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CRE READING PROGRAM INSTRUCTIONS

The Society of Financial Examiners has a Reading Program for earning Continuing Regulatory Education credit by reading the articles in The Examiner.

You can earn 2 CRE credits for each of the 4 quarterly issues by taking a simple, online test after reading each issue for a maximum total of 8 CREs per year. There will be a total of 9–20 questions depending upon the number of articles in the issue. The passing grade is 66%.

Earn Continuing Regulatory Education Credits by Reading The Examiner!

To take the test, read all of the articles in the issue. Go to the Members section of the SOFE website to locate the online test. This is a password protected area of the website and you will need your user name and password to access it. If you experience any difficulty logging into the Members section, please contact sofe@sofe.org.

NOTE: The Reading Program Test from this issue and future issues of the Examiner will be taken online. You will no longer print out the test and send it in for scoring. Each new test will be available online as soon as possible within a week of the publication release. The Reading Program online tests are free. Scoring is immediate upon submission of the online test.

Retain a copy of your online test score in the event you are audited or if you need the documentation for any other organization's CE requirements. Each test will remain active for one year or until there is a fifth test ready to be made available. In other words, there will only be tests available for credit for four quarters at any given time.

The questions are on the following page. Good luck!

CRE READING PROGRAM QUESTIONS

The Reading Program Test from this issue and future issues of the Examiner will be offered and scored online. Please see the details on the previous page.

All answers are True or False

On the Road to Receivership

True or False Questions — Submit Answers Online

1. Examiners and analysts have no role in a receivership.
2. Department personnel should make sure that all communications with the Company area clear as to what is being required or requested and are well documented.
3. A company can be placed into liquidation based upon rumors of unethical activity by one of its executives.
4. Examiners and analysts can make the judge's decision in the receivership process easier by making sure that all statutes have been complied with and the Company has been given every reasonable opportunity to correct their problems.

Financial Solvency and Unclaimed Benefits

True or False Questions — Submit Answers Online

1. The AICPA has not yet listed unclaimed property as an audit risk for life insurance companies.
2. Life insurance companies would not use the social security death index to alert them to deaths in order to stop annuity payments unless they also used the index to identify unclaimed life insurance benefits.
3. The liability for unclaimed death benefits plus reserves held on these policies is reportable as IBNR claim reserves.
4. IBNR claim reserves are often based on historical claims reporting and payment experience and include claims which are never reported.
5. The following is not a good control for unclaimed life insurance benefits "Does the company include claims which are never reported as part of the IBNR."

We're Connected…now what?

True or False Questions — Submit Answers Online

1. According to the Accenture 2012 Consumer Electronics Report, consumers in the US have been spent $750 dollars in the past 12 months on electronic devices.
2. Eighty percent of US users of electronic devices use these devices for personal use.
3. Both the Interview note taking and documenting walk-through processes can be made simpler using an application on an electronic tablet.
4. Tablet PCs differ from the iPad and Android tablets in that they operate on a Windows platform.

U.S. Insurance Financial Regulatory Oversight and the Role of Capital Requirements

True or False Questions — Submit Answers Online

1. Under the defined limits investment limitation approach, regulators restrict investments based on a "prudent person" approach, allowing for discretion in investment allocation if the insurer can demonstrate their adherence to a sound investment plan.
2. According to the article, the U.S. solvency oversight framework is designed to eliminate all insolvencies.
3. Although the NAIC Financial Analysis Working Group (FAWG) may request the domiciliary regulator of a potentially troubled insurer to answer questions and make a presentation to FAWG, FAWG does not have specific regulatory authority.

Evolving Insurance Regulation: On the Move

True or False Questions — Submit Answers Online

1. The IAIS was established in 1997 with the broad aim of harmonizing international insurance regulatory requirements.
2. A key concern of the financial crisis is capital adequacy which renewed the push for reform.
3. The new Insurance Core Principles will be a step in achieving consistency in regulatory requirements.
4. Companies who are actively involved in shaping the new reforms will be at a competitive advantage in meeting the new challenges in regulation

On The Road to Receivership

By Wayne Johnson, CFE

The Basics of the Project

Sometimes it is difficult to know when a project actually begins. Remember when you painted that room in your house last year? You were standing there with the paint roller in your hand wishing you were done and thinking that you had been painting for two hours already. But didn't you have to prep the room first with that blue tape? And what about going to the store and picking out the paint and then waiting for them to mix it. And if you went on Saturday morning penalize yourself another hour.

In some respects, a receivership is a lot like that painting project. If you want it to turn out well you have to go through all the steps, skip just one and you may have a mess on your hands. It is easy to say that a receivership begins when the judge signs the order officially placing an insurance company in conservation, rehabilitation or liquidation (each is a form of a receivership), but in reality I would suggest that the "project" started long before.

So what if anything does an examiner or analyst have to do to make a receivership turn out "well". We are definitely going to have to know what "well" means, but let's answer two other questions first.

What is the examiner's role in a receivership?

What is the analysts' role in a receivership?

You may be surprised to learn that as an examiner or analyst you have an official role in a receivership. Actually that role can either be scapegoat or hero, and in almost all cases a witness. It is almost a given that as the examiner or analyst you will be a witness in a receivership unless you manage to successfully talk your boss into doing that for you. Since you forgot "Bosses Day" last year it is probably safe to assume you will be a witness. Before I forget to mention it, there is one other option to avoid being the witness and that is to do such a good job that the insurance company in question decides to give up and consent to the receivership. But before we talk about that, let's cover your new role as a witness. The legal counsel for the insurance company will want to review each and every document that you prepared, received or read regarding the insurance company. Since you are not busy it will be easy for you to go through your files and make copies of all of these documents for the insurance company's legal counsel. Did I forget to mention all of the e-mails regarding this company and documents that you have archived? They will want those as well. Don't forget to make a second copy of all of these documents for your legal counsel. Some of you are now polishing up your resumes and drafting a very polite resignation letter. Hold the thought and let's discuss how you might avoid this dilemma.

First, answer this question. *The legal counsel for a company that is failing is most likely to*;

A. Blame you for the company's failure;
B. Blame the Commissioner for the company's failure;
C. Blame the Department for the company's failure;

If you answered anything other than A, B or C we need to talk. Knowing that you are a very likely candidate for scapegoat of the year there are a number of things that you can do to avoid this honor. The first is to simply understand the playing field. When legal counsel is retained by an insurance company their job is to advocate for their client. In most cases that means finding any defense that will protect their client. After combing through all of the documents in the possession of the Department, there is a good possibility that opposing legal counsel will point to one of those documents and argue that you gave them permission to do the very thing that the Department is now challenging. Before we get to a discussion of your deposition, let's back up and consider another course.

I'm going to suggest that like the painting project, a receivership actually begins at an earlier point. The foundation for the Department's future regulatory actions, including a possible receivership is built on the examiner's or analyst's actions every time he or she touches a file or the exam work papers. Obviously no one likes the thought that he or she missed something during an exam, the review of a financial statement or the review and approval of another type of transaction. I'm going to give you a provisional pass at this point and say that you did not miss anything *based on the information that was provided to you*. Let's focus on some other aspects of how we deal with companies from a communication perspective.

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On The Road to Receivership (cont.)

Earlier this week I was deposed and asked to recall events that happened in the fall of 2004. I realize that several of you have total recall abilities, but for the rest of us recollection of events that occurred seven years earlier may present a problem. The only reasonable chance that most of us have is to be able to look at a document that will help us recall the events in question. That leads us to the unofficial rules for receivership projects:

Rule #1: Any communication *of substance* with an insurance company or someone representing a company needs to be in writing. An e-mail is acceptable provided that form of communication does not violate your Department's policies. Generally anything other than a comment regarding the weather or the location of a meeting with a company is *of substance*. I once had a conversation with a representative of a company during an NAIC meeting regarding the weather. The representative of the insurance company then phoned one of the examiners at the Department indicating that I had given approval to his client's request. The examiner told him that was great, and asked to see a copy of the letter from me in order to process the transaction.

