An Overview of Solvency Regulation in the United States

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DEDICATION

This book is dedicated to the memory of Vincent B. Vaccarello, the founder of the Financial Examiners Education Foundation which was originally known as the Society of Financial Examiners Foundation, and Morty Mann who was a Director and Officer of the Foundation when it was created in 1981.

FINANCIAL EXAMINERS EDUCATION FOUNDATION

The Financial Examiners Foundation is a non-profit 501(c) (3) qualified under the Internal revenue Code and is dedicated to providing research and educational opportunities for state insurance regulators involved in solvency regulation in the insurance industry in the United States. All proceeds from this sale of this book to others outside of state government will be used by the Foundation to further its mission.

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PREFACE

The Financial Examiners Educational Foundation and the Center for Executive Education at the Peter J. Tobin College of Business and St. John's University are pleased to offer this paper on solvency regulation. While we designed the paper for new insurance commissioners, others in regulation or in the insurance industry may find it of value.

This course introduces a new insurance commissioner to key considerations and aspects of insurance company solvency regulation in the United States. Solvency regulation is a complex subject, comprising elements that involve actuarial science, finance, accounting and reporting, risk management, administrative law, and other technical subjects. But as Justice Frankfurter once said when commenting on the traits of a new insurance commissioner, these skills do not have to be "on top but on tap," noting that a new insurance commissioner often comes to the job with none of these professional skills.

The course consists of two parts. The first part will be available to insurance department regulatory staff, insurance company personnel, agents, brokers, and others who would like to obtain a basic understanding of solvency regulation. The second part is available to only insurance commissioners and contains some suggestions in solvency regulation for their consideration.

For this course we use the term 'insurance commissioner' as a universal term, including 'insurance superintendent' and 'insurance director' used in some states.

Finally, solvency regulation in the U.S. is not stagnant. It is ever changing in response to problems that arise. This course presents an overview of the system that exists as of the fall, 2020.

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PART ONE

Introduction

The objective of the course is to give the course taker a fundamental grasp of the elements of solvency regulation. The insurance industry and its regulators speak using a lot of technical jargon and language, which we tried to avoid to the extent feasible. As time goes on, you will become familiar with this language and jargon and the many acronyms in use. We appreciate that many participants in this course will have an interest in not only the current system but its history. So, throughout the text, that history is set forth.

The course begins with brief descriptions of the role of the insurance commissioner. Next, the objectives of regulatory functions and their importance are explained.

The state system of insurance regulation, which has survived since the mid-1800s, has an interesting history which is covered under the caption of 'Foundations of Solvency Regulation.' Next, an important part of the state regulatory system, the National Association of Insurance Commissioners (NAIC), is explained as well as some of its important activities.

Insurance commissioners have a lot of power, authority, and surveillance tools to effectively execute solvency regulation and monitor insurers. Some major ones are identified and explained in the following section.

The next section covers the subject of intervention when an insurer encounters financial difficulty and becomes subject to administrative or receivership proceedings.

Next, insurance company failures are briefly discussed. While these are an unavoidable part of our system, historically the number of failures has been very low. A 2003 report issued by The Council of Insurance Agents and Brokers cites the conclusions of an earlier 1988 report, which are: "The regulatory mission is not to ultimately prevent insolvencies—they are inevitable—but to minimize the public harm from insolvencies. Minimizing harm means taking troubled companies out of the market promptly." Therefore, we should see solvency maintenance as an active and dynamic process of ensuring consumer protection and maintaining a healthy market.

The state system is in place to protect and pay the claims of policyholders and others of a failed insurer as described next.

The history and description of the International Association of Insurance Supervisors is next discussed. This is the only international organization of government officials concerned with insurance regulation.

The Dodd-Frank federal legislation brought parts of the federal government into the arena of insurance regulations. A brief overview is presented.

It is important to observe that solvency regulation is continually being enhanced and improved so a brief history of this historical development is included next. It is often heard that predecessors lived in a simpler time implying that they did not face the challenges present commissioners confront. Be aware that your forerunners faced difficult problems and did some remarkable things. The enhancements noted were done without the large NAIC staff and other resources that have existed in the last decade or so.

Lastly, once you complete the course you will be given an opportunity to test your comprehension of the key parts of the course through a series of review questions.

The Role of the Insurance Commissioner

There was a period in the history of insurance regulation when there were insurance laws but no insurance regulation. The laws were enforced like any other laws by methods then available.

As the insurance business grew and expanded and insurance laws became more explicit and technical, a government agency was needed to ensure that insurers followed the law and to initiate corrective action if they did not. A government official was put in charge of that agency. Insurance departments have existed in every state for well over a century. These agencies are staffed with qualified experts and have exclusive responsibility for the implementation and enforcement of the insurance laws.

Most commissioners are appointed by the governor for a set term or employed at-will, subject to legislation confirmation. Twelve states elect their insurance commissioner. Which system produces the most effective regulations is open to debate. At one time, Colorado had a civil service commissioner—the only one to exist.

Some commissioners head a department of insurance regulation, which is a part of a large government agency with a variety of government responsibilities. This comes from a movement in the late 1960s and early 1970s to create a super agency by consolidating several agencies, in

part, on the assumption this would save money. The importance of insurance supervision would seem to indicate that the insurance commissioner should be directly responsible to the governor and legislators, and not another agency head.

In most states, the insurance commissioner wears two hats; a regulator of the insurance industry and statutory receiver of insurers placed in delinquency proceedings. As a regulator, the commissioner is responsible to the insurance-buying public. As receiver, the commissioner is in a proprietary role responsible only to policyholders, claimants, and the creditors of the insurer in receivership.

The insurance commissioner's role is not only to oversee and manage the insurance department staff, but to enforce and execute all the insurance laws of the state, using the exclusive authority, rights, powers, and duties of the position. The commissioner has the general power to:

- Make reasonable rules and regulations as may be necessary for making effective insurance laws.
- Conduct investigations to determine whether a person has violated the insurance laws.
- Conduct examinations, investigations, and hearings as may be necessary and proper for the efficient administration of the insurance laws.
- Institute actions and proceedings to enforce the insurance laws.

Later in this course, we will cover some specific provisions and authorities of the insurance commissioner as it relates to solvency regulation.

Of course, an insurance commissioner's authorities and responsibilities are not limited to solvency regulation and allied activities. Other traditional regulatory activities may include insurance rate approvals, approval of policy forms, licensing of insurance intermediaries, market conduct surveillance, and handling consumer complaints.

To be sure, insurance commissioners have taken on other tasks, such as consumer education and assistance, but it is important that a commissioner discharge effectively statutory obligations of the office before ancillary activities are undertaken. No other person in state government can perform these duties.

Regulatory Functions-Purpose & Basis

Insurance regulatory functions can be divided into two fundamental areas: (1) financial or solvency regulation and (2) market regulation. Protecting policyholders and society against excessive insurer insolvency risk is the traditional and primary goal of insurance regulation. Therefore, it is important that a new insurance commissioner understand not only the various aspects of solvency regulation but also the rationale for regulating the insurance industry, specifically from a solvency standpoint. Also, while there are two distinct areas of regulation, it is important that information is coordinated between both units.

In the section that follows, there is an explanation of the history of state regulation and important court decisions which establish that regulating the business of insurance belongs to the states. In these cases, and others, the United States Supreme Court and lower courts have long recognized insurance is business coupled with a public interest. These court decisions have long held that insurance is pervasive in its influence, and insurance failures can affect persons other than those directly involved in the transactions. An insolvency event can be devastating for an insured and their beneficiaries. Further, it has been found that since individuals and businesses purchase insurance to protect against financial loss at a later date; it is important to the public welfare that the insurer promising indemnification of its insured for future losses be able to fulfill its promises. Because the interests protected by insurance are so important—retirement benefits, medical treatments, and providing for dependents—the industry must be regulated in the interest and welfare of the public.

The states use their inherent policing power to impose restrictions on the insurance industry that are necessary to promote the public welfare and protect the public interest. Such power is conferred upon the states by the Tenth Amendment of the United States Constitution, which is subject to due process considerations.

The ‘public interest’ rationale for regulation also recognizes that the insurance industry holds vast amounts of money in trust for the public and should be regulated because of its fiduciary character. As discussed in the section on ‘Powers and Authorities’, the fiduciary nature of insurance and the substantial influence of insurance on society demand regulation of various aspects of an insurer’s operation, such as investment practices, reserving entry into new insurance markets, maintaining minimum capital and surplus levels, and many other regulations related to solvency. There are many other reasons for regulation, including the complexity of insurance and the inability of consumers to understand and assess an insurer’s present and future financial condition.

The invested with 'public interest' rationale also justifies the other fundamental part of regulation—market regulation. This area includes three primary segments of regulation: (1) insurance rates and products, (2) treatment of policyholders and claimants, and (3) licensing of agents and brokers. As will be later discussed, while solvency regulation is for all practical purposes uniform in every state within the United States, market regulation varies from state to state because of political, social, and economic differences and other local influences and factors. Another variation is that in the case of solvency regulation, the state of incorporation (domestic state) of the insurer is primarily responsible for conducting financial regulations; however, in case of market regulation, an insurer is subject to the requirements in each state it does business.

While the domestic state is primarily responsible for solvency regulation, other states in which the insurer does business (foreign states) do monitor the financial condition and operations of all licensed insurers. This dual layer of monitoring is but one strength of the state regulatory system.

When an insurer is found to be troubled or in hazardous financial condition, the regulation of the domestic state is primarily responsible for intervention to address the situation. This may include receivership proceedings. As will be discussed later, the NAIC has two working groups that coordinate regulatory activity with respect to nationally significant insurers that are troubled or subject to receivership proceedings.

In conclusion, a critical element of solvency regulation is early detection of insurance carriers having financial difficulty, so that corrective action can be instituted or the insurer is removed from the marketplace as early as possible to minimize losses to consumers and others, including the insurance industry that picks up, in large part, the cost of an insolvency through state insurance guaranty fund assessment.

Foundations of Solvency Regulation

Two overriding principles of insurance solvency regulation and insurance regulation in the United States are: (1) regulation takes place primarily at the corporate entity level, not the group level and (2) regulation of insurance is performed at the state, not the federal level. Both rules have exceptions but are generally present throughout the history of insurance in the United States.

Both principles can be traced to early state departments of insurance formed in the mid-nineteenth century, but the roots are firmly planted in the United States Supreme Court's ruling in *Paul v. Virginia,* 75 U.S. 168 (1869). Justice Stephen Field wrote the opinion, and there is no

evidence in the record of dissent. Justice Field was a colorful character who left New England for California to join the Gold Rush and rose in politics until he became Chief Justice of the California Supreme Court. President Lincoln appointed Field to the newly created tenth seat on the United States Supreme Court in 1863. Although the U.S. Supreme Court returned to the current nine justices in 1865 with the death of Justice John Catron, Field went on to serve until 1897, a record at the time.

When Field penned the *Paul* opinion in 1868, the country was still in crisis. The Civil War was over, but Union troops still occupied the decimated former Confederate states. Andrew Johnson, a southern Democrat who had become President of the United States upon Abraham Lincoln's assassination, faced enormous resistance from the Republican-led Congress (which impeached him and shrank the Supreme Court to prevent Johnson from appointing any new justices). Although Field uses the word "state," Virginia would not be readmitted to the Union for more than a year after his opinion was written.

Against that backdrop, Mr. Samuel Paul wanted to sell insurance policies issued by New York insurance companies in the state of Virginia. Field does not say if Paul was a carpetbagger in search of riches in the former Confederacy, but it seems a possibility. Virginia had recently passed two laws, one requiring that insurers wishing to sell policies in Virginia post Virginia state bonds with the Virginia state treasurer, and the second requiring agents of out-of-state insurance companies to obtain a license and register as an agent of the insurance companies represented. Paul was happy to get a license and pay a license tax but refused Virginia's requirement that the insurers post Virginia bonds with the Virginia state treasurer.

When Virginia fined Paul $50 for selling without meeting the requirements, he turned to the courts for relief. He made two main arguments; first, that the Privileges and Immunities Clause of the Constitution protects the insurers' right to do business in various states, and second, that the Commerce Clause of the Constitution prevents states from regulating interstate commerce.

Justice Field began with the Privileges and Immunities Clause, which provides that "the citizens of each State shall be entitled to all the privileges and immunities of citizens in the several States." First, he found that a corporation is not a "citizen" within the meaning of the Privileges and Immunities Clause and only has a legal existence in the state that created it. He seemed to fear that states would not give rights to their own corporations if they were forced to give those rights to "intruding" corporations from other states. Field then went on to hold that the Privileges and Immunities Clause only secures rights for the traveler, equal to those living in the state where

the traveler arrived "on the same footing with citizens of other states," not the rights available in the traveler's home state.

Next, Field took on the Commerce Clause, which empowers Congress to, "regulate commerce among the several states." Field found that Congress had no business with insurance since, "insurance is not a transaction of commerce." Rather, "the policies are simple contracts of indemnity against loss by fire, entered into between corporations and the assured, for consideration paid by the latter. These contracts are not articles of commerce in any proper meaning of the word."

In Field's view, insurance was neither commerce nor interstate commerce within the jurisdiction of Congress. Under the Commerce Clause, "such contracts are not inter-state transactions, though the parties may be domiciled in different states." Instead, "They are, then, local transactions and governed by the local law." The states, not Congress, could regulate insurance. This, combined with the weak extraterritoriality of corporations, became the foundation upon which state (not federal) regulation of insurance entities (not corporate families) was built.

