as fewer, rules. Further, there appears to be no empirical evidence to suggest that one approach is superior to the other or that the choice of approach affects the U.S. regulators' ability to meet the standards set out in the various ICPs. U.S. authorities fully support a regulatory environment based on principles and made operational by rules that can provide consistent standards throughout the marketplace, yet remain flexible enough to adapt to new developments.

33. The IMF's assessment of ICP 28, the AML and CFT standard, identified some areas where U.S. AML requirements may be improved upon, but fails to fully recognize the robust protection provided U.S. citizens against money laundering activities. Of note, the United States has a bifurcated regulatory scheme regarding AML regulation. As noted, the federal government has primary jurisdiction of AML statutes while the regulation of insurance and expertise in financial examination of insurance is the responsibility of the states. Although both state and federal authorities have agreed to work together to review the current examination process, it is important to note and remember that an in-depth legal analysis has yet to be undertaken on this subject.

34. U.S. Authorities appreciate the assessment and will thoroughly review the Report's recommendations and take them into account when initiating and implementing any insurance regulatory reforms. We look forward to engaging in continuing ongoing dialogues with the IMF on how to best collectively improve international financial stability and supervision of the global financial services sector.

II. DETAILED ASSESSMENT

Table 4. Detailed Assessment of Observance of the Insurance Core Principles

Conditions for Effective Insurance Supervision	
Principle 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.
Description	Insurance regulation is carried out against the background of a highly-developed legal and institutional framework and mature and liquid financial markets. While insurance regulation is principally a responsibility of the states, there is a developed national framework of coordination across state insurance departments (see introduction to this assessment). Policy on wider financial sector issues, including the maintenance of financial stability, is handled at the federal level, in Congress and by relevant agencies of the executive branch, including the President's Working Group on Financial Markets. Certain federal legislation has regard to the insurance sector. For example, the 1999 Gramm-Leach-Bliley Act (GLBA), which established the framework for the regulation of cross-sector conglomerates, provides for federal regulation of conglomerates containing insurers, while preserving the regulation of individual insurance companies as a state responsibility. There is regular dialogue between the NAIC and federal banking supervisors, building on the increased cooperation that followed, and is required under, the GLBA. The provisions of the federal Bank Secrecy Act on anti-money laundering apply to certain insurance business (see assessment of ICP 28). However, because it is mostly a state responsibility, insurance regulation is not directly represented in federal discussions of wider financial sector issues, particularly financial stability policy. Expertise on insurance issues in the Treasury Department, although growing, has traditionally been focused on federal programs such as TRIA, and on insurance dialogues with foreign governments. During the financial crisis, to the extent that the insurance sector was affected, the monitoring of the sector and most of the action to address issues has been carried out by states. However, federal support for financial institutions under the Troubled Assets Recovery Program (TARP) has been extended to insurance groups, although only where there was a federal regulator (because the group also contained at least one institution federally chartered as a bank or thrift). The intervention in the insurance conglomerate American International Group (AIG), which also included a thrift, was undertaken by federal authorities. The administration and Congress are working on proposals for reform that would strengthen federal government capacity in insurance through a new office dedicated to insurance issues within the Treasury Department. One function of such an office may be to take the lead on international policy and coordination in relation to prudential supervision of insurance. Staff from state insurance departments and from the NAIC, rather than the federal government, negotiate in international fora on insurance regulation (but not on trade issues) at present, although under the U.S. constitution, only the federal government has powers to conduct foreign policy.

	The reforms may also result in some insurance groups being brought within the scope of federal regulation aimed at systemically important institutions. Insurance issues affecting financial stability would be handled by the Secretary of the Treasury, supported by the new office within the department, on a proposed new Financial Services Oversight Council of financial regulators which would be responsible for identifying emerging systemic risks and improving interagency cooperation. These discussions on regulatory reform were continuing at the time of this assessment. The legal and court system, at state and federal level, provide for disputes on insurance issues to be heard and resolved through enforceable decisions. There is extensive insurance expertise in the legal profession. Mechanisms for alternative dispute resolution are rare by comparison with many other countries. In respect of retail consumer complaints against insurance companies and intermediaries, a key focus of such mechanisms in other countries, departments themselves take a direct role in hearing and adjudicating on complaints and requiring companies and intermediaries to take appropriate action, where the department judges necessary. There is also an extensive framework of accounting, actuarial and auditing standards and relevant professional bodies. Their standards are in compliance with international standards. • Accounting for insurance assets and liabilities for regulatory purposes has to be undertaken using standards (Statutory Accounting Principles—SAP) developed under NAIC processes, codified in the NAIC's Accounting Practices and Procedures Manual (APPM) and implemented in state laws and regulations. Regular financial reports to the regulator must be drawn up using these standards. These are available to the public via insurance departments or the NAIC. U.S. GAAP accounting (FASB) standards also set out accounting requirements for insurance but apply only to publicly-traded insurance companies. There is extensive dialogue between insurance regulators, FASB and practicing accountants, particularly on the development of SAP. • There is an extensive body of actuarial standards—ASOPs—set by the Actuarial Standards Board (ASB). This is a non-statutory self-regulatory body established by the five actuarial professional bodies to promulgate standards which actuaries must use when providing professional services in the U.S. ASOPs provide a principles-based framework to support professional advice, mainly in the form of guidance. They are not formally part of regulatory requirements (and may potentially conflict with such requirements) but reference is made to them in regulatory requirements such that actuarial work and opinions required for regulatory purposes must in practice comply with ASOPs. • The requirement for use of ASOPs is contained in the (separate but identical) Codes of Professional Conduct which the professional bodies adopt and apply to members. Ethical standards are set and enforced by the professional bodies themselves. • A separate body, the Actuarial Board for Counseling and Discipline (ABCD) hears disciplinary cases and makes recommendations for action to the professional bodies themselves. Since it began work in 1992, the ABCD has recommended severe sanctions (public reprimand or expulsion) in 18 cases. There is extensive cooperation between the actuarial profession and NAIC, particularly on technical issues. • Auditing standards applicable to insurance are the same as for companies generally—for publicly-traded companies, those of the Public Company Accounting Oversight Board (PCAOB), as modified or supplemented by the SEC; and for others, those of the Auditing Standards Board of the American Institute of Certified Public Accountants (AICPA). PCAOB standards are applied and enforced by the PCAOB on auditors of publicly-traded companies

	under the Sarbanes-Oxley Act of 2002. The AICPA requires members to use its standards through its binding Code of Professional Conduct. Accounting, actuarial and auditing standards are publicly available. Insurance departments monitor the quality of accounting, actuarial and auditing work and report individuals and firms to professional bodies where they have serious concerns. Regulatory standards and practices are updated to reflect market wide concerns—for example, disclosures have been extended in response to concerns over potential under-reserving in certain business lines. There is a generally an adequate supply of professional services available to support the business of insurance and insurance regulation. There are over 16,000 members of the actuarial profession. There is wide availability from public sources of the basic economic, financial data and social statistics relevant to insurance and insurance regulation. For example, data on mortality are made available by the actuarial bodies. The money and securities markets provide for the variety of short and long term instruments necessary to back insurance liabilities—with some exceptions, as in other countries, for example in relation to the particularly long term liabilities associated with some annuity contracts.
Assessment	Largely Observed
Comments	The preconditions for effective insurance supervision are generally met—reflecting the highly developed legal and institutional framework within which it operates and the scale and liquidity of U.S. financial markets. But there is a need for some development of the policy framework in relation to insurance and financial stability and international issues. Because insurance regulation is state-based, whereas the broader regulatory and financial sector policy framework, including international relations, falls to federal authorities, there is a risk of a lack of coordination on insurance regulatory matters. This risk arises particularly in relation to the impact of insurance groups and the insurance market on system wide stability, where there are at present no explicit responsibilities or coordination arrangements. On international insurance regulatory issues, there is a mismatch between the authority reserved to the federal government to enter into international agreements and that of the states to regulate the insurance sector, taking account of such agreements. This has not prevented sensible and practical arrangements, for example to enable states and the NAIC to contribute their expertise to the negotiation of international agreements. However, current arrangements have led to some ambiguity and uncertainty, particularly outside the United States, about the status of the NAIC and state regulators in relation to international agreements. In this context, there is a need for: (i) increased information-sharing and coordination between state regulators and federal authorities, including representation of state regulators in national bodies with responsibilities for system wide oversight and financial stability; (ii) agreed policies and procedures for the regulation of systemically important institutions, markets and instruments, where assessed to exist in the insurance sector; and (iii) new arrangements to increase the authority of federal authorities in relation to the implementation in the United States of international agreements.
The Supervisory System	
Principle 2.	**Supervisory objectives** The principal objectives of insurance supervision are clearly defined.
Description	There is no single statement of supervisory objectives for insurance regulation across the states. The 1945 McCarran-Ferguson Act, which returned regulatory jurisdiction over “the business of

	insurance" to the states, while exempting it from most federal antitrust law to the extent that it was regulated by state law, did not set out regulatory objectives. Nor are regulatory objectives generally set out explicitly in state legislation (i.e., in the insurance codes of individual states). As it is not itself a regulator, the NAIC's objectives are expressed in relation to its role in providing assistance and support for state regulators in achieving their goals. Insurance departments express their objectives (or mission) individually and differently, for example on their websites. The protection of consumers of insurance products is central to all departments' understanding of their role. This is usually defined as ensuring the financial soundness of insurance companies, so as to limit consumers' exposure to loss due to financial failure, and promoting appropriate standards of market conduct (by companies and producers). The focus on consumer protection is reinforced in the NAIC's accreditation process with its objectives of ensuring there are "adequate solvency laws and regulations in each state to protect insurance consumers." In addition, individual departments have objectives such as: the maintenance of competitive insurance markets; eliminating fraud, other criminal abuse or unethical conduct in the industry; focusing on consumers' needs for affordable and available products; and fostering the development of the insurance industry. The McCarran-Ferguson Act's focus on the application of federal antitrust law informed an early emphasis in insurance regulation on promoting competition but the approach to consumer protection has since greatly widened. Many states now have a role in ensuring that insurance is available to consumers when private markets are unable or unwilling to underwrite risks—through the organization of "residual markets" (see the introduction to this assessment) or through subsidies and other support for particular risks, such as health cover for certain otherwise hard to insure or uninsurable groups. Some states assign development of the insurance sector (including attraction of more companies to do business in the state) to insurance departments—because that is where insurance expertise is located. Insurance departments generally explain how their activities support different objectives. Funding arrangements make significant deviations from objectives unlikely. Budgets allocated to departments by legislatures are linked to particular tasks—such as examinations or direct consumer services—which link back to objectives. Departments may draw attention to conflicts between objectives (for example, between consumer protection and industry development), where new objectives are under discussion.
Assessment	Largely Observed
Comments	The objectives of departments are generally not established explicitly by law. They reflect the evolution of their roles and responsibilities over the years since the McCarran-Ferguson Act, the risks and challenges in insurance business in different states and the political preferences of state legislatures. The close cooperation of departments through the NAIC processes has helped align core objectives. Departments have a clear understanding that their primary role is to promote consumer protection and the role of departments in this regard appears to be well-understood by the industry and by consumers. However, there are differences in the ways individual departments view their objectives, which may hamper moves toward greater uniformity of state regulation and limit understanding of U.S. insurance regulation, both domestically and abroad. There is also some scope for conflict of objectives, in particular given states' financial interests in attracting more insurance business. There should also be an explicit acknowledgment of the need to balance the objectives of achieving financial safety and soundness and consumer protection with the desirability of fostering

	market efficiency and competitiveness. Departments, the NAIC and state legislatures should develop a clear, joint statement of the objectives of insurance regulation, taking into account good practice internationally, and align the objectives of individual state departments with these objectives. This work should address whether there are potential conflicts between existing objectives and how to manage them.
Principle 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.
Description	State legislation clearly identifies authorities – state insurance departments for most insurance supervisory work (other authorities, including at federal level, also have certain supervisory responsibilities). Insurance departments have extensive powers to license, supervise and take enforcement action against insurance companies. They also have powers to make rules—mostly in the form of regulations covering many detailed requirements under delegated authority from state legislatures. The legislatures themselves enact most of the principal regulatory requirements. Insurance departments have wide-ranging powers to enforce their own rules and state laws (see ICPs 14 to 16). Departments can and do take urgent action—including using receivership powers against companies—where required to protect policyholders. Governance structures at insurance departments vary (for example, to take account of whether the Commissioner is elected or appointed—see below). But in all departments, authority to exercise functions and use powers under state law and regulations is granted to the commissioner, i.e., to an individual rather than a body such as a Board of Directors or commission. (Some state laws also give certain authority explicitly to a chief examiner). Departments have varying approaches to internal control. Powers may be delegated, for example to the chief examiner. Many departments have their own internal auditor (reporting direct to the commissioner) and all are subject to the audit arrangements of the state administration. There are explicit procedures for the appointment of commissioners: 12 of the 56 are directly elected and the others are appointed by the state governor, with the advice and consent of the state senate, generally to hold office until the term of office of the appointing governor expires. Appointed commissioners hold office at the governor's pleasure—and can therefore be dismissed at any time. Relationships with the legislature and executive authorities are clear—legislatures enact state laws and generally set spending limits (see below). Departments are accountable to legislatures as well as state governors and produce annual reports to legislatures on their activities (which are also publicly available). In general, insurance departments act independently of both state legislatures and other state executive offices in their day to day regulation. Powers are vested in the commissioner and there are no decisions that require the involvement of executive officers outside the department, for example. Independence from other executive officers may be greater where the commissioner is elected. As parts of state administrations, all departments are subject to state budgetary authority. Spending limits are set by the state legislature. Departments also collect a large amount of revenue for the states—totaling over US$18 billion in