A meeting is also a form of communication with a company. Don't leave a meeting with a company without making the Department's position clear. It is a good practice to follow-up a meeting with a letter to the company conveying the Department's understanding of what was said and agreed to during the meeting.

Rule #2: Make sure that your communications are clear, all of them. I recognize that many of you majored in something other than English or written communications, but this is a critical point. Whatever you are asking for or directing a company to do needs to be clear to the judge that will read it. Count on legal counsel for the insurance company to have another interpretation of what is being requested or approved in your letter or e-mail. One of my examiners once sent a confirmation letter to a bank asking them to "confirm" a list of certificates of deposit. The bank "confirmed" the certificates of deposits, but neglected to mention that they were all pledged, because as they argued at a later trial, they were not specifically asked about pledges. Just as important, if you give approval be clear as to what you are approving. In most cases that means indicating that your approval is based on the documents provided (I would list them in my letter), referencing the applicable statute or rule and giving an explicit approval. A more general or vague approval may later be interpreted in a way that you never intended.

This rule has a couple of sub-rules. Those of you that are tempted to characterize individuals at the company or the company with words such as *fraudulent conduct, clearly illegal, flagrant violation, criminal*, or *unethical* would be better served with a more neutral tone. Not just in letters to the company, but in internal e-mails as well. I have heard the "they were out to get us" defense on more than one occasion. The second sub-rule is to have someone proof-read your communications with a company. Whether the edit is a simple typo or a more critical edit the time to fix it is before it leaves the Department.

Rule #3: In order for a company to be ordered into rehabilitation or liquidation you must prove one or more grounds for rehabilitation or liquidation exists. So, what are the grounds for receivership in your state? If your answer was anything other than to start naming them we have a problem. Beyond the obvious impaired or insolvent benchmarks, generally there are ten or more statutory grounds in every state for a receivership. If you have documents in your files that show a company meets one of the grounds for a receivership, and the Department has not taken any action, the company may argue that they have notified the Department and the practice has been approved. Some of you may have a homework assignment.

Rule #4: Know the Department's policies and procedures as well as the statutory procedures associated with a receivership proceeding. There is nothing worse than being deposed and having to admit that you did not follow the Department's written procedures or that you failed to give the company the time frames allowed by statute to correct a problem. This may also foster the "they were out to get us" defense and/or get the case dismissed.

Rule #5: Judges are often reluctant to order a company into any form of receivership. They are in the difficult position of weighing the information that the Department has presented against the arguments that have been made by the company. Don't make it a close call for the judge. Make sure that you have complied with every statute and given the company every reasonable opportunity to correct their problems. Moreover, make sure to provide the judge with documents that respond to every argument made by the company's legal counsel.

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On The Road to Receivership (cont.)

Earlier I suggested that we would circle back to a definition of "well" in the context of a receivership. First there is "well" for you as the examiner or analyst. In that context if you have followed the five rules above then the company may consent to the receivership (I just gave away one of the answers to Rule #3) and you may not have to produce a lot of records, be deposed or testify at a hearing. That should be a relief. Then there is also "well" in terms of the receivership itself. The receivership does not end when the judge signs an order placing the company in rehabilitation or liquidation. The Court appointed Receiver in most cases is trying to recover assets that belong to the company or may bring an action against someone or some firm that caused the failure of the company. The recoveries made by the Receiver ultimately flow to consumers to pay for their losses. Those recovery activities will be based in large part on the regulatory record that is created by the examiner or analyst. The communications with the company, the exam reports, and the company filings will all play a part in the ultimate outcome of the receivership.

The regulatory record created by the examiner and the analyst is a lot like picking out that color of paint. You can't finish the project without doing all the steps.

About the Author

Wayne Johnson, CFE, is the Director of Insolvency Consulting with McGladrey. He has over 20 years of experience in insurance regulation and insurance company receiverships. He was the Director of the Florida Department of Financial Services Division of Rehabilitation and Liquidation and a past chair of the NAIC Receivership Technology and Administration Working Group. He has made numerous presentations on receivership issues and best practices for a receivership. Wayne can be contacted directly at wayne.johnson@mcgladrey.com or at (850) 363-4853.

Financial Solvency and Unclaimed Life Insurance Benefits

By Randall A. Stevenson, ASA, FCA, MAAA

Several states have been conducting unclaimed property examinations of life insurance companies. The AICPA listed unclaimed property as an audit risk for life insurance companies for 2012. Unclaimed property is associated with escheat liabilities but also has financial solvency implications. Unclaimed benefits directly impact the Incurred But Not Reported (IBNR) claim reserves. This article will help financial examiners determine the likelihood and impact of unclaimed life insurance benefits for a risk-focused examination. It will also present means for testing controls and substantively testing to determine the liability.

Background

Between 1970 and 2000, several mutual life insurance companies converted to stock ownership. Many of these companies escheated demutualization proceeds to states for policyholders who could not be located (about 8%). State custodians found many (about 10%–30%) of these policyholders were deceased. Approximately 85% of unclaimed property is never recovered by the owners, so escheat is a non-tax revenue source for states. Several states initiated unclaimed property examinations of life insurance companies, often in conjunction with market conduct examinations. These were often conducted by firms specializing in locating unclaimed property for state treasurers for contingency fees of 8%-10% of the amounts recovered. The market conduct examinations were based on companies using the social security death index to alert them to deaths in order to stop annuity payments but not using the index to identify unclaimed life insurance benefits. The financial solvency considerations have not been as much of a public focus as the escheat and market conduct issues.

When an insured individual dies and no death claim is filed with the insurer, several things can happen:

1. The policy lapses with no value and no reserves,
2. The policy converts to extended term insurance and eventually expires with no value and no reserves,
3. The policy remains in force as paid-up or reduced paid-up insurance, or
4. The policy uses the cash value to fund automatic premium loans until the cash value is less than a premium payment and the policy converts to its non-

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Financial Solvency and Unclaimed Life Insurance Benefits (cont.)

forfeiture benefit.
If the company has no knowledge of death, paid-up policies are to be escheated to the appropriate state within a few years after the insured would have attained the mortality table limiting age. If a person dies while extended term insurance is in force or the policy is funded with automatic premium loans, the family may not know the policy was in force at the time of death. The liability for unclaimed death benefits less reserves held on these policies is reportable as IBNR claim reserves.

Likelihood and Impact

A few key considerations in determining the likelihood and impact of unclaimed benefit liabilities are type of policy, size of policy, status of policy and the company's procedures for addressing unclaimed benefits. Industrial policies are the most likely to have unclaimed benefits, followed by ordinary life policies, then credit life and finally group policies. The primary reason for the difference is financial sophistication. Group policies are usually through an employer or association and there are often people in those organizations who help beneficiaries collect the insurance proceeds. With credit life, the creditor will often assist in the benefit collection upon being informed of the insured's death. Industrial policies are often smaller and associated with specific funeral homes. Beneficiaries of life insurance policies with smaller face amounts are more likely to fail to file claims than beneficiaries of policies with larger benefits. This is due to the effort required in filing a claim, level of financial sophistication and likelihood of beneficiary's knowledge of the policy and the age of the policies. Premium paying policies are less likely to have unclaimed benefits than policies which are not premium paying.

Some other considerations are the agent relationships with the policyholders, the age of the policy and stability of the insuring company identity. Consolidated financial planning and low agent turnover improve the likelihood of an agent pro-actively assisting beneficiaries. Direct written insurance has a greater chance of the beneficiaries not being informed of a potential claim. Older policies are more likely to have unclaimed benefits for several reasons, including the insured individuals are generally more likely to be deceased. New issues are not very likely to generate significant unclaimed benefits because the family is usually aware of the recent purchase. When companies change names or transfer policies through assumptive reinsurance agreements it is more difficult for beneficiaries to identify the company by which the decedent was insured.

