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NAIC White Paper

THE U.S. NATIONAL STATE-BASED SYSTEM OF INSURANCE FINANCIAL REGULATION

and the

SOLVENCY MODERNIZATION INITIATIVE

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Section 1: Executive Summary

1. In 2008, through the NAIC, state insurance regulators in the U.S. embarked on the Solvency Modernization Initiative (SMI) to perform a critical self-evaluation to improve the insurance solvency regulatory framework in the U.S., including a review of international developments and potential options for use in U.S. insurance supervision.

Regulatory Success

2. Opinions vary on an appropriate definition for "regulatory success," but first and foremost, in the U.S. and around the world, there is agreement that a regulator's main priority is to protect policyholders and those who rely on insurance coverage. There are differences, internationally, however, about the relative weight policyholder protection plays compared to other regulatory goals, such as maintaining an insurance market with available coverage at affordable prices and/or fostering successful financial markets. Differences in regulatory missions will likely result in different views of regulatory success.

3. The U.S. has adopted the following **U.S. Insurance Regulatory Mission:** *Protect the interests of the policyholder and those who rely on the insurance coverage provided to the policyholder first and foremost, while also facilitating the financial stability and reliability of insurance institutions for an effective and efficient market place for insurance products.*[1]

4. Protection of the policyholder, beneficiaries, and claimants is a top priority in all U.S. regulatory decisions. However, regulators must continuously evaluate the optimum level of regulation in terms of the costs and benefits associated with facilitating effective and efficient markets for insurance products, the fair and equitable treatment of insurance consumers and the financial stability and reliability of insurance institutions.

5. One way to measure success is to determine how well a jurisdiction meets its own regulatory mission; but, even then, regulatory success is not fully quantifiable. The primary goal of U.S. regulators is policyholder protection by attempting to remedy areas of concern so there is no adverse impact on policyholders and others relying on insurance coverage. However, regulators will liquidate an insurer, if necessary, to ensure policyholder protection and successful rehabilitation outcomes. One can measure a variety of quantifiable activities in the business and regulation of insurance, but that does not measure the scope or success of a regulatory regime. Regulatory success also includes the extensive, and not often quantifiable, value regulators bring to "fix" ongoing insurer financial and market issues with insurers to prevent insolvencies.

6. Regulatory success in the U.S. is a judgment call that involves consideration of many factors: the frequency and extent the regulatory regime or framework aided insurers by identifying and rectifying potential problems before those problems could cause harm to policyholders and claimants; the rate of insolvencies and the payments to policyholders in those insolvencies; effective and efficient rehabilitation actions; market health, viability and competition; and a perceived and actual costs - benefits analysis of the regulatory regime.

[1] "The United States Insurance Financial Solvency Framework," NAIC Financial Condition (E) Committee, 2010

7. The U.S. national state-based insurance regulatory system has a strong track record of protecting consumers and overseeing solvency, especially during the recent crisis when the insurance sector remained relatively stable compared to other financial sectors. Success is also evidenced by the depth and breadth of the U.S. insurance industry and capacity of the insurance guaranty system. With close to 8000 insurers, few (if any) systemically important financial institutions (SIFIs), and limited interconnectivity between insurers and banks, the market is alive and well.

Implementation of the U.S. Financial Regulatory Mission

8. Considering the variety of ways to implement all of the aspects of a regulatory regime, U.S. regulators decided that combining both financial and market regulation is the best means to achieve our regulatory mission.

Financial Regulation

9. The SMI project first produced a succinct description of the entire current U.S. financial regulatory framework, including the underlying principles in which U.S. regulators operate, entitled "The United States Insurance Financial Solvency Framework[2]" (hereafter called "Framework"). The financial regulatory process is essentially a three-stage process: (1) mitigate or eliminate some risks in the insurance business through guardrails around or restrictions on insurers' activities; (2) use financial tools and oversight to work with insurers to implement corrective actions in order to avoid failures, and, (3) provide a back-stop of financial protection in the event that insurer rehabilitation or liquidation is required.

10. Stage one uses legal restrictions or regulatory approval requirements on significant, broad-based transactions/activities to mitigate or eliminate certain risk exposures at the outset. For example, the licensing application process requires extensive analysis of potential financial failure or marketplace illegal or improper risks. Not all requests to conduct insurance business are granted; thereby protecting policyholders by avoiding unacceptable risks. Insurers must obtain approval for extraordinary dividends before payment, thereby avoiding inappropriate investor payments or distributions. Other examples of pre-approval requirements include change of control, transactions with affiliates, investments, and some reinsurance transactions.

Financial Oversight

11. Regulators spend a vast amount of time in the second stage of regulatory activity in which regulators focus on financial oversight. Regulators evaluate companies to determine if they are in potentially hazardous financial condition, using financial analysis and financial examination tools based on an extensive and uniform financial reporting system along with correspondence with the insurer and other relevant entities (as may be necessary). Uniform and detailed reporting allows regulators to benchmark one company to other companies, identifying outliers, unique situations, and potentially under-valued risks. These financial oversight activities also allow regulators to look for new risk concentrations and/or optimistically-valued risks in order to prioritize companies and catch issues long before they become apparent in the marketplace. Notably, the system maintains confidentiality of the financial analysis calculations so companies cannot "game" the reporting to achieve certain desired outcomes. In this way, regulators try not to place too much reliance on the "over-optimism"

[2] http://naic.org/documents/committees_e_us_solvency_framework.pdf

that will exist in a company's own measurement of regulatory capital needs. Due to the significance of financial reporting in the U.S. financial regulatory system, regulators focus considerable activity and oversight on consistent appropriate reporting (audits, compliance, actuarial opinions, etc.).

12. Probably the most difficult stage of regulatory oversight occurs when an insurer becomes insolvent or financially impaired, either in receivership[3] (conservation[4], rehabilitation[5], etc.) or liquidation[6]. Most-often, regulators cite hazardous financial condition[7] as the basis for regulatory action. While one might expect the piercing of the required regulatory capital level (called Risk-Based Capital - RBC) to be the most-often-cited finding prompting regulatory action, most regulators take action before companies fall below the required RBC levels. In the U.S., regulators do not use RBC as an insolvency predictor in isolation; but rather, they rely upon other significant financial indicators and analysis. Besides enhancing uniformity in regulatory action, the value of the RBC comes as back-stop protection. RBC provides the legal authority for regulatory action - a final line whereby regulators are required to take action with limited court intervention. Because of this automatic nature and mandatory regulatory action requirements, RBC action and control levels must be accurate as measures of truly weakly capitalized companies to avoid inappropriate, yet mandatory, action.

13. As a final measure of protection, the state-created insurance guaranty funds provide policyholder protection in the event of insolvency. Guaranty association member-insurers provide coverage to the policyholders of an insolvency insurer; however, not all claims are covered in full but to the limits of coverage and types of policies specified in state law. By design and in an effort to cover the most vulnerable, guaranty funds generally do not pay high limits of coverage.

Market Regulation

14. Market regulation consists broadly of analysis and oversight of insurers' behavior in the market including treatment of policyholders and claimants in product development and pricing, competition, statistical reporting, administration of residual markets, licensing of insurance producers, and consumer assistance and information services. Because problems arising from market activities can increase risks to solvency, regulators balance market regulation and financial regulation activities to achieve our financial regulatory mission, including consideration of availability and affordability of insurance coverage and market competition. Effective communication between financial and market regulators is integral to the analysis process. Market regulators employ a variety of oversight techniques ranging from analysis conducted within the various departments of insurance to on-site examinations. Such techniques as data analysis, correspondence, interviews and interrogatories or questionnaires are also used.

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[3] Receivership actions include three different types of judicial proceedings—conservation, rehabilitation, and liquidation—which may be ordered by the Court to resolve problems with insurance companies not in compliance with state financial statutes. The state's chief insurance regulator petitions the Court for the appropriate form of receivership. Receivership proceedings are usually commenced against insolvent or financially impaired insurers in the insurer's domiciliary state (the state in which the insurer is incorporated) and in specific courts within that state. Each state requires that the chief insurance regulator of the insurer's domiciliary state be appointed receiver of the insurer to administer the receivership under court supervision. (GRID FQAs: https://i-site.naic.org/grid/gridPA.jsp)

[4] In some states, a court may enter an order of conservation upon the petition of a regulator. An order of conservation is designed to safeguard the assets of the insurance company and give the regulator an opportunity to determine the course of action that should be taken with respect to the insurer. In some states a court ordered conservation may be confidential. (GRID FQAs: https://i-site.naic.org/grid/gridPA.jsp)

[5] The chief insurance regulator may petition a state court for an order of rehabilitation as a mechanism to remedy an insurer's problems, to protect its assets, to run off its liabilities to avoid liquidation, or to prepare the insurer for liquidation. (GRID FQAs: https://i-site.naic.org/grid/gridPA.jsp)

[6] In liquidation, the receiver/liquidator must identify creditors and marshal and distribute assets in accordance with statutory priorities and dissolve the insurer. In most states, the insurer must be insolvent to be placed in liquidation. (GRID FQAs: https://i-site.naic.org/grid/gridPA.jsp)

[7] Hazardous financial condition is cited within the authority of the state law based on the NAIC's *Model Regulation to Define Standards and Commissioner's Authority for companies Deemed to be in Hazardous Financial Condition.*

Future of Financial Regulation

15. In the late 1980s and early1990s, state insurance regulators, through the NAIC, developed a uniform solvency system, introducing "risk-focused" processes into the supervisory system and creating the Risk-Based Capital (RBC) tool to replace fixed capital requirements that did not vary by company size or risk exposure. U.S. regulators have made continuous improvements to our financial regulatory system over the past two decades, with many enhancements such as the model audit rule, risk-focused financial analysis and examination, and uniform statutory accounting practices and procedures. Today, the enhanced risk-focused surveillance process implemented across the states focuses on the insurer risks, the mitigation of those risks and on prospective risk analysis. In this way, U.S. regulators have developed and implemented a financial regulatory system based extensively on financial review and analysis, risk management, and corporate governance.

16. Extensive peer review is an essential element of the U.S. financial regulatory system. Communication and collaborative efforts among the states and through the NAIC have evolved over time and continue to progress each year. State regulators follow NAIC processes for discussions of financial regulatory issues and make changes every year to statutory accounting requirements, risk-based capital, financial rules, regulatory guidance, etc. Nonetheless, we have not conducted a comprehensive evaluation of our regulatory Framework since the early 1990s. Broadly speaking, the U.S. financial regulatory system meets the needs of U.S. regulators in achieving their regulatory mission, but, no regulatory system should remain stagnant and every regulatory regime should continuously evaluate its system in light of new industry issues, market conditions and regulatory developments.

17. Today, even though the U.S. insurance regulatory system proved successful through difficult financial markets in 2008-09, regulators can learn from the financial crisis (e.g. the need for improved group supervision) and international developments (e.g. the G-20 agreement for the International Monetary Fund's (IMF) Financial Sector Assessment Program (FSAP)). Accordingly, a comprehensive evaluation of the U.S. Financial Regulatory Framework is appropriate. Regulators implemented the SMI project to evaluate and report on regulatory areas in need of modification and supplementation and to offer methods for implementation of those changes.

18. The following sections will provide an overview of the current U.S. Framework; an evaluation of U.S. market competiveness, considering our regulatory mission; a more detailed description of financial regulation and regulatory tools used in the Framework; and an elaboration on expected SMI changes to the Framework. The following describes the purpose of each section:

    Section 1: Executive Summary

    Section 2 *The United States Insurance Financial Solvency Framework:* The purpose of this section is to describe the U.S. insurance regulatory framework for financial solvency, the core principles underlying that framework, and the U.S. Insurance Regulatory Mission.

    Section 3 U.S. Insurance Financial Regulatory Oversight: The purpose of this section is to expand on the framework of the system, drilling down to the mechanics of the processes in U.S. financial solvency insurance regulation.

Section 4 Market Regulation: The purpose of this section is to tie financial and market regulation together, as required in the U.S. Insurance Regulatory Mission: *Protect the interests of the policyholder and those who rely on the insurance coverage provided to the policyholder first and foremost, while also facilitating the financial stability and reliability of insurance institutions for an effective and efficient market place for insurance products.* This section describes the market place and considerations for insurance regulators.

Section 5 Solvency Modernization Initiative: The purpose of this section is to document the SMI self-review, the improvements made in the SMI, and the reasons why U.S. regulators made or did not make changes. Given the purpose, this section is expected to evolve over time as the SMI progresses.

Section 2

The United States Insurance Financial Solvency Framework and Core Principles

Executive Summary

Introduction

1. In June 2008, the NAIC's Solvency Modernization Initiative (SMI) was announced, with one of its objectives being an articulation of the United States Insurance Financial Solvency Framework and its Core Principles. The purpose of this document is to describe the framework for financial solvency insurance regulation in the United States and the core principles underlying it.

U.S. Insurance Financial Solvency Framework

2. Ultimate regulatory responsibility for insurer insolvency rests with each state insurance department and the state insurance Commissioner (sometimes also known as the Administrator, Director or Superintendent of Insurance). State insurance departments are assisted by the NAIC, which is a voluntary organization of the Commissioners of the state insurance departments. The NAIC's overriding objective is to assist state insurance regulators by offering financial, actuarial, legal, computer, research and economic expertise to state regulators.

3. The starting point or context for the framework is the U.S. Regulatory Mission which is to protect policyholders/claimants/beneficiaries first and foremost, while also facilitating the financial stability and reliability of insurance institutions for an effective and efficient marketplace for insurance products. The U.S. meets preconditions required for effective regulation. These are primarily designed to ensure that regulators have appropriate regulatory authority over insurers, operate independently of insurer and political interference, maintain an adequate staff of sufficiently trained personnel, and treat confidential information appropriately.

4. The U.S. insurance regulatory system is unique in the world in that (1) it relies on an extensive system of peer review, communication and collaborative effort that produce checks and balances in regulatory oversight; and (2) it includes a diversity of perspectives with compromise that leads to centrist solutions. These, in combination with a risk-focused approach to regulation, form the foundation for insurance regulation. As an example, the accreditation program relies on state certification by other regulators (i.e., peer review), requires risk-focused financial surveillance including on-site examinations, and requires solvency-related model laws, rules and guidelines that have been produced through consensus and collaboration.

5. Financial solvency core principles underlie the active regulation that exists today. A core principle, for purposes of this framework, is an approach, a process, or an action that is fundamentally and directly associated with achieving the mission. Seven core principles are identified for the U.S. insurance regulatory system. These are discussed individually in the second part of this summary.

6. It is primarily through the states' adoption of NAIC model laws and model regulations, many of which are associated with accreditation, that the core principles operate through the regulatory system. Accreditation is a certification given to a state insurance department once it has demonstrated

that it has met and continues to meet a wide range of legal, financial, functional and organizational standards. Fifty states and the District of Columbia are currently accredited. The purpose of the accreditation program is for state insurance departments to meet minimum, baseline standards of solvency regulation, especially with respect to regulation of multi-state insurers.

7. The implementation of the Accreditation program requires state adoption of model laws and regulations that incorporate Insurance Financial Solvency Standards and Monitoring. These can be categorized into Insurance Company Financial Solvency Requirements and Regulatory Monitoring Requirements. U.S. Insurance Company Financial Solvency Requirements consist of specific state laws, guidelines, regulations, or rules that apply to insurers (e.g., filing of standardized financial statements that have been audited by a CPA). U.S. Insurance Financial Solvency Regulatory Monitoring Requirements are laws, regulations and rules that must be adopted by the state and that apply to state regulators (e.g., insurers are required to be examined at least once every 5 years or more frequently as deemed appropriate). Additional regulatory monitoring is conducted by the NAIC through its surveillance processes (such as the Financial Analysis Solvency Tools (FAST) and the Financial Analysis Working Group).

U.S. Insurance Financial Solvency Core Principles

8. Seven core principles have been identified for the U.S. Insurance Financial Solvency Framework, as described below.

   (1) *U.S. Insurance Financial Solvency Core Principle 1:*
   Regulatory Reporting, Disclosure and Transparency

   Insurers are required to file standardized annual and quarterly financial reports that are used to assess the insurer's risk and financial condition. These reports contain both qualitative and quantitative information and are updated as necessary to incorporate significant common insurer risks.

   (2) *U.S. Insurance Financial Solvency Core Principle 2:*
   Off-site Monitoring and Analysis

   Off-site solvency monitoring is used to assess on an on-going basis the financial condition of the insurer as of the valuation date and to identify and assess current and prospective risks through risk-focused surveillance. The results of the off-site analysis are included in an insurer profile for continual solvency monitoring. Many off-site monitoring tools are maintained by the NAIC for regulators (such as FAST).

   (3) *U.S. Insurance Financial Solvency Core Principle 3:*
   On-site Risk-focused Examinations

   U.S. regulators carry out risk-focused, on-site examinations in which the insurer's corporate governance, management oversight and financial strength are evaluated, including the system of risk identification and mitigation both on a current and prospective basis. The reported financial results are assessed through the financial examination process and a determination is made of the insurer's compliance with legal requirements.

(4) *U.S. Insurance Financial Solvency Core Principle 4:*
Reserves, Capital Adequacy and Solvency

To ensure that legal obligations to policyholders, contract holders, and others are met when they come due, insurers are required to maintain reserves and capital and surplus at all times and in such forms so as to provide an adequate margin of safety. The most visible measure of capital adequacy requirements is associated with the risk based capital (RBC) system. The RBC calculation uses a standardized formula to benchmark specified level of regulatory actions for weakly capitalized insurers.

(5) *U.S. Insurance Financial Solvency Core Principle 5:*
Regulatory Control of Significant, Broad-based Risk-related Transactions/Activities

The regulatory framework recognizes that certain significant, broad-based transactions/activities affecting policyholders' interests must receive regulatory approval. These transactions/ activities encompass licensing requirements; change of control; the amount of dividends paid; transactions with affiliates; and reinsurance.

(6) *U.S. Insurance Financial Solvency Core Principle 6:*
Preventive and Corrective Measures, Including Enforcement

The regulatory authority takes preventive and corrective measures that are timely, suitable and necessary to reduce the impact of risks identified during on-site and off-site regulatory monitoring. These regulatory actions are enforced as necessary.

(7) *U.S. Insurance Financial Solvency Core Principle 7:*
Exiting the Market and Receivership

The legal and regulatory framework defines a range of options for the orderly exit of insurers from the marketplace. It defines solvency and establishes a receivership scheme to ensure the payment of policyholder obligations of insolvent insurers subject to appropriate restrictions and limitations.

The United States
Insurance Financial Solvency Framework

I. Objective and Overview

Objective of Paper

9. In June 2008, the NAIC's Solvency Modernization Initiative (SMI) was announced. This initiative has several key objectives, including articulating an overview of the United States Insurance Financial Solvency Framework and its principles. The purpose of this paper is to describe the framework of the U.S. Insurance Financial Solvency System and present a set of core financial principles underlying this framework.

Overview of Paper

10. This paper provides a description of the U.S. Insurance Financial Solvency Framework that, while drawing upon ideas developed by the International Association of Insurance Supervisors (IAIS), goes beyond the IAIS in important, material ways. In particular, in the U.S. regulatory system, ongoing collaborative regulatory peer review, regulatory checks and balances, and risk focused financial surveillance form the foundation of the regulatory process.[1] Also, the framework indicates that the U.S. Insurance Financial Solvency Core Principles are embodied in the NAIC's Financial Regulation Standards and Accreditation Program, which is a uniform program to which all states subscribe. Finally, included in this paper is a discussion of the U.S. Insurance Financial Solvency Core Principles.

Presentation of U.S. Insurance Financial Solvency Framework

Introduction

11. The state regulatory system in the United States has had over a 100 year history of solvency regulation. This system is comprised of state insurance departments (currently 50 states, D.C. and 5 territories), and can best be described as a national system of state based regulation. The National Association of Insurance Commissioners (NAIC) assists regulators in a nonbinding, supplementary role.

12. Ultimate regulatory responsibility for insurer solvency rests with each state insurance department and the state insurance Commissioner.[2] In a free market economy, such as in the U.S., some insurer insolvencies are naturally expected. However, by following solvency standards, performing risk focused financial surveillance including on-site examinations, and enforcing solvency related insurance laws, regulations and guidelines, the state regulatory system has limited insurer insolvencies. A hallmark of the state regulatory system is its dynamic efforts to constantly improve

[1] For purposes of this document, the term "regulator" refers to the ongoing supervision and oversight of entities under the authority of the state insurance department with the assistance of the NAIC. This terminology contrasts with the use of the term "regulator" in other parts of the world. In other parts of the world, regulator refers to the government agency responsible for developing regulations (e.g., Ministry of Finance or Treasury Department), while the term "supervisor" refers to the government officials responsible for overseeing insurance entities.