	2008. The largest element, the state insurance premium tax, is passed in full to the general fund of the state but other elements (fees and assessments) are in most states retained by departments as funding for their regulatory and other operations. Fines and penalties usually go into the state's general fund. In many states, amounts raised in excess of spending limits may be retained and used to build up a reserve (this approach is known as a "dedicated funding system"); in other states, excesses must be passed to the state general fund (a "quasi-dedicated system"). Shortfalls in revenue collection have to be addressed through spending cuts or by transfers from reserves. In practice, however, legislatures and governors generally determine spending limits according to current priorities and financial conditions independent of the availability of dedicated funding. Some departments have, for example, experienced significant cuts in spending because of the effect of economic recession on state finances. There are limits on departments' discretion to allocate resources as they choose. Some state legislatures restrict certain funding to particular purposes or programs. For example, funds allocated to direct consumer services (handling complaints, for example) may not be used for the regulation of firms—or vice versa. Departments have substantially increased resources in recent years. Total budget for all the departments was US$1.6 billion in 2008, a 50 percent increase on the 2002 level, and staff totaled over 11,905 at the year end. Many contract staff and staff from other agencies are also used—totaling a further 1,325. (Detailed data on staff numbers, grades and pay ranges by state are published annually in the NAIC Insurance Department Resources Report.) In addition, the NAIC employs just over 400 staff, many of them in IT support for the extensive NAIC databases. The adequacy of state staff resources is considered under the accreditation process. Overall resources are greater, in proportion to the size of the market, than at any other national insurance regulator in G–7 markets, although comparability among departments and with other regulators globally is hampered by the wide and varying functions, regulatory and other, undertaken by departments. Resources appear adequate for core tasks, including financial analysis and examinations. But departments face some pressures to recruit and retain more highly skilled staff—qualified actuaries for example, and staff equipped for the demands of a more risk-focused approach to supervision (see ICP 13). The accreditation standards include an expectation that departments have specialist resources and that these are used on examinations of more complex companies or where there are concerns about financial condition. Departments are able to hire external experts and outsource work to supplement staff resources, where legislation specifically permits it—in particular to support examinations (the model law specifies a wide range of professional competencies) or action taken in response to a breach in minimum RBC requirements (a Regulatory Action Level event—see ICP 14). Staff remuneration is generally linked to the general pay grades for state employees. Some states have limited flexibility to pay above normal rates to meet particular needs. Most are free to pay market rates for consultants for examination work, for which costs are charged to companies. Partly as a result, use of experts is particularly common for examinations. External experts are subject to the same confidentiality requirements, under the terms of their contracts, as staff in respect of their work for insurance regulators. Staff have legal protection from lawsuits resulting from specific actions taken in the course of regulatory work. For example, the Model Law on Examination, #390, provides for immunity from liability for statements made or conduct performed in good faith while carrying out the provisions of the Act. Insurance departments protect staff from the costs of defending their actions, where this is necessary. Insurance supervisory work, like administration generally in the United States, is subject to a strong

	presumption that information should be made publicly available, absent specific provisions requiring confidentiality. The ability of departments to maintain the confidentiality of relevant supervisory information varies. Information gathered from companies using the powers of examination is protected in all states as are RBC returns (the accreditation process addresses this issue). All states are able to protect information received from other government agencies, including other state regulators ("derivative confidentiality"). Following an NAIC initiative in 2000 on confidentiality and information sharing internationally, provisions of several model laws were changed to provide for the protection of information received from international regulators.
Assessment	Partly Observed
Comments	While the vesting of regulatory powers in the commissioner in principle ensures that departments are operationally independent, the ability of the governor in most states to dismiss commissioners at any time, and without a public statement of reasons, exposes departments to potential political influences. Elected commissioners may be subject to the pressures of the electoral cycle. In addition, departments are dependent on state legislatures in respect of principal legislation (where they compete for time with many other state legislative priorities) and for budgetary resources, which cannot always be allocated according to the departments' own regulatory priorities (although income from examination work charged to companies can mitigate budgetary pressures). Departments are exposed to budgetary cuts during economic downtowns, when workloads tend to rise. The use of statewide remuneration policies constrain departments' ability to hire specialist skills and can result in extensive and (for companies being examined) costly reliance on external experts, including consultants. The NAIC and state legislatures should make reforms such as (i) providing for fixed terms to be standard for commissioner appointments, with dismissal mid-term to be possible only for prescribed causes and with publication of reasons; (ii) making departments fully self-funding, subject to continued accountability to and oversight by state legislatures, while allowing them greater flexibility to hire staff with specialist skills and reduce reliance on external experts; and (iii) extending the rule-making powers of departments to a wider range of technical issues (for example valuation and risk-based capital), and subject to appropriate consultation and requirements for due process. This last approach may also help deliver faster implementation of NAIC model laws. State laws should be changed, where this has not already been done, to extend the protection of information received from other government agencies to foreign agencies, which is essential to support the widest scope of information-sharing internationally. The NAIC and state legislatures should consider extending the protection of confidentiality, to the extent consistent with the wider legal environment, to all relevant information which is received by departments, rather than limiting protection according to the source of the information, as at present.
Principle 4.	**Supervisory process** The supervisory authority conducts its functions in a transparent and accountable manner.
Description	Laws and regulations are developed, at state level and at the NAIC (for model laws), through an open process that allows for extensive input from interested parties, and opportunities to influence decisions, at both state and national levels. Administrative measures (including regulations made by departments under authority from legislatures) are subject to Administrative Procedures Acts in each state which require departments to publish proposed rules and regulations and accept public comment. There is no requirement for quantitative analysis of the costs or benefits of proposed new requirements (or regulatory impact assessment of any kind). Such work is carried out occasionally rather than routinely. All laws and regulations of individual states are published and accessible on relevant websites and

	are updated as requirements change. In this respect, departments are bound by state policies and procedures which mandate a high degree of openness and availability of information. The NAIC is similarly committed to openness and model acts and other material are available, although for the most part only on payment of a fee. Summary information on the NAIC's accreditation process is publicly available—a 14 page pamphlet sets out the standards and processes. This publication mentions that all states and the District of Columbia are currently accredited. However, reports and scores relating to individual departments are not available to the public (even states themselves see only the reports and not the scores). The NAIC also publishes: • a report, Model Laws, Regulations and Guidelines, which includes, for each instrument, a "state action page" citing each state's enacted model or similar and related legislation. This makes it possible to monitor differences between model laws and state measures; and • a Compendium of State Laws on Insurance Topics which sets out in chart form state laws on specific issues, allowing cross-state comparison by topic. These publications are available for a fee. The NAIC carries out periodic self-assessments of the compliance of U.S. regulation with IAIS Insurance Core Principles. However, until recently, the most recent published self-assessment related to 2001 and the version of the Insurance Core Principles issued in October 2000, which has since been revised and extended. Within individual departments, governance arrangements (which differ by state) are in place to maximize consistency of decision-taking. Key decisions may be delegated to chief examiners or referred to the commissioner only with the evidence of sign off from all relevant departments and officers. Decisions on the use of regulatory powers are subject to appeal and to judicial review. This is provided for by individual model laws. Companies may also appeal against findings in draft examination reports. Initial appeals are normally to the commissioner but may be heard by other senior staff in the department (not the relevant analyst or examiner); or an officer may be designated in law to hear appeals. Beyond that, cases can be litigated through the courts. (See in particular NAIC Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition, section 4 C, which gives an insurer a right to a hearing; and section 5, which prescribes judicial review of any order or decision of a commissioner in relation to this regulation; the Insurance Holding Company System Model Act (#440) by contrast provide for judicial review on commissioner decisions on application to a court). Separate procedures apply in the case of receiverships—see Insurer Receivership Model Act, section 205, which provides for appeal to the receivership court. Once a receivership decision is confirmed by the court, departments are not required to await the outcome of an appeal before appointing a special deputy receiver to manage the company. Internal processes allow for urgent decision-taking where required to expedite action that is required to meet regulatory objectives. Regulatory actions are published. A number of model laws and regulations give commissioners discretion to exempt insurers or transactions from requirements by order or regulation (see for example, section 4 J of the Insurance Holding Company System Model Act (#440)). In the area of accounting, departments may, on application of an insurance company, agree to a modification of requirements. These "permitted practices" are published in full by individual companies, including the impact of the modification on surplus, and in some years have been published on the NAIC's website soon after the end of the year to which they relate.

	The departments publish annual reports on activities and performance. The NAIC publishes both an annual report and the Insurance Department Resources Report which catalogues resources available to individual state departments and regulatory actions taken in the course of the year. Information on the role of the departments is made available on websites and the role of most departments in handling consumer complaints has promoted an awareness of their regulatory role in protecting consumers.
Assessment	Largely Observed
Comments	Insurance regulation is carried out openly and transparently, with clear accountability to the state administration and legislature and rights of appeal (and judicial review) which balance the need for due process with the importance of regulators being able to act swiftly and decisively where necessary to achieve regulatory objectives. However, measures could be considered to foster improved understanding of the work of the states and NAIC and to increase regulatory impact analysis. In particular, the NAIC should: (i) make publicly available some information that is currently available only on payment of a fee or by subscription (for example the NAIC model laws and material on how states have adopted them); (ii) publish summary information on their assessment of states' compliance with accreditation standards (even if scores remain private); and (iii) commit to publication on a regular basis (maybe every two years) of their self-assessment of compliance with IAIS Insurance Core Principles. These measures would help to foster improved understanding of state regulation and the role of the NAIC. In addition, the NAIC should develop its approach to regulatory impact analysis and make such work a routine part of its analysis of proposed new or changed requirements.
Principle 5.	**Supervisory cooperation and information sharing** The supervisory authority cooperates and shares information with other relevant supervisors subject to confidentiality requirements.
Description	There is extensive sharing of information between individual insurance departments and between departments and the NAIC. The NAIC developed a Master Information Sharing and Confidentiality Agreement for its members, into which all states have entered. The accreditation process assesses whether departments have policies and procedures for sharing information. The standard requires that information be shared with regulatory officials of any state, federal agency or foreign country providing that the recipients are required, under their law, to maintain its confidentiality. The extension to foreign countries followed an NAIC initiative to update the confidentiality and information sharing provisions of several key model laws to allow for the sharing of information with international regulators. Specifically, the Model Examination Law, Standard Valuation Law, Risk-Based Capital For Insurers Model Act and Insurance Holding Company System Regulatory Act were revised. There is extensive information sharing with federal agencies. These include banking supervisors (particularly in relation to the nine groups with bank holding companies regulated by the Federal Reserve and the 42 groups which also contain a thrift regulated by the Office of Thrift Supervision). A Joint NAIC/Federal Banking and Thrift Regulatory Agencies Forum meets quarterly. There is also cooperation with federal authorities responsible for the various government programs—Treasury Department (TRIA), FEMA (flood insurance), Department of Agriculture (crop insurance), and the Department of Labor (workers compensation). Generally, however, departments, and particularly the NAIC whose involvement results from its role in managing the extensive databases on insurance companies across the country, provide information to these agencies in a one way flow. The amount of reciprocal exchange and discussion of issues is limited—except where events force such exchanges. There were, for example, extensive

	exchanges in relation to the crisis at AIG and in its aftermath. There is no requirement for the signing of a Memorandum of Understanding or other formal agreement prior to sharing of information with another supervisor, domestic or foreign. The scope of information exchange can be wide, encompassing confidential financial data and factual material on companies, their officers etc. There is no requirement for reciprocity of information exchange – departments will exchange information without requiring information to be provided in return. Departments have to ensure that the recipient of information can keep it confidential before releasing the information. In respect to information-sharing with foreign regulators, the NAIC has developed with the EU a model information sharing agreement for use as a basis of bilateral MoUs generally. All MoUs are signed with foreign regulators directly by individual insurance departments. The current body of MoUs reflects the key international relationships in respect of major global groups with operations in the United States and major U.S. companies' operations abroad. MoUs are also in place between some states for which global reinsurance providers are of particular importance (because of the significance of catastrophe risks) and the countries where the global reinsurance companies are located. However, departments would exchange information on request with other regulators provided that they are assured it will be treated as confidential. Partly because many MoUs have been put in place in response to particular needs for regular information exchange relating to particular groups or markets, such exchanges are taking place, bilaterally and, in some cases, within the framework of supervisory colleges. These actual exchanges at present focus on these particular needs—and departments are not likely to take the initiative to inform home or host supervisors of changes in supervisory practice that would affect relevant groups. They would inform home or host regulators in advance of taking regulatory action, taking into account the materiality and likely impact of the action in the other jurisdiction.
Assessment	Largely Observed
Comments	Although the main focus of information exchange with other regulators has traditionally been on cooperation with other insurance departments, regulators are able to share information with relevant federal authorities and with regulators abroad. There is a need to continue developing the network of MoUs. Many have been put in place only recently and the network is not comprehensive. As mentioned in connection with ICP 3, all state insurance departments should ensure that laws are updated to enable them to protect information received from foreign regulators. This will ensure that overseas regulators are not deterred from sharing information freely.
The Supervised Entity	
Principle 6.	**Licensing** An insurer must be licensed before it can operate within a jurisdiction. The requirements for licensing are clear, objective and public.
Description	The insurance business that requires licensing is defined, for each state, in the state insurance codes, in terms of lines of business that are permitted to be undertaken. States adopt broadly similar, but not uniform approaches. The scope of the licensing requirement is broad and covers most of what would generally be regarded as insurance business. Typical exclusions are product warranties, certain pet insurance and prepaid funeral plans. Entities owned by state governments that write insurance business may be subject to licensing requirements but this varies by state as do miscellaneous exemptions, for examples for certain charitable organizations. Life insurance must be undertaken in a different corporate entity from property and casualty business (there is one company which still operates as a composite, having been subject to

	grandfathering when the new approach was introduced). Insurance companies may be established as corporates or as mutual companies. Under state insurance law, there are few restrictions on a licensed insurer's ownership by, or affiliation with, other financial or non-financial companies provided the owner meets criteria through the regulatory approval process. An exception is a widespread prohibition on foreign government ownership of an insurer. Insurance companies generally have to obtain a license (known as a certificate of authority) to conduct business from each jurisdiction in which the company wants to underwrite insurance. The exceptions are surplus lines business (see introduction to this assessment) and reinsurance, where provided the company has a license in one state, it can undertake business in other states without a separate license (it may be subject to other requirements of the host state in which it is writing business). Insurance companies based outside the United States have to be licensed in the states in which they propose to write business, whether as a subsidiary or a branch. Reinsurance may be written directly by an overseas reinsurer with a primary insurer based in the United States (although it may not attract credit in the primary insurance company's financial statements). Departments consult with the home supervisor before licensing a company (or a company with a parent) based outside the United States and obtain necessary information on the status of the company and the business which it is licensed to write in the home market. Minimum conditions for licensing are set out in state legislation. There is no NAIC model law on licensing nor is licensing covered by the accreditation process at present. New accreditation standards related to company licensing have been agreed and will take effect on January 1, 2012. Requirements in state law generally refer to minimum ongoing requirements—for example, that applicants meet the requirements for surplus funds set out in the general requirements. There may be certain overriding criteria that are less objective in nature—for example enabling the commissioner to refuse to issue or renew a license if such refusal is judged to promote the interests of the people of the state. The NAIC has developed a standard form and process for application – the Uniform Certificate of Authority Application (UCAA), which all states accept for all lines of insurance except Health Maintenance Organizations (HMO). Under the UCAA arrangements, a distinction is made between: • a primary application—where a company is applying to establish for the first time as a corporate entity in a state or is moving its corporate location to that state ("redomesticating"); and • an expansion application—where the company is already licensed in one state and wishes to do business in another. • The process provides for more time to consider a primary application (90 days) than an expansion application (60 days)—in both cases, more time may be required, and if so, will be taken in practice. • The UCAA is a NAIC guideline and not a model law. Individual states may impose additional licensing requirements. Under the UCAA process, applications must include information that will enable insurance departments to assess the standing and financial condition of the insurance company. Information has to be submitted covering: the business profile of the applicant; any management offices that