The potential impact on surplus is the difference in the total estimated unclaimed benefit amounts and total estimated reserves for policies with unclaimed benefits. Life insurance companies have indicated about 1% of death claims are never filed. This indication closely matches the results from the escheated demutualization proceeds. One very quick method to estimate impact is to consider 0.5% of death claims for the past several years. This includes an adjustment for the expected reserve release.

Example

According to its annual statement XYZ Life Insurance Company paid $273 million in death benefits (Line 10, Page 4). If we were considering 10 years retroactively, a quick estimate of the potential impact would be

10 years X $273 million in death claims per year X 0.5% of death claims = $13.65 million.

Another way to estimate the impact is to apply weighting to policy groups. This takes into account the types of business issued by the company. An example is the table below.

The table is provided for illustrative purposes only and should be modified based on the examiner's judgment and expectations. For example, the 0.1% for premium paying ordinary life insurance may be based on the assumption the company has automatic premium loan provisions on its policies and the company offers automatic bank drafts for these policies. If a company has simplified claim filing procedures (from the perspective of the ben-

Unclaimed Benefits Amounts Estimate Table (% of In-Force)

	Industrial Life	Ordinary Life	Credit Life	Group Life
Premium Paying	0%	0.1%	0%	0%
Paid Up	20%	10%	1%	1%
Extended Term	5%	2%	1%	1%

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Financial Solvency and Unclaimed Life Insurance Benefits (cont.)

eficiary) for small face amount policies, then the impact of industrial policies would probably be lower.

The reserve released may be estimated using the ratio of reserves released due to death (Line 10, Page 7) to the death benefits paid net of reinsurance (Line 10, Page 4 or Line 10, Page 6).

Example

According to the Exhibit of Life Insurance In-Force (Pages 24–25) XYZ Life Insurance Company has the following amounts of life insurance in force (in millions):

	Industrial Life	*Ordinary Life*	*Credit Life*	*Group Life*
Premium Paying	*$24*	*$10,573*	*$400*	*$0*
Paid Up	*$10*	*$36*	*$175*	*$0*
Extended Term	*$2*	*$7*	*$0*	*$0*

Applying the factors in the unclaimed benefits amount table above, we get the following:

	Industrial Life	*Ordinary Life*	*Credit Life*	*Group Life*
Premium Paying	*0% of $24 = $0.0*	*0.1% of $10,573 = $10.6*	*$0*	*$0*
Paid Up	*$2.0*	*$3.6*	*$1.8*	*$0*
Extended Term	*$0.1*	*$0.1*	*$0*	*$0*

The estimate of unclaimed death benefits is $18.2 million.

From line 10 on pages 6 and 7 of the annual statement, we see the company paid $273 million in death benefits and released $128 million in reserves due to death. So the estimate of reserves held on unclaimed benefits is

$18.2 million X $128 million /$273 million = $8.5 million.

The estimated IBNR adjustment would be $18.2 million - $8.5 million = $9.7 million.

Controls

There are four principle areas of control for unclaimed life insurance benefits:

5. Does the company attempt to determine if an insured individual is deceased?
6. Does the company include claims which are never reported as part of the IBNR?
7. Does the company correctly compute the unclaimed death benefits?
8. Does the company have escheat procedures in place, which transfer liabilities from IBNR to escheat liability?

According to SSAP 61, the event which creates the liability for a claim (i.e. death of the insured) causes the liability to be reportable, even if the company does not have knowledge of death. The better a company is at determining whether insured individuals are deceased, the better it will be in determining the liability. Ideally, companies will attempt to contact policyholders or determine if the insured is still alive when there is returned mail, a change in premium payment status or a change in coverage status based on a default or previous policyholder election. At a minimum the company should determine, within a year of termination of coverage or conversion to reduced paid-up, whether a covered individual was alive when coverage terminated or converted to reduced paid up. A good practice would be to check extended term policies and paid up policies periodically. If a claim or death notice is filed for an individual for one policy or contract, the company should have a means to identify other policies and contracts covering the individual. Company policies and procedures for these activities are often found in the company's escheat procedures.

IBNR claim reserves are often based on historical claims reporting and payment experience and exclude claims which are never reported. The part of IBNR for claims which are never reported is sometimes jokingly referred to as Incurred But Not Really, since ignoring this liability results in the liability disappearing from the financial

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Financial Solvency and Unclaimed Life Insurance Benefits (cont.)

statement. For paid-up policies the reserve at the limiting age is the death benefit, so companies often do not consider these policies when computing IBNR.

When unclaimed death benefits are computed, they should be based on the policy coverage at the time of death. Before reserving or escheating a policy based on reduced amounts, the company should be reasonably certain the individual was alive when the policy converted to a reduced paid-up status. Similar issues apply to automatic premium loans or policy loans being deducted from benefits payable and to the payment of policy dividends and interest on death benefits.

If proper IBNR and escheat liabilities are established, the IBNR and policy reserves would be reduced for liabilities as they are transferred to the escheat account. Each entry into the escheat liability should be tied to a reserve release and an IBNR reduction.

Substantive Testing

Substantive testing of unclaimed benefits presents several challenges. Since the size of a policy affects the likelihood it will generate an unclaimed benefit, probability proportional to size (PPS) testing is likely to produce biased results. Although a true substantive test would include policies which have terminated in the past and for which the company no longer carries any reserves, such testing is not always practical. Policies issued prior to the mid-1970s were often issued without a record of the insured or policyholder's social security number. Identifying these individuals as deceased is often difficult. Other factors that make identifying individuals on the social security death index difficult include alternative first names, incorrect years of birth, transposed or transcribed digits in the social security numbers and changes of last names due to changes in marital status. Companies are hesitant to provide personally identifiable information, such as social security numbers and other information needed to adequately identify the insured individual. Additional security precautions are needed when such information is used. As of November 1, 2011, the Social Security Administration removed death information obtained from States from the publicly available social security death master index. This resulted in the removal of 4.2 million of the 82 million death records and will eliminate about 1 million of the 2.8 million deaths reported each year. There are errors in social security death master index.

To quantify the impact on IBNR and surplus of unclaimed benefits, one could compare the entire database of policies – in-force, terminated and expired – to the social security death master index or another source of death records. This can be cost prohibitive and very time consuming.

The best sampling methods would be a stratified sampling, which involves selecting random samples from all of the status-type combinations (referred to as strata) of policies to be tested and extend the results of testing from each stratum to the entire stratum. The optimal allocation of the sizes of samples from each stratum would require estimating variances of each stratum (Neyman Allocation). Another method is to select samples for testing proportional to the number of policies or amount at risk in each stratum. Stratified sampling can be computationally complex. The advantage is it can minimize the number of policies needed to provide an estimate.

A simplified sampling method is to combine all the non-premium paying policies (including policies paying premiums through automatic premium loans) and policies which have lapsed without additional benefits in the prior year (or years to be tested) as the policies to be tested. From these policies select 2 or more random sample sets of at least 30 policies each. The actuary on the examination can assist in determining sample size and the number of sample sets to select. For each policy in the sample sets, attempt to determine if the insured is deceased and the benefit payable at the time the insured deceased. Ancestry.com, LexisNexis and other online resources have this information available. Until recently Ancestry.com could be accessed free, but now the use of their information requires registration after a trial period. Other potential sources include credit reporting agencies, state's departments of vital records and firms which offer unclaimed property services. Categorize policies as active with unclaimed benefit due, expired with unclaimed benefit due, no benefit due, or indeterminate. Indeterminate policies are those where there is some evidence of death, but not enough to make a determination based on the examiner's judgment. To obtain an estimate of the impact on surplus the following formula may be used.

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Financial Solvency and Unclaimed Life Insurance Benefits (cont.)