[2] In some states the terms Director of Insurance or Superintendent of Insurance are used rather than Commissioner.

the regulatory solvency system and adjust the system as needed, especially regarding inputs into the model used to determine asset, liability and capital requirements.

13. The NAIC is a voluntary organization of the chief insurance regulatory officials of the state insurance departments, and its overriding objective is to assist state insurance regulators in protecting consumers and helping maintain the financial stability of the insurance industry. The NAIC achieves this by offering financial, actuarial, legal, computer, research, market conduct, and economic expertise to state regulators. It is through the NAIC that insurers are provided the uniform platforms and coordinated systems they need in an ever-changing marketplace.

14. This paper, the U.S. Insurance Financial Solvency Framework, has been created to document the processes utilized by regulators to monitor and assess the financial condition of insurers. It indicates how information flows to the regulator and how that information is used by regulators to take appropriate actions with respect to an insurer. Regulatory intervention, when it occurs, is generally focused on insurers where policyholders are most at risk (i.e., financially distressed insurers). Finally, the framework shows that a system of orderly exit from the market exists when insolvency becomes inevitable.

Regulatory Mission as Starting Point for Framework

15. The starting point or context for the U.S. Insurance Financial Solvency Framework is the mission of insurance regulation in the United States. The mission or purpose of insurance regulation is:

    U.S. Insurance Regulatory Mission: To protect the interests of the policyholder and those who rely on the insurance coverage provided to the policyholder first and foremost, while also facilitating the financial stability and reliability of insurance institutions for an effective and efficient market place for insurance products.

16. This mission has been used for years as the basis on which regulatory decisions have been made, including overall industry policy decisions and regulatory decisions for individual insurers. While the policyholder is the focal point of the mission, this mission is mindful that regulatory actions and decisions will have an impact on the operation of insurance markets and their efficiency. Because it is felt that "facilitating the financial stability and reliability of insurance institutions for an effective and efficient market place for insurance products" is in the best interests of policyholders (e.g., cost efficiencies and product innovation), this is not considered to be a separate and distinct or secondary mission, but is considered to support a focus on the policyholder.

Preconditions for Effective Regulation

17. To achieve its mission the regulatory system must have the requisite authority. This requisite authority is comprised of the following elements: a legal basis, independence and accountability, adequate powers, financial resources, human resources, legal protection and confidentiality. These elements form the preconditions for effective insurance regulation:

    Preconditions for Effective Regulation (Regulatory Authority)
    The regulatory authority has adequate powers, legal protection and financial resources to exercise its functions and powers; is operationally independent from commercial and political interference in the exercise of its functions and powers; is ultimately accountable to the public; hires, trains, and

maintains sufficient staff with high professional standards; and treats confidential information appropriately.

18. The U.S. Insurance Financial Solvency Framework has been created over many years through the unified development of NAIC model laws, regulations, and other NAIC requirements. The adoption of these model laws within the individual states has created a legal framework for insurance regulation that is largely uniform throughout all of the states. To carry out the laws, regulations and other requirements, individual states have created insurance departments that are staffed with personnel that have the necessary knowledge and expertise. These state insurance departments act independently of insurers. In the course of pursuing their regulatory responsibilities, especially when solvency is at issue, regulators allow for the sharing of otherwise confidential documents with any state, federal agency or foreign country provided that the recipients are required, under their law, to maintain their confidentiality.

U.S. Insurance Financial Solvency Regulation Foundations

19. Among the unique features of U.S. insurance regulation are (1) the extensive systems of peer review, communication and collaborative effort that produce checks and balances in regulatory oversight and (2) the diversity of perspectives with compromise that leads to centrist solutions. These, in combination with a risk-focused approach to regulation, form the foundation for insurance regulation in the U.S., as explained below.

20. The U.S. insurance market is comprised of thousands of small to large-sized insurance companies and groups, as well as conglomerates. To effectively regulate in such a large market, a risk-focused approach is utilized by state regulators. Under a risk-focused approach, attention is paid to the greatest risks faced by insurers and the insurance market. Explicit examples where this practice is applied are in on-site examinations and the ongoing analysis of nationally significant U.S. insurance groups (as explained later in this paper).

21. Mechanisms for peer review encourage effective regulatory and supervisory practices. The ongoing analysis of insurance groups provides an example of the checks and balances provided by peer review. Most regulators' interactions are collaborative and collegial. But situations arise where other state insurance commissioners can question the actions of another state insurance department, and, if necessary, pressure another state insurance department to act. This pressure is possible because regulators in other states have the power to examine all companies doing business in their state even though headquartered in other states and, in the worst case, to suspend their licenses to operate. Of course, free-flowing information among state regulators underlies this process; and the willingness of state insurance regulators to challenge and be challenged by other state regulators has developed over time in the U.S. as regulators work cooperatively with each other.

22. In regulation, there is a constant need to balance regulatory costs and benefits. Overregulation can impose unnecessary costs on consumers, while under-regulation (or de-regulation) can allow unnecessary harm to consumers and taxpayers. The balance between these two regimes is difficult to determine, but because of the multitude of diverse perspectives in the state U.S. regulatory system, it is less likely to end up at either extreme. Rather, the search for compromise tends to produce centrist solutions. Thus it is highly unlikely that a dogmatic move toward excessive deregulation (or overregulation) could occur in the state-based system.

23. The risk-focused approach, peer pressure/checks and balances, and ongoing collaboration based on consensus interact with each other to form the foundation of U.S. state insurance regulation. As an example of all of these approaches and processes, the accreditation program relies on state certification by other regulators, requires risk-focused financial surveillance including on-site examinations and requires enactment of solvency-related model laws, rules, and guidelines that have been reached through consensus and collaboration. This foundation makes insurance regulation in the U.S. unique in the world.

U.S. Insurance Financial Solvency Core Principles and the Accreditation Program

24. For purposes of this paper, a core principle is an approach, a process or an action that is fundamentally and directly associated with achieving the mission. The following comprise the U.S. Insurance Financial Solvency Core Principles.

Formulation of U.S. Insurance Financial Solvency Core Principles

(1) *U.S. Insurance Financial Solvency Core Principle 1:*
Regulatory Reporting, Disclosure and Transparency

(2) *U.S. Insurance Financial Solvency Core Principle 2:*
Off-site Monitoring and Analysis

(3) *U.S. Insurance Financial Solvency Core Principle 3:*
On-site Risk-focused Examinations

(4) *U.S. Insurance Financial Solvency Core Principle 4:*
Reserves, Capital Adequacy and Solvency

(5) *U.S. Insurance Financial Solvency Core Principle 5:*
Regulatory Control of Significant, Broad-based Risk-related Transactions/Activities

(6) *U.S. Insurance Financial Solvency Core Principle 6:*
Preventive and Corrective Measures, Including Enforcement

(7) *U.S. Insurance Financial Solvency Core Principle 7:*
Exiting the Market and Receivership

The Accreditation Program

25. It is primarily through the states' adoption of NAIC model laws and model regulations that the U.S. Insurance Financial Solvency Core Principles can function effectively within competitive market dynamics. Accreditation is a certification given to a state insurance department once it has demonstrated it has met and continues to meet a wide range of legal, financial, functional and organizational standards as determined by a committee of its peers. Fifty states and the District of Columbia are currently accredited.

26. The purpose of the accreditation program is for state insurance departments to meet minimum, baseline standards of solvency regulation especially with respect to regulation of multi-state insurers. The emphasis in the accreditation program and the processes it creates is on: (1) adequate solvency laws and regulations to protect consumers; (2) effective and efficient financial analysis and examination processes based on priority status of insurers; (3) cooperation and information sharing with other state, federal or foreign regulatory officials; (4) timely and effective action when insurance companies are identified as financially troubled or potentially troubled; (5) appropriate organizational and personnel practices; and (6) effective processes for company licensing and review of proposed changes in control. At the present time, for a state to be accredited, it must adopt certain laws, regulations or administrative practices that provide appropriate regulatory authority and consumer protections in a variety of aspects of solvency regulation.[3] Appendix 2 provides more details about accreditation.

27. To become accredited, the state must submit to a full on-site accreditation review. Depending on the results of the review, the state is accredited or it is not (i.e., a pass/fail system is used). To remain accredited, an accreditation review must be performed at least once every five years with interim annual reviews. If necessary management letter comments may be provided to the state and interim follow-up reviews may be required.

U.S. Insurance Financial Solvency Standards and Monitoring

28. The implementation of the Accreditation Program requires state adoption of model laws and regulations that incorporate Insurance Financial Solvency Standards and Monitoring. These can be categorized into Insurance Company Financial Solvency Requirements and Regulatory Monitoring Requirements. Examples of each are provided below.

U.S. Insurance Company Financial Solvency Requirements

U.S. Insurance Company Financial Solvency Requirements consist of specific state laws, guidelines, regulations, or rules which are applicable to insurers. These standards are documented in the NAIC's Financial Regulation Standards and Accreditation Program.

Examples of U.S. Insurance Company Financial Solvency Requirements:

(1) Insurers' submission of the annual and quarterly financial statements ("the annual statement" or "blank").
(2) Most insurers' must annually submit a financial statement audited by a CPA, and their reserve estimates must be attested to by an actuary.
(3) *Management's Report of Internal Control over Financial Reporting* is required of all insurers whose premiums exceed a predefined threshold.
(4) Insurers are required to report the results of their risk-based capital calculation in the annual statement.[4]
(5) Insurers must adhere to state minimum capital and surplus requirements.

[3]Specific standards must be complied with that relate to financial analysis, financial examinations, information sharing, and procedures for troubled insurers. States encourage professional development and establish organizational and personnel standards regarding minimum educational and experience requirements and must have the ability to attract and retain qualified personnel to obtain and maintain accreditation status.
[4] The risk-based capital (RBC) system is discussed in more detail later in Core Principle 4.

(6) Insurers must submit to examinations as deemed necessary by the regulator.
(7) Each state has statutes requiring insurers to invest in a diversified investment portfolio both with respect to type of investment and the issuer.
(8) There is a limitation on the amount on any single insured risk a property casualty insurer may underwrite.
(9) Producer controlled insurers must meet special contract provisions, have an audit committee and separate reporting requirements.
(10) For life and accident and health insurers, reserve requirements must adhere to statutory minimums and actuarial standards.
(11) All insurers are required to report investment values in the financial statements in accordance with the *Purposes and Procedures Manual of the Securities Valuation Office*.
(12) Insurers are required to use the NAIC's *Accounting Practices and Procedures Manual* and the *Annual Statement Blank and Instructions* in constructing their statutory financial statements.[5]
(13) Reinsurance credit is governed by the NAIC Credit for Reinsurance Model Law, which imposes standards on allowing such credit.

U.S. Insurance Financial Solvency Regulatory Monitoring Requirements

U.S. Insurance Financial Solvency Regulatory Monitoring Requirements are laws, regulations and rules that must be adopted by the state and that are applicable to state regulators. Many of these solvency standards are requirements of the accreditation program.

Examples of U.S. Insurance Financial Solvency Regulatory Monitoring Requirements:

(1) Regulators are required to examine an insurer at least once every five years or more frequently as deemed appropriate and have the authority to examine a company at any time it is deemed necessary by the Commissioner.
(2) If a potential capital deficiency is signaled by the RBC result, a ladder of intervention exists under which regulators are required to undertake certain actions depending on the degree of deficiency. This intervention can vary from requiring insurers to file a plan of corrective action to regulatory takeover of the insurer.
(3) Certain transactions require approval (e.g., transactions among affiliated insurers).

Additionally, regulatory monitoring includes other surveillance processes such as:

(1) NAIC's Financial Analysis Solvency Tools (FAST). FAST encompasses a wide-ranging review/testing system that includes (but is not limited to): (1) a scoring system based on over 20 financial ratios; (2) the Analyst Team System (ATS) (an automated review process that creates a national prioritization system using statistical analysis, a scoring system, and RBC to assign review levels for insurers); (3) RBC trend test; and (4) loss reserve projection tools. Insurers deemed to be performing poorly from the FAST analysis are reviewed by experienced analysts to determine the degree of financial distress present, if any. Insurers

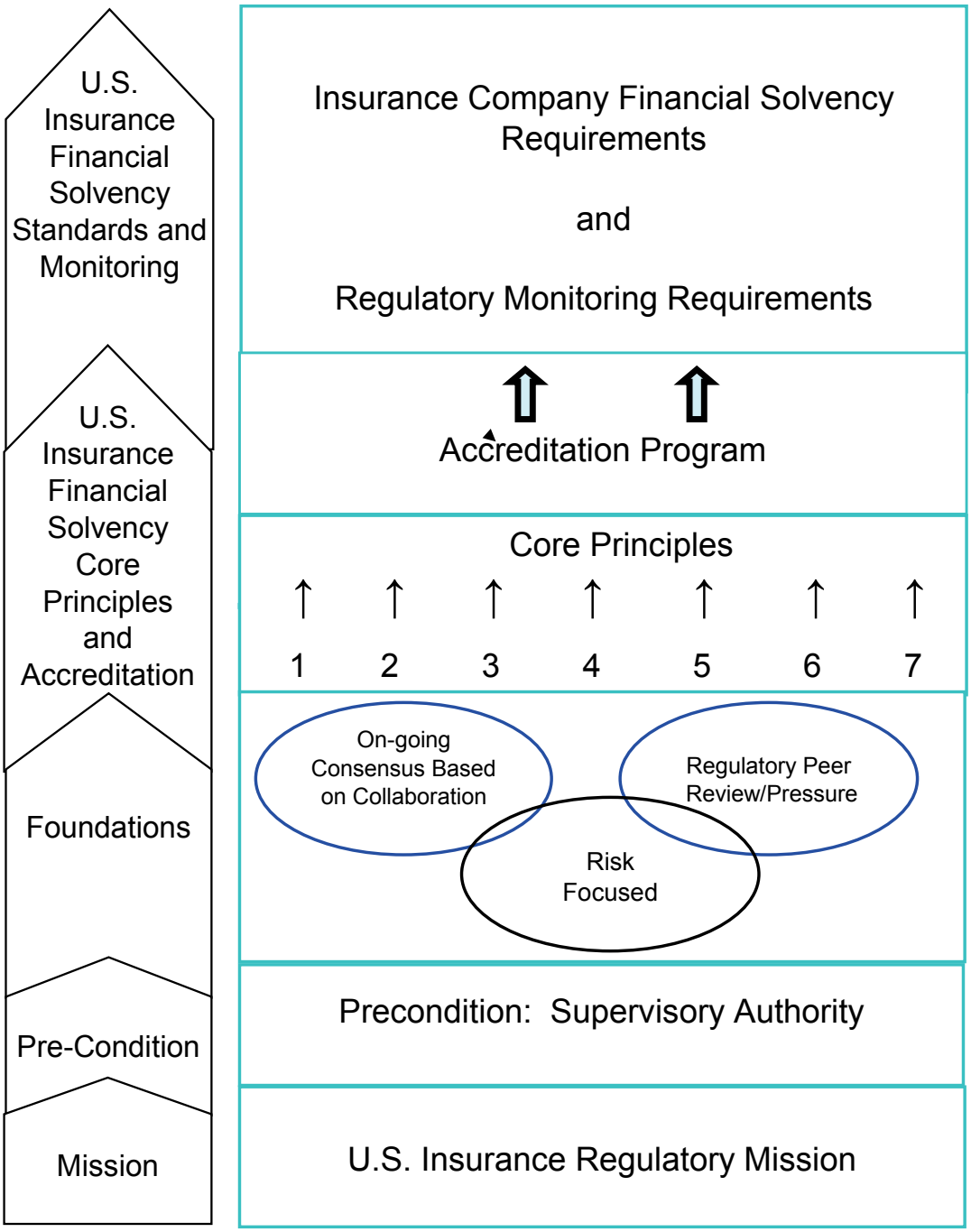
[5]For example, these tools restrict discounting property and casualty reserves, and specific tables approved by regulators are required to establish reserves for various life insurance products. Only certain assets (admitted assets) are allowed to be considered as statutory assets. There are significant reinsurance requirements that take into account the ability of reinsurers to pay. One of these requirements includes statutory accounting requirements for taking a reserve credit for reinsurance.

deemed to be in financial distress are prioritized by the degree of financial distress and the results are communicated to the state insurance departments in which the insurer is licensed.[6]

(2) Nationally significant insurers are reviewed every quarter and those that appear to be performing poorly are prioritized for more detailed analysis by a group of experienced, seasoned financial regulators (i.e., the Financial Analysis Working Group (FAWG)). The FAWG committee confirms/informs the lead state regulator of problems with insurers in their state and can assert peer pressure on the regulator to intervene to address the troubled insurer's situation.

[6] The domestic regulator gives all insurers a priority status which is a driver for the level of risk focused surveillance an insurer receives.

Diagram of U.S. Insurance Financial Solvency Framework



Overview of U.S. Insurance Financial Solvency Core Principles

This section provides a brief discussion of each U.S. Insurance Financial Solvency Core Principle.

29. **U.S. Insurance Financial Solvency Core Principle 1: Regulatory Reporting, Disclosure and Transparency**
U.S. regulators receive required financial reports from insurers on a regular basis that are the baseline for continual assessment of the insurer's risk and financial condition. Standardized financial reporting is used in the financial statements to ensure comparability of results among insurers. To address concerns with specific companies or issues, supplemental data is requested in addition to the standardized data, and these data may be requested on a more frequent basis from specific companies. The standardized format is updated as necessary to incorporate significant, common insurer risks.

30. The financial reports filed with the regulator include the set of comprehensive financial statements known collectively as the Annual Statement. Also included in the financial reporting requirements is the filing of quarterly financial statements. To increase comparability and consistency in reporting, the insurer is required to complete the annual and quarterly statements in accordance with NAIC instructions, which provide specific direction on how the statements are to be completed. In addition, NAIC statutory accounting principles are used as the baseline accounting requirements in all financial reports.

31. The financial reports also include numerous qualitative disclosures, each of which are designed to identify potential risks of the insurer. These include but are not limited to general and specific interrogatories, the notes to financial statements, management's discussion and analysis, an actuarial opinion, and an annual audit opinion from an independent certified public accountant. Other standardized reports are filed with the regulator throughout the year that identifies more specific risks (e.g., investment risk interrogatories).

32. The information contained in all of these financial reports is designed to be thorough, so that sufficient information is provided to the regulator to continually monitor and identify specific risks faced by the insurer.[7] The financial reports are used extensively in regulatory solvency monitoring, including on-site examinations and off-site monitoring. That is, the regulatory reports feed into the off-site monitoring analysis and provide a foundation for on-site examinations. In turn, off-site monitoring and examinations are used to determine whether additional or more frequent reporting may be required of an insurer.

33. The annual and quarterly statements are electronically captured by the NAIC in two formats: data tables available for querying and automated analytical tool usage; and PDF files that are publicly

[7]Carrying value, fair value, credit quality designation and other pertinent information are disclosed for every applicable investment held by the insurer; and the detailed disclosures are categorized by asset type, e.g., issuer obligations vs. collateralized mortgage obligations and other structured securities. Similarly, each reinsurance contract is disclosed along with various amounts payable or receivable, grouped by assumed vs. ceded insurance, and categorized by type of entity, e.g., affiliated or mandatory pool. Property and casualty lines of business, which use a principles-based reserving approach, are disclosed in great detail regarding losses and loss expenses, including loss reserve triangles and historical development of various aspects of reserves, e.g., bulk and incurred but not reported (IBNR) reserves.

available and intended to provide consumers with direct access to financial information submitted by any insurer.[8]

34. **U.S. Insurance Financial Solvency Core Principle 2:**
Off-site Monitoring and Analysis
U.S. regulators and the NAIC conduct off-site risk-focused analysis of insurers.

The primary purpose of off-site solvency monitoring is to assess on an on-going basis the financial condition of the insurer as of the valuation date and to identify and assess current and prospective risks through risk-focused surveillance, the results of which are included in an insurer profile for continual solvency monitoring. To accomplish this task, state insurance regulators conduct detailed financial analysis on a quarterly basis using regulatory financial reports, financial tools and other sources of information. Two key sources of information are the results of the most recently completed independent certified public accountant (CPA) audit report and the results of the most recent on-site regulatory financial examination.[9] Other sources utilized in the analysis include SEC filings, corporate reports, financial statements of ultimate controlling individual/corporation or reinsurers, market conduct reports, rate and policy form filings, consumer complaints, independent rating agency reports, correspondence from agents and insurers, and business media.