	exercise control over insurance operations and any operation that is delegated to an affiliate or third party; the plan of operation setting out the product lines planned by the applicant. The applicant must submit a "Biographical Affidavit" on behalf of all officers, directors and key managerial personnel of the applicant and individuals with a ten percent (10 percent), or more, beneficial ownership in the applicant and the applicant's ultimate controlling parent (see ICP 7). In considering applications for licenses, departments investigate litigation, criminal, Uniform Commercial Code and bankruptcy records in respect of these officers. 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. Some states require additional information including fingerprints 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. • 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. Additional surplus above the statutorily prescribed minimum may be required of individual applicants. • Applications for expansion or redomestication must include a copy of the most recent Annual Statement, actuarial opinion, audited report performed by a CPA who is not an employee of the applicant. • If an applicant, its parent or its ultimate holding company is publicly traded, it has to submit a copy of the applicant's most recent U.S. GAAP consolidated financial statements. Applicants who are members of a holding company system (see ICP 17) have 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 also has to be included with the application.
Assessment	Observed
Comments	While approaches in individual departments vary, the core requirements embodied in the UCAA process adopted by all states represent a comprehensive set of requirements and processes for insurance company licensing. (See ICP 24 on producer, i.e., intermediary, licensing). Differences between state requirements, on licensing and other issues, could in principle encourage companies to choose for their domestic regulator a state with less onerous requirements and to redomesticate as individual state requirements or their business needs develop. In practice, departments and the NAIC staff appear alert to these risks and, for example in relation to redomestication applications, consult with the previous domestic state on the circumstances of the application before agreeing to a license. The system of retaliatory taxes may discourage redomestication for tax reasons. The number of redomestications is monitored—at an average of 50 per year in 2006–8, it is less than 1 percent of the total of nearly 8,000 companies at end-2008. The extension of the accreditation process to licensing standards in 2012 should nonetheless provide assurance that the core licensing requirements are being complied with in practice by state departments.

Principle 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.
Description	Departments focus on the fitness and propriety of significant individuals in the course of reviewing applications from new companies and in their examination work in respect of licensed companies. There are no requirements for individuals themselves to seek authorization or approval (licensing of producers, by contrast, is done on an individual basis). Nor are there detailed provisions in law defining when an individual will be regarded as fit and proper. In relation to significant owners, departments' requirements are based on the Insurance Holding Company System Model Act (#440), which in Section 1 defines control in terms of "the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person." In addition, "Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10 percent) or more of the voting securities of any other person." Fitness and propriety is assessed at application and on change of control (see ICP 8). The process for considering individuals in connection with applications is described under ICP 6. On an ongoing basis, licensed 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. There is no specific requirement on companies to notify the department when they become aware of issues in relation to the fitness and individual of a key functionary. As part of the on-site examination process conducted at least once every five years, the suitability of the Board of Directors, management, auditors and actuaries is assessed. The approach to be taken is set out in the Financial Condition Examiners Handbook, which is publicly available for a fee. This assessment focuses on the independence, experience and background and ethics of these individuals and functions. Individuals are interviewed to assess suitability. If deficiencies are identified, the examination team makes recommendations for improvements to the insurer and adjusts its ongoing solvency monitoring of the insurer accordingly. Through the use of tools such as increased reporting requirements or more frequent examinations, regulators aim to provide a strong incentive for the insurer to make changes in those areas where unsuitable individuals are identified. Where an insurer is deemed to be in a hazardous financial condition, the department can use specific powers under their implementing measures to order companies to "adopt and utilize governance practices acceptable to the commissioner." (Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition, #385). 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 (#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. The guidance also prohibits actuaries who have committed specific violations from acting as the appointed actuary. Departments refer concerns about particular actuaries to the professional bodies. Under the NAIC Annual Financial Reporting Model Regulation (#205), which is covered by the accreditation standards, departments impose independence and experience requirements on auditors, but do not prior approve appointments of auditors. However, departments can prohibit auditors who have committed specific violations or who do not meet other qualification standards

	from performing insurance company audits. As part of this process, the auditor must submit a letter of qualifications indicating their knowledge and experience in the industry to the supervisor on an annual basis. Departments may also refer CPAs, where they have concerns, to their professional body (the American Institute of Certified Public Accountants) or to the state's Board of Accountancy which has oversight responsibility for audit work (the PCAOB covers auditors on publicly-traded companies). There are no specific provisions enabling departments to disallow actuaries, auditors and senior managers from simultaneously holding two positions that could result in material conflict. Departments would use powers and procedures described above to prevent or rectify such conflicts based on their assessment of circumstances at each firm.
Assessment	Largely Observed
Comments	Departments take a view on all significant owners, Board members, senior management, auditors and actuaries and take appropriate action where concerns arise. However, the approach is based on assessment of the fitness and propriety of key functionaries at the point of application for a license, and on an ongoing basis through the examination process, rather than the approval of individuals (which is the approach taken in some other countries). Specific requirements in relation to individuals' fitness and propriety should be adopted. There are also gaps in the specific requirements—companies do not have notify departments of concerns about the fitness and propriety of key individuals and departments cannot disallow functionaries from holding two positions that could result in material conflict.
Principle 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.
Description	Change in the control of an insurance company is subject to supervisory approval process performed during the off-site monitoring process as required by the NAIC Insurance Holding Company System Regulatory Act and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#440 and #450). Adoption of these two models is required under the accreditation program. Section 1 of the Act defines control in terms of "the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person." In addition, "Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10 percent) or more of the voting securities of any other person." Fitness and propriety is assessed at application and on change of control (see the assessment of ICP 8). The model laws require departments to evaluate a potential acquirer of control for compliance with fit and proper requirements. The acquiring individual or entity is required to complete the Acquisition of Control Form (Form A) requiring background information of each applicant. The proposed acquisition is approved by the domestic supervisor. There are minimum requirements for resources, both financial and non-financial, and a requirement that background information on applicants is provided. In addition, there are requirements to ensure that adequate competition continues after a change of control and to make sure that policyholders are not adversely impacted. Within the Holding Company Act, regulators have clear criteria for denying a change in control. The Act provides that regulators can deny an application for change of control for any of the

	following: • 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; • 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; • 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; • 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 or not in the public interest; • 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 • The acquisition is likely to be hazardous or prejudicial to the insurance-buying public. These requirements cover acquisition of control, whether the party proposing to acquire control is located inside or outside the state, or outside the United States. 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 transfers** The Holding Company Act requires that the domestic insurance department must be notified of major transactions with affiliated entities, which departments interpret as including 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, 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. The NAIC Disclosure of Material Transactions Act (#285) requires insurers to report to their 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
Comments	There are extensive requirements and related reporting forms governing changes in control and

	portfolio transfers.
Principle 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.
Description	Corporate governance standards for publicly-traded U.S. companies, including insurers, are set and enforced by the SEC, including requirements in relation to expertise and independence for the audit committee as well as requirements to maintain effective internal controls over financial reporting. Provisions based on SEC requirements will be introduced for all insurance companies through revisions to the NAIC Annual Financial Reporting Model Regulation (#205), which take effect in January 2010. (See ICP 10). There are currently no NAIC model laws or regulations that address corporate governance directly. Departments assess governance mainly in the context of applications for licenses from new insurers and producers, in requiring and reviewing annual statements, in conducting examinations, in approving mergers or other changes of control involving domestic insurers, and in the assessment of solvency. Of increasing importance in this regard is the risk-based examination process. Under the relevant provisions of the Financial Condition Examiners Handbook, examiners must consider and evaluate the insurer's corporate governance and risk management processes. Discussions will be held with Board members and with senior management. The Handbook provisions distinguish between the role of the Board in providing oversight and the responsibility of senior management to manage the business. • Issues assessed by examiners in connection with the role of the Board include knowledge and experience of directors, independence from management; whether there are adequate Board committees, Board oversight of the determination of compensation for executive officers and their appointment and termination; sufficiency and timeliness of information provided to the Board; and the Board's role in establishing the appropriate (what the Handbook refers to as) "tone at the top" including the development and enforcement of a code of conduct. • Issues assessed in connection with the 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 toward financial reporting and internal controls; and management's role in developing, communicating and enforcing a code of conduct. If deficiencies in the corporate governance practices of a company are identified, the examiners make recommendations to the company, and update the insurer summary profile and supervisory plan accordingly. The department may adjust its ongoing solvency monitoring of the insurer. 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 (#385).
Assessment	Largely Observed
Comments	Corporate governance standards for publicly-traded U.S. companies, including insurers, are set and enforced by the SEC, while requirements for all insurance companies will be introduced from January 2010.

	Departments have been increasing their focus on governance issues, mainly as a more risk-based approach to examinations has started to be implemented (see ICP 13). Examinations had previously focused more on financial condition and related controls, with corporate governance receiving more limited attention. The new examination approach is still being rolled out but the risk-based approach becomes part of the accreditation standards in 2010. Both regulators and companies are adjusting to the need to make evaluations in an area of examination where there are few rules against which to assess individual company practice—and where, in the case of insurance groups, many governance and control functions are organized at group rather than solo company level. As examiners gain experience, the NAIC and/or departments should consider issuing more guidance on good and bad practices in corporate governance for insurers. This would help examiners and firms to develop a clearer expectation of what constitutes effective governance for insurance business, including for groups.
Principle 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.
Description	For publicly traded companies, standards relating to internal controls over financial reporting are set and enforced by the SEC. Under the 2002 Sarbanes-Oxley Act, management and the external auditor must 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 (set at US$1,000,000 per year in the model law), inter alia: • to have an independent audit committee—the model law sets out detailed requirements as to the composition and scope of work of the committee (and smaller companies covered by the requirements are exempt from having to have any independent members of the committee); and • to rotate their audit partner on a regular basis—as in the Sarbanes-Oxley Act, there is a five years limit. In addition, insurers with US$500 million or more in premium are required to issue Management's Report of Internal Control Over Financial Reporting, attesting to the adequacy of internal controls. Similar to the SEC requirements, the attestation must be based on 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 law are scheduled to go into effect on January 1, 2010. To avoid duplication, companies subject to and in compliance with Sarbanes-Oxley Act equivalent requirements are broadly exempt. In addition, all insurance entities are required to receive an annual audit in accordance with the Annual Financial Reporting Model Regulation (#205). As part of each audit, as required by the American Institute of Certified Public Accountants, the CPA must understand and assess an entity's internal controls over financial reporting. 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. As with corporate governance (see ICP 9), internal controls are increasingly being assessed as part

	of the new risk-based examination process currently being implemented by departments. Use of the Examiners Handbook is required under the accreditation program, although the risk-based approach takes effect only in 2010. The overarching principles set out in the handbook include the need for adequate and clear policies, authorization limits and procedures; comprehensive internal controls; and processes to assure compliance with laws and regulations. Under the risk-based examination process, the examiner must identify and assess all significant inherent risks faced by the insurer, whether they relate to financial reporting issues or to business and operational issues. The examiner then identifies and assesses the internal control processes that can mitigate each risk. Controls are assessed by considering both their design and operating effectiveness. The Examiners Handbook sets out an extensive list of the issues to be addressed in the examination including: delegation of authorities and segregation of duties; the role of internal audit and the external auditor in the overall control framework; the role of the Board in establishing internal controls and monitoring their effectiveness. There is detailed guidance on the importance of assessing the risk in outsourcing of critical functions. This emphasizes that it is the responsibility of management to determine whether processes which have been outsourced are being effectively and efficiently performed and controlled. Although the adequacy of the function is assessed in relation to the risks and control frameworks of individual companies, there are no requirements either that an insurer has an internal audit function or in relation to the scope of the work which such a function should carry out. Examiners require access to internal audit reports when carrying out their work. 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 regulators aim to provide an incentive for the insurer to address 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 (#385), which is a required model under the Accreditation Program.
Assessment	Largely Observed
Comments	Other than controls relating to financial reporting, departments have established few rules and requirements relating to internal controls on insurers at present. For publicly-traded companies, the Sarbanes-Oxley provisions provide a general framework of detailed control requirements and testing of controls. From January 1 2010, much of this framework will be extended to all insurers, with the exception of smaller companies—after extensive debate with the industry, these were excluded from the new approach on the basis that costs would be disproportionate to benefits. These requirements will take time to implement in full. Departments are increasingly looking to ensure sound internal controls at insurers via the risk-based examination process. As mentioned under ICPs 9 and 13, this approach is still being implemented. As examiners gain experience, the NAIC and/or departments should consider the scope for issuing guidance on good and bad practices in internal control. They should also make it a formal requirement for insurers to have an internal audit function. Such a function is now widely considered as an important part of a good control framework—similarly to audit committees, where there are now extensive requirements of all but the smaller insurers.