Estimated IBNR Adjustment = NAR X $(ActBen_{UB} – RES_{UB}) / (RepBen_{UB} + Ben_{NP} – Res_{UB} – Ben_{NR})$

Where

NAR = Net Amount at Risk

= Sum of Death Benefits Reported – Reserves Reported for the Population,

$ActBen_{UB}$ = Unclaimed benefits payable from policies in test sample

(Actual amount payable, not necessarily the amount reported),

$RepBen_{UB}$ = Reported benefits on unclaimed benefits payable from policies in test sample,

Res_{UB} = Reserves reported on unclaimed benefits payable from policies in test sample,

Ben_{NP} = Reported amounts tested which were not payable from policies in test sample, and

Res_{NR} = Reserves reported on policies which were not payable from policies in test sample.

A simpler alternative is to apply the average unclaimed benefit in the sample set(s) to the entire population.

No. of policies in population X $(ActBen_{UB} - Res_{UB}) / (No.$ of policies in sample – No. of indeterminate polices)

For policies in reduced paid-up, automatic premium loan or terminated status, the death benefit payable may exceed the amount reported on the database. For policies which were believed to terminate or expire, the reported benefit and reserve would be $0. The results for these policies can be multiplied by a factor to account for prior years with terminated and expired policies purged from the data file. This factor could be the number of years considered retroactively or the sum of the death benefits for the years considered divided by the death benefits for prior years. Reduced paid-up policies would also have benefits greater than the reported benefit if the insured died prior to the policy converting to non-forfeiture status.

Example

Company ABC has been stable in benefits and insurance in force for the past several years. We want to consider unclaimed benefits assuming we can go back 5 years. The database tested is limited to active policies with no premium being paid and policies which terminated coverage in the previous year. The population to be sampled contains 20,000 policies, $190 million of insurance in force and reserves of $24 million. Two samples of 50 policies each were selected, the results are below:

First group of 50 policies

	Active with Unclaimed Benefits Payable	*Terminated with Unclaimed Benefits Payable*	*No Benefits Payable*	*Indeterminate*
Number of policies	*7*	*1 –> 5*	*39*	*3*
Reported Benefits	*$13,000*	*$0*	*$380,000*	*$75,000*
Actual Benefits	*$20,000*	*$2,000 –> $10,000*		
Reported Reserves	*$3,000*	*$0*	*$42,000*	*$10,000*

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Financial Solvency and Unclaimed Life Insurance Benefits (cont.)

Second group of 50 policies

	Active with Unclaimed Benefits Payable	*Terminated with Unclaimed Benefits Payable*	*No Benefits Payable*	*Indeterminate*
Number of policies	*5*	*1 –> 5*	*42*	*2*
Reported Benefits	*$12,000*	*$0*	*$420,000*	*$25,000*
Actual Benefits	*$12,000*	*$5,000 –> $25,000*		
Reported Reserves	*$2,000*	*$0*	*$58,000*	*$5,000*

NAR = *$190 million - $24 million = $116 million*

$ActBen_{UB}$ = *$20,000 + $12,000 + (5 x $2,000) + (5 x $5,000) = $67,000*

Res_{UB} = *$2,000 + $3,000 = $5,000*

$RepBen_{UB}$ = *$25,000*

Res_{UB} = *$380,000 + $420,000 = $800,000*

Ben_{NR} = *$42,000 + $58,000 = $100,000*

Estimated IBNR Adjustment = $116 million X ($67,000-$5,000) /($25,000+$800,000-$5,000-$100,000)

= $9,988,889

Using the alternative method we get:

Estimated IBNR Adjustment = 20,000 policies x ($67,000-$5,000)/(100 policies -5 policies) = $13,052,632

Due to the relatively small number of policies with unclaimed benefits payable, the range of the error of the estimate can be quite large.

For the first group of 50 policies the average unclaimed benefit IBNR per policy was ($30,000-$3,000) /47 or $574.47. For the second group it was ($37,000-$2,000) /48 or $729.17. The average of the two, $651.82, is the expected average unclaimed benefit. Taking the standard deviation of the sample averages, $109.39, and using a t-distribution statistic, there is a 90% confidence that the true average is in the range of $651.82±6.314x$109.39, or between ($38.87) and $1,342.51. Applying these to the 20,000 policy population, we get a range of ($777,400) to $26,850,200.

If this range is too large, additional samples of 50 can tested, until the range is sufficient for the purposes of the examination. If a third sample of 50 had an average of $600.00, the new average would be $634.55 and the sample standard deviation would be $77.35. Applying the appropriate t-distribution statistic we obtain a 90% confidence the average range is within $634.55±2.920 x $77.35. Thus, the total impact is 90% likely to be between $408.68 and $860.41 per policy in the population or in the aggregate ranges of $8.1 million to $17.2 million. This process may be repeated until the range is sufficiently compact for the purpose of the examination.

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Financial Solvency and Unclaimed Life Insurance Benefits (cont.)

Conclusions

Through proper evaluation of the likelihood and potential impact, the level of a company's inherent risk related to unclaimed benefits can be reasonably assessed with minimal effort. Although most companies will probably not be significantly impacted by unclaimed life insurance benefits, companies should have controls in place to properly establish IBNR claim reserves and escheat liabilities. Substantive testing and accurate estimation of unclaimed benefit liabilities can be challenging and time consuming. It may require the use of experts.

Having companies appropriately report unclaimed benefits as liabilities will more accurately reflect the companies' liabilities and provide them an incentive to locate beneficiaries, settle claims and develop expedited claim settlement procedures for life insurance with small benefits. It will also help ensure companies the correct amount of unclaimed benefits to states in a timely manner.

About the Author

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We're connected…now what?

By Patricia Rowlett, CISA, CISSP

Are you a new e-reader or tablet user? Did you trade in your cell phone for a smartphone? If so, you are not alone. According to the Accenture 2012 Consumer Electronics Report[1], consumers in the United States have spent almost $1000 over the last 12 months on electronic devices. And these devices can do just about anything! Just like your laptop, there are applications for these devices. There are many applications or "apps" for these devices. Think of any task and yes, there's an app for that!

Even better, these apps are far cheaper than in the past. Some are free, some are as low as 99 cents, and most are well under $50. Many offer trial versions that allow you to take them for a test drive.

How we get these new apps is far different from the days of the PC Jr or Apple IIc. Gone are the days of feeding several diskettes or disks into the computer and selecting what seemed like a hundred configuration settings. Now the apps are available online. We simply visit the app store and make our selection and viola, we have new functionality!

But are you an app user or just an app collector? Do you use apps just for entertainment? On Apple's App Store, the "Hall of Fame" lists the "very best of the best" apps. Most are games, many are informational or news reading, and some are how-to guides (i.e., cooking). But only about a handful are productivity-oriented.

Do you make use of your new gadget at work as well as at home? In the survey, Accenture found 61% of US users use their tablet mainly for personal use. While it may not be a good idea (or even within policy) to use your work laptop to update Facebook, it may be a good idea to use your personal device to help you be more productive at work. Are you making the most of your new devices? Are you making the most of your older devices or are you using your laptop only for spreadsheets and e-mail?

Let's take a look at some solutions that can help put your device to good use. Where would you welcome efficiency? What are the apps that can increase your productivity? Consider three basic areas: time keeping, documenta-

[1] Always On, Always Connected, *Finding Growth Opportunities in an Era of Hypermobile Consumers, The 2012 Accenture Consumer Electronics Products and Services Usage Report*

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We're connected…now what? (cont.)

tion, and reference. I will share with you some apps I have found to help me in these areas in both my work and personal life.

Time Keeping

Tracking time can be…well time consuming! We are often working on many examinations or projects at a time. While our organizations all have time reporting applications that we must enter our time on a weekly or bi-weekly basis, they are not designed to track the time on a daily basis. Without tracking on a daily basis it is pretty much a memory test or worse a guess at the end of the week. A small note pad can do the trick, but it doesn't offer any options to compile the information.