For the next 75 years, insurance was a business only states could regulate. The passages of the Sherman Act, Clayton Act, and Federal Trade Commission (FTC) Act, designed to regulate monopoly and anticompetitive consolidation, did not apply to the insurance industry because insurance was not interstate commerce.

Then came the South-Eastern Underwriters Association (S.E.U.A.), which was alleged to have abused the market power of 200 insurance companies to fix and maintain premium rates and monopolize commerce in six southern states (ironically, including Virginia). Their conduct was egregious as the Court explains by reciting the indictment:

> The indictment made against The Southeastern Underwriters Association makes the following charges: The member companies of S.E.U.A. controlled 90 per cent of the fire insurance and 'allied lines' sold by stock fire insurance companies in the six states where the conspiracies were consummated. Both conspiracies consisted of a continuing agreement and concert of action effectuated through S.E.U.A. The conspirators not only fixed premium rates and agents' commissions, but employed boycotts together with other types of coercion and intimidation to force non-member insurance companies into the conspiracies, and to compel persons who needed insurance to buy only from S.E.U.A. members on S.E.U.A. terms. Companies that were not members of S.E.U.A. were cut off from the

> opportunity to reinsure their risks, and their services and facilities were disparaged; independent sales agencies who defiantly represented non-S.E.U.A. companies were punished by a withdrawal of the right to represent the members of S.E.U.A.; and persons needing insurance, who purchased from non-S.E.U.A. companies, were threatened with boycotts and withdrawal of all patronage.

United States v. South-Eastern Underwriters Assn., 322 U.S. 533, 535-36 (1944) (footnote omitted).

The federal government's patience with this conduct was exhausted, and they determined to stop the conduct on antitrust grounds. However, the district court held that "the business of insurance is not commerce, either intrastate or interstate" 51 F. Supp. 712, 713 (N.D. GA 1943) and dismissed the indictment. The United States Supreme Court took a direct appeal. Justice (and former senator from Alabama) Hugo Black wrote the majority opinion on behalf of himself and three other justices over three dissents (two justices did not participate). Black concluded that "The modern insurance business holds a commanding position in the trade and commerce of our Nation." Black felt that he could not strike down a statute passed by Congress or limit its effects because the subject matter included insurance. Always a traditionalist, Black grounds this conclusion in a statement of Alexander Hamilton and references to the Federalist Papers. Just because insurance contracts might be local in nature, the business of insurance crosses state lines. Black concluded, "No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance." After 75 years, insurance was commerce. Black continued that the antitrust laws, including the Sherman Act, must also apply to insurance.

The United States had been at war for over three years in June 1944 when the Supreme Court released the opinion. The war consumed the nation for over a year afterward. The three dissenters focused on the long history of insurance being a state-governed industry. Although the war is never mentioned in either the majority or dissenting opinions, Justice Jackson, former Attorney General and no friend of Black's, asked, "Why now?" "To use my office, *at a time like this*, and with so little justification in necessity, to dislocate the functions and revenues of the states and to catapult Congress into immediate and undivided responsibility for supervision of the nation's insurance businesses is more than I can reconcile with my view of the function of this Court in our society." *United States v. South-Eastern Underwriters* 322 U.S. 533, 594 (opinion of Jackson, J. dissenting, emphasis added).

Now, in the middle of World War II, Congress was faced with determining its role regarding the business of insurance. On March 9, 1945, with the war still raging, Congress passed the McCarran Ferguson Act, affirming the primacy of the states in insurance regulation and assuring that no federal statute would "invalidate, impair or supersede" state law regulating the business of insurance unless the federal law was specifically directed toward insurance.

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, that after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.15 U.S. Code §1012(b)

Although Congress would pass legislation directly concerning insurance, including the Gramm Leach Bliley Act, the Dodd Frank Act and the Affordable Care Act, federal laws of broad application, such as the antitrust laws or the Bankruptcy Code, are "reverse pre-empted" by state laws regulating insurance. This turns the usual rules of preemption granted by the Supremacy Clause of the Constitution (acts of Congress are "the Supreme Law of the Land") upside down. The states would govern unless Congress deliberately stated its intent to regulate insurance.

In two great times of national crisis, Reconstruction and World War II, first the Supreme Court and then the Congress turned insurance regulation over to the states, and the states continued to be left with the responsibility of regulating the solvency of insurance companies. The tradition of regulating individual corporate insurance entities instead of corporate families was also fully developed.

Although the precedent is thin, the United States Supreme Court has provided some ground rules for when the McCarran Ferguson Act can be employed to reverse the usual rule of preemption to allow state law to trump a federal law of broad application (often called "reverse preemption") when normally federal law would take precedence. In *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 99 S.Ct. 1067 (1979) and *Union Labor Life Ins. Co. v. Pireno* 458 U.S. 119, 102 S.Ct. 3002 (1982), the court formulated a three-part test to determine if a business practice and the state law regulating it are part of the "business of insurance."

> *First*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Union Labor Life Ins. Co. v. Pireno 458 U.S. 119, 129, 102 S.Ct. 3002, 3009 (1982).
A decade later, the Supreme Court would conclude that a state statute could be parsed, and only part of the statute granted reverse preemption over federal law if the state law is "reasonably necessary to further the goal of protecting policyholders." *U.S. Dept. of Treasury v. Fabe,* 508 U.S. 491, 510, 113 S.Ct. 2202, 2212 (1993). Within those guideposts, the business of insurance belongs to the states to regulate insurance company solvency.

Life insurance became a product in the mid-1800s that stimulated many individuals to purchase insurance for the first time. In an era of unregulated capitalism marketing excesses occurred, little attention was paid to reserves, and underwriting was weak. As a result, the financial condition of many life insurers was shaky at best. During the financial recession of 1870, many life insurance companies failed. In the next section the NAIC will be discussed, which was not coincidentally formed in this turbulent time.

Concern about life insurance reserves mobilized Elizur Wright to lobby the legislature in Massachusetts to create regulations over the life insurance industry, particularly, and other insurers as well. He has become known as the father of insurance regulation in the U.S. Wright's efforts resulted in an invigorated life insurance industry in the 1870s.

At the turn of the century in 1900, consumer protection became a serious issue nationally. In 1906, the Armstrong Committee, formed by the New York legislature, released its report. This report urged a series of reforms in the insurance law in New York. These changes covered most operations of life insurance—governance, investments, political contributions, standard policy forms, and controls to limit growth. The Armstrong Committee's reforms had far-reaching effects since many states passed similar reforms. Henry D. Appleton, New York Insurance Superintendent at the time, created a rule that prohibited life insurance companies not domiciled in New York from conducting business in New York unless they substantially complied with New York law. It became known as the 'Appleton Rule.' Since the New York insurance market was large, few insurers were willing to forego that market.

The result of the Appleton Rule was that most insurance contracts were regulated by New York law in every state. The Rule was not popular with other insurance commissioners. Over the years, the impact of this Rule has been lessened. Insurers have created New York subsidiaries that do business only in that state or ceased doing business in New York.

The history of insurance business and its regulation is an interesting subject. We hope that the above brief discussion of some of its history will stimulate further reading and research. Such study of the past will help formulate the future in the best interest of all stakeholders.

The National Association of Insurance Commissioners and Its Role

History and Overview

The insurance regulatory structure existing in the U.S. today is the result of numerous historical developments. State regulation of the business of insurance commenced with the incorporation of stock insurance companies after ratification of the proposed United States constitution by the thirteen states in 1788. Corporate insurance company charters placed restrictions on the companies in the form of types of permitted investments, minimum capitalization, and required reserves and public financial reports.

State oversight was extremely limited until the New Hampshire General Court in 1851 created the first Board of Insurance Commissioners with authority to examine the financial records of all insurance companies. New Hampshire's lead was followed shortly by Massachusetts, Vermont, and New York. Two decades later, the industry and regulators alike quickly realized that since insurance is a national business and companies do business in many states, it would be necessary to find a way to integrate the regulatory processes of the several states.

On May 24, 1871, only six years after the end of the Civil War, the chief insurance regulators of 19 of the 36 states gathered in New York City for the first meeting of the organization that would become known as the National Association of Insurance Commissioners (NAIC). Uniform financial reporting by insurance companies was one of the first major steps taken by the NAIC to address the challenge of overseeing insurers doing multistate business.

Over the years since then, the NAIC has played a fundamental role in the regulation of the insurance industry. It has become a way for insurance commissioners to pool scarce resources, discuss issues of common concern, and align their oversight of the industry with increasingly new levels of expertise in data collection and greater technological capability. The NAIC's members are the elected or appointed chief insurance regulators, along with their departments and staff of each state, the District of Columbia, and the five U.S. territories. While the NAIC deals with insurance regulatory matters and makes highly influential recommendations

to the U.S. insurance industry, it does not actually regulate. Each state is responsible for regulating within its jurisdiction.

The NAIC is a nongovernmental entity and is an Internal Revenue Code section 501(c)(3) nonprofit organization.

Today, the NAIC describes itself as "the U.S. standard setting and regulatory support organization created by and governed by the chief insurance regulators from the 50 states, the District of Columbia and the five U.S. Territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. The NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S."

The NAIC website further states,

> "The mission of the NAIC is to assist the state insurance regulators, individually and collectively, in serving the public interest and achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost effective manner, consistent with the wishes of its members.
>
> ***Protect the public interest;***
> ***Promote competitive markets;***
> ***Facilitate the fair and equitable treatment of insurance consumers;***
> ***Promote the reliability, solvency and financial solidity of insurance institutions; and***
> ***Support and improve state regulation of insurance."***

From the beginning, the NAIC's work product reflected the importance of uniform regulation of national carriers. Today, through its many committees, task forces, and working groups, the NAIC serves as a forum for the creation of model laws and regulations. It is up to each state to decide whether to adopt each model, and, in many cases, a state may make changes to the model in the enactment process. The NAIC also acts at the national level to advance laws and polices supported by state insurance regulators.

Members of state insurance departments, NAIC staff, and insurance industry representatives meet at three national meetings each year to learn NAIC initiatives and emerging regulatory issues. The work of all committees, task forces, and working groups are recorded and

made available through the NAIC website. Following each national meeting, the official proceedings of the NAIC is published as a permanent record of all NAIC actions, including model laws and regulations, with the current and some archival issues of the proceedings available for download in PDF format on the NAIC Publications Department website.

State regulators can achieve efficiencies by pooling resources through the centralized facilities provided by the NAIC. It is much more efficient to have one central repository of insurer financial data than for every department to capture the same data from the same insurers as was done at a point of time. The NAIC has a staff of over 400 and an annual budget in excess of $100 million. Almost half of NAIC revenues come from database fees paid by insurers, with most of the balance coming from the sale of database products, publications, and conference registration fees. Insurance departments also pay a nominal fee to the NAIC proportionate to the premiums written in their jurisdictions.

The NAIC supports state regulatory efforts in several ways, including:

- Maintaining an extensive insurance database and computer network linking all insurance departments.
- Analyzing and informing regulators as to the financial condition of insurance companies.
- Coordinating examinations and regulatory actions with respect to troubled companies.
- Establishing and certifying states' compliance with minimum financial regulation standards.
- Providing financial, reinsurance, actuarial, legal, computer, and economic expertise to insurance departments.
- Assigning credit quality designations and valuing securities held by insurers.
- Analyzing and listing non-admitted alien insurers.
- Developing uniform statutory financial statements and accounting rules for insurers.
- Conducting education and training programs for insurance department staff.
- Developing model laws and coordinating regulatory policy on significant insurance issues.
- Conducting research and providing information on insurance and its regulation to state and federal officials and the public.

The NAIC's Securities Valuation Office (SVO), based in New York City, determines uniform accounting values and credit quality designations of insurers' investments, which include government, municipal, corporate, and structured bonds; and common and preferred

stocks. A separate rating organization for insurer securities was established because many of them are private placements that were not rated by the public rating agencies when the SVO was created in the early 1900s.

Financial Analysis Working Group (FAWG) and Receivership Financial Analysis Working Group (RFAWG)

It is important to highlight two NAIC working groups—FAWG and RFAWG—which have unique and important responsibilities amongst the multitude of NAIC committees, task forces, and working groups. These working groups are exceptional because they result in peer review of the domiciliary state's regulatory actions concerning a potentially troubled insurer. FAWG examines the analysis performed by the NAIC's Financial Analysis Division of companies identified for further study. For these insurers, FAWG questions the domiciliary state on aspects of the insurer's financial condition and actions taken. If FAWG determines that the home state regulator has taken appropriate action, then FAWG may close the file or continue to monitor the insurer. If FAWG determines that further measures are needed, it will recommend the appropriate corrective action to the domiciliary state. If the home state does not follow FAWG's recommendations, FAWG will alert other states and coordinate their action against the troubled company.

This peer review process can apply substantial pressure on the domiciliary state. Also, it forces the home state to consider the interests of all states in which an insurer transacts business and not just the particular concerns of the domiciliary state.

The membership of FAWG consists of career senior regulators from the various states. The collective resources and expertise of the various insurance departments are coordinated and focused on a troubled company through this process. This peer review mechanism is one of the inherent strengths of the state insurance regulatory system.

RFAWG performs a similar peer review function except its focus is companies in receivership. RFAWG consists of state insurance department receivership personnel with expertise and experience in administering receivership proceedings. Again, the objective is to ensure that the receiver of the domiciliary state is effectively and efficiently conducting the receivership in the interests of policyholders and claimant wherever located.