Ongoing Supervision	
Principle 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 the conclusions and takes action as appropriate.
Description	State insurance supervisory authorities, and thus the NAIC, receive detailed quarterly and annual statistical and financial information. The majority of this information is stored in the NAIC FDR database. It is readily accessible to all state supervisory authority staff, and is therefore available for quantitative analysis of the market. The NAIC Insurance Analysis and Information Sources Department produces each half year separate industry commentaries for each of the life and accident and health insurance industry and the property and casualty insurance industry. Each commentary is about 6–8 pages and includes quantitative analysis and qualitative explanatory comment on issues such as industry size and growth; premium income by major business class and line; operational performance; investment income; insurance liability reserves; liquidity and capital as well as market share and market concentration information. Trend analysis on key indicators, such as capital and surplus, is commonplace in the commentaries. While the commentaries are for supervisory authority use only, the extremely rich database allows the NAIC to make available publicly not only much industry aggregate data but also individual insurer data. The latter are often available at a cost, but this does not appear to prevent significant further analyses, repackaging and on-selling of this data. So the U.S. market is the most analyzed insurance market in the world. The NAIC also has the expertise and IT capability quickly to analyze its databases to obtain answers to supervisory queries about the insurance markets', and individual insurers', ability to deal with market events (e.g. a collapse or default of a major counterparty to which insurers are exposed through investments or reinsurance, and the downgrading and devaluation of a certain asset class). These commentaries are one input used by the NAIC Financial Analysis Working Group (FAWG) to decide which sectors of the insurance market may be becoming problematic, or potentially more vulnerable to adverse market trends. On occasions this has led the FAWG to require the NAIC Insurance Analysis and Information Sources Department to produce special market sector reports (e.g., reports on medical malpractice insurance and on financial guaranty insurance) to decide if supervisory authority action (sector-wide or only for specific insurers) is required or if temporary monitoring is all that is needed. There are several NAIC databases which can be so analyzed, including those for consumer complaints, insurance producers (i.e., intermediaries), supervisory authority actions and ratings agency actions. Especially because of the exposure of the U.S. property and casualty insurance market to natural catastrophes, the NAIC has built an impressive mechanism to facilitate specific event data collection and analysis. Individual states or the NAIC can decide if a special data call is needed. Once it has been decided what data or information is to be collected, the call is made using the authority under the state's financial examination laws. It is then shared among supervisory authorities pursuant to the Information Sharing and Confidentiality Agreement among the states. Aggregate and by company data are published (see ICP 26). Some industry stress testing has been performed by the NAIC using these capabilities (see ICP 23).
Assessment	Largely Observed
Comments	The absence of complete group-wide consolidated data for insurance groups and broader financial

	conglomerate groups hinders the ability of supervisors to analyse and monitor market-wide events of importance for the stability of insurance markets. The lack of analysis of developments outside the U.S. markets, given that it relies so heavily on offshore reinsurers, needs to be addressed. Otherwise, the NAIC data sources and analysis capabilities are world-leading. They should be more used in international supervisory college discussions to better understand the risks that U.S. insurers might create to international groups of which they are members and to encourage insurance regulators in other jurisdictions to develop similar capabilities.
Principle 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.
Description	The NAIC Model Law # 205 Annual Financial Reporting Model Regulation is designed to improve the states' 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, communication of internal control related matters noted in an audit, and management's report of internal control over financial reporting. The Law specifies that the notes to the financed statements are those required by the NAIC Accounting Practices and Procedures Manual (APPM) and Annual Statement Instructions (ASIs). The ASIs specify the requirements for, and contents of, the Statement of Actuarial Opinion (SAO) and statistical information to be filed. So regulators clearly have the ability to obtain the necessary information to undertake regular financial analysis of an insurer's financial condition. It also authorizes supervisory access to auditor work papers, lays down membership requirements for insurer audit committees and requires senior management attestation to the accuracy and fair representation of the financial reports and associated filed material. Because of its sweeping ambit for examinations, which can be conducted at the "sole discretion of the commissioner," NAIC Model Law # 390 on examinations provides the legal authority for the collection of any other information from insurers, even though information collection is not specifically referred to in the law. Differences among the requirements for financial reports and other information reporting reflect the different categories of insurance business undertaken, rather than the particular legal form of insurers. All insurers must file information, and the model examinations law effectively allows the supervisory authority to obtain information on any subsidiary of the insurer. Group information and financial statements are required to be filed via NAIC Model Law # 450 Holding Company System Reporting. However, reporting of consolidated group-wide financial and other data, which would allow monitoring of insurance regulatory capital compliance for an insurance only group, is not required. The ASIs do specify comprehensive reporting of transactions which can lead to off-balance sheet exposures. NAIC Model Law # 440 Insurance Holding Company System Regulatory Act requires transactions between affiliates to be reported before they are entered into. It specifies criteria which they can be assessed against, which are designed to ensure arms length dealings. It also provides that the insurer cannot enter into the transaction if the supervisory authority disapproves of the transaction.
Assessment	Largely Observed

Comments	NAIC data sources and analysis capabilities are world-leading. The affiliate transaction requirements provide a strong means of identifying and controlling intra-group dealings and exposures. However the prior notification requirement may lead to undue 'prior approving' of many transactions and may represent an ineffective use of supervisory resources (although U.S. regulators have found such transactions to be abused in the past). Reporting of consolidated group-wide financial and other data should be required—see also ICP 17 as there is no complete group-wide consolidated data for insurance groups and broader financial conglomerate groups.
Principle 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.
Description	The NAIC Model Law # 390 Examinations (included in the accreditation process) provides the authority for the supervisory authority to undertake on-site inspections, which are referred to as examinations. The commissioner has absolute discretion to require an examination and the form and scope of the examination. The law requires that examinations of each insurer must be conducted at least every five years (three years in some states). Examinations are conducted to comply with this requirement in the law, but also according to priorities developed from off-site analyses of insurer financial and other data. Beginning in 2001, the NAIC began work to move from examinations of an audit/compliance nature to risk-focused examinations. This shift is well advanced but still underway. It was formally agreed by the NAIC to make this move and in 2007 the NAIC Financial Condition Examiners Handbook, which was revamped to reflect this, was approved. The application of this handbook became an accreditation standard from January 1, 2010, with accreditation examinations of the states commencing then. Major states have begun early adoption of this new approach and there has been considerable retraining of examination staff. Market conduct examinations are also conducted and there is a NAIC Market Conduct Examiners Handbook. Depending on the resources and structure of the state supervisory authority, this examination work may be undertaken in conjunction with the financial condition examination or separately. Irrespective of which approach is taken, the outcome of market conduct examination work is an important consideration in assessing the inherent and residual risks in an insurer. The Financial Condition Examiners Handbook outlines seven major phases of the new risk-focused approach; namely: (1) understanding the company and identifying key functional activities to be reviewed, (2) identifying and assessing inherent risk in activities, (3) identifying and evaluating risk mitigation strategies/controls, (4) determining residual risk, (5) establishing/conducting examination procedures, (6) updating prioritization and supervisory plan, and (7) drafting the examination report and management letter based on findings. It also contains substantial amounts of supporting administrative (e.g., sources of material to analyze before and during an on-site examination, content of and approach to examination reports and management letters to insurers) and technical material (e.g., on reinsurance) to assist examiners. Examination reports of insurers are available to the public, but examination work papers and management letters to insurers are generally not public, although they are available to other state supervisory authorities. However, in some states there is some concern that work papers and management letters could in fact be obtained under freedom of information and similar state laws.

	There are extensive supporting NAIC systems for planning, documenting, following up and reporting on individual examinations as well as on examination activity in aggregate. Tables 19 through 22 of the NAIC Insurance Department Resources Report 2008 provide statistics on examinations by type and by state, which show there is extensive exam work occurring.
Assessment	Observed
Comments	The Financial Condition Examiners Handbook is comprehensive, well presented and easy to read. It has been sensibly designed to provide concepts and broad steps to follow, and deliberately emphasizes the need for examiners to think about issues and risks in the particular insurer in order to tailor what is examined in depth, rather than follow a checklist approach. From discussions with supervisory authorities and examiner staff and from inspection of examination work papers and reports, it is clear that financial examinations are thorough and well documented. Examinations also appear to identify the important issues. Consideration could be given to how to strengthen the confidentiality of examination work papers and findings to ensure that examiners can be frank in their findings and assessments of the financial condition of insurers. This will become more important as the risk-focused examination approach is rolled out, as proper implementation will require examiners to make more qualitative judgments about insurers' risks and controls, including scoring them for inclusion in the risk matrix. The move to risk-focused examinations involves a quantum shift in examination approach, mindset and skills. It is a progressive approach which should allow examiners' assessments to become more forward-looking. But effective implementation will not be easy because of the changes it demands of examiners. Therefore it is recommended that the NAIC assess the implementation of the risk-focused examination approach in the near future (e.g., in the course of 2012).
Principle 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.
Description	NAIC Model Law # 385 Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition (included in the accreditation process) lays down standards or criteria that the supervisory authority can use to determine if an insurer is in a hazardous financial condition. These are all appropriate criteria or trigger points and include such criteria as reserve adequacy, reinsurance adequacy and collectability, fitness and propriety of officers and directors, timely and accurate return filing, adequacy of administrative systems, liquidity and appropriateness of affiliate transactions. This model law also outlines the actions the supervisory authority can require an insurer to take to remedy its financial condition, which may include adjusting reinsurance, reducing or suspending acceptance and renewal of business, increasing capital and surplus, suspending dividend payments out of the insurer, increasing the frequency of financial reports, providing additional detailed reports, providing a new business plan, adjusting premium rates, changing investments and correcting corporate governance practice deficiencies. The regulatory compliance of insurers and the current position and trend of insurers' financial condition can be determined from the regular financial analyses, examinations, market conduct surveillance and examinations and the reasonably regular contact supervisory authorities have with insurers. In practice, supervisors raise issues and inappropriate practices with insurers when they become aware of them, especially during and following an examination, and they follow up to check on insurers' responses. Therefore they take appropriate and proportional corrective action when it is needed.

	As well as laying down the structure of the regulatory capital requirements the NAIC Model Law # 312, Risk-Based Capital (RBC) for Insurers sets down four action levels and the types of company or regulatory action which must be taken. The levels and associated types of event are: • Company Action Level ➢ Trigger event—insurer capital less than 200 percent of the RBC amount; or for life and/or health insurers, capital is less than 250 percent of RBC and has a negative trend; or for property and casualty insurers, capital is less than 300 percent of RBC and triggers the negative trend. ➢ Action required—insurer must prepare and submit an RBC Plan which identifies what contributed to reaching the trigger event; corrective action proposals; financial projections for at least 4 years out (both without and with the corrective action); key assumptions; and the problems associated with the insurer's business. • Regulatory Action Level ➢ Trigger event—insurer capital less than 150 percent of the RBC amount. ➢ Action required—insurer must prepare and submit an RBC Plan or revised RBC Plan: supervisory authority must examine the insurer's financial condition and review its RBC Plan; supervisory authority must issue a "corrective order" specifying the corrective actions the insurer must take. • Authorized Control Level ➢ Trigger event—insurer capital less than 100 percent of the RBC amount. ➢ Action required—as for Regulatory Action Level, or place the insurer under regulatory control (i.e., under formal rehabilitation or liquidation) if this is considered to be in the best interests of the policyholders, creditors and the public. • Mandated Control Level ➢ Trigger event—insurer capital less than 70 percent of the RBC amount. ➢ Action required—supervisory authority must place the insurer under regulatory control (i.e., under formal rehabilitation or liquidation), except for property and casualty insurers in run-off where the supervisory authority may allow the run-off to continue under its supervision.
Assessment	Observed
Comments	The structure of prompt corrective action triggers and required actions is thorough and is rigorously applied. While it could not, and should not, prevent insurers ever failing, it does lead to reduced insurer shortfalls in any failure (guaranty fund data suggests most shortfalls are in the 5–15 percent of liabilities range). It also provides clear messages to the insurers of the consequences of their reducing capital levels.
Principle 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.
Description	As described under ICP 14, there is a formal structure of prompt corrective action levels to ensure that the deteriorating financial condition of an insurer is addressed early to help prevent insurer failure and loss to policyholders. Once an insurer is deemed by the supervisory authority to be in a hazardous financial condition, the supervisory authority can take a range of actions, such as: • requiring the insurers capital levels to be increased; • restricting dividend and other payments out of the insurer;

	• directing the issuing of new, or renewing of current, policies to stop; • restricting the insurer dealing with investments and other assets, or require specific investments and other assets to be dealt with in a certain manner; and • requiring changes in management. NAIC Model Law # 558, Administrative Supervision Model Act, allows the supervisory authority to place an insurer under administrative supervision by the authority if continuance of the business is hazardous to the public or insured parties, the insurer has exceeded its powers or breached requirements, the insurer's business is being conducted fraudulently, or the insurer gives its consent. Administrative supervision essentially allows the supervisory authority to exert direct control over insurers' transactional activity related to investments, any dealing with assets, merger or consolidation of business, premium rates, reinsurance contracts, policy surrenders, premium refunds, management changes and insurer staff remuneration. In addition, NAIC Model Law # 555 Insurer Receivership Model Act allows supervisory authorities to place insurers into rehabilitation or receivership, which is then supervised by the court, but with the supervisory authority as the rehabilitator or receiver. Supervisory authorities use their authority to put an insurer under administrative supervision, rehabilitation or even liquidation to effect compulsory transfer of obligations from a failing insurer to another insurer. This is often done by keeping a failing/failed insurer in run-off and under administrative supervision and arranging a reinsurance transaction with the accepting insurer, or improving the financial condition of the problem insurer sufficiently for the accepting insurer legally to take ownership. The supervisory authority can and does use persuasion, civil penalties, follow up action and more detailed or focused examinations to prevent insurer breaches and inappropriate practice from recurring. Tables 23 through 25C of the NAIC Insurance Department Resources Report 2008, which provide statistics on actions taken against insurers, formal hearings with insurers, insurers in run-off, insurers under supervision or rehabilitation or in liquidation, demonstrates supervisory authorities are active in these areas. Throughout the model laws, there are penalty provisions which allow the supervisory authority to fine insurers. However, the authority to apply penalties to individuals (apart from producers) for breaches of insurance laws is limited. Issues of dishonesty and other felonies are dealt with mostly through laws other than insurance laws. In practice the supervisory authority does persuade insurers that certain individuals in senior management should leave the insurer, but there is no specific authority to bar individual directors or management of insurers from acting in responsible capacities in the industry in the future.
Assessment	Largely Observed
Comments	There is no clear authority for the supervisory authority to fine individual directors or senior managers of insurers, and to bar them from acting in responsible capacities in the future. The insurance laws should be changed to provide the supervisory authority with such clear powers.
Principle 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.
Description	As described under ICP 15, the legal and regulatory framework provides a clear structure for the points at which it is no longer permissible for an insurer to continue its business.