An easy and affordable application that I use to help me keep track of time is Easy Time Tracking (ETT). ETT allows you to set up projects and tasks and then log time against them. Tasks are associated with projects and you can have as many or as few tasks within a project. The start and end times of the project and billing rate are established. Time can be entered in hours and minutes or by start and stop time. A large text field is available to capture activities performed for the time being entered. You could indicate with whom you met, the sections you worked on, or any other information you think may be useful in the future. Options such as 'billable indicator' make it possible to track all of your unbillable time as well.

ETT's reporting is as granular or as broad as you like. I generated a report for a project that spanned a year and produced monthly totals for the time spent. I could quickly see what tasks were performed during each month and how much time was charged against each task. This was quite useful when I was planning future work for a similar project.

ETT also has other functions such as 'to-do list tracking and invoicing'. The app is $49 (with optional annual support) and is available to test drive for 30 days. See the ETT website for additional information www.easytimetracking.net/index.asp

Documentation

Interviews are a critical part of the examination. A lot of time is spent capturing and documenting interview notes. Capturing in an electronic form is an obvious solution. But how can this be accomplished? I have seen laptops in many meetings. While this does capture the notes, both the screen and the sound of the keystrokes can be distracting to the interviewee. Consider using an electronic tablet to capture your notes. Unlike typing on a keyboard where the clicking of the keys can be distracting; note taking on an electronic tablet is less intrusive to the interview.

Taking notes on an electronic tablet can, however, be more than a time saver. Transcribing notes written on paper can be a time killer. Transcribing your electronically captured notes can take just a few minutes. Many of the applications have a function that will convert your notes to a Word document. Depending on your needs or organization procedures, you may not need to transcribe the notes at all! Simply attach the electronic notes to your workpapers.

There are many options to record your notes electronically. Apps that run on the iPad and Android platforms are available to transform your touch pad into a note taking device. Using a stylus, you write as if you were writing on paper. Journaling apps are also available for both Android and iPad devices. The most popular is Apple's Evernote which operates on both as well as the Blackberry.

With Evernote you can create notes in a variety of formats including text. The notes can be organized in a variety of ways. You can search on keywords. But Evernote goes beyond capturing notes. Evernote can capture web pages, store photos, and voice recordings and even webcam recordings.

Your notes can be stored locally, remotely, or both. In addition, it offers encryption options for sensitive data. For examination notes, the local option would probably be best; however, for non-examination notes, consider the remote or cloud option. Using the cloud gives you a backup should you lose your device or it stops working.

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An older device may be the trick!

eBay is an excellent resource for used electronics. With technology changing so quickly, you can get barely used devices at less than half the cost! This is a great option if you are buying devices for your children or want to test a device out. These used devices may be sold by individuals or, like mine, may be a corporate lease return. My device was used by a salesman of a food distribution company in Canada. (The previous owner forgot to remove his business card from the carrying case!)

We're connected…now what? (cont.)

Evernote can be used on your iPhone and synced with your laptop. Collaboration functions can be used to share your notes. Evernote also offers to-do list tracking. It is available on the iTunes App Store and offers both free and pay versions. See www.evernote.com for a complete listing of functions and to download the app.

Another device option is the Tablet PC. Tablet PCs differ from the iPad and Android tablets in that they operate on a Windows platform. This means they can run Microsoft Office and most other PC programs. The newest models look more like the iPad and are called Slate PCs, but they still operate on a Windows platform. I use an older model of the Fujitsu Stylistic Tablet PC. I wanted to try the device but wasn't convinced I would see the return on the $900+ cost. I found my older model on eBay.

While a bit larger than the iPad the Fujitsu cost me only $200. I could justify spending $200 to see if the device would do what I wanted. And so far, it does. It has also been a great ice breaker in meetings as everyone wants to know what it is and is fascinated when I show them the journaling function. Oh and they appear to be quite impressed when I tell them how little I paid for it!

I-Pen by Finger Systems

If a Tablet PC or iPad is not in your budget, adding a pen-like input device to your laptop may be a solution. This gives you some of the capability of the tablet PC but at a much lower cost. Two of the options include the Dane-Elec Wireless USB Digital Pen, the ZPEN and the I-Pen from Finger Systems, USA. Unlike some of the other models, these pens do not require special paper. A sensor (either external or within the pen) is used to store and transmit your notes to your laptop. Some require custom software but most operate as a USB input device and can be used with your existing applications. Most can be purchased for under $50. Pen functionality can be found on or www.danedigital.com or search for "digital pen" on Amazon for a variety of options.

While there are many applications that operate in the Windows environment, only one is packaged with Windows. Windows Journal is a Tablet PC staple application that is also included on current versions of Windows 7. You will, however, not find this application listed under Microsoft Office. It seems to be in different locations depending on the PC device manufacturer. To see if you have Windows Journal, select the Start Icon and enter the text 'Journal' in the search box.

This application can be used with a keyboard, but is best if used with a stylus. Using this app with a stylus mimics the unobtrusive paper note taking activity.

The Tablet PCs, like laptops, also have a microphone that can be used to make voice recordings, or to record a meeting. I have not embraced this functionality as I am not comfortable with the legality of recording an interview, or with how this will affect the person being interviewed. The new iPhone 4 has Siri, a voice-activated "personal assistant" that helps you compose and send messages via vocal commands. With the iPhone's ability to record and Siri's ability to compose messages based on the verbal commands, I wonder if Siri will someday capture and record exam interview notes. Until that happens, we are destined to capture our own notes!

Annotating Workpapers

Another documentation task is marking workpapers. As examiners we add tick marks or other annotations to highlight exceptions and to assist in an efficient review. Highlighting items reviewed in a document helps a reviewer understand the auditor's thought process and quickly identifies the noted issues.

Considering that most of the evidence documentation is in electronic form, a solution that marks the electronic document is ideal. Often we print, annotate, and scan the document. This is both cumbersome and time consuming. Another option is to add our view the document in the application it was created and add our marks. However, most auditors are wary of modifying the source document. But I am uneasy about editing the document as I consider this altering evidence. A solution that allows you to overlay your annotations without changing the original document is an ideal solution. PDF Annotator does just that.

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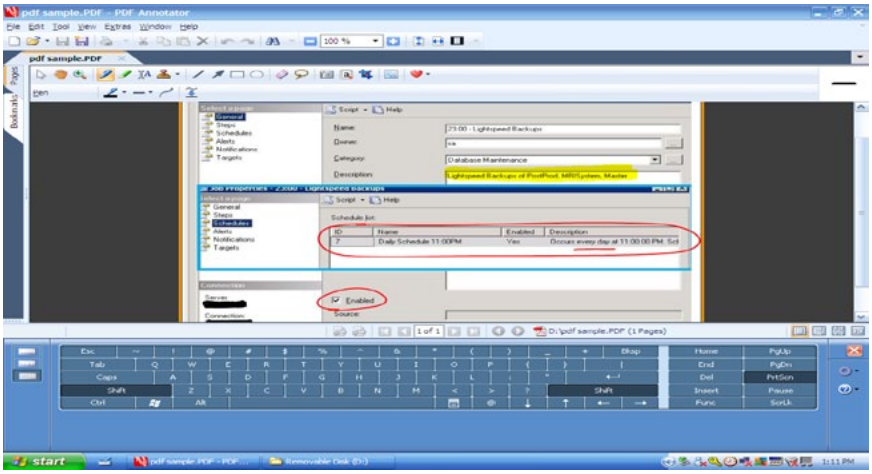

PDF Annotator Screenshot

PDF Annotator gives you the ability to 'write' on PDF files by overlaying the document. Original text in documents viewed in PDF Annotator cannot be altered. A document received in another format can be easily printed with PDF Annotators print to PDF function.