Financial Regulation Standards and Accreditation Program

As noted earlier, insurance regulation has evolved over the years in response to changes in the industry and its economic and financial environment. In the late 1980s, a wave of

regulatory reforms began that were primarily aimed at strengthening solvency regulation. A dramatic rise in the number and cost of property-liability and life-health insurer insolvencies in the mid-1980s led to a Congressional investigation and a report, "Failed Promises," that highlighted weaknesses in state-based regulation. Regulators reacted by working to adopt improvements to existing methods and policies for solvency regulation, which included risk-based capital standards, enhancements to the early warning systems, improved examination procedures, the codification of statutory accounting principles, and the development of the Financial Regulation Standards and an accreditation program for certifying the adequacy of each state's solvency regulation. Their hope was to define what constitutes an effective scheme of solvency regulation and to strengthen solvency regulation through the use of regulatory tools.

Regulators recognized the need for adequate statutory and administrative authority to oversee an insurer's corporate and financial affairs, as well as resources to carry out their authority. Just as important, regulators required organizational and personnel practices designed for effective oversight.

After much deliberation, the NAIC established in June 1989, the Financial Regulation Standards it believed would assist state insurance departments and strengthen solvency regulation. The purpose of the Financial Regulation Standards and accreditation program for state insurance departments was to meet minimum, baseline standards of solvency regulation, especially with respect to regulation of multistate insurers. The emphasis in the accreditation program and the processes it created 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.

To provide the states with guidance on the baseline standards and to encourage their implementation, a formal certification program was put in place in 1990, in which each state's insurance department would be reviewed by an independent team to assess its compliance with the standards. Those states not complying would be given NAIC guidance to eventually comply.

Today, the Financial Regulation Standards and Accreditation (F) Committee of the NAIC, comprised of regulators from across the country, decides whether a state has met the standard's requirements. Meetings to discuss state accreditation matters are held in confidential, regulator-only sessions, protecting the states, regulators, and insurers.

According to the NAIC, "The mission of the NAIC accreditation program is to establish and maintain standards to promote sound insurance company financial solvency regulation. The accreditation program provides a process whereby solvency regulation of multi-state insurance companies can be enhanced and adequately monitored with emphasis on the following:

- Adequate solvency laws and regulations in each accredited state to protect consumers and guarantee fund.
- Effective and efficient financial analysis and examination processes in each accredited state.
- Appropriate organizational and personnel practices in each accredited state.
- Effective and efficient processes regarding the review of primary licensing, re-domestications, and change of control of domestic insurers in each accredited state."

The NAIC further states: "The accreditation program will accomplish its mission by continually evaluating the adequacy and appropriateness of accreditation standards in accordance with the changing regulatory environment and through continued monitoring of accredited states by conducting the following accreditation reviews:

- Pre-accreditation reviews to occur approximately one year prior to a state's full accreditation review. This review will entail a high-level review of the financial analysis and financial examination functions to identify areas of improvement.
- Full accreditation reviews to occur once every five years, subject to interim annual reviews. This review will entail a full review of laws and regulations, the financial analysis and financial examination functions, organizational and personnel practices and primary licensing, re-domestications and change of control of domestic insurers to assist in determining a state's compliance with the accreditation standards.
- Interim annual reviews by state insurance department self-assessments are required to maintain accredited status between full accreditation reviews. This review will entail a review of any law and regulation changes, the financial analysis and financial examination functions, organizational and personnel practices and primary licensing, re-domestications and change of control of domestic insurers to ensure continued compliance with the accreditation standards and to identify areas of improvement. "

The program was intended to allow for interstate cooperation and to reduce regulatory redundancies and duplicative examination costs. A company domiciled in an accredited state would assure the other states in which that company is licensed or writes business that it has been adequately monitored for financial solvency. Each accredited state's laws or regulations on financial examinations require that all licensed companies be examined periodically. In lieu of

performing its own exam, a state may accept the examination report prepared by an insurance department that was accredited at the time of examination.

Solvency regulation must evolve with insurance industry practices. Thus, the NAIC has adopted a process to add new standards or modify existing standards, which requires considerable input from regulators, the industry, public officials, consumers, and academics. As of January 2020, all fifty states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands are accredited.

Statutory Powers and Authorities Related to Solvency

To regulate the solvency of insurance companies within their jurisdiction, state departments of insurance led by the commissioner of insurance are vested with specified statutory powers and authorities. State insurance commissioners regulate insurers under their state's police powers because insurance is affected with a public interest. Important ones are summarized below.

Investment Controls

All insurers are required to comply with applicable insurance statutes governing the types and threshold limitations of investments the insurer is permitted to invest. These limitations are designed to protect policyholders by ensuring that the insurer does not invest too heavily in any particular type of investment that may jeopardize its liquidity or solvency. For example, the investment statutes limit the extent to which insurers can invest in affiliates and subsidiaries and nonliquid assets like real estate. Statutes require that insurers invest a certain amount of the overall assets in high quality, liquid assets that are readily available to pay claims. Insurers are not typically required to file their investment agreements and/or guidelines with domiciliary regulators unless specifically requested to do so. Valuations of investments are set by state law. A commissioner may for good cause require an insurer to limit or dispose of an investment.

Reinsurance Regulation

Reinsurance is a transaction whereby an insurer shares or cedes a risk insured with another insurance company.

Insurance regulators do not directly regulate non-U.S. reinsurers. If the reinsurer is not licensed or otherwise accredited in the U.S., then it must typically post collateral equal to its reinsurance liabilities that it has assumed from a U.S. ceding insurer in order for that ceding

insurer to receive financial statement credit for reinsurance. In 2017 the U.S. entered into a covered agreement with the European Union which eliminated state based collateral requirements for EU reinsurers. In 2018 the U.S. entered into a similar agreement with the United Kingdom for their reinsurers. In 2019 the NAIC amended the Credit for Reinsurance Model by eliminating collateral requirements for Non- US Certified Reinsurers domiciled in Qualifying Jurisdictions. These changes addressed a longstanding concern of non-US reinsurers that the security requirement was unfair trade barrier.

Insurers typically purchase reinsurance to provide surplus relief and to spread the risk of loss. Ceding insurers transferring risk to another entity/reinsurer/assuming insurer enhance their statutory financial position so long as the reinsurance satisfies certain requirements. Reinsurance agreements often are required to be filed in order for the domiciliary regulator to monitor and understand the extent to which the ceding insurer is transferring risk to another entity/reinsurer/assuming insurer. Ceding insurers receive credit for reinsurance on their statutory financial statements if the reinsurance complies with applicable credit for reinsurance statutes and statutory accounting rules.

Financial Reporting

The financial solvency of insurers is an overriding concern for insurance regulators because there is a strong public policy interest in protecting the insurer's policyholders, insureds, creditors, and the insurance-buying public. Insurers generally are required to file NAIC quarterly and annual audited financial statements with regulators, permitting a thorough review of the insurer's financial condition. Insurers are required to file these statements based upon statutory accounting as opposed to generally accepted accounting principles (GAAP accounting). Statutory accounting is more conservative than GAAP and typically requires that insurers maintain minimum capital and surplus in addition to going concern operating assets. If a regulator's review of the filed financial statements raises concerns, then the regulator can initiate a targeted financial exam of the insurer to further investigate the insurer's financial condition. Insurers also are examined every three years but must be examined at least once every five years (Triennial Exam).

Accounting Practices

Insurers follow their domiciliary state's statutory prescribed or permitted accounting practices when preparing their statutory financial statements. With minor exceptions that may vary from state to state, the NAIC Accounting Practices and Procedures (NAIC Accounting Rules) are the statutory prescribed accounting practices for every state, and those accounting rules are

generally referenced in each state's statutes or regulations. The NAIC Accounting Rules provide a framework within which insurance regulators assess an insurer's financial solvency and monitor the insurer's financial condition on an ongoing basis. Commissioners have authority under state law to permit accounting practices that deviate from the NAIC Accounting Rules. If an insurer employs any of its state's prescribed or permitted accounting practices that depart from the NAIC Accounting Rules, the accounting practices that differ and the monetary effect of those differences on net income and surplus are required to be disclosed in its filed statutory financial statements. The NAIC also annually publishes a list of each state's statutory prescribed accounting practices that deviate from the NAIC Accounting Rules.

Independent Audits

Insurers must annually file with their insurance regulators independent financial audits. The NAIC Annual Financial Reporting Model Regulation requires insurers to hire independent certified public accountants to conduct audits of the insurer's financial condition and operations. Additionally, the independent certified public accountant must provide: (1) communication of internal control related matters noted in an audit to identify any "unremediated material weaknesses" in controls over financial reporting; and (2) management's report of internal control over financial reporting. The independent audits provide reasonable assurances that the financial information provided to insurance regulators is reliable.

Actuarial Opinions

Actuarial opinions of property and casualty insurers estimated loss reserves aide insurance regulators in monitoring the reasonableness of such reserves. Regulators want to ensure that the insurer has reasonably sufficient loss reserves to pay claims as they develop over time. Qualified actuaries provide expert opinions that regulators feel comfortable relying upon in monitoring the insurer's solvency. The actuarial reports typically are lengthier and more detailed in describing the calculations underlying the actuarial opinion.

Risk-Based Capital

In the early 1990s, the NAIC created a new statutory capital requirement for insurers based on each individual insurer's risk profile. The Risk-Based Capital (RBC) requirements effectively created an early warning system to combat insurance insolvencies. Insurers must comply with RBC laws to ensure that they are maintaining the required capital to support all of its risks, including asset and credit risk and underwriting risks. The more risk an insurer takes on, the higher the level of capital required. Failure to maintain the appropriate RBC level triggers the

lawful authority of regulators to take certain preventative and corrective actions against the insurer to protect policyholders. There are four different levels of capital triggering events: Company Action Level, Regulatory Action Level, Authorized Control Level, and Mandatory Control Level. For example, a domiciliary regulator is authorized by statute to place an insurer into state insurance receivership at the Mandatory Control Level. Short of such receivership triggers, regulators will monitor solvency through RBC Action Plans required of insurers with adjusted capital below Company Action Level. Such plans prescribe certain actions required of insurers to maintain liquidity and solvency. Further insight into RBC will be presented later in this paper.

ORSA

Own Risk and Solvency Assessment (ORSA) requires insurers to assess their overall risk so that insurers and their regulators can better understand the insurer's ability to handle financial adversity. The ORSA Model Act requires insurers of a certain size (*i.e.*, a U.S. insurer that writes more than $500 million of annual premium or insurance groups that collectively write in excess of $1 billion in annual premium) to conduct an internal assessment of material risks at the enterprise level to enable regulators to monitor the risks of the entire insurance holding company system. ORSA requires insurers to file an annual Enterprise Risk Report (*i.e.,* Form F) to describe material risks within the insurer's insurance holding company system. The ORSA Report and Form F are statutorily protected as confidential, and not subject to public disclosure.

Supervisory Colleges and Group Supervision

Solvency II originally was introduced to apply to insurers and reinsurers located in the European Union (EU). It was designed as a regulatory framework to monitor the financial solvency of such EU insurers and reinsurers and to ensure appropriate capital based upon the companies' assumed risk. The International Association of Insurance Supervisors (IAIS) monitors the solvency of EU insurers and reinsurers to ensure enterprise wide risks are properly capitalized. The NAIC has been working with the IAIS to address global group solvency issues of the largest international insurers and reinsurers.

Troubled Insurers

Troubled insurers are those that are experiencing adverse financial circumstances and are being actively monitored by insurance regulators. Typically, these insurers have RBC issues and are subject to RBC Action Plans or some form of administrative supervision. These insurers require some type of financial assistance or supervision to avoid state insurance receivership. Regulators will work with the insurers to help stabilize their balance sheets. Sometimes, the

troubled insurers will obtain permitted practices from the regulators for definitive periods of time to strengthen the insurer's financial condition. Permitted practices essentially are short-term waivers of certain accounting rules. For example, waiving for a period of time the requirement to non-admit a certain asset that the regulators are fairly certain will be considered admitted in the near term.

Impairments and Insolvencies

Insurers are not subject to federal bankruptcy laws because they are expressly excluded. Insurers are subject to state insurance receivership laws in each of the state jurisdictions. An insurer that is found to be financially impaired under applicable state insurance laws may be placed into state insurance receivership (for example, conservation or seizure actions) with the intent to cure the impairment and release it from receivership. Other insurers that are unable to pay their obligations as they become due, are unable to satisfy RBC requirements under applicable insurance laws or fail to maintain minimum capital and surplus may be found to be insolvent. Insolvent insurers will be placed into state insurance receivership, for example, rehabilitation or liquidation, to protect their policyholders.

Guaranty Funds

Once an insurer is found to be insolvent, state insurance guaranty funds are triggered to pay the claims of policyholders in accordance with state insurance guaranty fund laws. Guaranty funds pay policyholder claims up to certain dollar amounts set forth in the applicable guaranty fund laws. The guaranty funds then typically become creditors in the insurer's receivership estates and may receive reimbursement from the estates. Additionally, guaranty funds are funded through assessments on insurers writing business in the state. There are different guaranty funds for property and casualty lines, HMOs and life and accident lines. Reinsurers and unauthorized insurers are not subject to guaranty fund laws and their policyholders are not protected by guaranty funds.

Organization of New Insurers

An insurer is incorporated and initially licensed in its state of domicile. To obtain a license, an insurer must meet minimum capital and surplus requirements to ensure solvency, determined in part, on the lines of business the insurer intends to write. Further, the insurer must prepare a business plan, including pro forma financial statements for three through five years. To ensure that the insurer's board of directors and executive officers have good character and the necessary experience and expertise to run an insurance company (*i.e.,* Character and Fitness

Requirements), the directors and officers are required to provide biographical information (*e.g.,* NAIC Biographical Affidavit forms) as part of the insurer's application for formation and licensure.