35. Off-site monitoring includes follow up on risks identified during the previous quarter's analysis and the most recent on-site examination. Otherwise, state insurance departments generally prioritize the review of their domiciliary insurers based on a system of financial ratios, other screening tools and criteria that are both qualitative and quantitative in form. When insurers with anomalous results (e.g., insurers experiencing significant variations or negative financial results) that may impact financial solvency are identified, regulators will allot necessary resources and prioritize further analysis of these insurers (relative to other non-priority insurers). The results of the ongoing financial analysis are then used to help prioritize and provide focus to future quarterly off-site monitoring activities (potentially increasing monitoring activities to a monthly or weekly basis) and any on-site examination efforts.

36. Many tools used by state regulators are maintained by the NAIC and have been created as regulator only tools. These tools are designed to provide an integrated approach to screening and analyzing the financial condition of insurers and are referred to collectively as FAST (i.e., Financial Analysis Solvency Tools). The tools include a comprehensive handbook that sets forth an overall analysis process to be used, as well as more specific financial analysis/tests that utilize the data provided in insurers' financial reports to identify risks or anomalies.

37. In addition to the NAIC tools described above, the NAIC's Financial Analysis Working Group (FAWG) performs its own analysis of the financial condition of each nationally significant insurer or group each quarter, as well as other insurers or areas posing unique risks identified during a given period, looking not only at statutory financial statements but at other public information, including such financial market metrics as the market's valuation and rating of the insurer's debt and short sales of the insurer's stock. The FAWG does not meet publicly and does not share its deliberations with the

[8] Where an insurer's accounting differs from the baseline NAIC statutory accounting principles, the impact to capital and surplus as well as net income is disclosed in the notes to financial statements.
[9] The CPA audit report attests to the fair presentation of the financial statements on an annual basis to allow sufficient reliance upon the insurer's financial reports utilized in all off-site monitoring (see Principle 3).

general public due to its discussion being focused on the financial condition of individual insurers. This group also monitors industry trends in various risk areas.

38. **U.S. Insurance Financial Solvency Core Principle 3: On-Site Risk-focused Examinations**

U.S. regulators carry out risk-focused, on-site examinations in which the insurer's corporate governance, management oversight and financial strength are evaluated, including the system of risk identification and mitigation. Through the examination, the reported financial results are assessed and a determination is made of the insurer's compliance with legal requirements.

39. Insurers are subject to a full-scope financial examination at least once every 5 years.[10] However, based upon the results of off-site monitoring, regulators may place a higher priority on insurers which pose a financial risk and, therefore, conduct on-site examinations more frequently. These examinations may be limited to a review of a specific risk, as long as a full scope exam is conducted at least once every 5 years.

40. The primary purpose of an on-site examination is to allow state regulators to evaluate and assess the solvency of insurers as of the valuation date and to develop a forward-looking view of an insurer's risks and its risk management practices. This approach permits a direct and specific focus on the areas of greatest risk to an insurer. The results of the off-site analysis are also utilized in identifying areas of concern and key functional activities to be reviewed.

41. Through the on-site examination, corporate governance practices and processes that are in place to identify and mitigate risk are reviewed and assessed, including, among other things, the function and effectiveness of the board of directors and management, the adequacy of risk management (enterprise risk management), monitoring and management information systems. All significant inherent risks faced by the insurer are identified and assessed, whether they relate to financial reporting issues or to business and operational issues. After risks have been identified, the examiner is required to identify and assess the internal control processes that mitigate each identified risk. Controls are assessed by considering both their current and prospective design and operating effectiveness. The results of these on-site examination processes also provide regulators an indication of the reliability of the insurer's financial reports utilized in off-site analysis.

42. To prevent duplicative examination efforts by regulators for insurers writing in multiple states, regulators may rely on the exam work of the NAIC accredited domiciliary state. Additionally, for large insurance holding company groups, regulators are encouraged to coordinate their examinations of individual entities by following a lead state concept, thereby allowing the pooling of resources to complete one coordinated exam for the insurer group.

43. In conjunction with both the on-site examinations and off-site monitoring, regulators review insurer compliance with laws and regulations. Laws and regulations can vary by state.[11] Some states will combine their review of compliance with market conduct activities with a financial on-site exam.

[10] In some states the period is three years.

[11] These laws typically include, but are not limited to, compliance with investment statutes and regulations regarding types of permissible investments and diversification and liquidity of investments, compliance with (minimum) reserving standards and minimum capital and surplus requirements (including RBC), and the restriction of certain reinsurance activities.

44. **U.S. Insurance Financial Solvency Core Principle 4:**
Reserves, Capital Adequacy and Solvency
To ensure that legal obligations to policyholders, contract holders and others are met when they come due, insurers are required to maintain reserves and capital and surplus at all times and in such forms so as to provide an adequate margin of safety.

45. Accounting standards, risk-based capital requirements, minimum statutory reserves and state-specific minimum capital requirements form the backbone of the reserve and capital adequacy requirements. Conservatism is a pervasive concept in specification of these requirements. As an example, conservatism is one of the foundations of the statutory accounting system.[12] Conservative statutory accounting reporting provides a reasonable level of assurance that an insurer's resources are adequate to meet its policyholder obligations at all times. Other NAIC standards are designed with the same conservatism principle (e.g., model investment laws, credit for reinsurance laws, etc.).

46. The most visible measure of capital adequacy requirements is associated with the risk based capital (RBC) system. The risk-based capital calculation uses a standardized formula to benchmark specified level of regulatory actions for weakly capitalized insurers. A significant portion of the risk-based formula is derived from the annual statement, which is based upon statutory accounting. The RBC amount explicitly considers the size and risk profile of the insurer.[13] The risk-based capital calculation provides for higher RBC charges for riskier assets or for riskier lines of business so that more capital is needed as a result. Although risk-based capital results indicate when an insurer's capital position is weak or deteriorating, a ladder of intervention levels exists within the RBC system. Thus, regulators have the authority to require insurers to take some action or the regulator may have the authority to take action with respect to an insurer when the capital level falls within certain threshold amounts that are above the minimum capital requirement. The degree of action depends upon the relative capital weakness as determined by the RBC result and the existence of any mitigating or compounding issues.

47. States maintain fixed minimum capital requirements (statutes) relating to incorporation and licensing within the particular state that must also be met. Further, the state has the authority to require additional capital and surplus based upon the type, volume, and nature of the insurance business transacted.

48. Insurers have conservative minimum reserve requirements in addition to capital requirements. Thus, the effect of having both reserves and capital adequacy requirements means that (1) policyholder obligations are covered by enough resources to meet most future economic scenarios, and (2) there are enough resources so that an adverse trend can be detected in time for the regulator to suggest/take corrective action.

49. **U.S. Insurance Financial Solvency Core Principle 5:**

[12] Statutory accounting practices stress measurement of the ability to pay claims of insurers in the future, while generally accepted accounting principles (GAAP) stress measurement of earnings of a business from period to period, and the matching of revenues and expenses for the measurement period. Source: Preamble of the NAIC *Accounting Practices and Procedures Manual*.
[13] The factors used in the formula are based on considerable research and reflect industry loss experience.

Regulatory Control of Significant, Broad-based Risk-related Transactions/Activities

The regulatory framework recognizes that certain significant, broad-based transactions/ activities affecting policyholders' interests must receive regulatory approval.

50. Certain significant, broad-based transactions/activities of insurers that affect risk are not part of the day-to-day routine of underwriting and issuing insurance and/or have broad social and equity consequences. To control these risks, regulatory approval of these transactions/activities may be required. Many of these transactions are also reviewed during the off site monitoring or the on-site examination process to assess insurer compliance. These transactions/activities encompass licensing requirements; change of control; the amount of dividends paid; transactions with affiliates; and reinsurance as explained below.

    (1) **Licensing Requirements:** An insurer must be licensed before it can operate in a state. The regulator sets the criteria for licensing, and these criteria are clear, objective and public. Regulators assess the license application; this assessment consists of a review of the ownership structure, quality and history of management, internal controls, and projected financial condition. Applicants that do not meet the criteria do not obtain a certificate of authority and/or license to conduct the business of insurance. [14]

    (2) **Change in Control:** Notification is required for changes in ownership or control. No transaction involving a change in ownership or control can be completed unless regulatory approval is granted or waived. The regulator bases the approval or rejection decision on financial statements and other relevant information filed with the regulator.

    (3) **Dividends:** The regulator requires prior notice of all stockholder dividends and dividends in excess of a predefined standard (extraordinary dividends) must be filed for approval. Extraordinary dividends cannot be paid until regulatory approval is granted.[15]

    (4) **Transactions with Affiliates:** The regulator requires notice for transactions with affiliates and has the authority to reject the transaction. These transactions include, but are not limited to, various intercompany cost sharing arrangements, guarantees, reinsurance, asset purchase and disposal agreements, and tax allocation agreements between the insurer and its affiliates.

    (5) **Reinsurance:** Reinsurance transactions are subject to regulatory review and approval, with the result that some reinsurers may be required to post collateral.

51. **U.S. Insurance Financial Solvency Core Principle 6:**
    Preventive and Corrective Measures, Including Enforcement
    The regulatory authority takes preventive and corrective measures that are timely, suitable and necessary to reduce the impact of risks identified during on-site and off-site regulatory monitoring. These regulatory actions are enforced as necessary.

[14] Effective January 1, 2012, the Accreditation Program will incorporate new standards related to company licensure and change in ownership. These standards require that state insurance departments have sufficient, qualified resources to review applications in a timely manner and have appropriate procedures to properly analyze the application.

[15] This is a general requirement, but individual state requirements may vary. For example, not all states require approval of ordinary dividends. Some states require that all stockholder dividends be approved.

52. If significant solvency risks are identified as being improperly mitigated such that the insurer is in a hazardous financial condition, the regulator may take corrective or preventive measures including, but not limited to: requiring the insurer to provide an updated business plan in order to continue to transact business in the state; requiring the insurer to file interim financial reports; limiting or withdrawing the insurer from certain investments or investment practices; reducing, suspending or restricting the volume of business being accepted or renewed by the insurer; ordering an increase in the insurer's capital and surplus; ordering the insurer to correct corporate governance practice deficiencies; requiring a replacement of senior management; and seeking a court order to place the company under conservation, rehabilitation, or liquidation;

53. In addition to the corrective measures that can be taken when the insurer is determined to be in a hazardous financial condition, under the RBC system, regulators have the authority and statutory mandate to take preventive and corrective measures that vary depending on the capital deficiency indicated by the RBC result. The broad authority for determining if an insurer is considered to be in a hazardous financial condition is an important part of the U.S. system, and allows for more precision within the RBC calculation.

54. These preventive and corrective measures are designed to provide for early regulatory intervention to correct problems before insolvencies become inevitable, thereby minimizing the number and adverse impact of insolvencies.

55. **U.S. Insurance Financial Solvency Core Principle 7:**
Exiting the Market and Receivership
The legal and regulatory framework defines a range of options for the orderly exit of insurers from the marketplace. It defines solvency and establishes a receivership scheme to ensure the payment of policyholder obligations of insolvent insurers subject to appropriate restrictions and limitations.

56. Receivership laws provide measures for regulators to attempt to prevent insolvencies, minimize losses and provide protection for claimants (including policyholders) before an insolvency and/or if an insurer is found to be insolvent. Options considered by regulators as possible alternatives to insolvency include mergers, acquisitions, reinsurance arrangements, non-renewal of part or all of the insurer's book of business, and the viability of allowing the insurer to be placed in run-off mode under its own management. When insolvency cannot be prevented, receivership laws give some priority to the provision of benefits to claimants, including policyholders, or the payment of claims arising under policies. State guaranty associations have been established to protect policyholders, claimants and beneficiaries against financial losses due to insurer insolvencies. Fundamentally, the purpose of an insolvency guaranty law/association is to cover an insolvent insurer's financial obligations, within statutory limits, to policyholders, annuitants, beneficiaries and third-party claimants.

Section 2
Appendix 1
List of relevant Model Laws, Rules, Regulations and Working Groups by U.S. Insurance Financial Solvency Core Principle

U.S. Insurance Financial Solvency Core Principle 1:
Regulatory Reporting, Disclosure and Transparency

NAIC *Accounting Practices and Procedures* Manual
NAIC Blanks Working Group
Statutory Accounting Practices Working Group
EAI Working Group
Financial Analysis Handbook Working Group
NAIC's Standard Valuation Law
Actuarial Opinion and Memorandum Regulation
Part B of the Financial Regulation Standards and Accreditation Program
NAIC Annual Financial Reporting Model Regulation (#205)
Securities Valuation *Purposes and Procedures* Manual.
NAIC *Annual Statement Instructions*
NAIC's *Purposes and Procedures of the Securities Valuation Office*
NAIC *Valuation of Securities Manual*
Business Transacted with Producer Controlled Property/Casualty Insurance Act (#325)

U.S. Insurance Financial Solvency Core Principle 2:
Off Site Monitoring and Analysis

Analyst Team System
FAST
NAIC *Accounting Practices and Procedures Manual*
NAIC Annual Financial Reporting Model Regulation (#205)
NAIC Model Insurance Holding Company System Regulatory Act
NAIC Actuarial Opinion and Memorandum Model Regulation (#822)
NAIC Blanks Working Group
Part B of the Financial Regulation Standards and Accreditation Program
Business Transacted with Producer Controlled Property/Casualty Insurance Act (#325)
Financial Analysis Handbooks (as reviewed and updated by the Financial Analysis Handbook Working Group)

U.S. Insurance Financial Solvency Core Principle 3:
On-site Risk-focused Examinations

Model Law on Examinations (#390)
Financial Condition Examiners Handbook (Examiners Handbook)
NAIC Annual Financial Reporting Model Regulation (#205)
Insurance Company Holding Company Regulatory Act
NAIC Investment of Insurers Model Act (Defined Limits Version)

NAIC Derivative Instruments Model Regulation
NAIC's Investment of Insurers Model Act (#280)
NAIC Actuarial Opinion and Memorandum Model Regulation (#822)
Part B, Financial Regulation Standards and Accreditation Program

U.S. Insurance Financial Solvency Core Principle 4:
Capital Adequacy and Solvency

NAIC Risk-Based Capital for Insurers Model Act
NAIC Risk-Based Capital for Health Organizations Model Act
NAIC *Accounting Practices and Procedures* Manual
NAIC Financial Regulation Standards and Accreditation Program (Capital and Surplus Requirements)
NAIC *Annual Statement Instructions*
NAIC *Risk-Based Capital Report Including Overview and Instructions*
Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition (#385)
NAIC Credit for Reinsurance Model Law (#785)

U.S. Insurance Financial Solvency Core Principle 5:
Regulatory Control of Significant, Broad-based Risk-related Transactions/Activities

Interest Maintenance Reserve calculation (life insurers)
NAIC Investment of Insurers Model Act (#280 and 283)
Actuarial Opinion and Memorandum Regulation
Business Transacted with Producer Controlled Property/Casualty Insurance Act (#325)
Part A, Financial Regulation Standards and Accreditation Program
Insurance Holding Company Regulatory Act

U.S. Insurance Financial Solvency Core Principle 6:
Preventive and Corrective Measures, Including Enforcement

NAIC *Troubled Insurance Company Handbook*
NAIC's Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition (#385)
Risk-based Capital (RBC) for Insurers Model Act
NAIC Administrative Supervision Model Act
Part A, Financial Regulation Standards and Accreditation Program

U.S. Insurance Financial Solvency Core Principle 7:
Exiting the Market and Receivership

NAIC *Troubled Insurance Company Handbook*
NAIC's Rehabilitation and Liquidation Model Act
Part A, Financial Regulation Standards and Accreditation Program

Section 2
Appendix 2
Requirements for Accreditation

1. The Standards have been divided into three major categories: laws and regulations (Part A); regulatory practices and procedures (Part B); organizational and personnel practices (Part C); and organization, licensing and change of domestic control of insurers (Part D).

Part A: Laws and Regulations (Traditional Insurers)[16]

Preamble

2. The purpose of the Part A: Laws and Regulations Standards is to assure that an accredited state has sufficient authority to regulate the solvency of its multi-state domestic insurance industry in an effective manner. The Part A standards are the product of laws and regulations that are believed to be basic building blocks for sound insurance regulation. A state may demonstrate compliance with a Part A standard through a law, a regulation, an established practice which implements the general authority granted to the state, or any combination of laws, regulations or practice, which achieves the objective of the standard.

3. The Part A standards apply to traditional forms of "multi-state domestic insurers." This scope includes life/health and property/casualty/liability insurers and reinsurers that are domiciled in the accredited state and licensed, accredited or operating in at least one other state. This scope also includes insurers that are domiciled in the accredited state and operating or accepting business on an exported basis in at least one other state as excess and surplus lines insurers or as risk retention groups; except that the term does not include risk retention groups incorporated as captive insurers. It also does not include those insurers that are licensed, accredited or operating in only their state of domicile but assuming business from insurers writing that business that is directly written in a different state. The terms "insurer" and "insurers" used in the Part A standards fall within the definition of "multi-state domestic insurers." For the purpose of this definition, the term "state" is intended to include any NAIC member jurisdiction, including U.S. territories.

(1) **Examination Authority**
The Department should have authority to examine companies whenever it is deemed necessary. Such authority should include complete access to the company's books and records and, if necessary, the records of any affiliated company, agent, and/or managing general agent. Such authority should extend not only to inspect books and records but also to examine officers, employees, and agents of the company under oath when deemed necessary with respect to transactions directly or indirectly related to the company under examination. The NAIC Model Law on Examinations or substantially similar provisions shall be part of state law.

[16]Part A differs for risk retention groups.

(2) **Capital and Surplus Requirement**

The Department should have the ability to require that insurers have and maintain a minimum level of capital and surplus to transact business. The Department should have the authority to require additional capital and surplus based upon the type, volume and nature of insurance business transacted. The Risk Based Capital (RBC) for Insurers Model Act or provisions substantially similar shall be included in state laws or regulations.

(3) **NAIC Accounting Practices and Procedures**

The Department should require that all companies reporting to the Department file the appropriate NAIC annual statement blank, which should be prepared in accordance with the NAIC's instructions handbook and follow those accounting procedures and practices prescribed by the NAIC's *Accounting Practices and Procedures Manual*, utilizing the version effective January 1, 2001 and all subsequent revisions adopted by the Financial Regulation Standards and Accreditation (F) Committee.

(4) **Corrective Action**

State law should contain the NAIC's Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in a Hazardous Financial Condition or a substantially similar provision, which authorizes the Department to order a company to take necessary corrective action or cease and desist certain practices that, if not corrected, could place the company in a hazardous financial condition.

(5) **Valuation of Investments**

The Department should require that securities owned by insurance companies be valued in accordance with those standards promulgated by the NAIC's Securities Valuation Office. Other invested assets should be required to be valued in accordance with the procedures promulgated by the NAIC's Financial Condition (E) Committee.

(6) **Holding Company Systems**

State law should contain the NAIC Model Insurance Holding Company System Regulatory Act or an Act substantially similar, and the Department should have adopted the NAIC's model regulation relating to this law.

(7) **Risk Limitation**

State law should prescribe the maximum net amount of risk to be retained by a property and liability company for an individual risk based upon the company's capital and surplus. This limitation should be no larger than 10% of the company's capital and surplus.

(8) **Investment Regulations**

State statute should require a diversified investment portfolio for all domestic insurers both as to type and issue and include a requirement for liquidity. Foreign companies should be required to substantially comply with these provisions.

(9) **Liabilities and Reserves**

State statute should prescribe minimum standards for the establishment of liabilities and reserves resulting from insurance contracts issued by an insurer; including life reserves, active life reserves, and unearned premium reserves, and liabilities for claims and losses

unpaid and incurred but not reported claims. The NAIC's Standard Valuation Law and Actuarial Opinion and Memorandum Regulation or substantially similar provisions shall be in place.

(10) **Reinsurance Ceded**

State law should contain the NAIC Model Law on Credit for Reinsurance, the NAIC's Credit for Reinsurance Model Regulation and the NAIC Life and Health Reinsurance Agreement Model Regulation or substantially similar laws.

(11) **CPA Audits**

State statute or regulation should contain a requirement for annual audits of domestic insurance companies by independent certified public accountants, based on the NAIC's Annual Financial Reporting Model Regulation.

(12) **Actuarial Opinion**

State statute or regulation should contain a requirement for an opinion on reserves and loss and loss adjustment expense reserves by a qualified actuary or specialist on an annual basis for all domestic insurance companies.

(13) **Receivership**

State law should set forth a receivership scheme for the administration, by the insurance commissioner, of insurance companies found to be insolvent as set forth in the NAIC's Insurer Receivership Model Act.