This app can be used on a laptop with a keyboard, but you will get the maximum benefit of this tool when used with a tablet PC or other device that allows you to write on the screen. PDF Annotator can be purchased at www.pdfannotator.com and runs about $70.

Reference

There are many procedures and other reference documentation we need to be familiar with to perform our exams. In addition, we are expected to keep up with changes in our industry. Finding time to read journal articles and white papers is difficult. If your exam work requires travel (and whose doesn't) do you remember to bring the journals?

Why not consider using your e-reader? Who says e-readers are only for leisure books? The management book that your supervisor recommended is probably available as an eBook. But did you know the e-reader isn't limited to books? Download the latest industry journal or subscribe to the relevant publications and read them on your e-reader. Did you know that you can also load PDF files on your Kindle? Download those white papers and read away! I have found that I am more likely to read these now that they are on my Kindle. Why? Because it is easily accessible! Copies of procedural documentation or even the Examiner's handbook can be stored on your e-reader for quick and easy reference. Studying for the AES? Store your study materials so they are always handy!

Conclusion

Computing devices are becoming more and more part of our lives. To see the true value of the technology we must use them beyond the entertainment space. Getting past using the devices as just an entertainment resource may take some effort, but it should be worth it. As the lines between personal and business devices blur, integrating these devices into your everyday routine will be expected.

When looking at a new device, keep in mind that not all devices have the same capability nor are the applications offered for all platforms. Before succumbing to a fancy new device, remember to first identify how you plan to use it and think about where you want to improve your efficiency.

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U.S. Insurance Financial Regulatory Oversight and the Role of Capital Requirements

By Kris DeFrain, Director, Research and Actuarial Services
NAIC/Center for Insurance Policy and Research (CIPR) Newsletter, January 2012

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Introduction

Regulators require insurance companies to maintain specified levels of capital in order to continue to conduct business. Requirements differ by country or regulatory jurisdiction, ranging from specified amounts of capital to risk-based capital, where the capital amount varies based on characteristics of the insurance company and the risks it faces. While international discussions are driving some convergence in regulatory capital requirements around the world, there are still significant differences. Some of the differences include the use of internal models instead of standardized models, the choice of metrics and company-specific inputs to be used, and the means of calibration (e.g., statistical or other measure). Not all jurisdictions agree on approach; perhaps because there is not agreement on the purpose for regulatory capital requirements. In the United States, the regulatory capital requirements form a back-stop to an extensive financial and risk analysis, so the U.S. would not rely on the capital requirements to the extent a country would where capital requirements are used as the means of risk analysis.

To aid international discussions so that supervisors from different jurisdictions might better understand differences of opinion, the following describes the role of capital requirements in the U.S. solvency system and how the entirety of the U.S. financial regulatory framework works together for effective financial regulation. The purpose of this article is to provide the reader with a better understanding of the U.S. approach and why capital requirements are not the sole focus of U.S. regulators.

U.S. Financial Regulation Overview

The U.S. insurance financial regulatory system can be described in the following three stages: (1) state lawmakers and regulators eliminate or limit some risks through restriction on activities, prior approval mechanisms and regulatory focus; (2) regulators perform financial oversight, the step in the process where most of the regulatory activity exists, looking for companies in hazardous financial condition and evaluating the potential for insolvency; and (3) lawmakers and regulators establish regulatory backstops or safeguards, most notably the guaranty funds and risk-based capital (RBC) requirements, to make up the final stage of the regulatory process.

Limitation of Risk through Design of the System

Some risks are deemed material and potentially contrary to the best interests of policyholders, so lawmakers and regulators restrict or discourage those activities or require preapproval. Regulators discourage activities in numerous ways, including requiring conservative valuation in the financial statement, limiting investment options, and focusing time and attention on certain risky endeavors.

Regulators utilize a codified statutory accounting system, where general purpose financial reporting is either adopted as-is, modified or rejected. Statutory accounting is, generally, more conservative than general purpose accounting. Insurers may choose to invest less in those assets valued more conservatively. Valuation of liabilities can also be conservative in some cases. Credit for reinsurance transactions is only allowed when the reinsurance is from an authorized reinsurer or when security (i.e., collateral) is posted to cover obligations.

Premium and claim reserve valuation for life insurance can be considered conservative when some required parameters and assumptions are selected to be less-than-optimistic and for property/casualty insurance when the reserves are not allowed to be discounted. Even the RBC capital requirements have the potential to influence business decisions. For example, capital charges are greater where the risk is deemed to be higher. Insurers may make different investment decisions depending on the extent of the differences in the capital charges for assets.

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U.S. Insurance Financial Regulatory Oversight and the Role of Capital Requirements (cont.)

Because investment is a large part of the insurance business, regulators pay close attention to investment risk, encouraging less risky investment when appropriate. In the 1990s, insolvencies caused by high-risk investment strategies led U.S. regulators to consider their oversight and possible restriction of insurer investments by imposing either a defined limits or a defined standards approach. Using a defined limits approach, regulators place certain limits on amounts or relative proportions of different assets that insurers can hold to ensure adequate diversification and limit risk. Using a defined standards approach, regulators restrict investments based on a "prudent person" approach, allowing for discretion in investment allocation if the insurer can demonstrate their adherence to a sound investment plan. Also, the NAIC Capital Markets & Investment Analysis Office reviews insurers' assets for credit risk, potentially driving insurers toward less-risky investment.

For certain material transactions—such as large investment or reinsurance transactions, extraordinary dividends, change in control and the amount of dividends paid—commissioner preapproval is required in an insurance holding company system. This is to help ensure that the assets of an insurer adequately protect the policyholders and are not unfairly distributed to others.

Finally, the transparency of the regulatory process in the United States often sends signals to insurers about where regulators see significant risks in the current financial environment and offer signs where different business decisions could be made to limit those risks and, therefore, limit regulatory attention. Regulators are transparent about their focus on particular issues, especially when an issue arises from specific "risky" activities. The NAIC process highlights areas of concern and aids insurers to appropriately address issues.

Financial Oversight and Intervention Powers

An insurance company must hold capital greater than the minimum regulatory capital levels to continue in business; but financial regulation extends beyond just capital requirements. U.S. commissioners can order conservation, rehabilitation or liquidation on numerous statutory grounds ranging from financial insolvency to unsuitable management and operations. The Insurer Receivership Model Act (NAIC model law #555) includes the following grounds for regulatory action (among others):

- Impairment, insolvency or hazardous financial condition.
- Improperly disposed property or concealed, altered or destroyed financial books.
- Best interest of policyholders, creditors or the public.
- Dishonest, improperly experienced or incapable person in control.

The most typical financial intervention occurs when a company is in hazardous financial condition; this usually occurs prior to an insurer triggering an RBC level. A regulator may deem a company in hazardous financial condition based upon adverse findings in a financial analysis or examination, a market conduct examination, audits, actuarial opinions or analyses, cash flow and liquidity analyses; insolvencies with a company's reinsurer(s) or within the insurer's insurance holding company system; finding of incompetent or unfit management/director; a failure to furnish information or provide accurate information; and, any other finding determined by the commissioner to be hazardous to the insurer's policyholders, creditors, or general public.

Financial oversight and determination of hazardous financial condition is the most valuable and extensive part of U.S. insurance financial regulation. Oversight focuses on appropriate asset and liability valuation, the risks accepted by the insurer, the mitigation of those risks and the amount of capital held in light of the residual risks.

This valuable oversight is possible because of the extensive financial reporting databases at the fingertips of each insurance regulator, allowing the financial analysis to occur without additional significant and time-consuming company input. Insurers are required to file standardized annual and quarterly financial reports that the regulators use to assess the insurer's risk and financial condition. These reports contain both qualitative and quantitative information and are updated as necessary to incorporate significant common insurer risks. Reporting requirements run the gamut from typical accounting requirements (e.g., balance sheet and income statement) to detailed data reporting on specified schedules (e.g., Schedule D – investment schedules, Schedule F – reinsurance issues and Schedule P – loss triangles). An actuarial opinion on major components of an insurer's financial statement (asset adequacy and claim/loss/premium reserves) is required to ensure the adequacy and/or reasonableness of reserves. The independent financial audit helps to provide assurances that all material aspects of

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the insurer's financial reporting are accurate.