Admission of Foreign Insurers

Before transacting insurance in states outside of the insurer's state of domicile, the insurer must be admitted (*i.e.*, licensed) in any state in which it intends to transact insurance. The process for obtaining a license from a commissioner in a foreign jurisdiction is similar to obtaining a license in the insurer's state of domicile, including satisfying capital and surplus requirements, providing a business plan with pro forma statements, and providing biographical affidavits for the directors and executive officers. In addition, many states have "seasoning" requirements whereby the insurer must have been transacting insurance for a period of two through five years in its state of domicile before it can seek admission in another state. The "seasoning" requirement provides foreign regulators with confidence that the insurer is able to operate profitably and soundly before permitting admission into their states.

Insurance Holding Company Systems

Insurers are often part of an insurance holding company system which may operate within and outside the insurer's state of domicile. The Insurance Holding Company System Act (the Act) provides a state insurance regulator a mechanism through its required filings, including its annual registration statement (NAIC Forms B and C) and oversight into affiliate transactions (NAIC Form D). Filings under the Act provide transparency into the insurer's holding company structure operating by providing access to information about the insurer's holding company's management, business practices, and financial condition, thus allowing a regulator to assess current and/or potential risk to the insurer and its insurance affiliates. In addition, the Act provides a mechanism for state insurance regulators to coordinate with other jurisdictions in reviewing transactions that affect multiple insurance subsidiaries domiciled in different jurisdictions. In order for a change of control of a domestic insurer to occur, the commissioner must determine that the acquiring party meets the standards set forth in the Act.

Corporate Governance

The NAIC defines corporate governance to include "not only the obvious corporate structure (board of directors, senior management, business area functions, *etc.*), but also an insurer's organizational culture (values, ethics, *etc.*) and strategies and controls, as well as, all the governing documents that capture the spirit and the letter of an insurer's guiding principles and mandates." The NAIC has developed both the Corporate Governance Annual Disclosure Model

Act (# 305) (Model Act) and the Corporate Governance Annual Disclosure Model Regulation (#306), requiring insurers to provide a corporate governance disclosure annually to their lead state regulator or domestic state regulator. The Corporate Governance Model Act and Model Regulation do not prescribe specific corporate governance standards, but rather require confidential disclosure of such practices. The Model Act and the Model Regulation provide latitude for an insurer to decide whether such disclosure should be provided by the insurer, the ultimate controlling party, or an intermediate holding company. Further, the insurer has flexibility with respect to the format of the disclosure, but the report must contain "the insurer's corporate governance framework and structure; the policies and practices of its board of directors and significant committees; the policies and practices directing senior management; and the process by which the board of directors, its committees and senior management ensure an appropriate level of oversight to the critical risk areas impacting the insurer's business activities." Effective January 1, 2020, individual states must have passed laws based on the Model Act to receive NAIC accreditation.

Corporate Transactions Review & Approval

Insurers are required to obtain the commissioner's approval to amend its articles of incorporation and bylaws, appoint officers and directors, merge with another insurer, change the lines (types) of insurance business it underwrites, and many other corporate changes and transactions it seeks to undertake.

In the next section, those above requirements, which create important tools for the insurance department staff to monitor the solvency of the elements of the insurance industry operating in the state, are discussed further. Similarly, given the importance of the subject, a later section will cover in greater detail powers and matters relating to intervention into troubled insurers and insurer receivership proceedings. Most larger states have a separate staff for dealing with troubled insurers and those in receivership.

Solvency Surveillance Tools

Regulatory requirements are of little value if there is no mechanism to monitor an insurer's financial risk and regulatory compliance. Fundamentally, the objective of solvency monitoring should be to ensure that insurance companies meet regulatory standards and alert regulators of actions which need to be taken against a company to protect its policyholders. Solvency monitoring encompasses a broad range of regulatory activities, including annual financial statement reporting, financial examinations, financial analysis, and risk-based capital reports. It also includes the review of required filings, such as insurance holding company system reports, solvency risk assessments, independent actuarial reports and opinions, and independent

certified public accountant reports. Also, the insurance department has access to Securities Exchange Commission filings and rating agency reports to assist in monitoring of insurers.

The following paragraphs provide some further insight into the fundamental components of solvency monitoring—annual statement reporting and accounting, examinations, and risk-based capital reports. Also, given the importance of rating agency reports, these are also discussed.

Insurance Accounting and Annual Statement Reporting

A document that historically has been key to the monitoring of insurers is the annual statement blank or convention blank as it is sometimes referred to. “Blank” refers to the fact that it is a form to be completed, and “convention” means it was adopted by the National Convention of Insurance Commissioners (NCIC), which was the original name of the NAIC. One of the first acts of the NCIC after its formation in 1871 was the development of a uniform reporting form for insurers to report financial information. A permanent committee on the “blank” was one of the first committees established by the NCIC to keep the blank current, so that insurance departments received up-to-date, complete, and useful information. While the committee structure has changed over the years, the blanks committee still exists as an important activity of the NAIC.

The annual statement is a very comprehensive document, containing now well over 75 pages of data and information well beyond basic financial statements. It also includes various exhibits and schedules, which give specific insight into items in the balance sheet and the statement of profit or loss. In addition, it contains commentary on management’s analysis of the insurer’s operation, responses to interrogatories covering key items and footnotes to the financial statements. The quarterly statement is a much more condensed filing. The basis of accounting used to report financial condition and results of operation in the annual and quarterly statements follows statutory accounting principles and not generally accepted accounting practices. Statutory accounting consists of those procedures and methods prescribed by statute, which includes a comprehensive accounting manual promulgated by the NAIC. All states have adopted the NAIC accounting manual for the purposes of financial reporting by insurers. If state law differs from accounting practice set forth in the NAIC manual, an insurer must follow the requirement in state law.

There are annual statement blanks for each major type of company-life insurers, health organizations, property and casualty insurance carriers, and title insurers- due to the peculiarities

and risks unique to a line of business. Annual statement filings by insurers are public information and, therefore, are available to consumers, rating agencies, and others for review.

As stated above, the accounting basis for financial reporting in the annual and quarterly statement is referred to as statutory accounting since it is based on the accounting prescribed in state law. Before the creation of the accounting manuals by the NAIC, the accounting practice to be followed by insurers was set forth to some extent in the statute, which prescribed what assets could be included in the financial statement and a description of the reserves that had to be established for various lines of business. It also encompassed custom and practice which had evolved over the years, as well as administrative decisions made by an insurance commissioner when presented with an accounting issue. It also included the limited accounting instructions set forth in the instructions for the annual statement blank. This system worked well for decades, but as the insurance industry increased in complexity and diversity, it recognized that a more comprehensive and consistent approach to accounting principles was needed. It was also clear that these principles had to be assembled in one place and available in written form to all concerned with knowing what the prescribed accounting principles were. Independent auditors who expressed an opinion on an insurer's financial statements were also interested in a more structured approach. As a result, in the early 1970s, the Illinois Insurance Department created the first "codification" of accounting practices for insurers domiciled in Illinois. They urged that a similar project be undertaken by the NAIC. In the late 1970s, the NAIC promulgated two accounting manuals-one for life and health insurers and another for property and casualty insurers. Improvement and updating of the accounting direction were again identified as a need in 1991. Thereafter, the NAIC and its members, with external professional assistance, initiated a comprehensive project to not only update the existing manuals but to expand the contents so they addressed more accounting issues. The project was called "codification of statutory accounting practices and principles". In the late 1990s, the NAIC finalized its work and a new manual was adopted, which became effective January 1, 2001. This new manual consists of two volumes containing a statement of concepts underlying statutory accounting to guide future pronouncements, a specific direction on accounting of assets and liabilities and for each element of the operating statement as well as the rationale for the proscribed accounting. Each year since, the NAIC issues an updated manual based on the changes recommended by the committee charged with that responsibility.

Insurance Company Financial Examinations

The insurance laws of the states permit the insurance commissioner to examine an insurer licensed to do business in the states as often as the commissioner deems necessary and requires that each insurer be examined at least once every three to five years, depending on the

provision of state law. Customarily, domestic insurer examinations are conducted by the home state, which may involve the participation of examiners from other states where the insurer is licensed. An examination may be a full-scope review or a targeted examination. Full scope examinations resemble in many ways the financial statement audits conducted by a CPA but include procedures to determine if the insurer is in compliance with state law and regulations. The procedures used on full scope examinations are risk focused, in that they concentrate on areas that present the greatest risk to solvency and stability. The NAIC has published a handbook that covers the conduct of examinations and the procedures to be utilized. A state may perform other procedures it feels are necessary.

Examinations are conducted by employees of the insurance department, but commissioners have the authority to hire external assistance when specific expertise is required and not possessed by the insurance department.

At the conclusion of the examination, a comprehensive report containing the examiner's findings is prepared. A draft of the examiner's report is presented to the company under examination for comment before it is filed as a public document. If the insurer disagrees with the examiner's findings, a hearing may be held to contest the examiner's findings. If the findings indicate violations of law or regulations, an order will be issued by the commissioner which may provide for corrective action and/or fines or other penalties.

On-site visits to the offices of an insurer by a state government official regulating insurers has been a cornerstone of surveillance activities before the creation of the NCIC in 1871. The NAIC, through its members, has played an important role in maintaining the efficiencies and effectiveness of these examinations. Nevertheless, examination of insurers has been a source of more criticism than any other phase of a commissioner's activities. As a result, this activity has been subject to change and attempts to correct abuses. For example, in the early 1900s, the NCIC developed a system for the exchange of reports of examination as a way to avoid multiple examinations, which was a significant problem at the time, and to some extent, still exists today. In the early 1970s, the NAIC retained McKinsey & Company to conduct a comprehensive study of the surveillance system of insurers in the U.S. This review resulted in many recommendations. Among the principal ones eventually adopted by NAIC members are the following:

1. The separation of market conduct issues from financial concerns, which resulted in two distinct systems of examination—market conduct and financial—each of which has since grown considerably in many ways. It was observed by McKinsey & Company that different expertise was required to conduct each type of examination.

2. The creation of an early warning system to identify potentially troubled insurers now known as the "Insurance Regulatory Information System," which will be discussed next. This put the NAIC in the data collection business, which has become a major source of revenue for the NAIC through fees paid by the insurance industry. It also started the NAIC in the business of providing services to the states through the sharing of data collected with state insurance departments and later providing analysis of that data. Neither of these results was envisioned by McKinsey.
3. The publication by the NAIC of a revised financial condition examiners handbook and, eventually, a new market conduct examiner's handbook.
4. Numerous other improvements of examinations, including increasing the professionalism and education of examiners. These resulted in the creation of the Society of Financial Examiners to be the training, testing, and certification institution for financial examiners, as well as the creation of the Financial Examiners Education Foundation to provide continuing education for examiners.

In the late 1980s, a new examination law was adopted by the NAIC, which sought to improve the timeliness of examination reports and provide due process to insurers subject to examination and other changes.

Financial Analysis

Financial analysis of annual statement data and other filings is an important way in which insurance departments monitor financial condition, particularly between examinations. In the late 1960s, the insurance departments of certain states began developing systems to capture electronically certain financial data from annual statements, using coding sheets and punch cards. Key ratio results were then calculated to help identify insurers that required priority attention. These states recommended that this be done for every insurer through the NAIC. Such a system was created and paid for by the insurance industry through fees paid to the NAIC on a voluntary basis. Soon thereafter, the system was named the Insurance Regulatory Information System and, as a result of the McKinsey & Company recommendations discussed previously, the system was greatly improved.

As a result of the activities described above and improvements in technology, insurance departments have available to them, through the NAIC, a collection of analytical tools within the Insurance Regulatory Information System (IRIS) to assist with the screening and analysis of the financial condition and results of operation for all insurers in the United States. IRIS has key current and historical data captured from annual statement and quarterly filings. One such analytical tool is a scoring system that, through a series of financial ratios, identifies insurers that

pose a higher risk based on financial position, results of operation, cash flow, liquidity, and leverage. Another tool is the IRIS ratios, which seek to identify those insurers that merit priority attention based on the results of a series of financial ratios that fall outside the range of usual or expected results. The system also contains profile reports, useful to insurance department analysts and others in the agency, which can assist in the identification of unusual trends and fluctuations that warrant investigation.

The NAIC has created a handbook of recommended financial analysis procedures that can be helpful to your staff.

Risk-Based Capital (RBC) Standard

One of the most successful additions to solvency regulation in the last couple of decades is the establishment of a risk-based capital (RBC) standard in state insurance law. Importantly, as intended, it requires a regulator to take action as capital is eroded by operations or other factors.

The RBC law sets forth a capital requirement that is related to the size, operation, and risk profile of an insurer. The amount of capital required is set by a formula that includes asset and underwriting risks and other risks present by the attributes of an individual company. The formula is set by an NAIC committee and is reviewed periodically. The formula is uniform throughout the U.S. since the state law references the formula developed and maintained by the NAIC. The formula utilizes data contained in the statutory financial statements. One of the most important aspects of the RBC law is the provision that mandates regulatory action or intervention. Application of the RBC formula results in the calculation of four levels of capital. Each of the four levels—company action level, regulatory action level, authorized control level and mandatory control level— result in harsher regulatory action as actual capital is a smaller percentage of the capital resulting from the RBC formula. For example, at the company level, an insurer is required to file a corrective plan to restore and maintain capital at or above that level. The most severe action is the mandatory control level. At this level, the regulator is required to take control of the insurer through receivership proceedings.