	The procedures for dealing with insolvency and the winding-up of an insurer are clearly set out, with NAIC Model Law # 555 Insurer Receivership Model Act (included in the accreditation process) providing specific requirements for the conservatorship, rehabilitation and liquidation of insurers. Policyholders are given the highest priority in wind-ups after the fees of the receiver are met. The broad and comprehensive powers of the supervisory authority for dealing with insurer insolvency and wind-up allow for strongly effective protection of policyholder obligations and minimal disruption to policyholders in the meeting of these obligations.
Assessment	Observed
Comments	There is a strong focus by the supervisory authorities on ensuring individual policyholder obligations are met. Customer complaints handling facilities in supervisory authorities, readily available information on the progress of insurer receiverships and a network of insurer guaranty funds provide a high level of policyholder protection. The arrangements for insurer wind-up and exit from the market are clear, have worked effectively and in conjunction with guaranty fund arrangements provide strong protection against policyholder loss if an insurer fails. There are not the same clear arrangements for dealing with the exit from the market of a financial conglomerate group with insurance subsidiaries (but this is not required by the ICPs).
Principle 17.	**Group-wide supervision** The supervisory authority supervises its insurers on a solo and a group-wide basis.
Description	The U.S. approach to supervision reflects a long-established focus on securing the financial soundness of individual insurance companies, if necessary by ring-fencing them from other operations in the group. This approach in part reflects the fact that insurance companies are generally less exposed than banks to contagion from problems elsewhere in the group. The United States has developed an extensive set of tools aimed at monitoring and, as necessary, controlling transactions with the holding company. It also has extensive powers to obtain information about U.S. entities that are a part of the same group as licensed insurers. Key requirements in relation to groups are set out in The Holding Company Act (#440) which creates the concept of an insurance holding company system—defined as consisting 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—see ICP 8). Groups containing one or more insurance companies may also be covered by the definition of financial holding company in the GLBA and the related regulatory requirements. Extensive information is collected on holding companies within an insurance holding company system and on transactions between the licensed insurer and the rest of the group. For example, the Annual Statement must include a detailed organization chart and summary of various types of transactions within the holding company system. The annual and quarterly statements also require disclosure of whether an insurer is affiliated with one or more banks, thrifts or securities firms (i.e., financial conglomerate/financial holding company). In addition, consolidated financial statements of the ultimate parent are required to be filed with the state of domicile by any company that is part of a holding company group. This information is included in the regular financial analysis of insurance companies, which draws on guidance for analysts in the Financial Analysis Handbook. Insurers are also required to submit ad hoc reports covering:

	• holding company registration (an insurer must register when it becomes a member of an insurance holding company system and annually thereafter); • notice of certain affiliate transactions – which are reviewed to determine if they are fair and reasonable to the interests of the insurer. Material transactions include sales, purchases, exchanges, loans, extensions of credit, guarantees, investments, reinsurance, management agreements, service agreements and cost-sharing agreements and there are rules on what is considered material; • notification of certain merger and acquisitions; and • prior approval of any extraordinary dividend or other extraordinary distribution to shareholders (definitions of what constitutes "extraordinary" vary by state). A lead state is designated for each insurance group to coordinate regulatory activities in their review of insurance groups. Insurers in a corporate group are required to file consolidated financial statements for their ultimate parent. However, these are based on US GAAP, not SAP, and are not required at an intermediate insurance holding company level. So they do not allow any group assessment against insurance regulatory financial requirements. Supervisors have not traditionally looked at internal controls or risk concentrations at group level. They are now focusing more on group management and controls in the context of the new approach to risk-focused examinations currently being rolled out (see ICPs 9, 10 and 13). Some of the internal control requirements applicable to insurance companies may be satisfied by compliance at the group level—for example, the requirement for audit committees that takes effect on January 1 2010 (see ICP 10) recognizes a group audit committee as meeting the requirement. As host supervisors in relation to U.S. operations of groups based in other countries, departments have been greatly increasing their cooperation with home regulators in the course of the crisis. There are regular exchanges of views and information. Departments have sent representatives to colleges of supervisors of groups based in Europe with significant U.S. business. International colleges of supervisors have met for some, but not for all (or even all the largest) U.S.-based insurance groups with international operations. A new NAIC working group is considering possible changes to the Holding Company Model Act in response to financial crisis lessons and developments internationally. The group is considering the need for group wide requirements and improved cross-border communication and coordination (both internationally and between states) among supervisors, including supervisors of other financial sectors where appropriate.
Assessment	Partly Observed
Comments	The U.S. approach is focused on securing the financial soundness of individual insurance companies. While this has not been unusual among insurance regulators internationally, many have been supplementing their strong solo company focus with financial and other requirements and more supervisory focus applied at group level and U.S. supervisors should do the same. They do not currently make an assessment of the financial condition of the whole group of which a licensed insurance company is a member. Risk-focused examinations are not yet generally focusing on group issues; and supervisory colleges are not meeting for all U.S.-based international groups. It is recommended that U.S. supervisors: (i) include fuller assessment of the financial condition of the whole group of which a licensed

	insurance company is a member; this may involve quantitative techniques and practices in use internationally; it would improve U.S. insurance regulators' ability to identify weaknesses in groups which may have an impact on the insurers; in the absence of global reserving and solvency standards for insurers, this will not be easy to do on an international basis (i.e., for the relatively few U.S-based international insurance groups) but may be introduced more readily for domestic groups—at least by applying the U.S. RBC requirements to the consolidated domestic insurance group balance sheet; (ii) extend the risk-focused approach to examinations of solo insurance companies to groups, again starting with U.S.-led groups—in effect extending the lead regulator and college of supervisors arrangements already in widespread use for such groups within the framework developed by the NAIC (a group wide approach to examinations is already being taken in some cases but is not standard across the states); and (iii) ensure that colleges of supervisors for the U.S.-led groups with major international operations are established and functioning effectively—and led by U.S. insurance regulators (existing arrangements under which agencies with limited insurance expertise have been designated as global lead supervisors have been shown to be inadequate). Adding this group wide focus to U.S. insurance regulation will be a significant change, maybe equal to that involved in the development of risk-focused examinations. It will require attention to skills and training. It may also be desirable for insurance regulators to be given additional powers, such as authority to license insurance holding companies, apply capital requirements to the consolidated insurance group and direct the insurance holding company to make changes at the group level to rectify any shortcomings.
Prudential Requirements	
Principle 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.
Description	The supervisory authorities do not explicitly require insurers to have comprehensive risk management policies and systems in place; however, the insurer's risks and its systems to measure and manage those risks are reviewed through the on-site examination process. It is clear from the NAIC Financial Examiners Handbook, from discussions with examination staff and from supervisory authority examination work papers that the review of risk assessment and risk management systems and controls in insurers is a large component of the examinations. Under the new risk-focused examination approach a large range of insurer risks are to be assessed, as well as risk mitigation strategies and approaches so that examiners can rate an insurer's residual risks.
Assessment	Largely Observed
Comments	The relevant laws, regulations or standards should be changed to include a requirement that an insurer have in place comprehensive risk management policies and systems capable of promptly identifying, measuring, assessing, reporting and controlling their risks. While the desired outcomes for this ICP appear to be achieved in practice owing to the comprehensive approach to examination of insurers, it is increasingly important that the risk management function of insurers is of high quality and given significant focus and influence within insurers.
Principle 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.
Description	The supervisory authority does not specifically require in any law or standard that the Board of Directors approve and regularly review the insurer's strategic underwriting and pricing policies.

	However, it is expected that an insurer has detailed underwriting, pricing, expense and reinsurance systems and controls, and these are inspected in some detail during an examination of an insurer. The NAIC Financial Examiners Handbook contains guidance on this in its Examination Repository (Section 4) which has considerable detailed material on how to examine activities relating to premiums, losses and benefits, and reinsurance for each of life, health and property/casualty classes. While there are variations across states, most states have some review or approval authority over policy forms and, in the case of property and casualty insurers, they also often regulate premium rates; in some cases, insurers must simply file rates and forms before using them; in other cases, both must be approved in advance. In respect to rates, the objective is to ensure that they are not inadequate, excessive or unfairly discriminatory to consumers. Through this process there are considerable analyses undertaken of an insurer's proposed pricing for specific products. (See also ICP 25). Details of all reinsurance contracts must be lodged with the supervisory authority so their degree of protection to the ceding insurer can be assessed for its adequacy. Much of this is simply examined and the supervisory authority intervenes or withholds approval only if there are concerns. The Examiners Handbook has a section (Section 6) dedicated to reinsurance and one of its sub-sections (i.e., sub-section VI) provides specific guidance on the evaluation of risk transfer, including the cash flow testing evaluation approach.
Assessment	Largely Observed
Comments	The relevant laws or regulations do not explicitly provide that an insurer must have in place strategic underwriting and pricing policies approved and reviewed regularly by the Board. Boards are not required to set the strategic limits on these core insurance functions within which management should operate. There is a risk that the prior notification requirement may lead to undue 'prior approving' of many reinsurance transactions, which could be an ineffective use of supervisory resources. The relevant laws or regulation should be amended to provide that an insurer must have in place strategic underwriting and pricing policies approved and reviewed regularly by the Board.
Principle 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.
Description	The NAIC Model Law # 820 Standard Valuation Law (included in the accreditation process) is the primary authority for determining adequacy of reserve liabilities for life and accident and health insurance companies. This is supported by further regulations and requirements. Reserve requirements for property and casualty insurers are outlined in the NAIC Accounting Practices and Procedures Manual (APPM—included in the accreditation process). The Annual Statement Instructions (ASIs – included in the accreditation process) also require that a Statement of Actuarial Opinion (SAO—included in the accreditation process) on an insurer's reserves is provided and that actuarial work on calculating reserves and opining on them is done in accordance with Actuarial Standards of Practice (ASOPs). There is also a specific ASOP on data quality. The SAO must be supported by a detailed actuarial report, which spells out the particular actuarial valuation methodologies used, the actuarial assumptions used and discusses the recent experience of the business compared with what was expected. This detail extends down to lines of business, and where necessary, even sub-lines of business where it is expected that loss experience may be substantially different. Reserves have to be calculated both gross and net of reinsurance.

	For life and health insurance, there is a set minimum standard valuation for most life and health insurance products. Generally this is a conservative net premium valuation, so statutory reserves for life insurance are mostly highly conservative. As this approach is not entirely satisfactory for more complex life products with numerous policyholder options and guarantees (e.g., variable annuities with living benefits), the NAIC and the actuarial profession have developed and are continually refining more sophisticated statutory reserving approaches (which include asset adequacy assessments, cash flow testing and stochastic modeling) for such products, to ensure interest rate risks and equity risks in the products are adequately reserved for. These are in addition to the overall required actuarial opinion statement mentioned above. This work is now leading to a more Principles Based Approach (PBA) for life reserving (not in effect at the time of this assessment), but also to adjustment to capital requirements for such products. For property and casualty insurance, there is not a set minimum standard valuation, rather the insurer will set its reserves on advice from its actuary. The actuaries must do their calculations and give their advice according to ASOPs. The actuary's SAO must also state the actuary's point estimate and high and low range for reserves along with the point estimate actually adopted by the insurer. Generally property and casualty insurance statutory reserves are determined on an ultimate cost basis (i.e., not discounted to produce present values) allowing for claims inflation, including 'superimposed inflation'. This approach should normally produce conservative reserves for highly predictable lines of business. Examinations of insurers do cover reserving and the handbook has significant guidance on how examiners can check the insurer's process for determining reserves. In carrying out the annual audit the external auditor will usually obtain its own actuarial advice, which generally involves the auditor's actuary reviewing the work of and opinion of the insurer's actuary. Actuaries within the supervisory authorities read all the SAOs and the actuarial reports (which the insurer must keep available for seven years) if there is a need to. If the supervisory authority has any concerns about an insurer's reserving they can obtain further independent actuarial advice on the reserves and ultimately can require the insurer to increase reserves to a level which they believe is adequate. See also Appendix – Technical Note: Accounting and Actuarial Framework for Insurance.
Assessment	Observed
Comments	The liability reserving methods and bases generally lead to conservative estimates, which is in line with the conservative, book value nature of statutory insurance accounting in the United States Elements of the reserving methods adopted involve stochastic modeling or scenario analysis techniques to estimate the reserves required under moderate adverse conditions. However, there is currently no particular or specified safety level which is targeted for reserving—or capital. For general transparency and for international comparison, it is recommended that consideration be given to specifying a target safety level for reserving (and an associated target safety level for capital). This should also assist in keeping margins for conservatism in reserves more similar across insurance classes and thus assist with peer comparisons of reserving.

Principle 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.
Description	Investment activities of insurers are regulated by one of two approaches to achieve diversification, namely: • defined limits – whereby restrictions are placed on the amount of an insurer's financial assets which can be invested into particular asset classes and lower grade investments. This is provided for in the NAIC Model Law #280 Investments of Insurers Model Act (Defined Limits Version) (included in the accreditation process); and • defined standards – whereby a more principles-based approach is used by requiring the Board of an insurer to establish and monitor an investment policy which meets specific criteria. This is provided for in the NAIC Model Law #283 Investments of Insurers Model Act (Defined Standards Version) (included in the accreditation process). Detailed information and statistical data on investments, including data on all individual investments held, bought and sold, has to be filed annually and is stored in the NAIC databases. This allows for extensive analysis of the investments and investment exposures of an individual insurer, as well as the insurance market. The Investments of Insurers Model Act (Defined Standards Version) contains requirements for insurers to monitor and manage asset/liability positions. Where an insurer is subject to the Defined Limits version of the model law, supervisors look for and expect to see these arrangements in place. In addition, the Annual Statement is required to include a Management's Discussion and Analysis section, in which liquidity, asset/liability matching and capital resources must be discussed in detail. Financial examinations of insurers involve detailed scrutiny of insurers' investment systems, reports and controls. The NAIC Financial Condition Examiners Handbook has specific guidance for examiners on this. The NAIC has established a Securities Valuation Office (SVO) which has expert staff to provide specific advice on, and standards for, the valuation of different types of securities. The APPM and ASIs require that securities owned by insurers be valued according to the SVO valuation standards. Requirements on securities lending, or sale and repurchase arrangements, are contained in the NAIC Model Law #280 Investments of Insurers Model Act (Defined Limits Version). Essentially, it is allowed up to 40 percent of an insurer's admitted assets with exposure to any single business entity through such transactions limited to 5 percent of admitted assets. Before undertaking such transactions an insurer must have a written investment plan for such activity which covers: • apart from dollar roll (i.e., short term sell/purchase) transactions, the need for a written agreement; • how the cash received will be invested; and • the operational procedures to be used to manage interest rate risk, counterparty default risk, the conditions under which proceeds from reverse repurchase transactions may be used in the ordinary course of business and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction. See also Appendix – Technical Note: Accounting and Actuarial Framework for Insurance.

Assessment	Observed
Comments	The regulatory requirements for investments are robust and they are likely to have contributed to the limited number of major investment problems for insurers from the financial crisis. As insurers move more to the defined standards investment model (i.e., a more principles-based approach), it will be important to ensure that all aspects of investment risk, especially asset/liability mismatching risks, are well covered in the reserving and capital requirements.
Principle 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.
Description	As well as the detailed requirements contained in the two model laws on investments (see ICP 21), there is a specific NAIC Model Law # 282, Derivative Instruments Model Regulation (which is, however, not included in the accreditation process), which sets standards for the prudent use of derivative instruments. This regulation contains requirements on: • insurer internal guidelines and control procedures—including requiring approval of these by the supervisory authority; • derivative transaction documentation; and • trading requirements. The two model laws on investments specifically prohibit the use of derivative instruments for any purposes other than hedging or income generation, in which case, derivative investments are restricted to covered transactions and limited to a percentage of the insurer's admitted assets. The NAIC Financial Examiners Handbook contains specific guidance on derivatives within its guidance on investments. This covers in detail activities that can be undertaken to examine derivatives dealing, pricing and valuation, hedge effectiveness, documentation, auditing and accounting disclosures. The ASIs require detailed reporting of derivative exposures and transactions. See also Appendix – Technical Note: Accounting and Actuarial Framework for Insurance.
Assessment	Observed
Comments	The requirements relating to derivatives use are robust and sensible in that they allow derivatives to be used for purposes which would enhance an insurer's investment management and returns without exposing it to undue risk of losses. There are no requirements on derivatives use at a holding company level outside of an insurer, but this is not required by the ICPs.
Principle 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.