Generally, regulators judge financial condition based on the company's financial reporting, accompanying audits and actuarial opinions, supplemented with additional information about the company. In addition, there are numerous financial analysis tools and resources that highlight "red flags." These tools are possible because of the detailed, validated and uniform financial reporting, which allows for the identification of risk concentrations and anomalies.

Regulatory Backstops

As a final backstop in the U.S. financial oversight process, state insurance regulators have the RBC calculation and analysis. Regulators developed RBC to supplement the fixed minimum capital and surplus requirements, which vary by line of business and do not sufficiently account for differences in size, risks or financial conditions among insurers. Although the RBC formula is the same for companies in a particular line of business, the specific calculation for each company reflects the particular risks unique to that specific company.

RBC strengthens the regulatory safety net in the U.S. system by recognizing a company's different size, financial condition and types of risks assumed. More important, regulators created RBC as a legal authority to provide for timely regulatory action, consistent across jurisdictional borders, with minimum court involvement when a company triggers an RBC intervention level.

The intervention levels consist of four trigger points: company action, regulatory action, authorized control and mandatory control. These intervention levels are established to require regulatory action, but the regulator may otherwise consider a company to be in hazardous financial condition, despite a specific RBC level finding.

Rounding out the policyholder protections, if a financially impaired insurance company is unable to pay its insurance claims, a state guaranty fund will pay them, subject to certain limits.

Financial Oversight Tools and Resources

In assessing the financial condition of an insurer, the overall goal is to identify potential adverse financial indicators as quickly as possible, evaluate and understand such problems more effectively, and develop appropriate corrective action plans sooner, thus potentially decreasing the frequency and severity of insolvencies. The U.S. solvency oversight framework is not designed to eliminate all insolvencies, but rather to minimize the number of insolvencies and their corresponding impact on policyholders and claimants. Regulators conduct a risk-focused surveillance of insurers' financial reports that includes financial analysis, financial examination and supervisory plan development.

Financial Analysis

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

Three key tools within the FAST System include:

- **Insurance Regulatory Information System (IRIS):** IRIS has served as a baseline solvency screening system for the NAIC and state insurance regulators since the mid-1970s. Its first (or statistical) phase involves calculating a series of confidential financial ratios for each insurer based on statutory financial annual statement data. Because the ratios by themselves are not indicative of adverse financial condition, an experienced team of state insurance examiners and analysts then reviews the IRIS ratio results and other financial information through the second (or analytical) phase.
  In this second phase, the Analyst Team reviews a computer-selected priority listing of insurers that might be experiencing weak or declining financial results and meets to identify insurers that appear to require immediate regulatory attention. The team then validates the listing based on further analysis of those companies, and provides a brief synopsis of its findings in a document that only state insurance regulators and autho-

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U.S. Insurance Financial Regulatory Oversight and the Role of Capital Requirements (cont.)

rized NAIC staff can access.

- **Scoring System:** The NAIC Scoring System is based on several financial ratios and is similar in concept to IRIS ratios, but provides results on an annual and a quarterly basis. The Scoring System also includes a broader range of financial ratios and assigns a score to each ratio based on the level of solvency concern each result generates. As with the IRIS results, the Scoring System results and scores are available only to state insurance regulators and authorized NAIC staff.
- **Insurer Profiles System:** Finally, the Insurer Profiles System produces quarterly and annual profiles on property/casualty, life, health and fraternal insurers that include either a quarterly or an annual five-year summary of a company's financial position. The Insurer Profile reports provide not only a snapshot of the company's statutory financial statement, but also include analytical tools, such as financial ratios and industry aggregate information, for analytical review. Insurer Profile reports also assist state insurance department analysts in identifying unusual fluctuations, trends or changes in the mix of an insurer's assets, liabilities, capital and surplus, and operations.[2]

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

Ensuring a nationwide system of checks and balances, the NAIC and, specifically, the NAIC Financial Analysis Working Group (FAWG), offer a layer of peer review for each regulator's solvency monitoring efforts, thus ensuring that experienced state regulator colleagues improve and enhance state regulator judgments regarding a company's financial condition.

FAWG's mission is to: identify nationally significant nsurers/groups that exhibit characteristics of trending towards financial trouble; interact with domiciliary regulators and lead states in order to assist and advise on appropriate regulatory strategies, methods, and actions; and encourage, promote and support coordinated, multistate efforts in addressing solvency issues.

For more than two decades, the NAIC FAWG has ensured that state insurance financial regulators have shared information and ideas to identify, discuss and monitor potentially troubled insurers and nationally significant insurance groups (a classification that considers the size of the company or group's premium volume combined with the number of states in which it writes business; i.e., insurers that write the majority of insurance in the United States). FAWG has identified market trends and emerging financial issues in the insurance sector and has leveraged the expertise of select chief financial regulators from around the United States to provide an additional layer of solvency assessment to our national system of state-based insurance regulation.

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

Through the FAWG forum, individual states work together to support and guide fellow regulators for the benefit of the whole. FAWG also reviews and considers trends occurring within the industry, often concentrating on particular market segments, product, exposure or other problem that has the potential of impacting the solvency of the overall industry.

[2] Testimony of the NAIC before the Subcommittee on Capital Markets, Insurance, and Government-Sponsored Enterprises, Committee on Financial Services, U.S. House of Representatives: "Supervision of Group Holding Companies," March 18, 2010.

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U.S. Insurance Financial Regulatory Oversight and the Role of Capital Requirements (cont.)

Financial Examination

U.S. regulators carry out periodic risk-focused, on-site financial examinations in which they evaluate the insurer's corporate governance, management oversight and financial strength. Regulators use risk identification and evaluate mitigation systems both on a current and prospective basis, assessing the reported financial results through the financial examination process.

Examinations consist of a process to identify and assess risk and assess the adequacy and effectiveness of strategies/controls used to mitigate risk. The process includes a determination of the quality and reliability of the corporate governance structure, risk management programs and verification of specific portions of the financial statements. Financial examiners evaluate the insurer's current strengths and weaknesses (e.g., board of directors, risk-management processes, audit function, information technology function, compliance with applicable laws/regulations, etc.) and prospective risk indications (e.g., business growth, earnings, capital, management competency and succession, future challenges, etc.). Then, regulators document the results of the examinations in a public report that assesses the insurer's financial condition and sets forth findings of fact with regard to any material adverse findings disclosed by the examination. Examination reports may also include required corrective actions, improvements and/or recommendations.

In between full scope examinations, additional examinations might be needed that are limited in scope to review specific insurer operations.

Supervisory Plan

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

AIC FINANCIAL ANALYSIS WORKING GROUP (FAWG)

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

- Identifying companies that are outliers when compared with industry benchmarks and reviewing companies individually submitted to FAWG by state regulators.
- Developing communication for the financial staff and commissioner for the state of domicile for the insurer/group under review; including a description of the issue, questions and suggestions on regulatory options.
- Reviewing domestic or lead state regulator responses on identified issues and questions.
- Considering whether responses identify a need for further regulatory action or FAWG intervention, including requesting that the domiciliary regulator answer questions and make a presentation to FAWG and other regulators.
- Considering whether to request the formation of a FAWG subgroup for certain insurers or groups to facilitate regular communication and collaboration with applicable regulators (when the state regulators have not proactively communicated with appropriate regulators on their own, as is the typical case).