(14) **Guaranty Funds**

State law should provide for a regulatory framework such as that contained in the NAIC's model acts on the subject, to ensure the payment of policyholders' obligations subject to appropriate restrictions and limitations when a company is deemed insolvent.

(15) **Filings with NAIC**

State statute, regulation or practice should mandate filing of annual and quarterly statements with the NAIC in a format acceptable to the NAIC except that states may exempt from this requirement those companies that operate only in their state of domicile.

(16) **Producer Controlled Insurers**

States should provide evidence of a regulatory framework, such as that contained in the NAIC's model law for Business Transacted with Producer Controlled Property/Casualty Insurer Act or similar provisions.

(17) **Managing General Agents Act**

States should provide evidence of a regulatory framework, such as that contained in the NAIC's Managing General Agents Model Act or similar provisions.

(18) **Reinsurance Intermediaries Act**

States should provide evidence of a regulatory framework, such as that contained in the NAIC's Reinsurance Intermediary Model Act or similar provisions.

(19)Regulatory Authority

State law should provide for a regulatory framework for the organization, licensing and change of control of domestic insurers.

(Note: If a state can provide evidence that none of the entities contemplated in above standards 14, 16, 17 or 18, is either present or allowed to operate in the state, it will not need to demonstrate compliance with that standard.)

Part B: Regulatory Practices and Procedures

Preamble

4. The purpose of Part B is to identify base-line regulatory practices and procedures required to supplement and support enforcement of the states' financial solvency laws in order for the states to attain substantial compliance with the core standards established in Part A. Part B identifies standards that are to be applied in the regulation of all forms of multi-state insurers.

5. Part B sets out standards required to ensure adequate solvency regulation of multi-state insurers. Each state must make an appropriate allocation of its available resources to effectively address its regulatory priorities. In addition to a domestic state's examination and analysis activities, other checks and balances exist in the regulatory environment. These include other states' regulation of licensed foreign companies, the appropriate application of FAST and IRIS ratios, the analyses by NAIC's staff, the NAIC Financial Analysis Working Group, the NAIC Analyst Team System project, and, to some extent, the evaluation by private rating agencies.

6. The scope of Part B is broader than the scope of Part A. "Multi-state insurer" as used in Part B encompasses all forms of insurers domiciled or chartered in the accredited state and licensed, registered, accredited or operating in at least one other state. This scope also includes insurers that are domiciled in the accredited state and operating or accepting business on an exported basis in at least one other state as excess and surplus lines insurers. It does not include those insurers that are licensed, accredited or operating in only their state of domicile but are assuming business from insurers writing that business that is directly written in a different state. The term "insurer" in Part B includes traditional insurance companies as well as, for instance, health maintenance organizations and health service plans, captive risk retention groups, and other entities organized under other statutory schemes. Although this scope includes risk retention groups organized as a captive insurer, it does not include any other type of captive insurer. While the unique organizational characteristics of some of these entities may require specialized laws, their multi-state activity demands solvency oversight that employs the base-line regulatory practices and procedures identified in Part B. For purposes of this definition, the term "state" is intended to include any NAIC member jurisdiction, including U.S. territories.

7. The accreditation program recognizes that complete standardization of practices and procedures across all states may not be practical or desirable because of the unique situations each state faces. States differ with respect to staff and technology resources that are available as well as the characteristics of the domestic industry regulated. For example, states may choose to emphasize automated analysis over manual or vice versa. Reliable results may be obtained using alternative, yet effective, financial solvency oversight methodologies. The accreditation program should not emphasize form over substance in its evaluation of the states' solvency regulation.

(NOTE: FRSAC has adopted Review Team Guidelines that provide detailed guidance to the review teams regarding how compliance with the Part B, Regulatory Practices and Procedures Standards should be assessed. These guidelines can also assist states in preparing for the accreditation review of their Department.)

(1) **Financial Analysis**

a. **Sufficient Qualified Staff and Resources**
The Department should have the resources to review effectively on a periodic basis the financial condition of all domestic insurers.

b. **Communication of Relevant Information to/from Financial Analysis Staff**
The Department should provide relevant information and data received by the Department, which may assist in the financial analysis process to the financial analysis staff and ensure that findings of the financial analysis staff are communicated to the appropriate person(s).

c. **Appropriate Supervisory Review**
The Department's internal financial analysis process should provide for appropriate supervisory review and comment.

d. **Priority-Based Analysis**
The Department's financial analysis procedures should be priority-based to ensure that potential problem companies are reviewed promptly. Such a prioritization scheme should utilize appropriate factors as guidelines to assist in the consistent determination of priority designations.

e. **Appropriate Depth of Review**
The Department's financial analysis procedures should ensure that domestic insurers receive an appropriate level or depth of review commensurate with their financial strength and position.

f. **Documented Analysis Procedures**
The Department should have documented financial analysis procedures and/or guidelines to provide for consistency and continuity in the process and to ensure that appropriate analysis procedures are being performed on each domestic insurer.

g. **Reporting of Material Adverse Findings**
The Department's procedures should require that all material adverse indications be promptly presented to the commissioner or an appropriate designee for determination and implementation of appropriate regulatory action.

h. **Action on Material Adverse Findings**
Upon the reporting of any material adverse findings from the financial analysis staff, the Department should take timely action in response to such findings or adequately demonstrate the determination that no action was required.

(2) **Financial Examinations**

a. **Sufficient Qualified Staff and Resources**

The Department should have the resources to effectively examine all domestic insurers on a periodic basis in a manner commensurate with the financial strength and position of each insurer.

b. **Communication of Relevant Information to/from Examination Staff**

The Department should provide relevant information and data received by the Department, which may assist in the examination process to the examination staff and ensure that findings of the examination staff are communicated to the appropriate person(s).

c. **Use of Specialists**

The Department's examination staff should include specialists with appropriate training and/or experience or otherwise have available qualified specialists, which will permit the Department to effectively examine any insurer. These specialists should be utilized where appropriate given the complexity of the examination or identified financial concerns.

d. **Appropriate Supervisory Review**

The Department's procedures for examinations should provide for supervisory review of examination workpapers and reports to ensure that the examination procedures and findings are appropriate and complete and that the examination was conducted in an efficient and timely manner.

e. **Use of Appropriate Guidelines and Procedures**

The Department's policies and procedures for the conduct of examinations should generally follow those set forth in the NAIC *Financial Condition Examiners Handbook*. Appropriate variations in methods and scope should be commensurate with the financial strength and position of the insurer.

f. Performance and Documentation of Risk-Focused Examinations

The Department's performance and documentation of risk-focused examinations should generally follow the guidance set forth in the NAIC *Financial Condition Examiners Handbook*. Appropriate variations in method and scope should be commensurate with the financial strength and position of the insurer.

g. **Scheduling of Examinations**

In scheduling financial examinations, the Department should follow procedures such as those set forth in the NAIC *Financial Condition Examiners Handbook* that provide for the periodic examination of all domestic companies on a timely basis. This system should accord priority to companies that exhibit adverse financial trends or otherwise demonstrate a need for examination.

h. **Examination Reports**

The Department's reports of examination should be prepared in accordance with the format adopted by the NAIC and should be sent to other states in which the insurer transacts business in a timely fashion.

i. **Reporting of Material Adverse Findings**

The Department's procedures should require that all material adverse findings be promptly presented to the commissioner or an appropriate designee for determination and implementation of appropriate regulatory action.

j. **Action on Material Adverse Findings**

Upon the reporting of any material adverse findings from the examination staff, the Department should take timely action in response to such findings or adequately demonstrate the determination that no action was required.

(3) **Information Sharing and Procedures for Troubled Companies**

a. **Information Sharing**

States should allow for the sharing of otherwise confidential documents, materials, information, administrative or judicial orders, or other actions with the regulatory officials of any state, federal agency or foreign countries providing that the recipients are required, under their law, to maintain its confidentiality. States also should allow for the sharing of otherwise confidential documents, materials, information, administrative or judicial orders, or other actions with the NAIC providing that the NAIC demonstrates by written statement the intent to maintain its confidentiality. The Department should have a documented policy to cooperate and share information with respect to domestic companies with the regulatory officials of any state, federal agency or foreign countries and the NAIC directly and also indirectly through committees established by the NAIC, which may be reviewing and coordinating regulatory oversight and activities. This policy should also include cooperation and sharing information with respect to domestic companies subject to delinquency proceedings.

b. **Procedures for Troubled Companies**

The Department should generally follow and observe procedures set forth in the NAIC *Troubled Insurance Company Handbook*. Appropriate variations in application of procedures and regulatory requirements should be commensurate with the identified financial concerns and operational problems of the insurer.

Part C: Organizational and Personnel Practices

(1) **Professional Development**

The Department should have a policy that encourages the professional development of staff involved with financial surveillance and regulation through job-related college courses, professional programs, and/or other training programs.

(2) **Minimum Educational and Experience Requirements**

The Department should establish minimum educational and experience requirements for all professional employees and contractual staff positions in the financial regulation and surveillance area, which are commensurate with the duties and responsibilities of the position.

(3) **Retention of Personnel**

The Department should have the ability to attract and retain qualified personnel for those positions involved with financial surveillance and regulation.

Part D: Organization, Licensing and Change of Control of Domestic Insurers

Preamble

8. The focus of the Part D standards is on strengthening financial regulation and the prevention of unlicensed or fraudulent activities. The scope of this section only includes the licensing of new companies and Form A filings. The section applies to only traditional life/health and property/casualty companies and this scope is narrower than that of Part B in that it does not include entities such as health maintenance organizations, health service plans, and captive insurers (including captive risk retention groups). These standards only deal with the department's analysis of domestic companies and do not include foreign or alien insurers. The initial company licensing process does not consider the "multi-state" concept since the company is in its initial licensing phase. The standards regarding Form A filings deal with only filings submitted related to multi-state insurers, as that term is defined in the Part B Preamble.

(1) Qualified Staff and Resources

The department should have minimum educational and experience requirements for licensing staff commensurate with the duties and responsibilities for analyzing company applications. Staff responsible for analyzing applications should have an accounting, insurance, financial analysis or actuarial background.

(2) Sufficient Staff and Resources

The department should have sufficient resources to effectively review applications for primary licensure or Form A filings in a timely manner.

(3) Scope of Procedures for Primary Applications

The department should have documented licensing procedures that include a review and/or analysis of key pieces of information included in a primary licensure application.

(4) Scope of Procedures for Form A Filings

The department should have documented procedures for the review of key pieces of information included in Form A filings.

(5) Use of the Form A Database

The department should utilize the Form A Database as a means of obtaining information on prior filings made by an applicant and informing other states of the receipt and status of Form A filings in a timely manner.

(6) Documentation of Work Performed

The department's files should include evidence that the department's procedures were adequately performed and well documented, including a conclusion regarding whether an application or filing is approved or denied.

Source: *Financial Regulation Standards and Accreditation Program*, March 2012, pp. 7-15.

Section 3

Regulating for Solvency Protects Consumers: U.S. Insurance Financial Regulatory Oversight

1. The U.S. financial regulatory system is generally a three-stage process. First, regulators eliminate or limit some risks through restriction on activities or prior approval mechanisms or when companies modify actions based upon perceived risk/reward assessment and potential RBC consequences. Financial oversight is the second stage of the process and where most of the regulatory activity exists. At this stage, regulators are looking for companies in hazardous financial condition and evaluating the potential for insolvency. Regulatory backstops or safeguards, most notably the state guaranty associations and RBC, make up the final stage of the regulatory process.

2. The core of the financial regulatory system in the U.S. is the financial surveillance process for financial oversight, which is predominately built around an extensive and uniform financial reporting system allowing for detailed analysis of asset holdings, reinsurance, and loss/claim reserves. Within minutes, regulators can perform stress tests on companies and determine the impact of other company insolvencies on the market. The data provides opportunities to find anomalies from one company to another through benchmarking and other processes and to look for new risk concentrations and/or optimistically valued risks. Because this data and disclosure is vital to the regulatory system, regulators spend considerable effort to validate appropriate financial reporting (e.g. audits, compliance evaluation, actuarial opinions, etc.) to allow for extensive analysis without significant extra attention from the company, thereby keeping regulatory disruptions to a minimum.

Limitation of Risk through Design of the System

Investment Requirements and/or Limitations

3. Regulators deem some risks to be so material and potentially not in the best interests of policyholders, that law and regulation either restrict those investment activities or require pre-approval of certain material transactions. Conservative valuation of assets and liability credits and application of the risk-based capital (RBC) formula can drive insurers toward less-risky activities.

4. In the 1990s insolvencies caused by high risk investment strategies led regulators to consider their oversight and possible restriction of insurer investments by imposing either defined limits or defined standards. Using defined limits, regulators place certain limits on amounts or relative proportions of different assets that insurers can hold to ensure adequate diversification and limit risk. Using defined standards, regulators restrict investments based on a "prudent person" approach, allowing for discretion in investment allocation if the insurer can demonstrate its adherence to a sound investment plan. Upon establishing eligibility for filing in the financial statement, insurance companies report securities ownership for credit risk evaluation through the NAIC's Securities Valuation Office (SVO). Credit quality of insurance company investments and the security's Unit Price provide a sound empirical anchor for certain regulatory functions related to financial solvency regulation.

Pre-Approval of Material Transactions and Activities

5. Commissioner approval is required for certain material transactions, such as large investment, or reinsurance transactions, extraordinary dividends. In an insurance holding company system, insurers also need regulatory approval for change in control and the amount of dividends paid.

Valuation Requirements and Reinsurance Credit

6. Statutory accounting principles value some assets conservatively and, thus, are less favorable for investment. Reinsurance is a valuable activity and can provide significant stability to an insurance company financially, but there is always risk in reinsurance reimbursement. Therefore, in order to receive credit for ceded reinsurance, the reinsurer must be authorized or post security to cover its obligations.

RBC

7. The RBC capital requirement calculation varies based on the type of asset and while RBC does not tend to drive investments (because companies' target capital levels are much higher than RBC), the RBC formula could have some influence on management decisions.

Financial Intervention Powers

8. Often international discussions about financial regulation focus on capital requirements given that capital requirements are an important part of every regulatory regime. Obviously, a company must hold capital greater than minimum regulatory capital levels to continue in business, but financial regulation extends beyond just capital requirements in most countries, and in the U.S., financial regulation is much broader still.

9. U.S. commissioners can order conservation, rehabilitation or liquidation on numerous statutory grounds ranging from financial insolvency to unsuitable management and operations. The Insurer Receivership Model Act (MO555) includes the following grounds for regulatory action:

(1) Impairment, insolvency, or hazardous financial condition;
(2) Improperly disposed property or concealed, altered, or destroyed financial books;
(3) Best interest of policyholders, creditors or the public; and,
(4) Dishonest, improperly experienced, or incapable person in control.

10. The most typical financial intervention occurs when a company is in hazardous financial condition. As a final policyholder safeguard, financial intervention (ranging from required company actions to mandatory regulatory control of the company) becomes a requirement when a company's RBC triggers an action or control level event.

Intervention Grounds: Hazardous Financial Condition

11. A regulator may deem a company in hazardous financial condition[1] based upon:

[1] MODEL REGULATION TO DEFINE STANDARDS AND COMMISSIONER'S AUTHORITY FOR COMPANIES DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION (MO385)

(1) Adverse findings in financial analysis or examination, market conduct examination, audits, actuarial opinions or analyses, cash flow and liquidity analyses;
(2) Insolvencies of a company's reinsurer(s) or within the insurer's insurance holding company system;
(3) Finding of incompetent or unfit management/director;
(4) A failure to furnish information or provide accurate information; and,
(5) Any other finding determined by the commissioner to be hazardous to the insurer's policyholders, creditors, or general public.

12. Generally, regulators judge financial condition based upon the company's financial reporting, accompanying audits, and actuarial opinions. There are numerous financial analysis tools, including public calculations, such as IRIS ratios and more detailed non-public calculations included in the FAST system that highlight "red flags." These non-public calculations are possible because of the detailed, validated and uniform financial reporting, allowing for identification of risk concentrations and anomalies.

13. Given that assets' and liabilities' valuations and reserves are a substantial portion of insurer risks, reserve analyses include actuarial opinions and, for life insurance, asset valuation reserves and interest maintenance reserves to help to ensure consistent asset and liability valuation.

Intervention Grounds: Capital Requirements

14. As a final back-stop in the U.S. financial oversight process, we have the U.S. RBC calculation and analysis.[2] Regulators developed RBC to supplement the fixed minimum capital and surplus requirements which vary by line of business (higher for casualty lines, and higher for multiple lines over mono-line companies) and do not sufficiently account for differences in size, risks, or financial conditions among insurers. Although the formulas are the same for a similar line of business, the specific RBC calculation for each company reflects the particular risks unique to that specific company.

15. Risk-based capital (RBC) raises the regulatory safety net in the U.S. system by recognizing a company's different size, financial condition, and types of risks assumed. And, even more importantly, regulators created RBC as a legal authority to provide for timely regulatory action with minimum court involvement when a company reaches an action level event.

16. The RBC formula is a process whereby the insurer calculates a Total Adjusted Capital (TAC), first by identifying dollar amounts of specific asset risk exposures in specific risk categories (i.e. direct/indirect affiliate/subsidiary insurer risks, fixed income risks, equity risks, credit risks, underwriting risks, etc.). An Authorized Control Level (ACL) amount is then established through many pages of calculations whereby individual risks are multiplied by risk factors to create RBC charges, the RBC charges are segregated into risk components based upon correlation, and a covariance calculation is used to account for the absence of perfect correlation among all risks.

Once the ACL is calculated, the trigger points for the regulator's four action and control levels are then determined as a percentage of the ACL number: Company Action Level is 200% of ACL, Regulatory Action Level is 150% of ACL, ACL is the third level, and Mandatory Control Level is 70% of the ACL.

[2]RISK-BASED CAPITAL (RBC) FOR INSURERS MODEL ACT (MO312)

Then the TAC is compared to the four regulatory action and control levels, and, in accordance with the RBC regulatory framework, all state statutes include specific actions that the regulator and insurer must take at each level to resolve risk exposures and capital inadequacies. These intervention levels are established to require regulatory action, but the regulator may otherwise consider a company to be in hazardous financial condition despite a specific RBC level finding.

Oversight of Hazardous Financial Condition

17. Financial oversight and determination of hazardous financial condition is the most valuable and extensive part of financial regulation. Oversight focuses on appropriate asset and liability valuation, the risks accepted by the insurer, the mitigation of those risks, and the amount of capital held in light of the residual risks. Without the extensive financial reporting databases, the financial analysis to evaluate hazardous financial condition would likely require much more significant and time-consuming company input.

18. In addition to numerous activities, such as consideration of management skills, products, sales, market activity, market concentrations, etc., evaluation of hazardous financial condition status includes review of an insurer's financial statement preparation, including preparation of all the schedules and audit and actuarial opinions, and regulators' financial surveillance, including financial statement validation, analysis and examination.

Financial Reporting Preparation and Requirements

19. Insurers are required to file standardized annual and quarterly financial reports that the regulators use to assess the insurer's risk and financial condition. These reports contain both qualitative and quantitative information and are updated as necessary to incorporate significant common insurer risks. Reporting requirements are specified in two forms: through the Accounting Practices and Procedures Manual, utilizing fully codified statutory accounting principles (SAP), and through the Quarterly and Annual Statement Instructions. Requirements run the gamut from typical accounting requirements (e.g. balance sheet and income statement) to detailed data reporting on specified schedules (e.g. Schedule D – Investment Schedules; Schedule F – reinsurance issues; and Schedule P – Loss triangles, etc.). Given the importance of accurate financial reporting to the financial oversight process, regulators pay particular attention to accuracy. Actuarial opinions on major components of an insurer's financial statements (asset adequacy and claim/loss/premium reserves) are required to ensure either adequacy and/or reasonableness of reserves. The independent financial audit helps to provide assurances that all material aspects of the insurer's financial reporting are accurate.

Financial Surveillance

20. In assessing the financial condition of an insurer, the overall goal is to identify potential adverse financial indicators as quickly as possible, evaluate and understand such problems more effectively, and develop appropriate corrective action plans sooner, thus potentially decreasing the frequency and severity of insolvencies. Regulators conduct a risk-focused surveillance of the insurer's financial reports that includes financial analysis, risk-focused examination, and supervisory plan development.

Financial Analysis

21. NAIC tools and resources (e.g. "FAST" Scores and Handbooks) supplement individual state regulatory efforts. The Financial Analysis Solvency Tools (FAST) is a collection of analytical solvency tools and databases designed to provide state insurance departments with an integrated approach to reviewing the financial condition of insurers operating in their respective states. FAST is intended to assist regulators in prioritizing resources to those insurers in greatest need of regulatory attention. The creation and development of sophisticated and comprehensive financial tools and benchmarks (through data management evolved from personal knowledge of troubled companies) encapsulate various categories, including leverage, asset quality, liquidity, and insurer operations.