The RBC standard replaced the practice of reliance on rules of thumb to determine capital required beyond organizational capital needed for licensing. In addition, it gave specific definition to statutory terms, such as hazardous or trending to hazardous financial condition.

Rating Agency Reports

Rating agencies play an important role in monitoring and evaluating an insurer's financial condition and operating results for use by insurance consumers and intermediaries, as well as others who need or desire an independent opinion for an insurer's ability to meet its insurance obligations. They have also become a valuable tool for insurance regulators. Financial ratings of U.S. insurers began in the early 1900s by a company named Alfred M. Best. Since then, other rating agencies have entered the field, including Moody's, Standard & Poor's, Fitch Ratings, Inc., and Demotech, Inc. The latter firm specializes in rating insurers that are more difficult to evaluate due to the size of the insurer or the nature of risks insured.

The efficacy of insurer ratings has vastly improved over the last few decades due to more rigorous procedures. As a result, more individuals and businesses rely on them. Having a high rating has become important to enable an insurer to grow. As a result, financial ratings have become of interest and use by state insurance regulators. Some observers have stated that, in recent times, rating agencies have become quasi-regulators due to their influence on the insurance industry and the marketplace's reliance on acceptable ratings. An insurance carrier with a low rating has difficulty growing its business or retaining business it has written. Insurance agents or brokers will be reluctant to place business in an unrated or low-rated insurer because doing so may expose them to liability if the carrier fails. Also, a producer may have difficulty obtaining errors and omissions coverage if they are using an unrated or low-rated carrier. So, because of these marketplace realities, rating agencies have become quasi-regulators.

Intervention and Receivership

Hazardous Financial Condition of Insurers

Every state has adopted a version of the NAIC's Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition. The Model Regulation sets out 20 standards for regulators to use, singly or in combination, to help identify insurers whose condition might be hazardous to policyholders, creditors, or the public. Without trying to be exhaustive, the standards that commissioners may consider include:

- "Adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinions, reports or summaries."
- Has the insurer "made adequate provision" for "anticipated cash flows," considering contractual obligations and assets on hand, including anticipated premium revenue?

- Are operating losses (excluding capital gains) in the last 12 months greater than 20% of the insurer's "excess" surplus?
- Age and collectability of receivables.
- Has the insurer failed to make timely financial and holding company act filings?
- Has the insurer grown "so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner?"
- Has management set reserves that do not meet minimum standards in state insurance laws, regulations, statutory accounting standards, or per accepted actuarial principles?
- "Any other finding determined by the Commissioner to be hazardous to the insurer's policyholders, creditors or general public."

In addition, this Model Regulation enumerates 12 steps that regulators can take when issuing an Order to improve the insurer's financial condition, including for example:

1. Reducing/suspending/limiting business volumes.
2. Suspending or limiting dividends.
3. Changing the insurer's investment mix.
4. Requiring more frequent interim financial reports.
5. Correcting governance deficiencies.
6. Adjusting premium rates (for non-life insurance contracts).

Many years ago, a group of regulators with professional assistance drafted a manual entitled "The Troubled Insurance Company Handbook" to assist state insurance departments in determining what steps should be taken when an insurer is identified as troubled. It provides useful guidance and assistance. The book contains several case studies describing a regulatory action that should be taken under various hypothetical situations.

Administrative Supervision

If the commissioner determines that more active involvement in an insurer's affairs is required, there are two forms of administrative supervision, formal and informal. Some states, like Texas, have a formal proceeding where the state brings an administrative proceeding, which it can maintain in confidence. The other way states do administrative supervision is on an informal basis pursuant to a consent letter. This is what California does. In essence, the company agrees to a plan of supervision. It may just be a plan to limit new business, terminate certain business, or require heightened financial reporting. There could or could not be an on-site supervisor, depending on what is needed.

While only roughly 30 states have adopted the NAIC's Administrative Supervision Model Act verbatim, or have a substantially equivalent law or regulation, commissioners in other states should find that they have the ability under local insurance laws to at least negotiate a period of administrative supervision. In general, however, the intervention by regulators and the actions taken or not taken by companies during such periods of administrative supervision are kept confidential.

Receivership

At any time during or after a period of administrative supervision, or in the absence of such a period, if the financial condition of an insurer merits more decisive action by regulators, a commissioner may apply to a local court for an order of conservatorship, rehabilitation, or liquidation. Now we are dealing with matters of public record; the intervention by regulators is not confidential. The NAIC's Insurer Receivership Model Act details the various categories of regulatory activity and powers that are exercised by the person appointed to act as conservator, rehabilitator, or liquidator, as the case may be. But one of the hallmarks of these conditions is that the insurer is no longer under the control of management and the board of directors. Control may be transferred back to management and the old board of directors at the conclusion of conservatorships or rehabilitations, but during such processes, control is firmly in the hands of those appointed by the courts. In state court liquidation proceedings, insolvent insurance companies are wound up under the supervision of local courts, much as noninsurance companies are wound up in Federal Bankruptcy Court proceedings. In the insurance context, it is conceivable that an insolvent regulated insurer is under the jurisdiction of a state court while its non-insurer holding company is the subject of a Federal Bankruptcy Court proceeding.

Conservation/Rehabilitation

For insurers that are "impaired" (admitted assets are less than liabilities, plus minimum surplus or total adjusted capital is less than the "authorized control level" of risk-based capital) conservation/rehabilitation is the next step, beyond administrative supervision, that the company's domestic regulator will consider. Conservation and rehabilitation are essentially two sides of the same coin, just a function of what a state calls the regulatory intervention process prior to liquidation. Pursuant to a court order, the regulator or a designee takes control of the insurer's assets, works with existing management to improve the financial condition of the insurer, and keeps insurance policies in force. The conservator will be required to report back to the court with a plan within, for example, six months. The conservator will be required to brief the appropriate state guaranty fund on progress. If the plan of conservation works and the

insurer's financial condition improves, control of the enterprise is returned to management and the company's board of directors.

Liquidation

If the insurance commissioner, or an already-appointed conservator or rehabilitator, determines that an insurer is in fact insolvent (when the insurer is unable to pay its obligations when due, or its total adjusted capital is less than the mandatory control level of risk-based capital), then liquidation is the next step. Every state has a detailed insurer liquidation statute. There are two model Insurer Receivership Model Acts. Most states still have an older version. Texas and Utah have the new one. New York has its own, quite old insurer liquidation law and a standalone Liquidation Bureau that manages insurer insolvencies. The NAIC would prefer that states adopt the more modern model legislation, but adoption by states has been slow.

If the supervising state court agrees, an order of liquidation will empower the state to wind up the insurer, terminating existing insurance contracts, gathering all books, records and assets, collecting available reinsurance contract proceeds, and assessing all claims against the insurer. Again, insurer liquidations are handled exclusively under the supervision of state courts, not by Federal Bankruptcy Courts. Many of the concepts found in the federal bankruptcy laws or developed in federal bankruptcy cases are found in insurance liquidation statutes, *e.g.*, fraudulent transfers, voidable preferences, etc. Two principal differences between federal bankruptcy proceedings and state insurer liquidations are (1) priority of claims in liquidation and (2) scope of the supervising state court's authority. In liquidation, administrative claims are Class One (priority) and the policyholder claims have to be Class Two. Then, there are subsidiary classes in insurer liquidations, *e.g.*, employee compensation, federal claims, state tax claims, general creditors (including reinsurers), and claims of owners. In federal bankruptcy proceedings, there are only two classes of claims—Administration (priority) and "all others." Both proceedings recognize "secured claims" that are otherwise outside the classes of claims. One difference with federal bankruptcy laws is that in insurance company insolvencies, policyholders are protected to an extent by state guaranty funds. There are limits to the size of claims that will be covered, and state guaranty funds will not cover claims of certain policyholders (*e.g.*, large corporations) at all. But the guaranty fund process is generally outside the liquidation process, other than for the fact that payments made by guaranty associations are the same priority as policyholder claims, and some states provide that claims expense of guaranty associations are also considered administrative (priority) level claims.

Insurance Company Failures

Insurance commissioners should be aware of the reality that an occasional failure of an insurer is a natural consequence of competition, and not all insurance company failures can be predicted or prevented despite the best efforts of regulators. As the chart which follows reflects, insolvency of property and casualty insurers is cyclical due to specific factors and reasons. While not shown, there was a spike in failures in the late 1800s due to big city fires. Another rise in failures occurred in the 1920s and 30s due to economic downturn or depression in the U.S. In more recent times, natural catastrophes, such as hurricanes in the early 1990s, caused an increase in failures. These events and other unpredictable ones are outside of the control of an insurance regulator to prevent. Nevertheless, the insurance commissioner will probably have to address the situation that follows in the marketplace from these failures, such as potential insurance availability problems and rising prices that might make an insurance product unaffordable. This is in addition to the responsibility for the administration of one or more receivership estates of those entities that have failed.

Another reason the number of property and casualty insurer failures is cyclical results from the insurance business or underwriting cycle. Insolvencies tend to rise after prolonged soft markets. Why? In soft markets due to competition and high demand, prices for insurance often fall and policy coverage expands. Such a marketplace can cause insurers to fail. It is in this competitive phase of the cycle and thereafter that the regulator must be vigilant in surveillance activities to detect insurers that may encounter financial difficulties due to deficient loss reserves, inadequate prices, or rapid growth. Fewer insolvencies tend to follow a hard market when prices are increasing, and policy coverage is tightening.

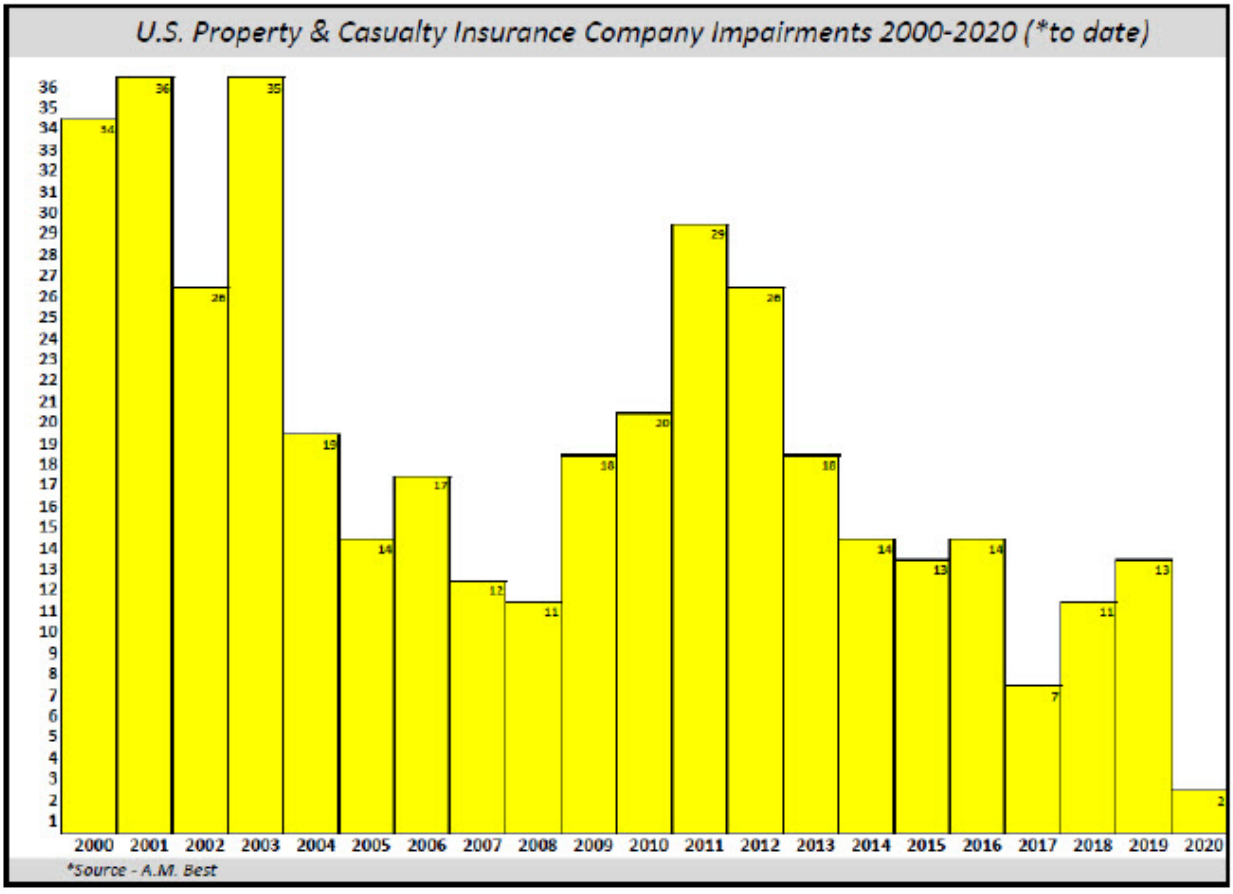
In the case of life insurance companies, failures tend to result from investment problems or fraud rather than from an insurer's insurance products and prices.