Description	There has for many years been a set of Risk-Based Capital (RBC) requirements for insurers. RBC requirements are covered under the accreditation process. The RBC rules differ between life and health insurance and property and casualty insurance. The risks covered by the RBC requirements are:
	
	• life and health
	  o asset value risk (essentially credit risk in the assets);
	  o insurance risk (essentially adverse experience in the insurance obligations);

	o interest rate risk (essentially due to changes in interest rates which lead to losses due to mismatching of assets and liabilities); and o all other business risks. • property and casualty insurance o asset value risk (essentially credit risk in the assets); o credit risk (essentially counterparty risk in reinsurance receivable); o underwriting risk (essentially adverse experience in the insurance obligations); and o all other business risks. An insurer'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. Capital and surplus of an insurer is essentially the excess of regulatory admitted assets over liabilities. The APPM specifies which assets of an insurer cannot be 'admitted' for statutory accounting purposes and thus will not count toward capital and surplus. Non-admitted assets include intangible type assets which cannot be readily realized in a liquidation; reinsurance which is disapproved, from an 'alien reinsurer' and not collateralized, or does not meet effective risk transfer criteria; investments in excess of regulatory limits. Unrealized gains/losses on investments are generally not brought to account, or are deferred by mechanisms such as an asset maintenance reserve or interest maintenance reserve for gradual release. They are therefore not counted as capital or surplus immediately. Some realized gains and losses are treated similarly. There is not a classification of capital into tiers as there is for banking. As described under ICP 14, there is a formal structure of prompt corrective action levels to ensure that the deteriorating financial condition of an insurer is addressed early to help prevent insurer failure and loss to policyholders. There are no specific or indirect requirements which address inflation of capital. The regulatory requirements are heavily structured to ensure tight "ring fencing" of an insurer's operations and total assets (see also ICP 17). There are elements of stress testing and other forward-looking analysis built into the reserving and capital adequacy frameworks. For example, for asset adequacy testing of the reserves in relation to certain product lines, tests must be performed and reported on in the SAO and Memorandum. Otherwise, stress tests are performed on an occasional basis but are being used more systematically in response to financial crisis. See also Appendix I – Technical Note: Accounting and Actuarial Framework for Insurance.
Assessment	Largely Observed
Comments	Insurance company reserves are determined conservatively and the regulatory capital is required in addition. So the combination of reserving and capital provides a sizable buffer against adverse experience. In the absence of a specified safety level which is targeted for reserving plus capital, it is difficult to determine the level of adversity that the combination of reserves and capital can cover, but it appears to be commensurate or higher than in many other insurance jurisdictions. For general transparency and for international comparison, it is recommended that consideration be given to specifying a target safety level for reserving and an associated target safety level for capital. This should assist not only with peer comparisons of reserving and capital across insurers,

	but also comparison against other insurance regimes internationally. Further development of stress testing could be considered, using the experience gained from exercises undertaken in the financial crisis.
Markets and consumers	
Principle 24.	**Intermediaries** The supervisory authority sets requirements, directly or through the supervision of insurers, for the conduct of intermediaries.
Description	Intermediaries are generally referred to as producers in the United States. While distribution channels vary, producers may act as agents of one or more insurance company (captive agents or independent agents) or as brokers—i.e., acting on behalf of the customer. Banks may also distribute insurance products. The NAIC's Producer Licensing Model Act (#218) contains a provision that states must license producers, as well as the licensing standards. This law has been implemented in a majority of the states but with a relatively high level of significant variations. A national system for producer licensing has been contemplated by the U.S. Congress—the Gramm-Leach-Bliley Act of 1999 (GLBA) placed a new federal mandate on states to achieve a prescribed degree of uniformity, or reciprocity (i.e., mutual recognition), in insurance producer licensing within three years or face federal intervention in the form of a federal preemptive insurance sales force licensing system, the National Association of Registered Agents and Brokers (NARAB). Although unable to meet the "uniform" test, a majority of states adopted the necessary laws and reciprocity arrangements to meet the "reciprocity" test, and thus prevented the triggering of NARAB. In the effort to promote uniformity, the NAIC has established a process of certification of state producer licensing regimes and currently 47 jurisdictions are assessed as meeting the reciprocity mandate of the GLBA. There is currently legislation before Congress that would revive NARAB. All individuals who sell, solicit or negotiate insurance are required by law to be licensed. Both the individual and the business entity through which the producer operates must be licensed. Resident applicants must pass a test specific to their line of business to ensure a minimal level of competency. Some state insurance regulators also require pre-licensing education before a resident applicant can sit for an examination. Sixteen states fingerprint their applicants to identify any prior criminal activity. (Discussions continue on achieving greater uniformity in this area to address a significant obstacle to uniformity in producer agent licensing—states that do extensive vetting of prospective licensees, including fingerprint checks are reluctant to grant reciprocity to states with weaker requirements.) Producers must also obtain a license in each non-resident state where they wish to sell, solicit or negotiate insurance (other requirements may also be applied in states which have not adopted the reciprocity provisions of the model law). Insurance producers who work as agents for one or more companies must, in most states (the model law provision is optional), obtain formal appointments with the companies they represent. Insurance companies are then required to notify relevant states of each appointment. Once licensed, producers must satisfy ongoing continuing education requirements in their resident state. They are required to provide appropriate disclosure on the products they sell and their potential impact on the consumer if purchased and to assess the needs of their clients and suitability of particular products. Under the Unfair Trade Practices Act model law (#880), producers must not misrepresent the benefits and conditions of a policy. However, producers are not required to make disclosures to customers of the status under which they are doing business, for example whether they are independent and which insurance companies have appointed them.

	Under the model law, state insurance regulators have various powers to address misconduct by intermediaries (section 12 of the model law lists types of misconduct). These include suspension or revocation of both a resident and non-resident license as well as the levying of fines. In addition, a Federal law, 18 U.S.C. 1033, imposes a lifetime ban from the business of insurance for criminal whose crime involves dishonesty or breach of trust. Departments analyze and respond to consumer (and insurer) complaints about particular agents. 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 account for the deposit of clients' funds; and there is no NAIC model law provision in this area. Where the producer is acting as agent, the legal framework relating to agents provides that monies paid to producers acting as the agents of insurers are liabilities of the insurer. Insurers in practice will make customers good where agents they have appointed fails to pass on premium payments. Some states have adopted their own provisions requiring brokers to establish separate accounts (premium trust fund accounts) to be used to hold money that has not yet been paid to insurers or which is to be remitted to clients. In many states, agents and brokers have a legal responsibility in relation to such funds in a fiduciary capacity—and may be required not to mingle their own and client funds. Producers are not subject to financial requirements or reporting – although some states impose surety bond requirements on individual producers. Examinations of producers are not mandated as they are for insurance companies; and departments have discretion whether and how often to carry them out (there is no NAIC examination manual for producers). Examinations of insurers may extend to producers acting as agents for the insurer, in particular where (i) the insurer has appointed one or more managing general agent (MGA) – i.e., agents, usually focused on commercial risks, which may have authority from the insurance companies who have appointed them to accept business on their behalf and may also handle claims or help place reinsurance; and (ii) the producer is a large broker focusing on commercial lines. Four major groups of mainly commercial lines brokers are subject to more intensive oversight as a result of settlement agreements in 2006 with Attorneys General and regulators in a number of states. These arrangements stipulate various business reforms required of these brokers including disclosure of commission and a ban on contingent commissions. While discussions continue on a general reform of requirements applying to all firms in this area that was envisaged at the time of the settlement arrangements with the four major groups, no measures have yet been enacted. While there are some provisions on disclosure in the Producer Licensing Model Act (#218) and most jurisdictions have some kind of disclosure requirement related to compensation or the role of the producer, the limited scope of the 2006 settlement agreements mean that there are not consistent commission disclosure requirements applying to brokers across the market. All information about producers is stored in a national database.
Assessment	Largely Observed
Comments	While producer regulation is less uniform than that it is for insurance companies, in respect of both requirements in law and the supervisory work of departments, most states have at least the core requirements—licensing, requirements in relation to producer skills and expertise, and powers to undertake examinations and to take action in case of producer misconduct. The general legal framework provides safeguards for client money where intermediaries act as agents (and this has been tested in numerous cases). There is less uniformity on the safeguards applying to money held by brokers but separate accounts with trust status are required in at least two states where large commercial lines brokers are domiciled.

	The major commercial lines brokers (including those with large global presences) are otherwise subject to relatively limited supervision, other than that provided for in the 2006 settlement arrangements. While these institutions should clearly not be regulated in the same way as major insurance companies (because they are not risk carriers), closer oversight would be appropriate to reflect the importance of their role in the commercial lines market. Some strengthening of the approach to producer regulation is recommended: (i) to extend broker trust fund arrangements across states (where not already in place) to ensure that client funds are fully protected; (ii) to develop a uniform approach to the regulation of major brokers which reflects their important role; and (iii) to complete the current work on a consistent approach to the regulation of commission disclosure. In addition, producers should be required to make disclosures to customers of the status under which they are doing business, including which insurance companies have appointed them.
Principle 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.
Description	There is an extensive set of provisions and processes aimed at protecting consumers entering into insurance contracts. Major elements are: • the producer licensing requirements (see ICP 24) – which address point of sale issues, since insurance products are mostly distributed through agents and brokers; • rate and form regulation: departments exercise at least some review or approval authority over policy forms and, in the case of property and casualty insurers, they also often regulate premium rates; in some cases, insurers must simply file rates and forms before using them; in other cases, both must be approved in advance. In respect to rates, the objective is to ensure that they are not inadequate, excessive or unfair to consumers. For certain life insurance, annuity, disability and long term care products, a central approval process has been developed under the 2006 Interstate Insurance Product Regulation Commission (IIPRC) which 34 states have so far joined; • requirements in insurance codes applicable to insurance business – drawn from the NAIC Unfair Trade Practices Act (#880) and Unfair Claims Settlement Practices Act (#900), although implementation is not uniform across states; the requirements focus on the prohibition of an extensive list of specific misconduct and of unfair trade and claims practices (see below); other measures cover issues with particular products—for example, the Suitability in Annuity Transactions Model Regulation; • market conduct examinations which departments undertake on individual companies and producers – which cover conduct issues in underwriting, claims handling, marketing and other areas (see ICP 13); • data collection from insurers on market conduct issues – the NAIC Market Conduct Annual Statement (MCAS), introduced in 2004 is used by companies (again, not uniformly across states) to report data such as length of time taken to settle claims and replacement rates for some product types (persistency); it is used to target market wide responses and examinations; and as input to the Market Analysis Working Group (MAWG), a cross-state group of

	regulators that operates on similar principles to the FAWG; • databases to enable departments to record and retrieve information on producers and companies—such as the Regulatory Information Retrieval System (RIRS) and the Special Activities Database (SAD) which is used to check applicants' background; • direct consumer services, particularly complaints handling but also consumer information and consumer education programs. Departments analyze and respond to complaints, taking up issues with companies or producers and requiring redress where appropriate. In respect of insurance claims handling, states uniformly require insurance claims to be settled in an equitable and fair manner. Specific acts are listed as "unfair claims practices," including knowingly misrepresenting relevant facts or policy provisions relating to coverage, not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear; and 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 material accompanying an application. Insurance regulators may levy civil penalties or take civil action in cases of unfair trade practices. In addition, policyholder protection in case of insolvency of an insurance company is provided by state guaranty associations covering individual life and health and property and casualty markets in each state. The scope and extent of the coverage of these organizations varies across states. With limited exceptions, they operate on the basis that insurance companies are assessed for contributions to the compensation paid to policyholders of an insolvent institution as payments become due. The annual assessment per insurer is capped, in most states at 2 percent of annual premium income. To date, actual assessments have been well below the cap.
Assessment	Observed
Comments	Departments have been increasing the scope of their consumer protection work in recent years, moving away from a traditional focus on financial issues (and handling of consumer complaints) to a more proactive approach to market conduct of insurers. Established regulatory tools from the financial area, and the model of cooperation and challenge between departments within an NAIC framework, have been extended to market conduct—for example in market conduct exams, MAWG and the extensive use of shared databases. Departments have tackled collectively some significant market conduct abuses at large multistate companies and across the market in respect of certain products and practices. This transition has further to go, however, particularly in respect of the ability of departments to identify and respond quickly to wider market issues as well as problems at individual companies. As with producer licensing, there is a marked lack of uniformity across states in the market conduct area, both in the requirements adopted by departments (including rate and form approval), and their participation in cross-state initiatives such as the IIPRC and MCAS. The absence of accreditation standards in this area makes it hard to judge the full impact of these variations, although it is clear that they create significant inefficiencies for multistate insurance companies and producers. However, as with the approach to producer licensing, core consumer protection requirements are apparently in place in most if not all states.
Principle 26.	**Information, disclosure & transparency toward 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.
Description	Insurance companies are not subject to any formal requirements from insurance regulators on their disclosure of financial or other information. Those which are publicly-traded companies or part of