22. Three key tools within the FAST System include:[3]

1) **Insurance Regulatory Information System (IRIS)**: IRIS has served as a baseline solvency screening system for the NAIC and state regulators since the mid-1970s. Its first, "statistical phase" involves calculating a series of confidential financial ratios for each insurer based on statutory annual statement data. Because the ratios by themselves are not indicative of adverse financial conditions, an experienced team of state insurance examiners and analysts then reviews the IRIS ratio results and other financial information through the second "analytical phase."

In this second phase, the Analyst Team reviews a computer-selected priority listing of insurers that may be experiencing weak or declining financial results and meets to identify insurers that appear to require immediate regulatory attention. The team then validates the listing based on further analysis of those companies, and provides a brief synopsis of its findings in a document that only state insurance regulators and authorized NAIC staff can access.

2) **Scoring System**: The NAIC Scoring System is based on several financial ratios and is similar in concept to IRIS ratios, but provides results both on an annual and a quarterly basis. The Scoring System also includes a broader range of financial ratios and assigns a score to each ratio based on the level of solvency concern each result generates. As with the IRIS results, the Scoring System results and scores are available only to state insurance regulators and authorized NAIC staff.

3) **Insurer Profiles System**: Finally, the Insurer Profiles System produces quarterly and annual profiles on property and casualty, life, health and fraternal insurers that include either a quarterly or an annual five-year summary of a company's financial position. The Insurer Profile reports provide not only a snapshot of the company's statutory financial statement, but also include analytical tools such as financial ratios and industry aggregate information for analytical review. Insurer Profile reports also assist state insurance department analysts in identifying unusual fluctuations, trends or changes in the mix of an insurer's assets, liabilities, capital and surplus, and operations.

23. To prioritize resources, regulators use the Analyst Team System (ATS), a multi-tiered solvency surveillance process. ATS utilizes the NAIC's Financial Analysis Solvency Tools (FAST) including: the Annual Scoring System, Insurance Regulatory Information System (IRIS) ratios, Risk-Based Capital and selected information from the Annual Statement Blanks. The primary goal of ATS is to

[3]From the Testimony of the National Association of Insurance Commissioners Before the Subcommittee on Capital Markets, Insurance, and Government-Sponsored Enterprises Committee on Financial Services United States House of Representatives Regarding: "Supervision of Group Holding Companies," Thursday, March 18, 2010.

use many of solvency tools working together to identify insurance companies (all of the insurance companies that file Annual Statement Blanks with the NAIC) that appear to require immediate regulatory attention.

24.

25. State regulators have also developed an NAIC *Handbook* to advise use of a stair-step approach that directs analysts to perform more in-depth analysis commensurate with the financial strength, prospective risks and complexity of each insurer. The *Handbook* requires regulators to use many analytical tools, databases and processes in completing their quarterly analysis of insurers (such as ratio analysis and review of the actuarial opinion, audited statutory financial statements, holding company filings, and the management discussions and analysis filings). The *Handbook* provides a means for insurance departments to more accurately identify companies experiencing financial problems or posing the greatest potential for developing such problems. Furthermore, the *Handbook* provides guidance for insurance departments to define and evaluate particular areas of concern in troubled companies.

26. Ensuring a nationwide system of checks and balances, the NAIC's Financial Analysis Working Group (FAWG) offers a layer of peer review for each regulator's solvency monitoring efforts, thus ensuring that experienced state regulator colleagues improve and enhance state regulator judgments regarding a company's financial condition. For over two decades, the NAIC FAWG has ensured that state insurance financial regulators have shared information and ideas to identify, discuss, and monitor potentially troubled insurers and nationally significant insurance groups[4]. For the past two decades, FAWG has identified market trends and emerging financial issues in the insurance sector and has leveraged the expertise of select chief financial regulators from around the U.S. to provide an additional layer of solvency assessment to our national system of state-based regulation.

27. While FAWG does not have specific regulatory authority, no state has ever refused a FAWG recommendation. Our system of supervision fosters healthy peer review that creates peer pressure to be a diligent and vigilant domiciliary regulator, knowing that each state where a company is licensed has the separate authority to act on a FAWG recommendation if the domiciliary state regulator does not.

28. FAWG's mission has three overriding themes:

1. Identify nationally significant insurers/groups that exhibit characteristics of trending towards financial trouble;
2. Interact with domiciliary regulators and lead states in order to assist and advise on appropriate regulatory strategies, methods, and actions; and,
3. Encourage, promote and support coordinated, multi-state efforts in addressing solvency issues.

29. FAWG's activities, oversight and insurer review includes, but is not limited to:

- Identifying companies that are outliers when compared with industry benchmarks although, state regulators may refer some companies to FAWG for review.
- Develop communication for the financial staff and commissioner for the state of domicile for the insurer/group under review; including a description of the issue, questions and suggestions on regulatory options.
- Review of domestic or lead state regulator responses on identified issues and questions.

[4] Nationally significant insurers is a classification that considers the size of the company or group's premium volume combined with the number of states in which it writes business. Nationally significant insurers write a large majority of insurance in the U.S..

- Consider whether responses identify a need for further regulatory action or FAWG intervention – including requesting the domiciliary regulator to answer questions and make a presentation to FAWG and other regulators.
- Consider whether to request the formation of a FAWG subgroup for certain insurers or groups to facilitate regular communication and collaboration with applicable regulators although state regulators generally proactively communicate with the most relevant regulators for each situation on their own.

30. Through the FAWG forum, individual states work together to support and guide fellow regulators for the benefit of the whole in an entirely open (among regulators) yet confidential (not public) process. FAWG also reviews and considers trends occurring within the industry, often concentrating on particular market segments, product, exposure, or other problem that have the potential of impacting the solvency of the overall industry.

Financial Examination

31. US regulators carry out periodic risk-focused, on-site examinations in which they evaluate the insurer's corporate governance, management oversight and financial strength, including risk identification and mitigation systems both on a current and prospective basis, assessing the reported financial results through the financial examination process to determine the insurer's compliance with legal requirements.

32. Examinations consist of a process to identify and assess risk and assess the adequacy and effectiveness of strategies/controls used to mitigate risk. The process includes a determination of the quality and reliability of the corporate governance structure, risk management programs and verification of specific portions of the financial statements, limited-scope reviews and reviews of specific insurer operations.

33. Financial examiners evaluate the insurer's current strengths and weaknesses (e.g. Board of Directors, risk management processes, Audit function, IT function, compliance with laws/regulations, etc.) and prospective risk indications (e.g. business growth, earnings, capital, management competency and succession, future challenges, etc.).

34. Regulators document the results of financial condition examinations in a public examination report that assesses the insurer's financial condition and sets forth findings of fact with regard to any material adverse findings disclosed by the examination. Examination reports may also include required corrective actions, improvements and/or recommendations.

Supervisory Plan

35. At least once a year, regulators develop a Supervisory Plan for each domestic insurer using the results of recent examinations and the annual and quarterly analysis process to outline the type of surveillance planned, the resources dedicated to the oversight and the coordination with other states. At the end of a financial examination, the financial examiner will document appropriate future supervisory plans for each insurer (e.g., earlier statutory exams, limited-scope exams, key areas for financial analysis monitoring, etc.). This Supervisory Plan provides an oversight link between financial examination and financial analysis processes.

Conclusion

36. As a national system of state-based regulation, we are keenly aware of our unique structure, and have developed tools and financial regulatory processes, adopted by all states, such as our Accreditation program, peer review and FAWG oversight, to ensure that we are effectively and efficiently maximizing our resources to protect consumers while maintaining the solvency of our regulated entities. U.S. regulators utilize a number of coordinated resources to assess the financial strength and condition of insurers – both small single-state insurers and large multi-state groups – to verify the consistency, integrity and success of our supervisory approach.

Section 4

Effective and Efficient Markets Protect Consumers –Analysis of U.S. Markets

U.S. Insurance Regulatory Mission

1. The mission or purpose of U.S. insurance regulation is to protect the interests of the policyholder and those who rely on the insurance coverage provided to the policyholder first and foremost, while also facilitating the financial stability and reliability of insurance institutions for an effective and efficient market place for insurance products. While the policyholder is the focal point of the mission, this mission is mindful that regulatory actions and decisions will have an impact on the operation of insurance markets and their efficiency. Because it is felt that "facilitating the financial stability and reliability of insurance institutions for an effective and efficient market place for insurance products" is in the best interests of policyholders (e.g., cost efficiencies and product innovation), this is not considered to be a separate and distinct or secondary mission, but is considered to support a focus on the policyholder.

2. Insurance regulators support the best way to facilitate an effective and efficient market place for insurance products and achieve cost efficiencies and product innovation is by cultivating a competitive market place.

Measuring Competitiveness of Markets

3. Economists often use the structure-conduct-performance hypothesis as a standard way to evaluate markets. This hypothesis states that market structure affects market conduct which in turn affects market performance. Market structure can be presented through market share, size of firms, number of firms, concentration measures and entry and exit rates. Market conduct refers to the degree of independence firms have in setting prices and output levels. Market performance for insurance markets can be measured through loss ratios, profit rates and insolvency rates. An evaluation of these factors can help one analyze insurance markets. A large number of sellers, along with free entry and exit lead to independent pricing and optimal market performance.

4. Insurance regulators strive for workable competition where insurance markets are relatively unconcentrated, barriers to entry are low, profits are comparatively moderate and inefficiencies are limited. A highly competitive market will lead to efficient, optimal outputs and available, innovative products. Under the U.S. capitalistic framework, companies are allowed to enter and exit markets and some will succeed and profit and others may fail. Financial insurance regulation is meant not to prevent companies from failing, but to protect policyholders by ensuring that claims are paid.

5. An evaluation of U.S. insurance markets shows that the vast majority of insurance markets in the vast majority of geographic regions are highly competitive with multiple writers,

relatively low concentration and reasonable profitability rates. The insurance-related benchmarks in the following section are presented as a way to evaluate the competitiveness of insurance markets.

Market Shares

6. Market shares can be used to determine the degree of concentration found in markets. When looking at concentration rates, it is important to evaluate insurance markets based on group status because insurance entities within a group are not competing against each other. There are several ways to look at concentration rates. One common measure used by economists is the four-firm concentration ratio which measures the market share of the four largest groups. Ratios below 50% are considered desirable in terms of competitiveness of the market.

7. A more robust tool to measure concentration is the Herfindahl-Hirschman Index (HHI). The HHI is calculated by summing the squares of the market shares (as a percent) of all groups in the market. Although there is no precise point at which the HHI indicates that a market or industry is concentrated highly enough to restrict competition, the Department of Justice has developed guidelines with regard to corporate mergers. Under these guidelines, if a merger of companies in a given market causes the HHI to rise above 1,800, the market is considered highly concentrated. If, after the merger, the HHI is between 1,000 and 1,800, the market is considered moderately concentrated, and an HHI less than 1,000 is considered not concentrated. Since these numbers are guidelines, judgment must be used to interpret what information the HHIs provide for a particular market.

8. Using these two measures, the data shows that nationally there is very little concentration in property/casualty insurance markets, especially within the larger lines of business (Tables 1, 2 & 3). States show slightly more concentrated markets but the data does not exhibit cause for concern. In addition, states benefit from the fact that there is ease of entry by insurers that may be operating in neighboring states and could easily begin writing in a new state.

Table 1

U.S. Property/Casualty Insurance - Measures of Competitiveness
National Data - 2009

	Market Share Largest Four Groups	HHI	Number of Sellers (Groups)	Return on Net Worth 10 Year Mean	Number of Entries Last 5 Years	Number of Exits Last 5 Years
Commercial Auto Total	27.77%	297	115	8.49%	33	25
Commercial Multiple Peril	27.80%	338	104	8.03%	25	27
Private Passenger Auto Total	44.79%	703	81	7.22%	11	12
Homeowners Multiple Peril	44.13%	737	101	4.67%	27	28

Source: NAIC's *2009 Competition Database Report*

Table 2

U.S. Property/Casualty Insurance – Overall Market Trends									
	Premiums Written	Market Shares: Four Largest Groups	HHI	# of Sellers (Groups)	# of Entries: Last 5 Years	# of Exits: Last 5 Years	Surplus Lines Market Shares: Latest Year	Surplus Lines Market Shares: 5-Year Mean	Return on Net Worth: 10-Year Mean
2009	481,448,809,393	27.51%	318.0	117	27	34	5.60%	6.13%	6.96%
2008	496,827,804,257	27.62%	314.2	118	27	32	5.63%	5.90%	7.00%
2007	509,000,957,021	28.29%	307.5	121	26	28	5.81%	6.01%	7.63%
2006	503,523,640,554	28.53%	310.5	123	32	27	6.20%	5.88%	7.65%

Source: NAIC's *2009 Competition Database Report*

Table 3

State	HHI - All P/C Companies	State	HHI - All P/C Companies
AL	534	MO	459
AK	611	MT	497
AZ	456	NE	378
AR	437	NV	428
CA	406	NH	102
CO	498	NJ	384
CT	416	NM	539
DE	887	NY	344
DC	490	NC	431
FL	340	ND	426
GA	458	OH	410
HI	491	OK	500
ID	445	OR	590
IL	463	PA	417
IN	397	RI	365
IA	340	SC	526
KS	408	SD	332
KY	529	TN	486
LA	548	TX	462
ME	371	UT	441
MD	525	VT	358
MA	437	VA	460
MI	455	WA	499
MN	395	WV	681
MS	497	WI	342
		WY	588

Source: NAIC's *2009 Competition Database Report*

Entries/Exits

9. Those analyzing competition are usually interested in how many insurance groups are participating in a market, as well as how many insurance groups are deciding to enter or leave a market. A market demonstrating a steady increase in the number of groups providing insurance (more groups enter the market than exit) can be considered a strong market where insurers see an opportunity to make a profit. Conversely, markets where more groups are exiting the market than entering may indicate that insurers are unable to earn a profit sufficient to justify a continued presence. Insurance data show that insurers are moving into and out of markets, without either entry or exit dominating the equation (Tables 1 & 2).

Residual Markets

10. When insurance is limited or not available through the voluntary market, a consumer may turn to the residual (e.g. assigned risk or other shared market plans) or surplus lines (i.e. unlicensed companies for hard-to-place risks) markets for coverage. Growth in these alternative markets may reflect a declining number of sellers in the standard market or a limited capacity to add new business. Data show that in most lines and most states, the residual markets are quite small and have fallen in recent years, indicating that the primary market is competitive with insurance relatively available and affordable (Table 2).

Profitability Rates

11. Insurer profitability results can be examined to determine whether a market is attractive to insurers to enter, thereby creating greater competition, or unattractive, causing insurers that are in the market to leave. Persistently high levels of profitability may indicate that a market is failing to attract competitors, thus enabling non-competitive rates of return to be earned. Alternatively, persistently low levels of profitability may indicate that insurers have difficulty estimating losses and/or are unable to set premium rates at adequate levels. Long-term profitability rates for the property/casualty insurance industry are relatively low, particularly when compared with other industries (Table 4).

Table 4

December 2009

Comparison of Rates of Return on Net Worth

(In Percent)

	(1)	(2)
Year	NAIC Property/ Casualty Insurance	Fortune Magazine All Industry

2000	6.6	14.6
2001	0.3	10.4
2002	1.7	10.2
2003	8.2	12.6
2004	8.0	13.9
2005	8.3	14.9
2006	12.2	15.4
2007	9.7	15.2
2008	2.2	13.1
2009	5.7	10.5
2000 – 2009 Averages	5.3	11.6

(1) Returns are calculated using mean net worth.
(2) Returns are calculated using year-end net worth.
Source: NAIC's *Report on Profitability by Line by State in 2009*

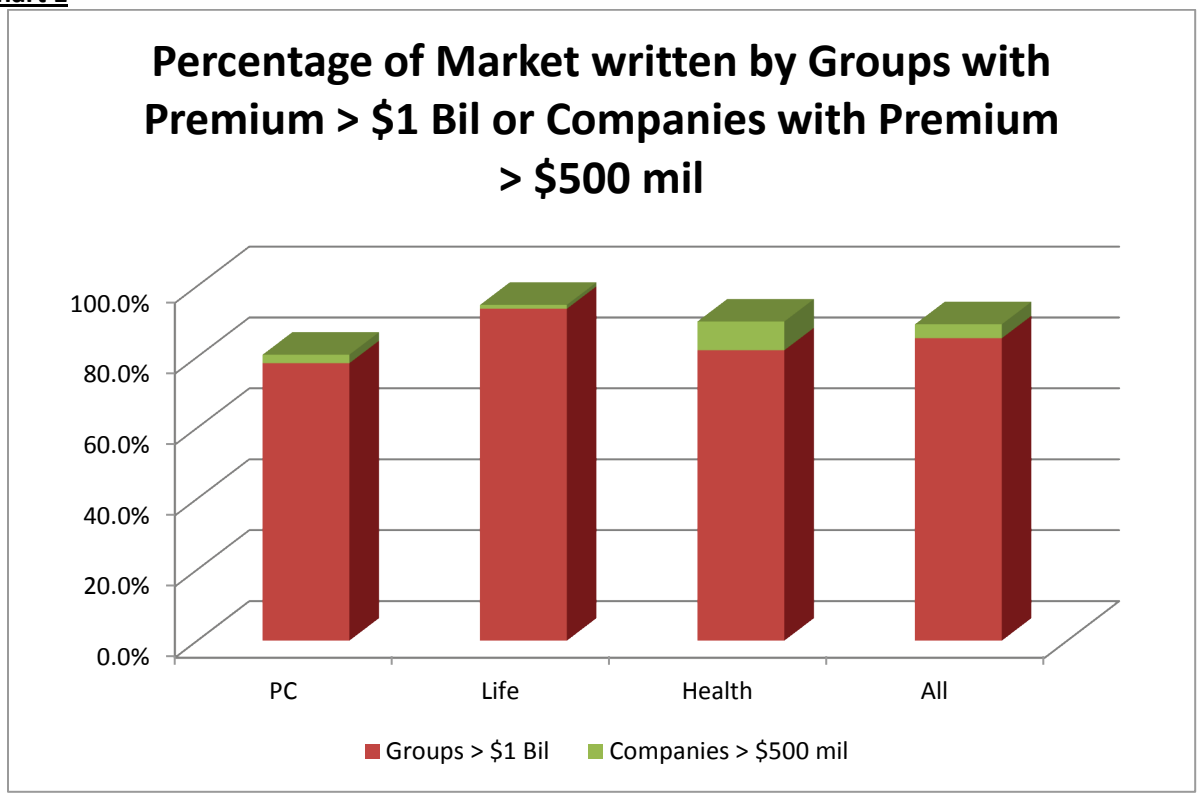
U.S. Markets are Competitive

12. Insurance markets have numerous companies ready to write in most lines of business in all states. The bulk of the business written is done so by large insurers, typically those groups writing over $1 billion in premium or individual companies writing over $500 million in premium (Table 5, Chart 1). The size of these competing companies would allow them to seamlessly step in and write business of an insurer that moved out of the market.