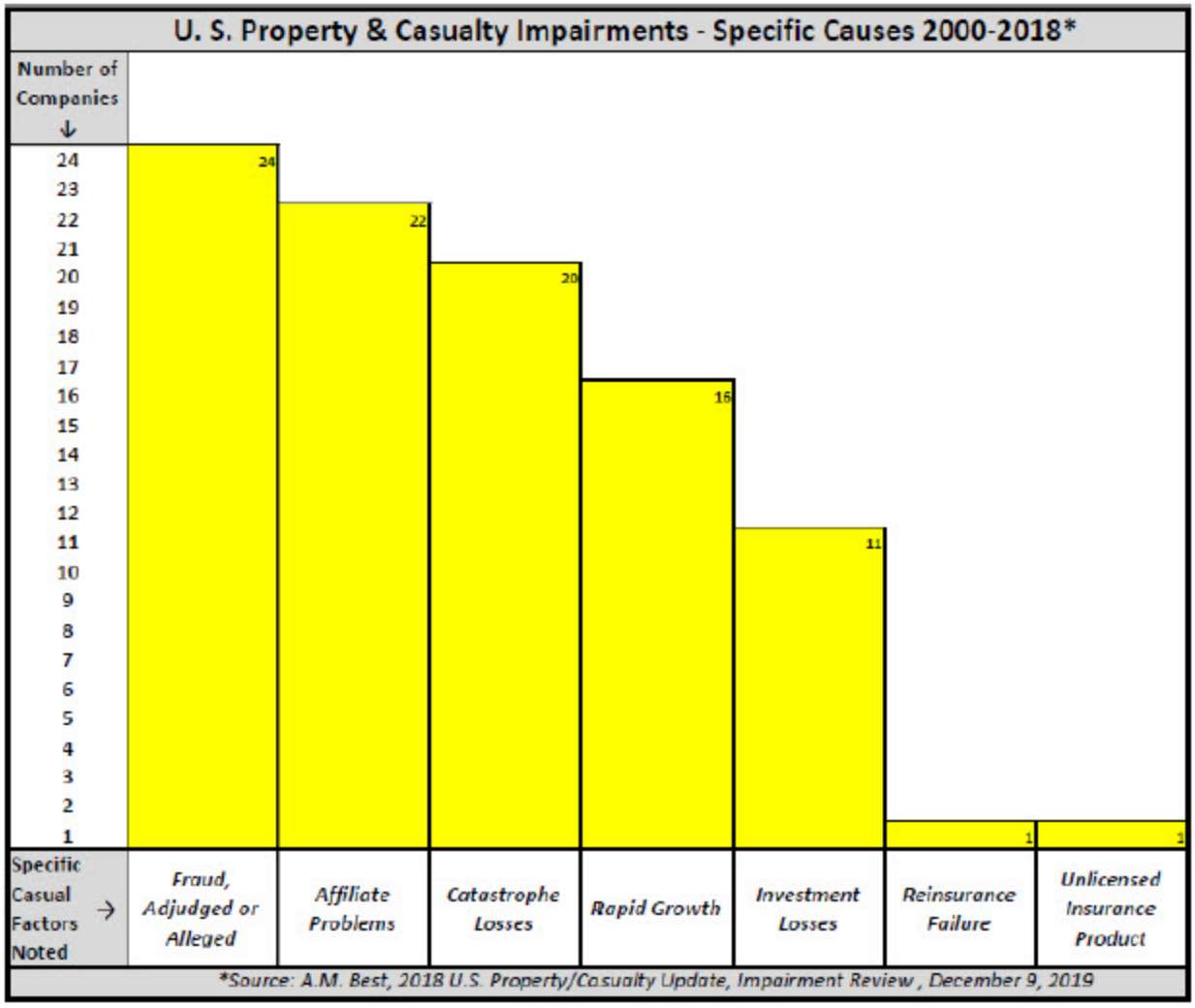
Of course, not all insurers that encounter financial difficulty end up in receivership. Often, these companies are acquired by other insurance carriers or merged into stronger insurers. Sometimes, these "marriages "of insurers are arranged by regulatory involvement. Regulators often take on the role of a "workout specialist" who, with management, develop and implement plans to address the causes of the insurer's problems and issues. Returning an insurer to viability can be rewarding to management and its customers as well as the regulator.

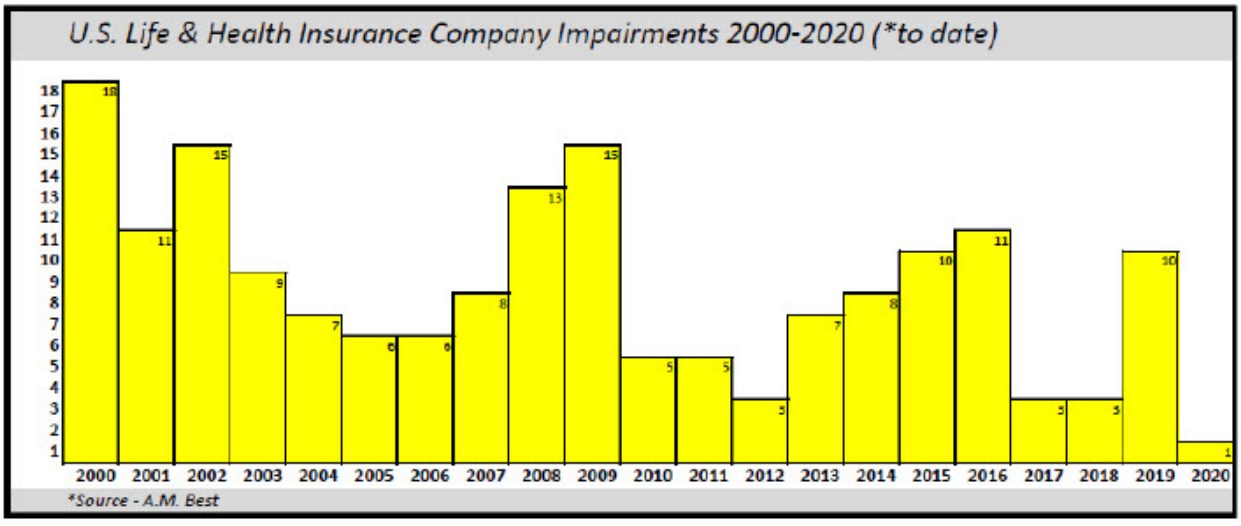
Contrary to the beliefs of many, insurance company failures do not just occur amongst smaller insurers. In the last 40 years, several large life and property and casualty insurers have been placed in insolvency proceedings.

It is interesting to note that in a doctoral thesis by Halem Bishara entitled “Analysis of Insurance Company Insolvencies and the Public Interest” he reports that between 1850 and 1899 an average of nine (9) insolvencies per year occurred and during the span 1900-1944 an average of nineteen (19) insolvencies occurred.

The following charts reflect the number of insurers failing in recent times and the primary causes of those impairments.




U. S. Property & Casualty Impairments - Specific Causes 2000-2018*
Number of Companies ↓
24
23
22
21
20
19
18
17
16
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
24
22
20
16
11
1
1
Specific Casual Factors Noted →
Fraud, Adjudged or Alleged
Affiliate Problems
Catastrophe Losses
Rapid Growth
Investment Losses
Reinsurance Failure
Unlicensed Insurance Product
*Source: A.M. Best, 2018 U.S. Property/Casualty Update, Impairment Review , December 9, 2019


U.S. Life & Health Insurance Company Impairments 2000-2020 (*to date)
18
17
16
15
14
13
12
11
10
9
8
7
6
5
4
3
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1
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11
15
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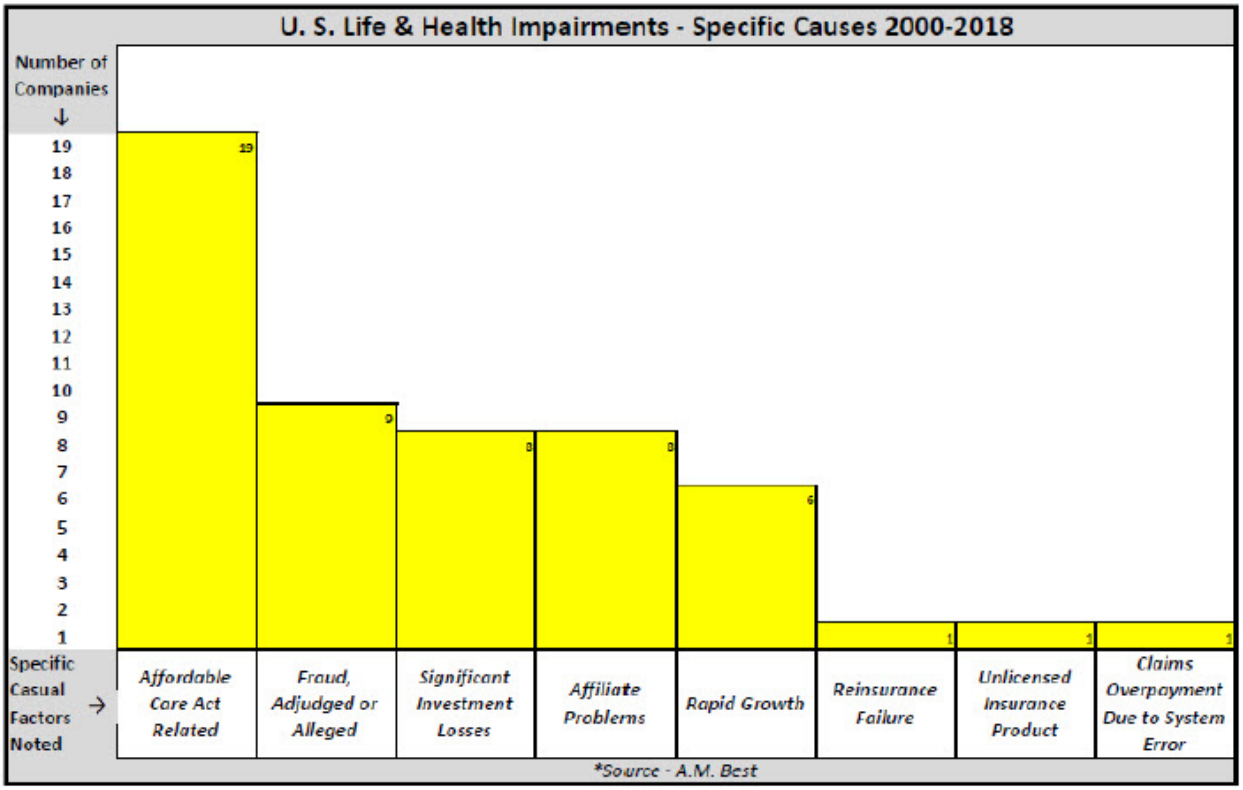
1
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020
*Source - A.M. Best



Note: the source of the above data and information is studies prepared by AM best of insurance company 'impairments.' 'Impairments' is defined by AM Best as the just action by State regulators preventing the insurer from conduct in normal insurance operations.

While insurance insolvencies do occur, the rate of insolvencies in any given year is very small and customarily less than 1%. Policyholders and claimants of a failed insurer usually are covered by a state insurance guaranty fund located in the state in which the policyholder or claimant resides.

Nevertheless, those policyholders insured by an insolvent insurer do face hardships, such as loss of coverage, difficulty in finding replacement coverage, delays in payment of claims by insurance guaranty funds and/or the receiver, and claims that are not covered by guaranty funds or ones that the receiver does not have the ability to pay. For these and other reasons, solvency surveillance is especially important.

Insurance Guaranty Funds and Associations

Every state has enacted legislation that creates an entity to pay the claims of an insolvent insurance company due to policyholders, resulting from the insurance contract issued by that

carrier. It is a safety net device with a purpose similar to the Federal Deposit Insurance Corporation, but different in its structure and operation. A separate fund exists for life and health insurers and another for property and liability insurers. Each fund has limits as to the amount of a claim that is covered by the fund. There are also exclusions from coverage for certain types of insurance contracts. Every licensed insurance company in a state is a member of guaranty fund and thereby becomes obligated to pay assessments that provides the source of funds to pay claims. States differ as to how these entities are governed, whether assessments paid may be offset against other state taxes and as to how covered claims are defined.

There are two national associations of insurance guaranty funds which seek to coordinate and exchange information as to insolvent insurers. The one concerning property and liability insurers is called "The National Committee on Insurance Guaranty Funds (NCIGF)". The other concerning life and health insurers is called "National Organization of Life and Health Guaranty Associations (NOLHGA)". Since, in the case of life and health insurers, the guaranty association can be triggered before an insurer is deemed insolvent, guaranty associations and their national association often get involved in the structure of receivership plans.

An Overview of the International Association of Insurance Supervisors

Introduction

In the mid-1980s, a handful of U.S. regulators led by the Illinois director of insurance and regulators from Bermuda, the Cayman Islands, and the United Kingdom planned and subsequently launched a series of International Insurance Symposiums hosted by the NAIC in conjunction with NAIC Summer National Meetings. This effort was stimulated by the annual meeting of bank regulators called the Basel Committee. The first gathering was held in Boston in June 1986. The primary goal was to improve understanding of various regulatory regimes and to foster international regulatory cooperation, particularly in connection with cross-border transactions. These gatherings, growing larger each year, continued to be held informally because of the reluctance to form a formal structure. However, in the summer of 1993 the first meeting of an "independent association of insurance regulatory officials" occurred. The International Association of Insurance Supervisors (IAIS) itself was incorporated in March 1994 in Illinois, subsequently relocating to Basel, Switzerland.

The IAIS is an international membership organization that develops principles, standards, and materials related to the supervision of insurance for the purpose of maintaining fair and stable insurance markets. The IAIS's membership is composed of insurance supervisors and

regulators from over 200 jurisdictions, constituting 97% of the world's insurance premium volume.