	groups headed by such a company are subject to SEC requirements on publication of financial statements and other information. Stakeholders do, however, have access to information through other means. Financial information can be obtained from the NAIC for a fee of US$2 per company by rating agencies and data vendors. Policyholders and other stakeholders may also obtain information on individual companies from the NAIC free (summary data and full financial statements on up to five companies) or a charge (more than five full statements). They can also approach relevant insurance departments direct, who make available financial statements direct but also refer enquirers to the NAIC. Reports describing the findings of examinations (principally matters of fact rather than examiners' judgments) are also available on departments' websites.
Assessment	Observed
Comments	While there are no regulatory requirements in relation to disclosure, full financial information, including the actuarial opinion and auditor's statement, are readily available to stakeholders. This reflects the relative ease of access and concentration of data that has resulted from financial statements being submitted direct to the NAIC. However, to improve the availability of information, in particular to policyholders without access to databases, ratings etc, and the understanding of insurers' risks, the NAIC should consider making publicly available for free more of the information which is currently subject to charges. The NAIC should consider a review of the benefits of developing a set of explicit disclosure requirements.
Principle 27.	**Fraud** The supervisory authority requires that insurers and intermediaries take the necessary measures to prevent, detect and remedy insurance fraud.
Description	Efforts to combat insurance-related fraud encompass a wide range of state, federal and private sector initiatives aimed at criminalizing fraudulent claims and other frauds, and committing resources to detect and prosecute cases of fraud. The NAIC model law Insurance Fraud Prevention Model Act (#680): • sets out a prohibition on insurance fraudulent acts; • gives investigative and other powers to the commissioner; • establishes mandatory reporting to the regulator; • provides for the confidentiality under law of relevant documents and information and for information to be shared with other agencies; • provides for the creation of fraud prevention units within departments; and • requires companies to take antifraud initiatives to detect, prosecute and prevent fraudulent insurance acts. As at April 2009, all states that had implemented the model had done so with significant variations and several had taken no action yet. The model is not covered by accreditation standards. There is also some federal legislation, such as measures against fraud in healthcare insurance. The model law does not explicitly refer to insurance claims fraud but defines "insurance fraudulent act" sufficiently widely (for example, with reference to presentation of false information) to cover such fraud. Departments may prosecute those found to have carried out insurance fraudulent acts themselves or refer the evidence to law enforcement agencies (for example where the department

	does not have a prosecutor on its staff). Insurance regulators may levy civil penalties or take civil action using powers available in cases of unfair trade practices, where these are relevant. Antifraud initiatives required of companies include an antifraud plan, which must be submitted to the commissioner. Most insurance companies now have special investigation units (SIUs) to identify and investigate suspicious claims. Most departments have fraud prevention units (or fraud bureaus), whose function includes initiation of independent investigations and reviews of reports or complaints of alleged fraudulent insurance activities from federal, state and local law enforcement and regulatory agencies and insurers. Some of these fraud bureaus have significant resources in relation to the total available to departments. Financial and market conduct examinations are tasked to identify evidence of fraud. Guidance is provided to examiners in the NAIC Market Conduct Examiners Handbook. Examiners look at the anti-fraud plan and assess the adequacy of the resource commitments (and training) it sets out. The overall control framework (including, for example, internal audit), is assessed for its effectiveness in controlling against fraud, which is treated as part of operational risk for the purposes of risk-focused reviews (see ICP 13). An exhibit in the handbook sets out how fraud assessments should be undertaken and presented. The reporting of fraud by insurers to departments must cover external, internal and suspected claims fraud. The NAIC provides (for use by consumers as well as insurers) an online system, the Online Fraud Reporting System (OFRS). A report made in OFRS is delivered to all states in which the relevant insurer does business. The National Insurance Crime Bureau (NICB), a not-for-profit organization supported by the property and casualty insurance companies, works with insurers and law enforcement agencies to facilitate the identification, detection and prosecution of insurance crime. As well as managing databases of insurance crime, it organizes training, and promotes public awareness. It also undertakes investigations in cooperation with companies and law enforcement agencies. The NICB shares suspected fraud claims information with the NAIC who make it available to states. Regulators have statutory authority to share information regarding investigations, actions and examination results with other insurance regulators, other state, federal and international regulatory agencies and law enforcement agencies. Departments maintain relationships with state and federal law enforcement agencies and cooperate on investigations. Federal authorities are typically closely involved and are more likely to take the lead where there are international issues.
Assessment	Observed
Comments	While approaches vary by state, core requirements (such as making insurance fraud a crime) are in place across states. The capacity of departments to address fraud-related issues is increasing as market conduct exams are undertaken and the availability of data on fraud improves with the development of databases. Remaining gaps in the framework – for example, where departments do not require an anti-fraud plan from insurance companies – should be addressed as soon as possible.

Anti-money laundering, combating the financing of terrorism	
Principle 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).
Description	Insurance companies are subject to the relevant AML/CFT provisions of the Bank Secrecy Act (BSA). In 2001, the USA PATRIOT Act amended the BSA to require that all businesses defined as financial institutions implement anti-money laundering (AML) programs. Insurers subject to the Act, including life insurance companies and other investment related insurers, are now required to comply with the provisions of the BSA, in particular, the AML program and suspicious activity reporting (SAR) provisions in respect to relevant business. The Financial Crimes Enforcement Network (FinCEN), a bureau of the U.S. Department of the Treasury, is responsible for the administration of the BSA and AML activities. The Internal Revenue Service (IRS) is the delegated examination authority for the insurance sector. FinCEN retains enforcement authority, including referral of cases to criminal law enforcement agencies. In 2005, the U.S. Treasury Department issued implementation rules as required under the amended BSA. The "Financial Crimes Enforcement Network; Amendment to the Bank Secrecy Act Regulations – Anti-Money Laundering Programs for Insurance Companies" (31 CFR 103.137) apply only to those insurance companies offering covered products. Covered products include: • a permanent life insurance policy, other than a group insurance policy; • any annuity contract, other than a group annuity; and • any other insurance product with features of cash value or investment. Since these requirements took effect in May 2006, each insurance company issuing or underwriting a covered product has had to develop and implement an anti-money laundering program reasonably designed to prevent the insurance company from being used to facilitate money laundering or the financing of terrorist activities. The insurer's program has to cover only the insurer's covered products. Key requirements are: • The program must incorporate policies, procedures, and internal controls based upon the insurance company's assessment of the money laundering and terrorist financing risks associated with its covered products. • The insurer is required to integrate the company's agents and brokers into its anti-money laundering program. Insurance agents and brokers themselves are not required to have separate anti-money laundering programs. However, the insurer is responsible for monitoring compliance by the company's agents and brokers with their obligations under the anti-money laundering program. (Certain insurance products fall within the definition of securities under the Securities Exchange Act and may only be sold by registered broker dealers who are subject to the separate anti-money laundering requirements of their regulators). • The insurance company must designate a compliance officer to be responsible for implementing and monitoring compliance of its anti-money laundering program including its agents and brokers. • The insurance company must provide training for appropriate persons.

	• The insurance company must provide for independent testing of the program on a periodic basis to ensure that it complies with the requirements of the rule. • The program must be in writing and be approved by senior management. The written program must be made available to the Department of the Treasury, FinCEN, or their designee upon request. The expectation of the authorities (see the supplementary information published with FinCEN Regulations in the Federal Register, November 3, 2005) is that policies and procedures adopted by insurance companies in their anti-money laundering and suspicious activity reporting programs will provide for obtaining all relevant customer-related information and appropriate assessment of customers and customer-related information (although the regulations do not explicitly refer to "customer due diligence"). In addition, the U.S. risk-based system requires enhanced measures with respect to higher-risk customers, and the general AML record-keeping requirements apply. A limited number of anti-money laundering examinations have been conducted by the IRS under an MOU with FinCEN since 2007. These have covered insurance companies' processes in relation to agents and brokers. Results have been shared with FinCEN. There have been no cases taken forward for enforcement action as yet. Foreign branches and subsidiaries are not examined. In parallel with further development of the IRS examination program, FinCEN and the IRS are now cooperating with the NAIC and state insurance departments on the development of procedures and information-sharing arrangements (MOUs). This may in due course result in the state regulators covering BSA anti-money laundering issues more fully in their examinations. At present, state regulators in their examinations determine whether insurers have established an anti-money laundering program that has been approved by senior management and contains the required elements. (Insurance departments may also look at how the company's compliance function takes account of money laundering risks.) If the examiner determines that the company has not established or is not maintaining such an anti-money laundering program, then they have the authority to refer this information to the appropriate federal authorities. The NAIC has formed a subgroup to discuss a number of issues with FinCEN, including review of the examination handbook, possible educational assistance and consideration of examination collaboration. Insurance companies also have to file reports in appropriate situations of the receipt of currency over US$10,000. This is in lieu of a requirement to file Currency Transaction Reports. They also have to make Suspicious Activity Reports as part of their anti-money laundering program. FinCEN has issued guidance on possible suspicious activity, including the purchase of an insurance product inconsistent with the customer's needs; unusual payment methods, such as cash, cash equivalents, or structured monetary instruments; and early termination of a product (including during the "free look" period), especially where it results in a cost to the customer. FATF Mutual Evaluation Report (MER), published in June 2006, identified various issues in the insurance area, in part relating to the division of responsibilities between the federal and state levels. They were regarded by the evaluators as significant weaknesses in the overall context of the 2006 AML/CFT evaluation. The relevant weaknesses identified were: • Obligations to identify beneficial owners are limited to specific circumstances, such as correspondent banking and private banking for non-U.S. clients, and do not extend to insurance business.

	• There are no measures in place to ensure that there is adequate, timely and accurate information on the beneficial ownership and control of legal persons that can be obtained or accessed in a timely fashion by the competent authorities. • No explicit obligation to conduct ongoing due diligence, except in certain defined circumstances. • Customer identification for occasional transactions limited to cash deals only. • No requirement for life insurers issuing covered insurance products to verify and establish the true identity of the customer (except for those insurance products that fall within the definition of a 'security' under the federal securities laws). • Verification of identity until after the establishment of the business relationship is not limited to circumstance where it is essential not to interrupt the normal course of business. • No explicit obligation to terminate relationship if verification process cannot be accomplished. • The existence of a US$5000 threshold for reporting suspicious activity (too high). • Measures relating to politically-exposed persons (PEPs) do not explicitly apply to the insurance sector. • No explicit requirement requiring life insurers to have policies and procedures for non-face-to-face business relationships and transactions; • There is no obligation under BSA for financial institutions to implement employee screening procedures. • For introduced business, no obligation on relying institution to obtain identification/verification information from introducer. • For insurance, no specific requirement to establish and retain (for five years) all of the written records set out in the FATF Recommendations; life insurers of covered products are only required to keep limited records of SARs, Form 8300s, their AML Program and related documents. • In the insurance sector, there is no specific requirement to establish and retain written records of transactions with persons from/in countries that do not or insufficiently apply the FATF Recommendations. In addition, at a number of points in the evaluation report, it was noted that "the effectiveness of applicable measures in the insurance sector (which went into force on May 2, 2006) cannot yet be assessed." Published updates provided to the FATF by the U.S. authorities do not provide additional information on implementation. 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 the federal government when suspected money laundering activities are discovered. Both state and federal regulators have the authority to cooperate and share information relating to AML investigations.
Assessment	Partly Observed

Comments	While money-laundering in connection with insurance has long been a criminal offence, the U.S. authorities have only recently brought relevant insurance business within the scope of anti-money laundering regulatory requirements (the Bank Secrecy Act). Implementing the approach has taken time, partly because of the careful consideration that has been given to the anti-money laundering risks in insurance. There were significant gaps in the framework when the most recent FATF MER was undertaken in 2006, particularly the absence of specific requirements in relation to customer information, while planned federal examinations had not then started. The IRS is now carrying out examinations. As its resources available for examinations are limited, it is cooperating with state insurance departments to make use of their expertise in this area. However, the effectiveness of cooperation between state and federal regulators is limited pending the consideration of legal issues arising from their collaboration and agreement of new procedures and information sharing arrangements. Both the federal government and state insurance departments wish to increase information sharing of examination information. This work has been given a high priority by the federal and state agencies but no deadline as yet. The regulatory approach also remains heavily reliant on requirements for insurance companies to include key processes, including customer due diligence, in anti-money laundering programs. It is recommended that a timetable is set for the agreement and implementation of new arrangements between state insurance departments and federal authorities that will deliver greater resourcing of supervisory activities as well as necessary information exchange. (A factual update on developments since the 2006 FATF work is being undertaken separately as part of the FSAP work.)

APPENDIX I: TECHNICAL NOTE ON ACCOUNTING AND ACTUARIAL FRAMEWORK FOR INSURANCE

Introduction

There is a well established and comprehensive framework of accounting and related actuarial requirements, which supports insurance regulation. While it is heavily rules-based, it is beginning to move toward more of a principles-based approach.

Regulatory insurance accounting is driven by the NAIC-established Statutory Accounting Principles (SAP), which are contained and elaborated on in the NAIC *Accounting Practices and Procedures Manual* – March 2009 (APPM), which in turn utilizes the framework of Generally Accepted Accounting Principles (GAAP) established by the United States Financial Accounting Standards Board (FASB). However, GAAP pronouncements do not become part of the SAP until and unless they are specifically adopted by the NAIC.

SAP vs. GAAP

While GAAP is designed to meet the varying needs of the different users of financial statements, SAP is specifically designed to address the concerns of regulators. Therefore, SAP stresses the ability to pay insurance claims in the future, while GAAP stresses the measurement of emerging earnings of a business from period to period (i.e., matching revenue to expenses). Put another way, SAP is balance sheet driven, whereas GAAP is performance statement driven.

As regards measurement, SAP is conservative in some respects, but not unreasonably conservative over the span of economic cycles. Areas where the differences between SAP and GAAP are most evident are:

- **Policy Reserves** – statutory policy reserves are intentionally established on a conservative basis, emphasizing the long-term nature of the liabilities. Under GAAP, the experience expected by each company, with provision for the risk of adverse deviation, is used to determine the reserves it will establish for its policies. GAAP reserves may be more or less than the statutory policy reserves.

- **Assets** – GAAP has recognized certain assets which, for statutory purposes, have been either non-admitted or immediately expensed. Policy acquisition costs are expensed as incurred under SAP since the funds so expended are no longer available to pay future liabilities. Insurance company financial statements prepared in accordance with GAAP defer costs incurred in the acquisition of new business and amortize them over the premium recognition period.

- **Deferred Income Tax Assets** – historically these have not been recognized under SAP.

- **Reinsurance** – the methods of accounting for certain aspects of reinsurance under GAAP may have varied from SAP (e.g., credit for reinsurance in unauthorized companies is not given under SAP).

APPM

The NAIC's APPM is a codification of all of the insurance regulatory accounting requirements and it incorporates much other material. It is maintained by the NAIC Accounting Practices and Procedures Task Force (APPTF), but the promulgation of new SAP guidance by the NAIC ultimately requires adoption by the NAIC membership. The APPTF employs two working groups with distinctly different functions to carry out the maintenance. The Statutory Accounting Principles Working Group (SAPWG) has the exclusive responsibility of developing and proposing new Statements of Statutory Accounting Principles (SSAPs). The Emerging Accounting Issues Working Group (EAIWG) responds to questions of application, interpretation, and clarification that are generally much narrower in scope than development of a new SSAP.