Table 5

Percentage of Insurance Markets Written by Size of Group or Company, 2010			
	Groups > $1 billion or Cos. > $500 million	**Groups > $1 billion**	**Cos. > $500 mil not in the Group >$1 B**
PC	80.6%	78.3%	2.4%
Life	94.6%	93.6%	1.1%
Health	90.0%	81.9%	8.1%
All	89.2%	85.3%	3.9%
Size of Group/Company Determined by Direct Written Premium Source: Data calculated from NAIC's *2010 Market Share Reports*			

Chart 1



Source: Data calculated from NAIC's *2010 Market Share Reports*

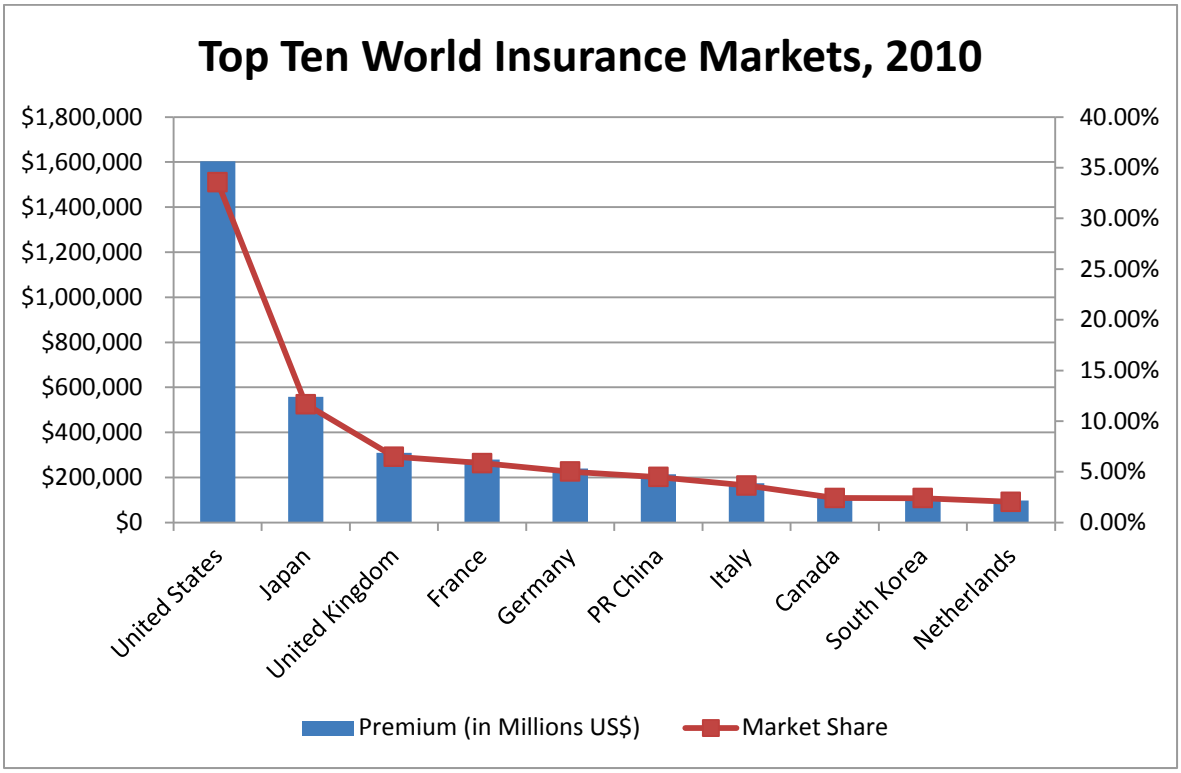
13. The structure and performance criteria for insurance markets confirm competitiveness at both the national and state level. Markets have large numbers of writers and the degree of market concentration falls below that which economists would typically use to identify preconditions necessary to show a lack of competition. The criteria described above provide the framework necessary for competitive markets. U.S. insurance markets are competitive and therefore the failure of a company in a U.S. insurance market can typically be absorbed by other market players without market disruption.

Size of U.S. Insurance Market

14. Insurance markets in the United States are large, competitive and well-functioning. Regulators continually ensure that markets remain competitive as this results in the most efficient markets for the ultimate benefit of consumers.

15. The overall insurance market in the United States is nearly three times larger than that of the next largest insurance market in the world. With $1.6 trillion in overall premium volume in 2010, the U.S. market makes up 33% of the world market, while Japan is the next largest with $557 billion in premiums (Chart 2). When individual states are compared to foreign countries, states make up five of the 14 largest insurance markets and 24 of the top 50 (Table 6).

Chart 2



Sources: NAIC Financial Data Repository, NAIC IID Filings, US residual market mechanisms, health insurers or captives not filing to FDR, and SwissRe Sigma No. 2/2010 for the remainder.

Table 6

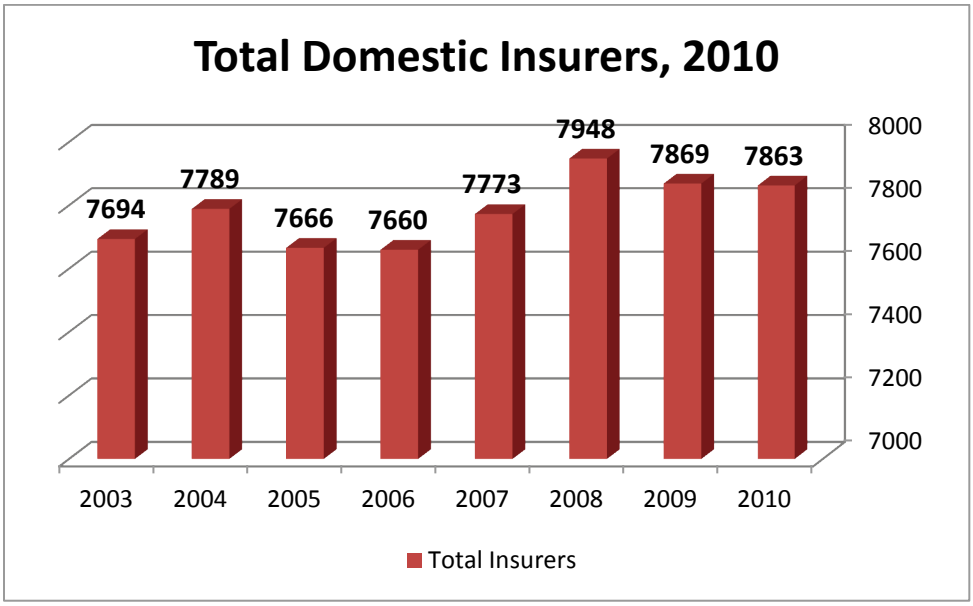
Rank	Jurisdiction	2010 Premium Volume (In Millions US $)	Market Share	Rank	Jurisdiction	2010 Premium Volume (In Millions US $)	Market Share
1	Japan	$557,439	11.67%	26	Ireland	$47,901	1.00%
2	United Kingdom	$310,022	6.49%	27	Massachusetts	$41,820	0.88%
3	France	$280,082	5.86%	28	Russia	$41,644	0.87%
4	Germany	$239,817	5.02%	29	Belgium	$41,104	0.86%
5	PR China	$214,626	4.49%	30	Georgia	$39,302	0.82%
6	California	$211,719	4.43%	31	Sweden	$38,218	0.80%
7	Italy	$174,347	3.65%	32	Virginia	$36,580	0.77%
8	New York	$130,465	2.73%	33	North Carolina	$35,979	0.75%
9	Canada	$115,521	2.42%	34	Luxembourg	$33,011	0.69%
10	South Korea	$114,422	2.40%	35	Washington	$32,204	0.67%
11	Florida	$105,837	2.22%	36	Wisconsin	$31,139	0.65%
12	Texas	$103,686	2.17%	37	Missouri	$30,597	0.64%
13	Netherlands	$97,057	2.03%	38	Tennessee	$30,106	0.63%

14	Pennsylvania	$82,652	1.73%	39	Minnesota	$29,980	0.63%
15	India	$78,373	1.64%	40	Maryland	$29,631	0.62%
16	Taiwan	$76,425	1.60%	41	Denmark	$29,449	0.62%
17	Spain	$76,082	1.59%	42	Arizona	$26,570	0.56%
18	Australia	$72,572	1.52%	43	Indiana	$26,165	0.55%
19	Brazil	$64,093	1.34%	44	Hong Kong	$25,725	0.54%
20	Illinois	$59,812	1.25%	45	Colorado	$25,696	0.54%
21	Ohio	$57,151	1.20%	46	Louisiana	$23,581	0.49%
22	New Jersey	$55,719	1.17%	47	Connecticut	$22,826	0.48%
23	South Africa	$53,297	1.12%	48	Finland	$22,426	0.47%
24	Switzerland	$52,118	1.09%	49	Austria	$22,232	0.47%
25	Michigan	$51,009	1.07%	50	Portugal	$21,780	0.46%

Sources: NAIC Financial Data Repository, NAIC IID Filings, US residual market mechanisms, health insurers or captives not filing to FDR, and SwissRe Sigma No. 2/2010 for the remainder.

16. Nearly 8,000 domestic insurers – including captives, risk retention groups, and state mutual – operate in U.S. markets (Chart 3). In terms of insurance markets on a state level, the average state has nearly 450 life/health insurers and nearly 850 property/casualty insurers licensed to write business in their state (Table 7). The presence of a large number of insurers with the capacity to take on new business ensures that markets will be well functioning as insurers are able to move in and out of markets without causing severe dislocations. As seen in greater detail below, most insurance markets in the U.S. are highly competitive and insurers aggressively seek market share by competing on product and price.

Chart 3



Source: NAIC's *2010 Insurance Department Resources Report*

Table 7

Number of Licensed Insurers by Type - 2010					
	Life/	Property/			
State	Health	Casualty	Health	Fraternal	Title
Alabama	425	840	33	12	21
Alaska	304	475	13	5	6
Arizona	645	987	21	26	18
Arkansas	521	894	12	15	21
California	436	801	0	42	17
Colorado	473	841	25	36	22
Connecticut	391	770	8	40	15
Delaware	460	838	16	21	18
Dist. of Columbia	463	763	15	26	20
Florida	441	895	100	38	20
Georgia	547	1,029	14	13	20
Hawaii	397	593	12	7	14
Idaho	459	834	11	13	11
Illinois	511	1,075	29	58	0
Indiana	517	1,020	32	49	29
Iowa	429	928	41	29	0
Kansas	528	1,013	16	30	18

Kentucky	458	916	57	18	18
Louisiana	516	824	47	23	16
Maine	354	648	9	14	14
Maryland	465	894	35	28	20
Massachusetts	398	719	20	32	20
Michigan	456	863	40	56	14
Minnesota	419	864	39	37	18
Mississippi	520	897	10	13	24
Missouri	509	935	35	30	19
Montana	502	833	3	24	15
Nebraska	503	902	7	32	15
Nevada	478	880	28	13	17
New Hampshire	304	625	27	17	11
New Jersey	388	786	30	45	20
New Mexico	497	708	23	19	21
New York	170	902	82	38	23
North Carolina	461	863	12	14	14
North Dakota	472	827	8	21	13
Ohio	507	981	29	58	24
Oklahoma	513	909	7	20	25
Oregon	474	904	22	21	11
Pennsylvania	484	1,069	36	61	23
Puerto Rico	125	182	13	1	8
Rhode Island	393	733	5	26	13
South Carolina	460	1,071	49	12	19
South Dakota	450	941	5	22	17
Tennessee	507	944	12	15	21
Texas	612	1,151	51	31	21
Utah	490	881	13	17	14
Vermont	335	627	5	15	11
Virginia	447	901	55	24	19
Washington	439	855	31	22	13
West Virginia	464	806	36	28	17
Wisconsin	420	1,029	74	47	17
Wyoming	430	674	3	14	15
Average	**449**	**849**	**26**	**26**	**17**

Source: NAIC's *2010 Insurance Department Resources Report*

U.S. Markets are Regulated by States Due to Local Differences

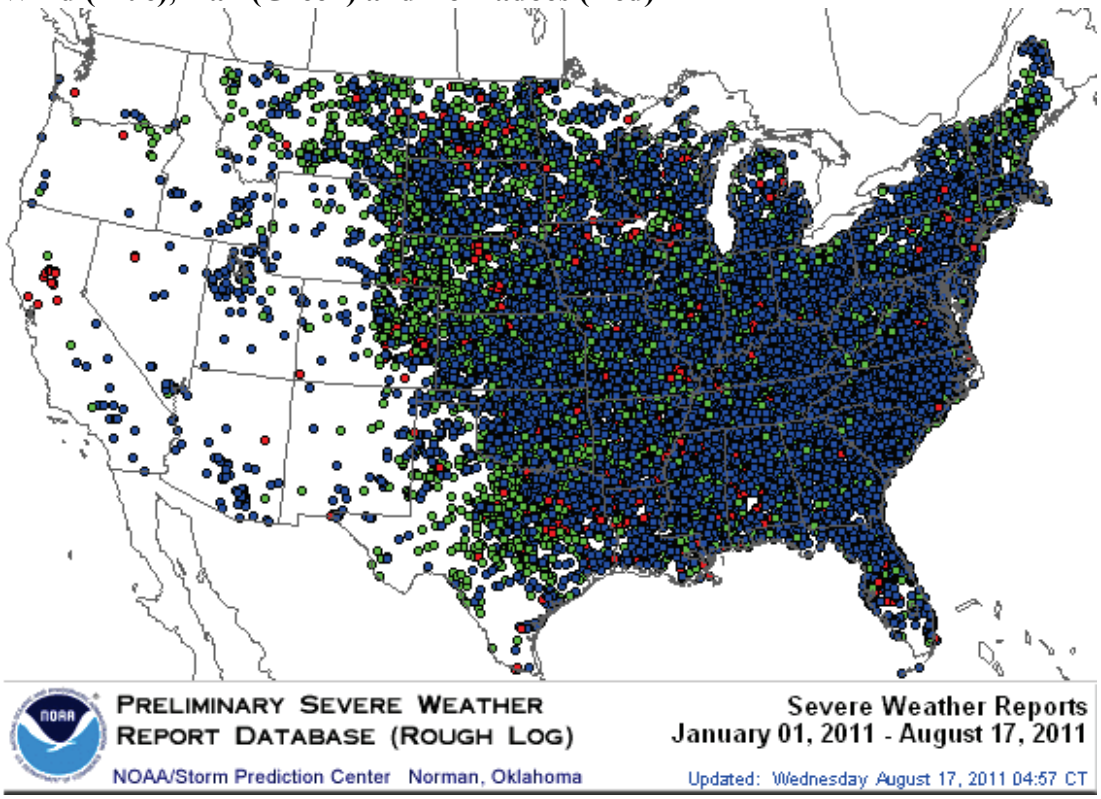
17. U.S. regulation is done on a state level rather than a federal level, partly due to Constitutional reasons and prior decisions made by U.S. Courts, but also due to practical reasons because it

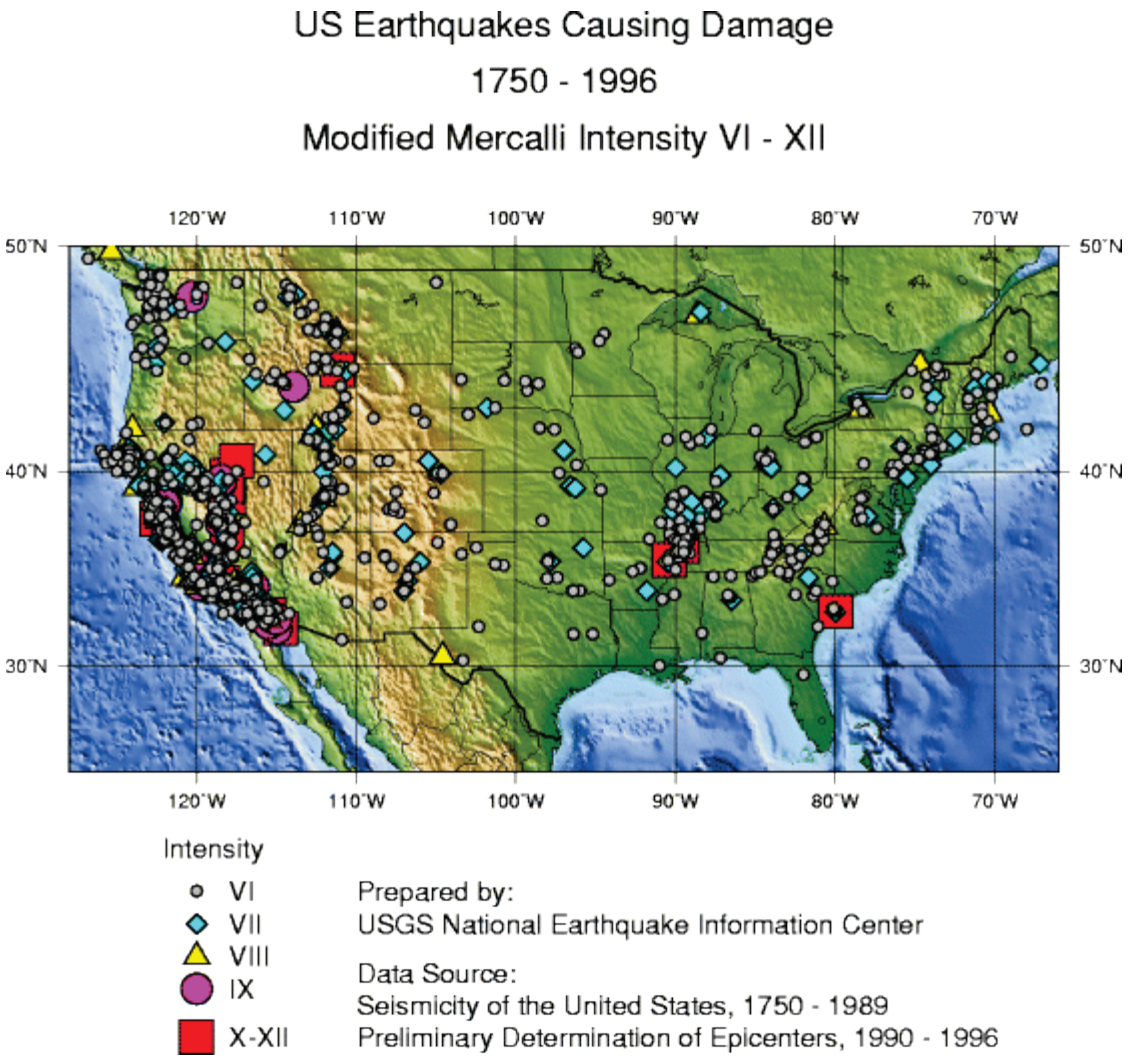
makes functional sense. The U.S. is large geographically and has differences between regions and states due to localized traditions, cultures, population densities and legal concepts. It is important to keep in mind that many state markets are as large or are larger than many foreign countries.

18. Effective consumer protection that focuses on local needs is the hallmark of state insurance regulation. Regulators at the state level understand the needs and special circumstances of consumers and insurers at the local level and are best able to properly address those unique circumstances.

19. Due to geographical differences, states experience unique perils within their individual markets. The following maps show that, depending on the state, catastrophic perils within a region might include any combination of tornadoes, wind, hail and earthquakes. States must focus their regulatory structure differently according to the perils contained within each state.

Wind (Blue), Hail (Green) and Tornadoes (Red)





20. In terms of factors affecting life and health insurance, states differ dramatically in population densities, ratios of urban and rural populations, age distributions, racial makeup and the overall health of the population. These factors make each state unique and call for different regulatory structures and rules.

21. States have chosen to enact different statutory workers compensation laws that determine the amount and forms of compensation to which employees are entitled, based upon that state's own preferences. States differ in laws concerning automobile insurance by enacting their own requirements on minimum levels of liability insurance and whether personal injury protection is mandatory. Each state's own legislature determines the needs in that state and creates requirements based upon that state's citizens.

22. An attempt to create a one-size-fits-all regulatory framework for all functions of regulation (beyond solvency) does not make sense due to the great differences found between regions

and states. This competitive-market framework complements solvency regulation which is a national system of state-based regulation where the regulatory responsibility for insurer solvency monitoring rests with the state insurance regulator.

23. Just as solvency regulation aids the policyholder by ensuring funds are available to pay claims, the existence of a competitive market helps the consumer by ensuring a vibrant, well-functioning efficient market place consisting of available, innovative products.

Section 5

Solvency Modernization Initiative – Future of U.S. Financial Insurance Regulation

1. The Solvency Modernization Initiative (SMI) is a critical examination in our continuous effort to look for improvements in the U.S. insurance financial regulatory framework. The U.S. financial regulatory system, using general authority and exception-based rule setting (vs. a detailed/explicit authority based system), has been utilized for years and has been very effective and successful, without the need for intrusive regulation for financially sound companies.

2. U.S. regulators support improving on an existing and time-tested regulatory framework, where the cost of regulation is reasonable and not excessive, rather than starting from scratch with all new and yet-to-be proven theories.

SMI ROADMAP

3. The SMI critical examination includes an evaluation of lessons learned from the 2007-08 global financial crisis, a focus on meeting the needs of the U.S. marketplace in an increasingly interconnected financial environment, and a review of international developments regarding insurance supervision, banking supervision, and international accounting standards and their potential use in U.S. insurance regulation.

4. Priorities in the SMI include the following:

    a. Create a document articulating the U.S. regulatory system, to communicate to domestic and international audiences.

    b. Examine international developments (accounting, insurance supervision) and their potential use in U.S. insurance regulation.

    c. Comply with International Association of Insurance Supervisors (IAIS) insurance core principles (ICPs) to the full extent appropriate in the U.S. system to aid assessment in the International Monetary Fund's Financial Sector Assessment Program (FSAP).

    d. While the recent financial crisis was not triggered by insurance matters, apply lessons learned from the global financial crisis, especially about group supervision.

5. The SMI focuses on the key components of the solvency framework: capital requirements, governance and risk management, group supervision, statutory accounting and financial reporting, and reinsurance. Our aim is to achieve almost all SMI policy decisions by the end of 2012, with implementation of many changes to follow. For each SMI focus area, the following sections describe what we are doing and why.