The IAIS operates under a committee system led by an Executive Committee. The Executive Committee oversees a variety of committees, and each of these consists of working groups that focus on particular issues. For example, the Policy Development Committee oversees the Market Conduct Working Group. This organizational structure functionally allows for both central oversight as well as focused examination of issues that are integral to the adequate supervision of the insurance sector.

Insurance Core Principles

As a way to promote fair and effective insurance markets and maintain global financial stability, IAIS has developed and published Insurance Core Principles (ICPs). ICPs consist of three components: (1) Principle Statements, (2) Standards, and (3) Guidance. These three components together ensure that the ICP framework provides both high level supervisory standards and specificity needed for adequate implementation.

Principle Statements identify essential elements that must exist in a jurisdiction for the protection of policyholders and promotion of fairness and stability. Standards are linked to particular Principle Statements and put forth key requirements for efficient implementation of the Principle Statement. Guidance supports the Principle Statements and Standards and offers recommendations and/or suggestions to facilitate the implementation of the Principle Statements.

ICPs are applicable to insurance supervision of all insurers, private or under government control, in all jurisdictions. Typically, unless otherwise indicated, ICPs do not apply to reinsurers or intermediaries.

The Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame)

The IAIS has also developed and published the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame), which focuses on developing supervision for Internationally Active Insurance Groups (IAIGs). ComFrame is largely a response to the 2008 global financial crisis and the increasing globalization of the insurance sector.

This major project builds on the globally accepted ICPs and tailors supervision to IAIGs by putting forth comprehensive qualitative and quantitative requirements for IAIGs. The standards put forth are not highly prescriptive and are meant to facilitate customization of supervisory requirements, foster commonality, reduce complexity, and provide a basis for comparability.

IAIG

In order for an insurance group to be considered an IAIG, it must meet several criteria:

- *International activity:* the group must have premium income from activities in three or more jurisdictions, and
- *International activity:* at least 10% of the group's total gross written premium must be written outside of the home jurisdiction, and
- *Size*: based on a three-year rolling average, the group must have total assets of at least $50 billion (USD) or gross written premiums of at least $10 billion USD.

The IAIS does not create or maintain a list of IAIGs and, instead, provides these criteria for supervisors to regularly assess whether ComFrame should be applied to a particular insurance group. The criteria allow for a degree of discretion in determining whether a particular group may be considered an IAIG.

ICS

Presently, the IAIS is working on creating a risk-based global insurance capital standard (ICS) (Version 2.0) to include in ComFrame and apply to IAIGs. The goal is to include a common methodology by which comparable outcomes are achieved across jurisdictions with regard to valuation, capital resources, and capital requirements. Beginning in 2020, there is a five-year monitoring period during which the ICS will be used by group-wide supervisors (GWS) for confidential reporting and discussion. During this period, there will be no supervisory action because of the ICS results as it is intended to monitor the performance of the ICS rather than the capital adequacy of the IAIGs. After a public consultation and economic impact assessment, the IAIS will be implemented as a group-wide Prescribed Capital Requirement.

IAIS's Strategic Plan and Issues in Insurance

In addition to publishing supervisory material, the IAIS monitors issues and topics that influence regulation and supervision of the global insurance sector and publishes issue papers, providing background and identifying anticipated challenges and possible responses.

Recently, the IAIS published an issue paper discussing the transformative impact digitalization has on the insurance business. In this paper, the IAIS considers the impact of artificial intelligence (AI), Big Data, Internet of things (IoT), and other digital deployment tools on the various aspects of the insurance value chain. Recognizing that although digitalization has increased efficiencies in underwriting, marketing, and distribution, as well as improved the customer experience, there exist risks related to innovation. One such consequence is protecting policyholder information and consumer interests. A key challenge supervisors face is striking a balance through which the spirit of innovation is fostered, and technology is used responsibly. IAIS recommends proactively engaging with market participants and developing tools to supervise digitalized firms, enhance cooperation with authorities, and safeguard supervisory parameters.

The 2020-2024 Strategic Plan sets out the strategies and high-level goals for the upcoming four-year period. As compared to previous strategic plans, the 2020 Strategic Plan places an emphasis on adaptability and response to a rapidly changing global environment that is driven by innovation and societal change. As part of the strategic review, IAIS identifies several trends and developments that impact insurance supervision. One such recent trend is the evolution of the insurance market as new lines of business emerge. This in turn is leading to creating market pressure for existing lines of business and convergence across sectors. Emerging markets and developing economies (EMDEs) are anticipated to exceed growth in advanced markets. The IAIS intends to prioritize engagement with EMDEs. Other strategic themes include technological innovation, cyber resilience, climate risk, conduct and culture, and financial inclusion.

One of the IAIS's core functions is to evolve alongside the insurance sector to meet the increasing demands and challenges faced by supervisors. This means developing supervisory material that is responsive to the overarching goal to promote and maintain global financial stability in a constantly changing world.

Multistate and International Cooperation

Many insurers operate on a national as well as international basis. Therefore, particularly in the area of solvency regulation, it is imperative that regulators have the ability to, and in fact they do, communicate information and coordinate with other regulators, not only across state lines but across borders.

The NAIC and its various committees provide a forum for commissioners and key staff to discuss an insurer that is of concern and coordinate regulatory action. Nevertheless, the primary responsibility for an insurer that is troubled remains with the domestic state. With respect to a

group of affiliated insurers, the NAIC has developed a "lead state" concept, which puts the state of domicile of the largest insurer in charge of coordinating regulatory activities, such as analysis and examinations.

For a variety of reasons, including local requirements, U.S. insurers who do business outside the U.S. do so through insurers located and incorporated in the country they do business. Likewise, non-U.S. insurers do business in the U.S. through an insurer incorporated in a U.S. state. As a result of increased international activity by non-U.S. insurance groups and U.S. insurance groups, the NAIC created a model law to form and require participation in supervisory colleges, consisting of regulators and supervisors that have authority over one or more member insurers of an affiliated group.

These members of a supervisory college meet periodically to share information about the group, insurers and non-insurers, and to assess business strategy, financial position, risk management, governance, and related matters. A model law was necessary for these supervisory colleges to be effective for many reasons, including the ability of U.S. regulators to share confidential information with non-U.S. insurance supervisors.

Dodd Frank / Federal Insurance Office / The Federal Reserve

While Congress has occasionally touched insurance regulation, for example in Gramm Leach Bliley Act or the Health Insurance Portability and Accountability Act (HIPAA), it has rarely done so as it did in 2010 with the Dodd–Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Public Law 111-203). Title V of Dodd-Frank deals specifically with insurance. Subtitle B, called the Non-admitted and Reinsurance Reform Act of 2010, provided a framework for both reinsurance regulation and surplus lines regulation by the states. Title V Subtitle A of Dodd-Frank, called the "Federal Insurance Office Act of 2010" (31 USC 313), created the Federal Insurance Office and gave it certain responsibilities and a little regulatory authority as outlined in section 502 of Dodd-Frank.

Section 312 of Dodd-Frank (12 USC 5412) transferred the duties of the now-defunct Office of Thrift Supervision to the Federal Reserve, granting the power to regulate holding companies that contain both an insurance entity and a bank/thrift. These tend to be large mutual companies that purchased a thrift/S&L during the 2008 financial crisis or before. Pursuant to Section 113 of Dodd-Frank (12 USC 5323), the Federal Reserve also regulates certain nonbank financial companies that have systemic importance (systemically important financial institutions, or "SIFIs").

The Federal Insurance Office (FIO) has several advisory responsibilities. The FIO's Director is appointed by the Secretary of the Treasury (not the President). The Director of the FIO is a non-voting member of the Financial Stability Oversight Council (FSOC), and the FIO has responsibilities to collect information as requested by the FSOC to help monitor the financial services marketplace for risks to financial stability. The FIO also coordinates with the Federal Reserve in the evaluation of the capital of systemically important nonbank financial companies and determining whether insurance companies might be systemically important. In addition, the FIO coordinates with the Federal Reserve in recommending whether the Federal Deposit Insurance Corporation should be appointed receiver of an insurance company that is part of a systemically important group. Additional responsibilities include:

1) Monitoring all aspects of the insurance industry to identify gaps in regulation that could lead to a systemic crisis.
2) Monitoring how the underserved and low-income people have access to insurance (except health insurance).
3) Recommending SIFI designation for insurers.
4) Administering the Terrorism Insurance Program under the Terrorism Risk Insurance Act.
5) Coordinating federal efforts and developing federal policy on prudential aspects of international insurance matters.
6) Consulting with the states (including state insurance regulators) regarding insurance matters of national importance and prudential insurance matters of international importance.

Congress explicitly limited the FIO from having any authority regarding health insurance, long-term care insurance, and crop insurance.

The FIO can require insurers to provide information, except those below a certain size and only after looking to see if the data is otherwise available from federal and state governments.

The FIO is charged with making annual reports to Congress on the state of the insurance industry, and the FIO's own activities that could pre-empt state law. FIO was also responsible for reports on the global reinsurance market and the impact of the Non-Admitted and Reinsurance Reform Act of 2010. In addition, the FIO was originally charged with a report on the regulation of insurance, specifically systemic risk and capital standards, plus whether some lines of insurance should be federally regulated and the impact of such a change. The FIO has also prepared a report on affordability of personal automobile insurance. These reports and the annual reports are available on the FIO's website https://home.treasury.gov/policy-issues/financial-markets-financial-institutions-and-fiscal-service/federal-insurance-office/reports-notices.Perhaps the

most visible activity of the FIO is its role in relation to covered agreements. Covered agreements are those negotiated by the Secretary of the Treasury and the U.S. Trade Representative with foreign governments or authorities regarding prudential measures with respect to the business of insurance. One covered agreement between the U.S. and the European Union regarding global reinsurance collateral and how prudential regulation will be conducted was signed on September 22, 2017. This covered agreement eliminates state-based collateral requirements for E.U. reinsurers. The covered agreement could pre-empt state regulation if the states do not adopt similar legislation within five years, and the FIO determines that state law conflicts with the covered agreement and takes steps to notify various parties. During 2017, the FIO provided notice (signed by the Secretary of the Treasury and the U.S. Trade Representative) of the covered agreement to a wide variety of committees and members of Congress, as required by Dodd-Frank. A second, remarkably similar covered agreement was entered into between the United States and the United Kingdom in anticipation of the U.K.'s departure from the E.U. ("Brexit").

The Federal Reserve Board has consolidated its regulation of insurance within its Supervision & Regulation Group. Within this group, the Federal Reserve carries out its supervision of Savings & Loan Holding Companies (SLHCs) and also conducts regulation of nonbank systemically important financial institutions (SIFIs) (although there are currently none of these to supervise).

The Federal Reserve's duties regarding SLHCs are carried over by Dodd-Frank section 312(b) (12 USC 5412) from the Office of Thrift Supervision (OTS), which regulated entities containing a thrift or saving & loan. The OTS was abolished by section 313 of Dodd-Frank. Supervision of SLHCs is also mandated by section 10 of the Home Owners' Loan Act of 1933 (12 USC 1467a). Many insurance groups purchased thrifts in order to receive government assistance through the Troubled Asset Relief Program, and these entities were the subject of group supervision by the OTS, although the OTS had few resources to devote to these new regulated entities. Although the insurance entities continue to be subject to state insurance regulation as to their solvency, the Federal Reserve now supervises them at a group level. Although declining in number over the years, these entities include several large mutual insurance companies that still own thrifts, such as USAA, and TIAA. Section 616(b) (12 USC 1844) of Dodd-Frank empowered the Federal Reserve to set capital requirements for SLHCs. The Federal Reserve has proposed regulations through a Notice of Proposed Rulemaking to advance capital standards for SLHCs. This is proposed to use a "building block" approach that evaluates capital through the aggregation of existing metrics for banks and insurance entities, and scales those metrics so that they can be added together on a comparable basis to evaluate the group's total capital.

The Federal Reserve also supervises those insurance nonbank financial companies that have been designated by the Financial Stability Oversight Council for regulation by the Federal Reserve pursuant to Section 113 of Dodd-Frank (12 USC 5323). These are those institutions that pose systemic risk to the U.S. financial system. There are currently no nonbank companies designated by the FSOC, but in the past, this group included Prudential, MetLife, and AIG. Dodd-Frank section 165 (12 USC 5365) provides the framework for prudential regulation of these companies. The Federal Reserve has proposed regulations through a Notice of Proposed Rulemaking to establish a comprehensive capital examination and required capital levels to ensure the safety of these large institutions. However, the regulations would not be used until the FSOC designates one or more insurance groups to be regulated by the Federal Reserve. In both of its regulatory capacities, the Federal Reserve functions as a group regulator to protect the financial safety of entire corporate families, as opposed to state regulation that focuses on the individual corporate entities that comprise the individual insurance companies. Areas of focus for the Federal Reserve include risk management, corporate governance, capital planning, information systems, and recovery planning. It should be emphasized that the Federal Reserve uses existing state regulatory tools, such as Own Risk Solvency Assessment, Corporate Governance Annual Disclosure, Form F Enterprise Risk Report, and participation in supervisory colleges.

Both the FIO and the Federal Reserve serve, along with some state regulators, as part of "Team USA," which represents the United States at the International Association of Insurance Supervisors, the body that helps to coordinate insurance regulation on a global basis.

Recent Solvency Regulation History

It is important to observe that each generation of regulators has brought enhancements to solvency regulation. Most often, these improvements have followed a collapse of a major insurer. Most of these improvements originated with a particular insurance department and were eventually adopted by the NAIC and other states. The interval between local implementation and national adoption allows for "field testing" and any necessary adjustments to be made.