Conclusion

The focus of the U.S. insurance financial regulatory system is the financial surveillance for financial oversight. Financial surveillance is predominately built around an extensive and uniform financial reporting system that allows for detailed analysis of asset holdings, reinsurance, loss/claim reserves, etc. Through the use of an extensive centralized database, regulators can perform stress tests on companies, determine the impact of other company insolvencies on the market, find anomalies from one company to another through benchmarking and other processes, and look for new risk concentrations and/or optimistically valued risks. Because this data and disclosure is vital to the regulatory system, regulators spend considerable effort to validate appropriate financial reporting to allow for extensive analysis without significant extra attention from the company, thereby keeping regulatory disruptions to a minimum.

As a national system of state-based regulation, insurance regulators are keenly aware of the unique structure and have developed tools and financial regulatory processes, adopted by all jurisdictions—such as peer review and FAWG oversight—to ensure that regulators are effectively

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U.S. Insurance Financial Regulatory Oversight and the Role of Capital Requirements (cont.)

and efficiently maximizing resources to protect consumers, while maintaining the solvency of regulated entities. U.S. regulators utilize a number of coordinated resources to assess the financial strength and condition of insurers—from small single-state insurers to large multi-state groups—to verify the consistency, integrity and success of the supervisory approach.

Capital requirements can encourage less risky behavior, but, for all intents and purposes, the RBC exists to be the back-stop in the financial regulatory process. Because of this, U.S. regulators look to create capital requirements that are lower in cost, fair, sufficiently accurate and verifiable.

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About the Author

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Evolving Insurance Regulation: On the move

By Rob Curtis, KPMG in the UK; David Sherwood, KPMG in the U.S.; Martin Noble, KPMG in China

The insurance industry does not benefit from a single regulatory framework with the weight which the Basel Accords carry in the banking sector. However, the International Association of Insurance Supervisors issues global principles, standards and guidance papers which are moving in a parallel direction. Later this year, the Association will publish a new suite of Insurance Core Principles. Over the next few years, a wide range of new requirements will be introduced to tackle issues such as capital adequacy and risk management.

Insurers coped relatively well with the financial crisis. A small number of global insurers and reinsurers encountered substantial difficulties through their participation in noninsurance activities, such as with their trading in structured credit products like collateralized debt obligations (CDOs) and credit default swaps. Monoline credit and bond guarantee insurers, which have a different business model from other insurers, also experienced significant losses from the general downturn in the economy and from their exposures to residential mortgage-backed securities and CDOs. For the life insurance sector, falls in the sale of unit-linked and single premium life insurance products were accompanied by average reductions in shareholder capital of between 30–40 percent, with some companies suffering declines of up to 70 percent. Nevertheless, there were few institutional failures and little direct regulatory intervention, unlike in the banking sector.

However, the crisis has nonetheless influenced the continuing process of regulatory reform. It has reinforced the need for renewed dialogue between regulators and the industry over effective regulation, supervision that delivers a risk-based approach to solvency, enhanced group supervision and greater cooperation among regulators. Greater harmonization of insurance regulation can al-

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Evolving Insurance Regulation: On the move (cont)

ready be seen. The International Association of Insurance Supervisors (IAIS) will introduce from October 2011 a new suite of Insurance Core Principles (ICPs), which will have a significant impact on the form and extent of regulation globally. In Evolving Insurance Regulation, our insurance experts from the Regulatory Centers of Excellence examine the implications this will have for the future of the industry.

Regulatory action and the IAIS

Since the financial crisis, groups like the G20, Financial Stability Board (FSB) and Joint Forum have been active in reviewing the regulatory framework for banks, and such analysis has invariably flowed across to the insurance sector. The IAIS was established in 1994 with the broad aim of harmonizing international insurance regulatory requirements. It acts as a forum for insurance supervisors to discuss developments in the insurance sector and topics affecting insurance regulation. The IAIS has now grown to represent 190 insurance supervisory jurisdictions, and is the world-standard setter for insurance.

The IAIS issues insurance principles, standards and guidance papers which apply to all member supervisory authorities. The IAIS also works closely with other standard setters such as the Basel Committee on Banking Supervision and the International Accounting Standards Board; its core principles are endorsed by the International Monetary Fund and the World Bank. The IAIS principles, standards and guidance apply to individual insurance supervisors who are members of the IAIS. National regulators are expected to implement the ICPs produced by the IAIS.

Lessons from the crisis

A number of key lessons have been learned regarding existing inadequacies in solvency assessment. These include:

- regulatory focus being too concentrated at the micro-economic level and not enough being undertaken at a macro-level;
- lack of oversight and monitoring of non-regulated subsidiaries/activities;
- legal and legislative limitations on insurance group supervision;
- limitations in the quality and content of both regulatory structure and supervisory practice;
- lack of coordination of responsibilities/established coordination mechanisms between supervisors; and
- lack of effective tools to minimize regulatory arbitrage on a cross sector and cross border basis.

The IAIS has responded to the need for reform by accelerating their plans to promote common regulatory standards and cooperation. Common themes emerging from current international regulatory developments are:

- the move towards more risk-based approaches to capital and solvency measurement;
- a greater focus on risk management and governance;
- increased use of stress and scenario testing; and
- group supervision.

Insurance supervisors are looking to harmonize these regulatory approaches by increasing cooperation and coordination of their activities by formal mechanisms, such as memorandums of understanding between one another and the development of a project within the IAIS to build a common framework for the supervision of internationally active insurance groups (IAIGs).

Such initiatives at the international level complement the significant efforts by many jurisdictions in further strengthening their own local requirements. In Europe, Solvency II is driving further regulatory harmonization, and this could eventually be extended to non-EU countries, which is relevant to the region's insurance market through the concept of 'equivalence'. However, in the short-term, broader cross-border mutual recognition of regimes is likely to remain limited, as few regions share the same degree of economic and political union. Countries such as the US are mindful of the changes and have commenced their own reforms such as the Solvency Modernization Initiative (SMI) where developments are more aligned to the IAIS's new ICPs concerning solvency and group supervision mechanisms. In Asia Pacific, an area of significant focus for inward investment by many international insurance groups, regulators are very much aware of developments in risk and capital management in Europe and by the IAIS; most have already effected or are considering significant change.

The crisis once again highlighted capital adequacy as a key concern for all regulators, and a renewed push for reform commenced. Globally, it is expected that supervisors will increasingly move to ensure insurers are ad-

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Evolving Insurance Regulation: On the move (cont)

equately capitalized with risk-based capital requirements, will require valuations of assets and liabilities on a consistent and economic basis, and will increasingly allow the use of internal models. These will be subject to stringent standards and prior supervisory approval and will enable regulatory capital requirements to be calculated using insurers' own internal models, which are a better reflection of their risks than a common standard formula.

What are the implications?

The introduction of the new IAIS ICPs in October 2011 will herald a significant new step in achieving international convergence and consistency in regulatory requirements. Covering capital adequacy and internal models, enterprise risk management, investments, systems and controls and group supervision, they will have a profound impact on both insurance supervisors and the insurance industry.

All supervisors will have to enact the requirements into their local supervisory frameworks. If they don't, the relevant territory risks receiving an adverse finding from the IMF/World Bank who conduct the Financial Sector Assessment Program (FSAP) reviews. So, understanding the changing regulatory landscape has never been more important. Firms that are aware of such changes and actively involved in shaping the new reforms stand to gain a competitive advantage and will be best prepared to meet the new challenges ahead. Above all, the substantial regulatory changes now being implemented will further reinforce the underlying structural changes insurers are making to their business models, particularly in regards to:

- cultural change;
- improved and enhanced sophistication of tools being used for effective risk and capital management;
- enhancing the quality and timeliness of making better business decisions; and
- demonstrating the underlying value proposition to investors thereby attracting greater investment.

Regulation is clearly on the move: the challenge has been laid down to the sector as a whole. Understanding the changing regulatory landscape has never been more important. Firms that are aware of such changes and actively involved in shaping the new reforms stand to gain a competitive advantage and will be best prepared to meet the new challenges ahead.

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KPMG Insurance Regulatory Center of Excellence

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