STATUTORY ACCOUNTING AND FINANCIAL REPORTING

6. Statutory accounting and regulatory financial reporting are at the core of solvency-based financial monitoring of U.S. insurers. The current statutory accounting model and financial reporting system are the culmination of extensive deliberation beginning with the insurance accounting codification project that became effective in 2001, and the continuous maintenance efforts led by insurance regulators since that time. U.S. Generally Accepted Accounting Principles (GAAP) plays a significant role in the maintenance of the statutory-based accounting model. In recognition of the convergence project underway between U.S. GAAP and International Financial Reporting Standards, the SMI Task Force has identified the statutory accounting model and regulatory financial reporting system as one of its focus areas.

7. The SMI Task Force tasked the International Solvency and Accounting Standards (E) Working Group to consider, among other things, the future of statutory accounting and reporting as a result of the global desire for a single set of high quality accounting and financial reporting standards that can be utilized internationally.

Background on U.S. SAP

8. The NAIC Accounting Practices and Procedures Manual includes the baseline statutory accounting principles (SAP) that insurers use for insurance regulatory financial statements, as modified by the accounting principles or practices prescribed or permitted by an insurer's domiciliary state. SAP is used to determine, at the financial statement date, an insurer's financial condition and its ability to pay claims and other obligations as they come due. Consequently, SAP includes not only accounting principles, but also other aspects designed to prevent or avoid particular solvency related problems. In this respect, it differs from GAAP. Despite this fact, it is important to understand that SAP utilizes the framework established by GAAP. It does this, in part, through the SAP maintenance process, which requires the NAIC to consider new GAAP pronouncements adopted by the Financial Accounting Standards Board (FASB). More specifically, the NAIC must adopt as is, adopt with modification, or reject GAAP once adopted by FASB.

9. Furthermore, the objectives of SAP differ from the objectives of GAAP. GAAP is designed to meet the varying needs of the different users of financial statements, such as investors. SAP is designed to address the concerns of regulators, who are the primary users of statutory financial statements. As a result, GAAP attempts to gauge a company's profitability by matching revenues to expenses, while SAP focuses on an insurer's ability to pay future claims. As an illustration of the difference, SAP expenses acquisition costs as incurred (because those funds are not available to pay claims), yet GAAP capitalizes acquisition costs and expenses them over time to match the revenues earned.

The Path of U.S. GAAP Convergence with IFRS

10. Following the Norwalk Agreement that was signed by both the International Accounting Standards Board (IASB) and the FASB in 2002, there have been numerous changes to GAAP towards convergence with International Financial Reporting Standards (IFRS). The FASB and the IASB have taken on projects with an aim of convergence. Included in these projects was the development of the Joint Conceptual Framework and the Insurance Contracts

project, which started in 1997 when the IASB decided to address accounting for insurance contracts in a two-phase project.

11. The first phase of the insurance contracts project was completed in May 2004 with the issuance of IFRS 4, which make a few restrictions in practice but generally allowed a wide variety of pre-existing insurance accounting practices. During the second phase, the FASB and the IASB have worked to determine the most appropriate accounting practices for insurance contracts. In July 2010, the IASB issued an exposure draft (ED) on the development of a single global comprehensive accounting standard for insurance contracts. The accounting changes set forth in the ED would radically change the presentation and measurement of insurance contracts. In September 2010, the FASB issued a Discussion Paper on the same topic, and although it requested input on the areas that both boards where considering, it also requested specific input on the advantages and disadvantages of pursuing a comprehensive reconsideration of insurance accounting versus more targeted improvements to current GAAP since some of the IASB proposals were similar to current GAAP.

12. The IAIS "considers it is most desirable that the methodologies for calculating items in general purpose financial reports can be used for, or are substantially consistent with, the methodologies used for regulatory reporting purposes, with as few changes as possible to satisfy regulatory requirements. However, the IAIS also recognises that this may not be possible or appropriate in all respects, considering the differing purposes. The IAIS believes it is essential that differences between general purpose financial reports and published regulatory reports are publicly explained and reconciled."[1] This ICP has been adopted by the IAIS, and agreed by the NAIC.

Looking Forward

13. Since the current SAP system requires evaluation of GAAP pronouncements to accept fully, modify, or reject those pronouncements, with no change to process, any convergence of GAAP and IFRS will flow through the SAP process for consideration, and some already have. However, it is likely that regulators will have to either modify the accounting or make adjustments in other parts of the regulatory system so as not to lose a solvency perspective on valuation.

14. One such example would be the introduction of full market consistency to the accounting basis for insurance contracts. At present, due to low market activity, financial assets (e.g., bonds) held by an insurance enterprise would qualify for amortized cost measurement, as it is a long-standing business practice of insurers to match invested assets with liabilities by holding many of those financial assets backing the liabilities, to maturity. With limited market activity, it seems clear and consistent that such assets would be appropriately accounted for at amortized cost. Otherwise, the use of fair value can cause fluctuations within an insurer's financial statements that are inconsistent with the insurance business model; thus reflecting a financial position that does not depict the most relevant information to the user of the financial statements. A concern we would have is that the mere fluctuation in interest rates may require a regulator to put an otherwise financially solvent insurer into receivership.

[1]International Association of Insurance Supervisors (IAIS), Insurance Core Principles (ICP) 14 Application Guidance, 14.0.1

15. Another example is the treatment of short-term contracts and long-term contracts, especially related to discounting. It is our view that discounting on *long-term contracts* is appropriate, but that discounting on *short-term contracts* would have an immaterial effect. More simplistic and less costly calculations could be sufficiently transparent.

16. As part of the SMI, regulators decided to document the following:

    a. The purpose of the regulatory accounting model;

    b. A potential recommendation whether the NAIC should continue to maintain an entire codification of statutory accounting;

    c. A recommendation of whether regulatory financial statements should continue to be utilized for public purposes.

17. A "Primary Considerations Document" was drafted to frame some of these issues, and included within it a continuum of options available to regulators on the policy issue. This document was exposed and discussed at the 2010 Summer National Meeting. Comments varied but some of the more significant comments dealt with: 1) the desire to maintain control and not relinquish it to a third party (IASB); 2) the value of prescribed and permitted practices; 3) the need for rules within the U.S., which is in conflict with the use of principle based accounting for IFRS; and 4) the timing and whether it is too early to make a decision.

18. The IASB and FASB continue to work on the insurance contracts standards. The Securities and Exchange Commission (SEC) is also watching what is transpiring with accounting standards and will decide how statements prepared in accordance with IFRS will be utilized within the U.S. With all of these moving parts, the SMI has placed its decisions related to the future of statutory accounting on hold. It should be noted that in November 2010, the NAIC provided comments to the IAIS and the FASB on the IASBs exposure drafts and the FASBs discussion paper. In general, the comments suggest that the NAIC sees an opportunity for improvement to the proposed insurance contracts standard. A final policy decision by NAIC would be made once the ultimate standard is adopted by the IASB/FASB and would depend on the extent to which the NAIC positions are accepted.

19. However, we are proceeding with the principle-based reserving project where the NAIC is considering the modernization of life and annuity reserves based upon the expected cash flows of those contracts. This is a movement away from formulaic reserves and is not inconsistent with either GAAP or IFRS, but it does deviate from them.

20. The NAIC has adopted a revised Standard Valuation Law (Model #820) and is in the process of drafting a Valuation Manual, which will enable principle-based reserving. At present, an impact study is being performed to determine whether changes should be made to the present draft of the manual. Once that Valuation Manual is adopted, it could become part of state insurance regulation within a couple of years.

21. One outstanding question is how to obtain the data necessary for regulators to judge the appropriateness of the reserves and for smaller companies to be able to credibly perform the reserve calculations. Statistical agent(s) are expected to be utilized to collect necessary information.

22. Similar to the historical approach taken with statutory accounting, the valuation under principles-based reserving would contain some regulatory constraints, or safeguards, that are designed to best serve the regulatory community and provide more specific rules that allow the financial statements to both represent the financial condition of the company and protect consumers.

CORPORATE GOVERNANCE

23. Corporate Governance can be defined as a framework of rules and practices by which a board of directors ensures accountability, fairness and transparency in an insurer's relationship with its stakeholders. In relation to corporate governance, the purpose of the SMI is to review standards and practices of insurers to determine whether improvements need to be made to U.S. regulatory processes.

Background

24. Historically, U.S. insurance regulators have reviewed the corporate governance of prospective insurer's before granting a certificate of authority to write insurance business. This review generally focuses on the background and experience of Directors and Senior Management that will be charged with governing the insurer. On an ongoing basis, a review of an insurer's corporate governance practices is performed during on-site financial examinations. The review of corporate governance during a financial examination has increased significantly as the U.S. moved to a risk-focused examination process beginning in 2007, and the increased review has highlighted deficiencies for many insurers in this area. Examiners have identified problems related to Board oversight, succession planning, lack of formal risk management and a failure to establish independent internal audit functions. These issues are typically dealt with indirectly, as there is not a set of uniform corporate governance standards for insurers within insurance regulation; and there may not be clear authority for regulators to exercise in this area. Consequently, this is an area of solvency regulation where some regulators believe improvements could be made.

25. Improvements have been made to the U.S. regulatory system over the years that consider the corporate governance practices of insurers. The most recent changes were targeted to respond to corporate accounting scandals in the early 2000's. U.S. insurance regulators took action to develop greater corporate governance standards for insurer's related to internal accounting controls for the financial reporting process. These actions took the form of amendments to the NAIC's Annual Financial Reporting Model Regulation, otherwise known as the Model Audit Rule, which went into effect in 2010. The adopted amendments were the result of nearly three years of continued research and discussion by financial regulators, members of industry, public accountants and representatives from trade associations. The revisions primarily dealt with three significant governance areas including external auditor independence, Board audit committee responsibilities and internal controls over financial reporting. Although these changes greatly improved insurance regulation related to corporate governance, the focus of the changes was on financial reporting and did not address many broader governance matters such as risk management.

26. The 2007-08 global financial crisis also led to continued discussions by other regulators regarding the importance of corporate governance and risk management. Although most insurers weathered the crisis, regulators have recognized a need to learn from the governance problems identified in other industries and act before a crisis in risk management directly impacts insurers. Many of the financial supervisors around the world have taken measures to clarify standards and expectations relating to corporate governance and risk management for regulated entities in their respective areas, and U.S. regulators have identified the need to make improvements consistent with what is being done around the world.

27. Other developments in this area relate to the comments received from the recent U.S. participation in the Financial Sector Assessment Program (FSAP), conducted by the International Monetary Fund. The FSAP review of U.S. insurance regulation performed in 2009-2010 was based upon the International Association of Insurance Supervisors' 2003 Insurance Core Principles. The results of the FSAP found that the U.S. largely observed many of the IAIS Principles related to corporate governance and risk management. However, the IMF cited considerations for enhancements in some areas. These recommendations included establishing: (1) specific suitability criteria (e.g. background, experience, etc.) for key persons; (2) requirements in relation to ongoing notifications regarding suitability; (3) additional requirements or guidance for insurers related to good corporate governance practices; (4) requirements for insurers in maintaining an internal audit function; and (5) explicit requirements for insurers in maintaining risk management systems capable of identifying, measuring, assessing, reporting and controlling risks.

Regulatory Action

28. Due to the results of the most recent financial crisis, enhancements recommended through the FSAP, and a move toward principle-based regulation, U.S. regulators have concluded that a greater regulatory focus on corporate governance is required. This led to the formation of the Corporate Governance Working Group in September 2009. Upon its formation, the Working Group received three distinct charges related to its mission.

29. The first charge is to outline high-level corporate governance principles for use in U.S. insurance regulation. To assist in the development of principles, regulators were asked to analyze the requirements, regulatory initiatives and best practices of the states, other countries, other regulators, and the insurance industry. As part of this charge, the Working Group was also asked to determine the appropriate methodology to evaluate adherence with such principles, giving due consideration to development of a model law and to develop additional regulatory guidance including detailed best practices for the corporate governance of insurers.

30. Secondly, the Working Group was asked to review the current IAIS principles and standards related to corporate governance. As part of this review, the Working Group was asked to provide input and drafting to the IAIS Governance and Compliance Subcommittee, and on other IAIS papers as assigned by the parent Task Force. From this work, the Working Group was meant to identify future initiatives to improve our regulatory solvency system. Finally, based upon the results of completing the first two charges, the Working Group was asked to consider the development of insurance regulatory education for Boards, Senior Management and regulators.

31. To begin the process of accomplishing its charges, the Working Group decided to perform a review of existing legislation and case law relating to corporate governance requirements for insurers in the U.S. This project was completed by summarizing the existing corporate governance laws in California, Delaware, Georgia, Illinois, Iowa, Nevada, New York and Texas. In addition, the Working Group studied Rhode Island's recent adoption of corporate governance provisions into its insurance code. The results of the study indicated that existing laws vary significantly from state to state, are generally not very detailed or specific in relation to overseeing the business of insurance, and do not seem to recognize a board of directors' legal duties to policyholders.

32. In addition to reviewing existing corporate governance law in the United States, the Working Group performed a study of corporate governance principles and standards placed upon insurers worldwide by the IAIS, Australia, Canada, Switzerland, and the United Kingdom. The study sought review and input from supervisors from each of these countries on the summarized principles. Working Group members noted that many of the standards and principles adopted in other countries, and included in the IAIS core principles, are not necessarily addressed within the current U.S. insurance regulatory system.

33. After reviewing existing corporate governance law in the United States as well as principles and requirements placed upon insurers in other countries, the Working Group developed a draft of a white paper outlining corporate governance principles for use in U.S. insurance regulation. The White Paper outlines principles that describe high-level standards for an insurer to follow in providing consumer protection and capital adequacy. Guidance supporting the principles is also included to provide detail regarding how an insurer can comply with a specific principle. In developing the principles and guidance in the White Paper, the Working Group was mindful of the recent corporate governance and risk management recommendations provided by the IMF in the FSAP Financial System Stability Assessment and Insurance Detailed Assessment Report. The principles and guidance developed are intended to be utilized by the Working Group as it fulfills its charge to determine what changes may be required to the U.S. insurance regulatory structure in order to evaluate adherence with such principles. Although some of the principles in the White Paper reflect existing legal or regulatory requirements, the paper is not intended on its own to impose any binding legal or regulatory obligations.

34. In addition to the development of a White Paper, and before finalizing work in this area, regulators plan to document an understanding of the existing corporate governance requirements, standards and regulatory monitoring practices that are applied to insurance entities in the United States. This study will provide references to existing requirements, standards and practices within insurance regulation (e.g. NAIC Models, Handbooks, etc.) as well as those outside of insurance regulation (e.g. SEC requirements, corporate law, etc.). After this study is completed, regulators will search for examples of corporate governance deficiencies that are not addressed by the system and represent gaps that need to be filled.

Looking Forward

35. Regulators continue to deliberate on the most effective and efficient means of implementing uniform corporate governance and risk management standards for insurers. The NAIC will continue deliberations in this area and seek additional input from the industry and consumers. However, regulators are committed to providing a uniform set of corporate governance best practices, customized for insurance companies, which can be effectively implemented across the United States.

REINSURANCE

Background

36. The U.S. system takes both a direct and an indirect approach in reinsurance supervision. For U.S. reinsurers licensed in the U.S., the direct approach is applied with similar if not the same regulatory requirements as for primary insurers. The indirect regulation of reinsurance relates to how U.S. primary companies are given statutory credit on their balance sheet for business they transfer via reinsurance. The Credit for Reinsurance laws, statutory accounting requirements and procedures applicable to reinsurance transactions, serve to provide regulators with an effective method of monitoring the reinsurance activities of U.S. companies. While there is nothing to prevent a company from transacting reinsurance business with any other company anywhere in the world, a U.S. ceding company is not permitted to take statutory credit unless such reinsurers meet certain requirements. Essentially, financial statement benefit is allowed for the U.S. insurer for reinsurance ceded to unauthorized insurers only to the extent that amount is appropriately collateralized.

37. The regulatory approach to reinsurance in the U.S. has traditionally been focused on the ceding company's reinsurance arrangements and the specific provisions in its reinsurance agreements. From the regulator's perspective, the overriding concern is with the solvency of the ceding company, the impact of reinsurance on the ceding company's financial condition, and ultimately the financial impact on consumers of insurance products. The basis for this approach is based on a presumption that there exists some relative equality of negotiating leverage between the buyer and seller of reinsurance products.

38. Unrecoverable reinsurance balances have played a critical role in some of the largest insurance company insolvencies in recent years. Due to this high risk, regulators require significant disclosure on reinsurance information, including assumed and ceded reinsurance balances and the aging of reinsurance recoverables by individual counterparty.

Looking Forward

39. The collateral requirements for non-U.S. licensed reinsurers have been a frequent subject of debate over the last few years within the NAIC Reinsurance (E) Task Force. Numerous non-U.S. reinsurers, as well as non-U.S. regulators, have called for elimination of the collateral requirement for reinsurers licensed in well-regulated jurisdictions. In addition, efforts continue internationally to facilitate a more global approach to reinsurance regulation through supervisory recognition of reinsurance supervision. Because insurance supervisors around the world are becoming more familiar with each others' systems and the IMF is implementing its FSAP process to provide some assurance that the systems are functioning well, we are in a better position to be able to consider modifications in our approach to reinsurance supervision.

40. The Reinsurance Regulatory Modernization Framework proposal (Framework) is a conceptual framework that was developed by the Reinsurance Task Force during 2007 & 2008 in response to its charges to consider the current collateralization requirements regarding unauthorized reinsurers, and to consider the design of a revised U.S. reinsurance regulatory framework. The Framework is intended to facilitate cross-border reinsurance transactions and enhance competition within the U.S. market, while ensuring that U.S.

insurers and policyholders are adequately protected against the risk of insolvency. The NAIC adopted the Framework during its 2008 Winter National Meeting.

41. The Framework recommended implementation through federal legislation in order to best preserve and improve state-based regulation of reinsurance, ensure timely and uniform implementation of this legislation throughout all NAIC member jurisdictions, and as a more comprehensive alternative to related federal legislation. The Reinsurance Task Force developed the federal Reinsurance Regulatory Modernization Act of 2009 in an effort to implement the Framework. At that time, Congress was focused on developing financial regulatory reforms within the Dodd-Frank Act. While the Dodd-Frank legislation did contain certain provisions that impact reinsurance regulation, the NAIC's proposed federal legislation was not included.

42. On July 21, 2010, the Dodd-Frank financial reform legislation became law, which includes the Nonadmitted and Reinsurance Reform Act (NRRA), creating the Federal Insurance Office (FIO). The NRRA prohibits a state from denying credit for reinsurance if the domiciliary state of the ceding insurer recognizes such credit and is an NAIC-accredited state. The NRRA preempts the extraterritorial application of state credit for reinsurance law, and would permit states to proceed forward with reinsurance collateral reforms on an individual basis if they are accredited.

43. The Dodd-Frank Act created the FIO to establish insurance expertise at the federal level. The Dodd Frank Act allows the office in Treasury to enter into binding "covered agreements" with international bodies, and preempt a state insurance measure to the extent that it: 1) results in less favorable treatment of a non-U.S. insurer domiciled in a foreign jurisdiction that is subject to a covered agreement than a U.S. insurer domiciled, licensed, admitted, or otherwise authorized in that state; and 2) is inconsistent with such covered agreement. It will be imperative that the FIO coordinate with state regulators in order to preserve the critical link between state-based solvency regulation and the impact that reinsurance has on U.S. insurer solvency.

44. Some states have begun moving forward with individual state-based reinsurance collateral reforms. Florida adopted changes to its credit for reinsurance laws and regulations in 2007 and 2008 respectively, New York adopted similar changes in November 2010, New Jersey and Indiana recently enacted similar legislation, as well. In addition, bills are currently being discussed in Illinois, Texas and Louisiana, as well as other states.

45. In light of these developments, the NAIC Plenary approved Recommendations Regarding Key Elements of the Reinsurance Framework for Accreditation Purposes in December 2010. To clarify, the Recommendations are not a change to the current NAIC accreditation standards regarding reinsurance collateral. However, it will be guidance to the Financial Regulation Standards and Accreditation (F) Committee which may be used when reviewing any individual state reforms to reduce reinsurance collateral that are enacted prior to NAIC adoption of amendments to the model law and regulation and any related changes to the accreditation standards.