Concepts

The following concepts provide a framework to guide the NAIC in the continued development and maintenance of the SAP:

- **Conservatism** – statutory accounting should be reasonably conservative over the span of economic cycles and valuation procedures should, to the extent possible, prevent sharp fluctuations in surplus;

- **Consistency** – meaningful, comparable financial information to determine an insurer's financial condition requires consistency in the development and application of statutory accounting principles;

- **Recognition**

  - Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests should not be recognized on the balance sheet but rather should be charged against surplus when acquired or when availability otherwise becomes questionable;

  - Liabilities require recognition as they are incurred; and

  - Revenue should be recognized only as the earnings process of the underlying underwriting or investment business is completed.

Structure of APPM

The manual is large (about 3,500 pages), has some duplication, shows signs of much evolution and addition, and is thus in need of an overhaul to improve readability and navigation. However, it is comprehensive and thorough. The main elements to its structure are:

- **SSAPs** – the primary accounting practices and procedures promulgated by the NAIC; these are contained in the body of the APPM;
- **Guidance for specific SSAPs** – contained in APPM Appendix A;
- **Interpretations of the EAIWG** – contained in APPM Appendix B;
- **Actuarial guidelines** – contained in APPM Appendix C (NB these are only for business written in life and health insurers);
- **GAAP cross-reference to SAP** – contained in APPM Appendix D;
- **Issues papers** – usually the first step in developing new SSAPs and contain a recommended conclusion, discussion and relevant literature section; contained in APPM Appendix E;
- **Policy statements** – these are for information only as they relate to the process of maintaining and updating the APPM; so they are not accounting requirements or guidance; contained in APPM Appendix F; and
- **Audit implementation guide** – to supplement the NAIC Annual Financial Reporting Model Regulation related to auditor independence, corporate governance and internal control over financial reporting, which is proposed to become effective in 2010.

Hierarchy of APPM elements

The following is the specified hierarchy of how the various elements of the APPM are to be applied:

- **Level 1 -** Statements of Statutory Accounting Principles (SSAPs)—the primary accounting practices and procedures promulgated by the NAIC, which are generally the result of issue papers that have been exposed for public comment and finalized. If differences exist between an underlying issue paper and the resultant SSAP the SSAP

prevails and shall be considered definitive. Also includes specific GAAP material[7] adopted by the NAIC, namely:

- *Category a* – FASB Statements and Interpretations, FASB Staff Positions, APB Opinions, AICPA Accounting Research Bulletins;
- *Category b* – FASB Technical Bulletins, AICPA Industry Audit and Accounting Guidelines, AICPA Statements of Position; and
- *Category c* – Consensus positions of the FASB Emerging Issues Task Force, AICPA Practice Bulletins;

- **Level 2 -** Consensus positions of the NAIC EAIWG;
- **Level 3 -** NAIC Annual Statement Instructions (ASI);
- **Level 4 -** NAIC Statutory Accounting Principles Statement of Concepts; and
- **Level 5 -** GAAP reference material below Category c in the GAAP Hierarchy.

Annual Statement Instructions (ASIs)

The NAIC issues ASIs for annual statements, which insurers must file with the NAIC, and which are available to all States through the NAIC's databases and systems. There are separate ASIs for each category of insurer or insurance business undertaken (i.e., life, health, property and casualty, fraternal, title). The type of the information and data to be provided is specified in detail in each ASI and the appropriate format for filing the annual statement data with the states and the NAIC is provided in the Annual Statement Blanks (Blanks). The ASIs specify how the Blanks are to be signed, the state insurance authority specifies which directors, officers and trustees are required to sign, and the Blanks require signing individuals to attest to the accuracy of the statements.

The type of information and data to be filed is:

- Actuarial Opinion—this is in relation to the insurance reserves (see below for more details);
- Annual Audited Financial Reports—there must an annual audit by an independent certified public accountant and an audited financial report must be filed as a supplement to the annual statement (see below for more details of audit);

[7] FASB has recently completed a major 5-year project of *Accounting Standards Codification*™ resulting in the Codification, which from 1 July 2009 is the single source of authoritative nongovernmental U.S. generally accepted accounting principles and replaces all previous U.S. GAAP standards. The NAIC APPM does not yet reflect this.

- Management's Discussion and Analysis—this must discuss the reporting entity's financial condition, changes in financial condition and results of operations in order to assist regulators properly understand and assess the insurer's financial condition. The items required to be covered include:

  - material historical developments;
  - explanation of operating performance, including long term trends;
  - prospective information, especially that which is likely to have a material impact on the insurer's business volumes, net income and surplus;
  - reasons for material changes in line items;
  - liquidity, asset/liability matching and capital resources;
  - loss reserves (property & casualty only);
  - off-balance sheet arrangements;
  - participation in high-yielding, highly-leveraged or non-investment grade transactions or investments; and
  - preliminary merger and acquisition negotiations.

- Financial Statement—usual items (assets, liabilities, surplus/capital, operating statement, cash flow statement), but also detailed analyses, exhibits or notes (which vary by category of business), such as:

  - breakdowns by line of business;
  - breakdowns of major line items (e.g., expenses, premiums, reinsurance);
  - changes in reserves;
  - non-admitted assets; and
  - five-year historical data.

- Investment Schedules—these cover summary information by asset class, but also detailed of the individual assets currently owned, acquired and/or disposed of during the year; and

- Annual Supplements—some are for all categories of business and some are specifically only for one category;

  - director and senior officer compensation (i.e., total compensation for each such individual)—all categories;

- allocation of insurance expenses to lines of business (to assist in assessing profitability by line of business)—all categories,
- investment risk interrogatories (to assist in identifying and analyzing the risks inherent in the entity's investment portfolio)—all categories;
- various claims experience analyses for specific lines of business; and
- actuarial opinion certificates.

These ASIs are almost identical across the categories of insurance business, but do contain some variations in the detail in the financial statements and annual supplements.

Actuarial requirements

Statements of Actuarial Opinion (SAO) and Actuarial Memorandum

In all categories of insurance business the insurer must obtain, and file as part of its annual statement, a Statement of Actuarial Opinion (SAO) by a qualified actuary on the insurance reserves. The precise form of the SAO varies by category of insurance, but includes:

- the identification of the actuary providing the opinion;
- which reserves are covered by the opinion;
- any reliance the actuary has placed on others in forming the opinion;
- the actuary's opinion on if the reserves:
  - meet the requirement of the insurance laws;
  - are computed in accordance with accepted actuarial standards and principles;
  - make a reasonable provision for all insurance obligations of the insurer; and
  - the adequacy of a life or health insurer's reserves and other liabilities in light of supporting assets and under moderately adverse conditions—a number of asset adequacy analysis methods are available to, and used by, actuaries. The most widely used method is cash flow testing.
- relevant comments by the actuary (e.g., material assumption changes, risk of material adverse deviation).

The SAO needs to be supported by some form of actuarial report and work papers (often described as the "Actuarial Memorandum"). The Actuarial Memorandum should provide sufficient narrative detail to clearly explain to company management, the regulator, or other authority the findings, recommendations and conclusions, as well as their significance. It should also provide sufficient technical documentation and disclosure for another actuary

practicing in the same field to evaluate the work. This technical component must show the analysis from the basic data to the conclusions.

Both the SAO and Actuarial Memorandum must be consistent with the appropriate Actuarial Standards of Practice (ASOPs) issued by the Actuarial Standards Board (ASB),[8] and any other relevant standards or principles issued by the relevant actuarial professional body.[9]

The SAO is publicly available, but the Actuarial Memorandum is confidential, and thus only available for regulatory examination.

Qualified Actuary

A qualified actuary generally needs to be a member in good standing of the American Academy of Actuaries (AAA) or a person recognized by the AAA as qualified for such an actuarial valuation. For property and casualty business the qualified actuary can be a member in good standing of the Casualty Actuarial Society. Qualified actuaries must also meet requirements related to their experience in working on such actuarial valuations, under the review of other qualified actuaries.

Appointment of and reporting by the qualified actuary

The qualified actuary must be appointed by the insurer's Board of Directors, or its equivalent, or by a committee of the Board and the NAIC must be notified each year of the qualified actuary which the insurer will be using for its categories of insurance business. If a qualified actuary is replaced the insurer must urgently notify the insurance regulatory authority, including stating if there have been any disagreements with the previous qualified actuary over the preceding two years, The insurer must also in writing request the previous qualified actuary to provide a letter to the insurer stating if the actuary agrees with the insurer's statement, or not, and then provide the actuary's response letter to the insurance regulatory authority.

When there is a change of qualified actuary, the incoming qualified actuary would generally consult with the previous qualified actuary, and the code of conduct of the AAA requires the previous qualified actuary to cooperate.

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[8] The ASB establishes and improves Actuarial Standards of Practice (ASOPs), which identify what the actuary should consider, document, and disclose when performing an actuarial assignment. Members of the ASB are appointed by the presidents and presidents-elect of the various U.S. actuarial bodies.

[9] These are the American Academy of Actuaries, the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

The qualified actuary must report to the Board of Directors or the audit committee each year on the items within the scope of the SAO. The SAO and the Actuarial Memorandum must be made available to the Board of Directors. The minutes of the Board of Directors should indicate that the qualified actuary has presented such information to the Board or the audit committee and that the SAO and the Actuarial Memorandum were made available.

Actuarial Discipline

The Actuarial Board for Counseling and Discipline (ABCD) was established by the U.S. actuarial bodies to strengthen members' adherence to the recognized standards of ethical and professional conduct. The ABCD has two primary functions: it responds to actuaries' request for guidance on professional issues, and it considers complaints about possible violations of the actuarial Code(s) of Professional Conduct. The ABCD is authorized to counsel actuaries concerning their professional activities and to recommend to the relevant actuarial body any disciplinary action.

Legal authority

NAIC Model Law #205 *Annual Financial Reporting Model Regulation* (Law #205) in Section 5 requires that the annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the department of insurance of the state of domicile. The annual audited financial report shall include the following:

A. Report of independent certified public accountant.

B. Balance sheet reporting—admitted assets, liabilities, capital and surplus.

C. Statement of operations.

D. Statement of cash flow.

E. Statement of changes in capital and surplus.

F. Notes to financial statements. These notes shall be those required by the appropriate ASIs and the APPM. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed with a written description of the nature of these differences.

G. The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections

> of the annual statement of the insurer filed with the commissioner, and the financial statement shall include comparatives.

Through Law #5, the SSAPs and all the detailed requirements of the APPM, as well as the ASIs obtain their legal authority. All 50 states and the District of Columbia have adopted this model law.

Life and health insurers are required by NAIC Model Law #820 *Standard Valuation Law* to value reserves for the liabilities for all their outstanding insurance policies. It specifies valuation methods and minimum standards for the computation of the reserves. It, along with NAIC Model Law #822 *Actuarial Opinion and Memorandum Regulation,* requires a SAO to be submitted as part of the annual statement of an insurer, and it specifies the substance and the form of the SAO. These SAO requirements are also contained in the life ASI.

For property and casualty insurers a number of SSAPs[10] specify for various types of business and types of reserves how the reserves should be calculated. They obtain their legal authority through Law #205. The SAO requirements in relation to property and casualty reserves are contained in the property and casualty ASI.

Move to a principles-based approach (PBA)

Legislation on the calculation of insurance reserves began in the United States in the 1850s. It covered only life insurance contracts and the initial commissioner chose a net level premium reserve method using a specified mortality table for expected death claims and specified interest rate for discounting future cash outflows and inflows. For life and health insurance, there has been little change over the last 150 years. So for traditional life and health insurance contracts the minimum reserve is still based on a formula approach with prescribed mortality and interest rates, although mortality varies by type of product and interest rate varies by year of issue. No actuarial judgment is allowed in determining the minimum reserves. The prescribed actuarial assumptions are mostly conservative leading to conservative reserves. Generally, minimum reserve standards have been established to be sufficient to cover future claims 75 percent-85 percent of the time.[11] In the 1990s an asset adequacy analysis test was added to the required SAO to test the adequacy of the formulaic reserves in the light of the supporting assets.

The formula-based system for calculating reserves relies on a static formula that may not capture all the risks of the contract. It is slow to respond to new and complex products or economic developments. It follows a ‘one size fits all’ approach, thereby restricting the use

[10] SSAPs 5, 53, 55, 57, 58, 60, 62, and 65.

[11] AAA presentation: *Introduction to Principles –Based Approach to life reserves and capital* – September 2009.

of actuarial judgment to incorporate the insurer's risk profile. Ideally the reserving and capital requirements need to take account of the insurer's actual product and business practice risks.

The first steps toward principle-based capital standards were C–3 Phase I (addressed interest rate risk in fixed annuities) in 2000 and C–3 Phase II (addressed interest rate and equity risk in variable annuities) in 2005. The first step toward principle-based reserves was VA CARVM (variable annuity Commissioner's annuity reserve valuation methods) in 2008 which is a framework of insurer-specific calculation for variable annuity reserves.

A principles-based approach can better allow for the insurer's 'tail' risks, where low probability events can have large adverse impact. It is generally more in line with how an insurer designs and prices its products, manages its investments, and internally reports and manages its performance and exposures. It is similar to using internal models for reserving and capital. So it involves identifying risks, generating economic scenarios, designing risk models, determining assumptions with appropriate margins, running models to do sensitivity testing of material risks, and documenting the results and processes. Using this approach to determine reserves and capital also requires a determination of the probability of sufficiency or safety desired in the level of desired reserving and the level of desired capital.

The project underway to develop the PBA for life insurance is part of the solvency modernization initiative of the NAIC, but involves considerable input from the U.S. actuarial profession. The approach to this project is to modify the standard valuation law to enable principles-based reserving to be used, by referring to a valuation manual which can then be amended as needed by the NAIC. The valuation manual would include detailed reserving requirements, will be implemented in phases and apply only to specific products. It will also be necessary to develop principles-based capital requirements to mesh with the principles-based reserving requirements. The principles-based capital requirements will also be developed in phases by risk type and product, commencing with interest rate mismatch and equity risk (C–3).

The basic framework for what will be developed is that the reserve will be the greater of a deterministic component and a stochastically derived component. The deterministic component will use a single economic scenario and acts as a floor under the stochastic component. The stochastic component will allow the reserving to be more closely related to each product's risks, it will be determined using multiple economic scenarios to capture tail risk and the reserve level will be targeted at a conditional tail expectation of 70 percent (i.e., the reserve amount is that needed to meet payouts from the average of the highest 30 percent of the economic scenario results).

It will also be necessary to adjust the capital requirements to mesh well with the new reserving requirements. Initially only the C3 capital requirement will be adjusted for those

products for which PBA reserving will apply. The capital requirement will be determined stochastically and the statutory reserves plus capital will be targeted at a conditional tail expectation of 90 percent.