A brief summary of some of these improvements in recent decades are set forth below:

1950s

- Major changes in the regulation of reinsurance adopted, including the requirement of an insolvency clause in all reinsurance agreements.

- Convention Blank (annual statement reporting form) for life insurers considerably modified by the NAIC to bring it in line with current life insurance products and practices.
- Multiline Fire and Casualty Convention Blank adopted by the NAIC to match the reporting form to the multiline products being offered by fire and casualty insurers.
- A six volume set of books entitled "Examination of Insurance Companies' published by a major insurance department (New York)

1960s

- Revision of the NAIC Examiner's Manual adopted to improve the technical guidance provided to examiners.
- Major changes in annual statement reporting for fire and casualty insurers instituted, including the addition of Schedules O and P to report loss development.
- Model Act creating a state guaranty fund for property and liability insurers adopted by NAIC.
- NAIC staff enhanced to provide independent research for insurance commissioners on current insurance issues rather than reliance on research conducted by the insurance industry.

1970s

- Adoption of a regulation requiring annual audits by independent CPAs was enacted by the first state (Illinois).
- McKinsey Study of the financial surveillance system in the U.S. undertaken by the NAIC which recommends major improvements in solvency regulation, including a revision of the 'Examiners Manual' and renaming it 'The Financial Condition Examiners Handbook.'
- Creation of an early warning system and separation of market conduct examinations from financial examinations.
- Early-warning system consisting of key financial ratios and the development of the insurance regulatory information system (IRIS) instituted by the NAIC at the urging of a group of mid-western states.
- First accounting manuals for property and liability and life and health insurers adopted by a state (Illinois).

1980s

- 'Bell/Budd Study' created to follow up on the state implementation of the recommendations of the McKinsey Study.
- Bell/Budd Study created a new financial examination model act.

- Major changes in annual statement blank, including reinsurance reporting in Schedule F for property and liability insurers and Schedule S for life and health insurers adopted by the NAIC.
- Adoption of annual statement amendment requiring independent opinion on loss reserves by a qualified loss reserve specialist for property and liability insurer
- Enhancement of the NAIC staff to strengthen solvency monitoring of insurers.
- Model Act creating life and health guaranty association adopted by NAIC.
- First meeting of the International Association of Insurance Supervisors held, which was sponsored by the NAIC and funded by members of the insurance industry.
- Model regulation requiring annual CPA audit of all domestic insurers adopted by NAIC.

1990s

- Adoption by the NAIC of new investment statute for life insurers and property and liability companies.
- NAIC adopts an historic resolution criticizing certain of its members for pursuing action detrimental to the rescue of a troubled life insurer.
- Risk Based Capital Requirement established by the NAIC through adoption of a Model Act and a RBC formula for life, health and property/casualty insurers. The formula has been modified in succeeding years to respond to changing circumstances.

2000s

- Requirements of the actuarial opinion for property and liability upgraded by the NAIC.
- Internal control reporting of insurers enhanced through amendment of the NAIC Model Act.
- Risk-focused financial examination process introduced by the NAIC through a new financial examination manual

2010s

- Own Risk Solvency Assessment requirement added by adoption of a model law by the NAIC.
- Corporate Governance Regulation Disclosure adopted by the NAIC.
- Holding Co Act amended by the NAIC to capture more related party transactions for notice to regulators and prior approval.
- Risk-focused financial analysis introduced by the NAIC through a new financial analysis handbook.
- Group supervision and supervisory college procedures model law adopted by the NAIC.

Suggestions for Further Reading

Find IAIS issue papers here: https://www.iaisweb.org/page/supervisory-material/issues-papers#

Read more about the IAIS's Strategic Plan for 2020: https://www.iaisweb.org/page/about-the-iais/strategic-plan

Learn more from the National Association of Insurance Commissioners' (NAIC) website: https://content.naic.org/cipr_topics/topic_international_insurance_supervisioniais.htm

Read an NAIC issue brief on international insurance issues: https://content.naic.org/sites/default/files/inline-files/government_relations_2013_flyin_ib_international_0.pdf

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PART II- Commissioners Only

Introduction

The state insurance department and its agency head is unique amongst state governmental agencies in that it has exclusive power, authority and responsibility to regulate a critical segment of the state's economy, the insurance industry, and exercises that regulatory power to protect the state's citizens with respect to the insurance coverage they purchase. The job of insurance commissioner is partly executive, partly judicial, and partly legislative. The role and authority over insurers operating in the commissioner's state has been described 'as cradle to grave' in a company's life cycle.

The following sections set forth some thoughts and ideas for a new commissioner to consider as he/she becomes the agency head, particularly as they relate to solvency regulation.

Staffing and Other Resources

Obtaining and maintaining an adequate professional staff, possessing the knowledge and experience in many technical disciplines, is absolutely necessary to be effective at solvency regulation. This is not a place to put political friends. To accomplish the objective of having a corps of insurance professionals in the agency requires, for budgetary, personnel activities and related matters, well-researched and thoughtful arguments to convince the governor's office and the legislature that the insurance department is unique amongst state agencies and needs sufficient resources to attract, obtain, and retain quality personnel. A document setting forth these arguments should be prepared if such a document does not exist. If one does exist, it should be reviewed to make sure it is current and presents a convincing case. This might be viewed as a form of risk assessment for the agency to determine if present conditions and resources might inhibit its ability to accomplish its mission as set forth in state insurance laws.

A new commissioner might consider retaining a qualified individual or firm to review the staff and organizational structure inherited from prior administrations to ensure it is sufficient to effectively discharge the duties and responsibilities of solvency regulation.

The insurance business is changing frequently, presenting new challenges to the insurance department staff and its commissioner. Therefore, neither one can ever rest content that there is nothing more to learn. They must keep their knowledge current by reading trade publications, attending conferences, asking questions of industry personnel that visit the agency,

and in other ways. The appropriation of funds to the insurance department should contain provision for this learning to continue.

Influence and Interference

It is expected that the insurance commissioner, like other public officials, will behave honestly and conscientiously, adhere to the highest ethical and moral standards, and fulfill his or her duties with professionalism, integrity, and care. It is expected that the commissioner's discharge of duties will be done on a politically neutral basis with everyone treated with impartiality and courtesy.

While attempts to influence and interfere with a commissioner's handling of a troubled insurer, or in the exercise of other regulatory duties and discretion, do not occur as frequently as it did decades ago, it may still come about. Thus, one needs to be prepared in the event it does occur. The following are some things to keep in mind:

It is highly likely that the Governor has established policies and procedures to handle attempts to influence or interfere with decision making of governmental agencies under the Governor's control. It is important that you are aware of these directives.

The Department of Insurance should have its own internal policies and procedures regarding these types of activities involving your internal staff and reporting processes.

You should be aware that information and data developed through examination or investigation must be treated as confidential. The insurance law may require that other information the agency receives must remain confidential. You and your staff should be aware of these restrictions.

Any departmental contact should be clarified and categorized as to whether it is inquiry, complaint, or attempt to influence, so it can be dealt with according to established procedures. Often, attempts to infer or influence are clouded and presented in a confused manner by those who feel they are entitled to do so.

Economic Development

It is important to understand that the insurance department's primary function is to regulate the insurance industry doing business in that state. This activity should be given priority

over other activities that are designed to boost economic conditions in the state—for example by attracting captives or other insurers. Such activity may distract from important activities, such as solvency regulation. There are other state agencies that are more suitable to pursue these sorts of activities.

Hearings and Investigations

Certain matters submitted for regulatory review require and demand a rigorous review due to the nature of what is being proposed. It might involve a complex and large transaction or a statutory provision that does not specifically provide for what is being proposed, or it might involve and impact a large number of policyholders. In such instances, the commissioner should not hesitate to use the power to appoint an independent hearing officer to hear the matter and prepare a report and recommendations. The cost of the outside hearing officer usually can be assessed against the moving party.

Domestic Insurer Review

At least once a year, a commissioner should conduct a detailed review with appropriate internal staff of the individual insurers that comprise the domestic industry in your state. The review should cover financial position and operating results, consumer complaints, results of market conduct and financial examinations, financial ratings, media reports, financial analysis results, and critical insights from filings, such as ORSA reports, holding company reports, and others. Such a review is useful for several reasons. It will give you a specific understanding of the domestic industry and will identify companies that are of staff concern and the reason for that concern. It will also allow staff to showcase its work and create a host of other benefits.

Receiverships

Insurance companies are expressly excluded from the definition of debtor under the federal bankruptcy code. Therefore, insurance companies that become insolvent or otherwise troubled are subject to state insurance laws. Under these statutes, the insurance commissioner of the domiciliary state of the insurer becomes the conservator, rehabilitator, or liquidator. This is the other 'hat' an insurance commissioner wears besides being a government official. Being a receiver imposes different duties and responsibilities than those of being a regulator. As a regulator, the commissioner seeks to protect the public, but as a receiver, the duty is to serve and protect the interest of the policyholders and other creditors of the impaired insurer (referred to as an 'estate'). This is a proprietary function rather than a regulator function. The receivership

proceedings are conducted before a state court, which oversees the matter and reviews and approves materials transaction proposed by the receiver.

The day-to-day administration of a receivership estate may be conducted by an individual or firm, who the commissioner appoints, or an office which administers several estates, depending on the system used in a particular state. The individual responsible for administration of an estate or several estates is called a special deputy receiver.

It is important that the insurance commissioner periodically review the status of each estate and to review progress on tasks and activities set forth in closure plans that have been prepared for each estate. There is an inherent potential conflict between the needs of the special deputy receiver and the objective or mission of receivership. This conflict arises from the fact that the special deputy receiver and his or her staff are paid from the assets of the receivership estate, whereas the policyholders and creditors that want to be paid as quickly as possible are paid from assets marshalled. The commissioner needs to be certain that estates are finalized as soon as possible. Thus, one of the responsibilities of the commissioner is to ensure that the estate receivership is being conducted efficiently and effectively with a closure plan that is in the best interests of policyholders and other creditors. To ensure this is being done, a commissioner might want to engage an individual or firm to conduct a review of each estate and provide recommendations.

Approval Procedures—Routing, Powers of Attorney

In the area of solvency regulation, there are a myriad of matters that require the commissioner's signature. These range from routine certification of documents to an application for approval of the change in control of the largest insurer in the state. By necessity, this situation requires that individuals be authorized to affix the commissioner's signature to certain routine documents. Such authorization is granted by a power of attorney given to a specific individual that states what can be signed and under what conditions.

Approval or disapproval letters or documents that require the commissioner's signature that cannot be affixed by others should be identified in an internal procedure policy. This policy should identify other areas or positions in the insurance department that must review and make recommendations to the proposed transaction before the file is routed to the commissioners' desk. This routing process permits the commissioner to receive input from various subject matter experts and other professionals in addition to the staff that does the initial review. The process also allows the commissioner to evaluate the scope and quality of staff reviews.

Postmortem

Despite best efforts in the solvency regulation area, an insurer may fail and be placed in some form of receivership proceedings. It is important and beneficial that a review be conducted of the department's pre-receivership activities and actions to determine if a different course of action might have prevented the failure or resulted in earlier detection. The purpose of such a study is not to "point fingers" at anyone, but rather to make improvements for the future.

The commissioner might consider retaining an individual or firm that is independent to conduct this postmortem review. If a significant domestic company fails, it is necessary that such a review be conducted. Since state insurance guaranty funds are given the authority to prevent insolvencies, the study proposed above might be funded by the applicable safety net organization.

Troubled Insurers

As suggested in the Troubled Insurance Company Handbook developed for the NAIC, it is highly desirable to have a full- or part-time special unit in the insurance department to monitor and regulate insurers that are of concern from a solvency standpoint. Such a unit should be staffed with highly knowledgeable individuals with experience with various lines of insurance business. They should be familiar with the powers and authorities the commissioner has to address a troubled or potentially troubled insurer. In addition, they should have personal characteristics that ensure they will treat information confidentially; they will be skeptical, diligent, and committed to the mission. The commissioner should meet with the staff of this unit at least weekly to receive status reports. All areas of the department should be instructed to report information on the subject insurer when received to the unit, so that intelligence can be analyzed. The commissioner should not hesitate to use external professional resources to supplement and assist the unit.

The National Association of Insurance Commissioners

As stated earlier, the NAIC is a voluntary association of insurance regulators from the various states. No state law requires a commissioner to participate in the organization. Nevertheless, as described throughout this course, this organization is an important and vital part of the state insurance regulatory system. While the NAIC has a sizable staff, they do have regulatory authority or frontline regulatory experience. They rely on insurance department staff to innovate and develop improvements in surveillance methods. The commissioner and staff must make other NAIC members aware of emerging issues and problems, so that appropriate

response can be achieved. Therefore, it is imperative that all states actively participate in the NAIC.

APPROACH to REGULATION

Little has been written about the role of state insurance commissioners in the US and how they develop their regulatory agenda. Most of the studies of regulation have been written by lawyers and economists with little attention paid to the "what', 'how' and 'why' of insurance regulation. Similarly, little has been written about the skills and qualities required to be successful in that position. In the view of most, a regulator should be an individual who can be fair, measured and balanced. An insurance commissioner, like any other governmental official or US citizen is entitled to his or her personal perspective on social and other issues; however, these personal views and preferences should remain at the door of the insurance department and not influence solvency regulation action or priorities. The insurance law should be enforced without bias or preferences and as written and intended by the state legislature.