46. The Task Force was also given a 2011 charge to consider amendments to the NAIC *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786) to incorporate key elements of the Reinsurance Framework. The Task Force released initial drafts for public comment in February 2011. Following discussion during meetings in March,

July and September, the Task Force and Financial Condition (E) Committee adopted revisions to these models on September 19. The Executive (E) Committee and Plenary adopted the revised models on November 6th, with a few additional amendments made during the meeting. The revisions include potential collateral reduction for reinsurers meeting certain criteria for financial strength and business practices that are domiciled and licensed in a qualified jurisdiction. Other key elements of the revisions include:

- Each state will have the authority to certify reinsurers, or a commissioner has the authority to recognize the certification issued by another NAIC-accredited state. This eliminates the need for a reinsurer to be evaluated by each and every state, but preserves a commissioner's right to do so.

- Reinsurers are subject to certain criteria in order to be eligible for certification, as well as ongoing requirements in order to maintain certification. Examples of evaluation criteria include, but are not limited to, financial strength, timely claims payment history, and the requirement that a reinsurer be domiciled and licensed in a "qualified jurisdiction."

- Each state may evaluate a non-U.S. jurisdiction in order to determine if it is a "qualified jurisdiction." A list of qualified jurisdictions will be published through the NAIC Committee Process. A state must consider this list in its determination of qualified jurisdictions, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justifications for approving this jurisdiction in accordance with the standards for approving qualified jurisdictions contained in the model regulation.

- A certified reinsurer will be eligible for collateral reduction with respect to contracts entered into or renewed subsequent to certification. A state will evaluate a reinsurer that applies for certification, and will assign a rating based on the evaluation. A certified reinsurer will be required to post collateral in an amount that corresponds with its assigned rating (0%, 10%, 20%, 50%, 75% or 100%), in order for a U.S. ceding insurer to be allowed full credit for the reinsurance ceded.

- A state will evaluate a reinsurer that applies for certification, and will assign a rating based on the evaluation. A certified reinsurer will be required to post collateral in an amount that corresponds with its assigned rating (0%, 10%, 20%, 50%, 75% or 100%), in order for a U.S. ceding insurer to be allowed full credit for the reinsurance ceded.

47. The Task Force will now turn its efforts toward: 1) providing guidance to the Financial Regulation Standards and Accreditation (F) Committee with respect to key elements of revised Model #785 and #786 to be considered for the purposes of the Financial Regulation Standards and Accreditation Program; 2) development of reporting instructions for forms CR-F and CR-S applicable to certified reinsurers under the revised Model #785 and Model #786; 3) development of an NAIC committee process to evaluate the reinsurance supervisory systems of non-U.S. jurisdictions, for the purposes of developing and maintaining a list that includes any such jurisdiction that is recommended through the NAIC committee process for recognition by the states as a qualified jurisdiction in accordance with the revised Model #785 and Model #786, under which an assuming insurer licensed and domiciled in a qualified jurisdiction is eligible to be considered for certification by a state as a certified reinsurer; and 4) formation of a new NAIC group to provide advisory support and assistance to the states in the review of reinsurance collateral reduction applications.

GROUP SUPERVISION

Background

48. U.S. state insurance holding company system[2] supervision (group supervision) is heavily influenced by the existing U.S. legal infrastructure, including but not limited to corporate law, insurance law, case/tort law with regard to legal liability (e.g. class action law suits) and receivership and bankruptcy laws. A good example to illustrate how the U.S. legal environment impacts group supervision can be seen by the emphasis placed on the ability to ring fence insurance legal entities and their related assets. Consider the following legalities:

    a. the U.S. receivership and bankruptcy proceedings allow for the separation of legal liability among the legal entities of a holding company system;

    b. holding company structures are permitted to include U.S. based insurers in many different forms with few restrictions;

    c. these holding company systems may include unregulated entities as well as regulated entities, including financial services entities, within the same holding company structure; and

    d. the existing state insurance holding company laws do not differentiate between a group that is local in nature and one that is internationally active.

49. By considering the above, one can draw legal conclusions to reinforce why ring fencing has become an important regulatory tool to safeguard policyholders and other claimants. These same factors have also influenced the "Windows and Walls" approach towards group supervision in the U.S., recognizing the legal distinction between entities by requiring strong "walls" between insurers and other legal entities operating within a group and clear "windows" (e.g. access to books and records) to enhance the understanding of risks, such as financial contagion from affiliated entities, within a group.

50. In the U.S., group supervision and oversight is conducted by state insurance regulators primarily through licensed insurance legal entities resulting from the implementation and execution of uniform insurance holding company laws and regulations. The U.S. system is often described internationally as an indirect approach that relies on exercising supervisory powers through a regulated entity in the group. For example, the U.S. indirect approach provides:

    a. access to information via the parent or other regulated group entities about activities or transactions within the group involving other regulated or non-regulated entities;

    b. consolidated financial information of the ultimate controlling person;

    c. fit and proper requirements;

    d. rights of inspection (examination); and

[2] A holding company system consists of two or more affiliated persons, one or more of which is an insurer. Of the roughly 7,800 insurance legal entities regulated by states, 78% of these are within a holding company system.

e. approval and intervention powers for certain transactions and events involving insurers.

51. Indirect approaches to supervision of non-regulated entities are found to be more common in practice among insurance supervisors in other jurisdictions. The "indirect" approach is in contrast to the "direct" approach (where supervisory approaches may be applicable to some entities in the group directly) or "hybrid" approach described by some jurisdictions. However, a closer review of a few of these jurisdiction's laws and practices would reveal approaches that are more similar to the U.S., as the definition of "group supervision" used by foreign jurisdictions usually is limited to the insurance segment of the respective holding company system, whereas the U.S. state insurance regulators consider group oversight to encompass the entire holding company system. Thus, depending on the legal definition of "group", a non-regulated entity may be within or outside the perimeter of group-wide supervision in a jurisdiction.

U.S. Group Supervisory Framework

52. The supervision of the holding company system is routinely applied using the following mechanisms: reporting requirements, licensing oversight, financial analysis and financial examination review procedures as described below.

State Laws Regarding Insurance Holding Company Systems

53. All states and the District of Columbia have adopted substantially similar language found within the NAIC *Insurance Holding Company System Regulatory Act (Model #440)* ("the Holding Company Act") and its related Regulation (Model #450). These models are required for the Financial Regulation Standards and Accreditation Program purposes. The laws apply directly to insurers and insurance holding companies and indirectly to non-insurance holding companies, but allow states to regulate transactions between insurers and other affiliated entities. The state insurance departments must also be informed of major transactions. For example: investment purchases, reinsurance agreements, management agreements, cost sharing, tax allocation agreements, certain guarantees, intercompany investments, and requests for extra-ordinary dividends.

Supervision Mechanism – Reporting

54. The state laws require annual filings regarding the holding company system and detailing intercompany contract terms, relationships and other financial information. Furthermore, additional holding company financial information is statutorily required through other statutory filings. For example, U.S. state regulators require insurers' completion of the NAIC Annual Statement, which requires various holding company information such as disclosure of affiliated transactions and a detailed organization chart (Schedule Y) to be included in the insurers filings. Overall, the holding company system financial information requests can also be ad hoc by state insurance regulators, as the Holding Company Act provides access to books and records of the holding company system and affiliates.

Supervision Mechanism – Financial Analysis

55. The *NAIC Framework for Insurance Holding Company Analysis* was incorporated into the *NAIC Financial Analysis Handbook* to assist analysts with performing routine analysis on

holding companies. The NAIC *Financial Analysis Handbook* contains an Analyst Reference Guide and Supplemental Procedures, including Form A, Form B, Form D, Form E and Extraordinary Dividend/Distributions procedures, as follows:

a. Holding Company Analysis Level One and Level Two Procedures

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

c. Form B—Insurance Holding Company System Annual Registration Statement

d. Form D—Prior Notice of a Transaction

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

f. Extraordinary Dividend/Distribution

56. As Form A, D, E and Extraordinary Dividend/Distribution are transaction specific, the occurrence frequency of these transactions may vary. The Accreditation Program requires that the state insurance department adequately and timely analyze these transaction specific filings and Form B. The depth and frequency of the analysis performed each year is based on the complexity and financial strength of the holding company system.

57. When there are two or more U.S. domestic insurers within a group, the applicable "Lead state(s)" will coordinate with other domestic supervisors within a group regarding the analysis procedures.

58. Additionally, the Financial Analysis (E) Working Group (FAWG) provides an additional layer of surveillance for insurance groups overall that supplements individual state insurance department's solvency monitoring by performing quarterly analysis on nationally significant groups that exhibit characteristics of trending toward or being financially troubled. The FAWG then works with domiciliary regulators and lead state(s) to assist and advise as to what might be the most appropriate regulatory strategies, methods and actions.

Supervision Mechanism – Examination

59. When multiple insurance legal entities are within the same group, states may also engage in group examinations to maximize resources and create efficiencies. Examination workpapers are typically shared real-time via a server and common software, allowing for timely update of insurer and group risk profiles under the NAIC's risk-focused solvency system.

Looking Forward

60. In response to the 2007-08 global financial crisis, policymakers and international standard setting organizations are taking steps to improve the international financial services regulatory system and encourage coordination among supervisors. The Group Solvency Issues (E) Working Group (GSIWG) reviewed the current U.S. group supervision approach

and is in the process of recommending enhancements where needed. While the current prudential framework has served U.S. policyholders well, the recent events in the global financial markets and the continued evolutionary developments of the insurance industry have challenged U.S. regulators to enhance some aspects of the U.S. framework to ensure that it continues to fulfill its regulatory mission.

61. Key fundamental facts continue to drive the discussion of the most appropriate enhancements. These include the depth of the overall regulatory framework in the U.S.; the legal framework for regulatory action; the protection of policyholders at the entity level and the absence of a clear path to the flow of capital between entities (fungibility of capital) regulated by different jurisdictions when solvency concern for a given entity arises.

62. Essentially, the NAIC is considering incorporating certain prudential benefits of group supervision, providing clearer windows into the risks and overall financial strength embedded in group operations, while building upon the existing walls which provide highest the level of availability of capital resources and, therefore, policyholder protection. Some examples of areas receiving enhancements include enterprise risk, group capital assessment, supervisory colleges, and own risk and solvency assessment.

Enterprise Risk

63. At the heart of the lessons learned from the recent financial crisis was the need for regulators to be able to assess the enterprise risk within a holding company system, evaluating any contagion upon the insurers within that group. In December 2010, the NAIC adopted the modified *Insurance Holding Company System Regulatory Act* (Model #440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (Model #450). The revised models include an expansion on the ability to look at any entity within an insurance holding company system that may or may not affect the holding company system, but could pose reputational risk or financial risk to the insurer through a new Form F – Enterprise Risk Report.

Group Capital Assessment

64. As one of the ways to provide clearer windows into the risks and overall financial strength embedded in group operations, U.S. regulators are proposing group capital assessment, utilizing the insurance group's capital analysis in concert with other information. Notably, the assessment does not establish a group capital requirement in the same sense as the legal-entity RBC requirement. However, the group capital assessment, in combination with the entity-centric legal framework for regulatory action, regulatory restrictions on the movement (fungibility) of capital, strong communication and cooperation between regulators, and other regulatory tools and safeguards, should allow earlier detection of potential financial and reputational contagion on insurance entities within the group or to the group as a whole.

65. A group capital reporting requirement is being created within the Own Risk and Solvency Assessment (or ORSA, see below) reporting requirement. The NAIC's *ORSA Guidance Manual* states the expectation to require a report on the insurer's/group's annual internal capital assessment and describe the supporting key assumptions and techniques underlying the assessment.

Increased Participation in Supervisory Colleges

66. The U.S. state insurance regulators welcome the concept of supervisory colleges[3] as a useful platform to improve supervisory cooperation and coordination between international regulators to discuss insurance companies operating internationally. State regulators both participate in and convene supervisory colleges. U.S. insurance regulators understand and embrace supervisory colleges; states have been conducting a similar process in the U.S. for decades for U.S. insurance legal entities within the same holding company system. The NAIC refers to this process as the "lead state" approach for insurance groups. Regulators adopted best practices, incorporating them in the Financial Analysis Handbook, and are actively monitoring participation in supervisory colleges.

Own Risk and Solvency Assessment

67. The purpose of Own Risk and Solvency Assessment (ORSA) is to require large insurers and/or insurance groups to annually assess and document the adequacy of its risk management and current, and likely future, solvency position. For smaller insurers, in consideration of proportionality, the extensive data reporting and disclosures currently in effect are considered sufficient as ORSA alternatives.

[3] Supervisory colleges are coordination mechanisms between international supervisors intended to foster cooperation, promote common understanding, and facilitate a communication and information exchange regarding insurance companies operating internationally.

CAPITAL REQUIREMENTS

68. Risk-based capital (RBC) is one of the methods used to monitor the capital adequacy of insurers. The RBC calculation is a standardized approach to measuring a minimum amount of capital for an individual insurance company in consideration of its size and risk profile. The RBC provides an elastic means of setting the minimum regulatory capital requirement which reflects the degree of risk taken by the insurer as the primary determinant. The standardized RBC formulas specified by the NAIC are utilized by all of the states.

69. The RBC formula is a factor-based approach, but should be distinguished from simplistic methodologies that are often called factor approaches. The RBC is a detailed calculation performed on a risk-by-risk basis using company-specific data. Modeling is used for some risks where factor approaches were not considered appropriate.

70. The SMI includes a holistic evaluation of the assumptions and methodology supporting the risk-based capital formulas and its use as a solvency tool.

Background

71. RBC work began in the early 1990s to address the deficiencies inherent in simplistic minimum capital and surplus requirements (e.g. a fixed dollar amount such as $1M). These deficiencies did not reflect differences that exist from one company to another, differences such as: the riskiness of one line of business (e.g. auto insurance) compared to another (e.g. workers compensation insurance), the amount of premium volume, the riskiness of the investment portfolio, and many others. RBC was developed as a capital adequacy standard that considers the risks and characteristics of the specific insurer.

72. The RBC formula generates a capital and surplus number, Total Adjusted Capital (TAC), which is compared to four levels: Company Action Level, Regulatory Action Level, Authorized Control Level (ACL) and Mandatory Control Level. The Authorized Control Level is calculated, and the highest trigger points for the other action and control levels are derived from this level: Company Action Level is 200% of ACL, Regulatory Action Level is 150% of ACL, ACL is the third level, and Mandatory Control Level is 70% of ACL. ACL itself is established through many calculations whereby individual risks are multiplied by risk factors to create RBC charges, the RBC charges are segregated into risk components based upon correlation, and a covariance calculation is used to account for the absence of perfect correlation among all risks. The TAC is compared to the four action and control levels, and state statutes include specific actions that must be taken by the insurer and which can be taken by the state insurance regulator. The current RBC formulas also employ trend tests to identify insurers with TAC that is within a range of concern of Company Action Level and exhibit other characteristics (e.g., a Combined Ratio is within a certain range for property/casualty insurers) to require the same actions as a triggered Company Action Level event.

73. It is these statutorily defined and authorized actions that provide the true benefit of RBC. RBC results identify potentially troubled insurers in terms of their capital and surplus compared to the risks assessed in the RBC formula. Notably, state insurance regulators have many analytical tools to identify potentially troubled insurers in a much more targeted fashion, and typically a troubled insurer has already been identified before RBC is triggered. The statutory authority and statutory responsibility to take prescribed actions based on the

RBC results is the unique feature distinguishing RBC from the other analytical tools and oversight processes.

Looking Forward

RBC Usage:

74. The RBC is an effective tool to measure weakly capitalized companies and to require company and regulator action with limited court challenge. RBC will continue to be a final backstop in the financial regulatory oversight process and will be more akin to the IAIS minimum capital requirement (MCR) than the prescribed capital requirement (PCR). Supplementing the RBC, financial oversight will provide the analysis of the company's ability to be a going concern, more akin to the PCR.

RBC Winding-Up or Going Concern:

75. RBC is a calculation of a minimum capital requirement (MCR) and, thus, reflects more of a winding up concern, at least compared to a calculation of going concern where future business would be considered. Going concern and the ability to write new business is evaluated in the financial reporting, examination and analysis process outside of RBC.

RBC Formula or Internal Model:

76. RBC was designed to utilize verifiable data for reliability and ease of verification. RBC is a standardized formula, varying by primary line of business (e.g. life, P&C, health), typically utilizing data disclosed in the insurer's statutory financial statement[4]. This annual financial statement filing must be audited by an independent Certified Public Accountant (CPA) every year, the reserves are opined on by qualified actuaries, and state insurance regulators perform some data checks during their on-site examinations for each domiciliary U.S. insurer. Thus, the RBC formula utilizes a significant amount of standardized data that is subjected to accuracy and completeness checks. This was a conscious decision by the U.S. state insurance regulators, as they wanted the RBC results to be reliable and easily verified.

77. However, in some instances where a factor-based method was not considered to adequately capture the risk, regulators introduced modeling approaches to replace or supplement a factor-based approach for the particular risk or risks. The life RBC formula has already been updated to include some stochastic modeling in the RBC charge calculation for certain annuity products ("C-3 Phase 2 – interest rate and market risk – for variable annuity guarantees), and more work is underway to expand the use of models to other life insurance products as appropriate and to catastrophe risk for property/casualty RBC.

78. Regulators have concern with a system that fully replaces a formula-based method with a company's internal model because of higher cost, less comparability of results, and introduction of the potential for competitive advantages. Given the focus on RBC to measure winding up more than going concern, the SMI regulators believe the use of internal models does not currently add enough benefits to outweigh the costs.

[4] The statutory financial statement is a uniform template adopted by the NAIC, known as the NAIC blank, and used by all insurers of a similar business type. The blank is filed with the NAIC and the state regulator. The insurers are also subject to a codified body of statutory accounting guidance that serves as the baseline requirement for all U.S. regulated insurers, and this includes uniform definitions of asset and investment types. By statute, the NAIC blank requires a significant amount of data and information from the insurers for the statutory annual statement.

RBC Measurement: Missing Risks

79. RBC is not the only safety mechanism for unexpected changes in valuation or unexpected losses. The underlying statutory accounting is performed on a conservative basis, which provides for some safety in the valuation before those values even enter into the RBC formula.

80. The RBC then aims to capture each significant risk for each particular insurance type. Some of the major general risk categories in the RBC formula include asset risk, insurance/underwriting risk, credit risk, interest rate risk and business risk. Some risks may not have been included in the RBC formulas because they were not considered to be significant or were overly complex to quantify or not quantifiable. Focus on RBC in the SMI has been about ensuring the formulas are capturing all material risks. Going forward, we are developing an explicit catastrophe risk charge for inclusion in the property/casualty RBC formula (and removing the current charges out of other risk calculations). We are also reviewing the credit risk calculation to improve the accuracy. At present, the NAIC is reviewing the asset risk factors, categories and designations based on historical default experience.

81. Operational risk is not explicitly identified in the RBC calculation, but could, arguably, be partially included via other calculations and the conservatism included in the accounting rules. Operational risk will be a subject expected to be discussed in the Own Risk and Solvency Assessment.

RBC Correlation

82. Risk charges are currently combined within a square root formula, under the assumption that particular risks are either fully correlated or uncorrelated. Some international methodologies are developed to apply risk matrices in their capital requirement calculations. At present, it can be argued that significant judgment was used to arrive at risk matrices. Regulators are investigating the application of correlations as a potential improvement over the current RBC square root formula.

83. Additional elements in the RBC formula address concentrations, correlations, and diversification. Examples include the bond formula and the property/casualty business line diversification adjustment.

RBC Safety Level and Time Horizon

84. Internationally there has been significant discussion about the appropriate statistical safety level and time horizon for capital requirements. At present the best practice seems to be implementation of a safety level for those risks where credible loss distributions are available and the use of judgment otherwise. Thus, no over-all determination of statistical safety is sufficiently credible at present. The U.S. has, thus, preferred an approach of calibrating the individual risk components and then verifying that the overall capital is appropriate, based on financial analysis and market knowledge. We believe this is consistent with practice in other jurisdictions.

85. Time horizons have been selected for each individual risk where data was available. The time horizons selected vary by risk. According to the American Academy of Actuaries, the time

horizon for individual factors in the life insurance RBC has been consistent with the time period where risks could cause rapid deterioration in statutory solvency. For example, bonds were modeled over ten years, the industry average time-to-maturity, and mortgages were modeled to their maturity with a portfolio average time to maturity of seven years[5].

RBC: Other Changes

86. Numerous other changes are being contemplated to RBC, ranging from public disclosure of company-specific RBC calculations to re-evaluation of the thresholds for the action and control levels. The SMI Roadmap will continue to be updated as we investigate these other changes.

[5] American Academy of Actuaries (AAA), http://www.actuary.org/pdf/life/American_Academy_of_Actuaries_SMI_RBC-Report.pdf