Insurance & Banking

Table of Contents

Insurance and Banking

CHAPTER 1 Insurance Sales in Banks

This first section of the course provides information for insurance professionals with information about the risks, controls and supervision of national banks' insurance activities. The information and guidance on the appropriate risks to national banks from insurance activities is provided along with a process that may be used in planning and conducting risk assessments. An important concept is the idea of functional regulation activities, where the Office of the Comptroller of the Currency defers regulatory supervision of the bank's insurance function to the state department of insurance in which the bank is located. From a banking perspective, the Federal Office of the Comptroller of the Currency (Comptroller's Office) does not consider debt cancellation contracts, debt suspension agreements, and fixed and variable rate annuities as insurance products within the scope of the guidance and policies that are to be discussed in this section of the book. Because of the complexity and importance of the legal requirements associated with insurance activities, this course also contains considerable legal information.

Overview

National banks have conducted insurance sales activities since the early 1900s. The types of insurance products and services offered and the associated distribution systems are changing significantly as this business line evolves. In recent years, national banks have engaged in insurance activities as a means to increase profitability mainly through expanding and diversifying fee-based income. Banks are also interested in providing broader financial services to customers by expanding their insurance product offerings. The Gramm-Leach-Bliley Act of 1999 (GLBA) is important legislation that addresses a number of significant issues affecting both national banks and the examination process. Among its provisions, GLBA reaffirms the authority of national banks and their subsidiaries to sell insurance. The law also clarifies the regulatory structure and product offerings related to national bank insurance activities. GLBA establishes a functional regulatory framework that reaffirms the states' authority to regulate insurance activities conducted within banks and through a functionally regulated affiliate (FRA). An FRA is an affiliate (including subsidiary) of a bank that is regulated by the SEC, CFTC, or a state insurance regulator, but generally does not include a bank holding company, savings and loan holding company, or a depository institution. FRAs can be either bank affiliates or bank subsidiaries. Additionally, GLBA reaffirms the OCC's responsibility for evaluating the consolidated risk profile of the national bank. This evaluation includes determining the risks posed to the bank from insurance activities and the effectiveness of the bank's risk management systems, including compliance with banking laws and applicable consumer protection requirements. This course examines the OCC's process for assessing risks to the national bank from insurance activities. This risk assessment process is consistent with GLBA's functional regulation requirements and is conducted at the bank level. It is anticipated that the OCC's examinations of FRAs will be infrequent.

National Bank Insurance Powers

Both federal and state laws may govern national bank insurance activities. A national bank is authorized to engage in insurance agency activities under 12 USC 92. Under 12 USC 92, a national bank that is "located and doing business in any place the population of which does not exceed five thousand may . . . act as the agent for any fire, life, or other insurance company."

Under this authority, a national bank may sell *most* types of insurance from an agency located in a "place of 5,000" or fewer inhabitants. An area designated as a "place" by the Census Bureau is acknowledged as a "place" by the Comptroller's Office for 12 USC 92 purposes. The Census Bureau defines "place" to include both incorporated places and census designated places.

There are no geographic restrictions on the bank's ability to solicit and serve its insurance customers. National banks are not, however, authorized to sell title insurance under 12 USC 92. National banks' authority to sell title insurance is based on GLBA section 303 (15 USC 6713). See "Permissible National

Bank Insurance Activities" section of the handbook for a discussion of a national bank's authority to sell title insurance under GLBA. National banks also may engage in various insurance agency activities under 12 USC 24(Seventh). This law authorizes national banks to engage in the "business of banking," and to exercise "all such incidental powers as shall be necessary to carry on the business of banking." Although an insurance product sold under this authority could also be sold under 12 USC 92, there are no geographic "place of 5,000" limits under 12 USC 24(Seventh). National banks also may engage in insurance agency activities without geographic restriction through their financial subsidiaries established under GLBA section 121 (12 USC 24a). A financial subsidiary is any company that is controlled by one or more insured depository institutions, other than a subsidiary that:
…engages solely in activities that national banks may engage in directly and that are conducted subject to the same terms and conditions that govern the conduct of these activities by national banks; or a national bank is specifically authorized to control by the express terms of a federal statute, and not by implication or interpretation. Financial subsidiaries of banks may engage in activities that are not permissible for the parent bank, as long as the activities are financial in nature. (12 CFR 5.39 Insurance Activities Comptroller's Handbook)

National banks are authorized under GLBA section 302 (15 USC 6712) to provide insurance as principal (underwriter or reinsurer) for any product the Comptroller's Office had approved for national banks prior to January 1, 1999, or that national banks were lawfully providing as of January 1, 1999. Refer to the "Permissible National Bank Insurance Activities" section of this book for a discussion of a national bank's authority to provide insurance as principal under GLBA.

Applicability of State Laws

In 1945, Congress passed the McCarran-Ferguson Act, granting states the power to regulate most aspects of the insurance business. The McCarran-Ferguson Act (15 USC 1012(b)) states that "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." Therefore, under the McCarran-Ferguson Act, a state statute enacted for the purpose of regulating the business of insurance preempts a conflicting federal statute, unless the federal statute specifically relates to the business of insurance. As a result of this law, national banks must be cognizant of the potential applicability of state law requirements. The extent to which states could regulate national bank insurance activities authorized by federal law was clarified in 1996 by preemption principles that were applied by the U.S. Supreme Court in *Barnett Bank of Marion County, NA v. Nelson*, 517 U.S. 25 (1996). Under Barnett and the substantial body of law upon which the Barnett Court relied, state laws that prevent, impair, impede, or hamper the exercise of national bank powers, or that discriminate against national banks, are preempted. As a result of GLBA, the standards for determining when state laws are preempted became more complex. Under GLBA, state laws generally cannot "prevent or restrict" insurance activities conducted by national banks and their subsidiaries. For insurance sales, solicitations, and cross marketing, however, state laws cannot "prevent or significantly interfere" with bank and subsidiary insurance activities, in accordance with the legal standards for preemption set forth in Barnett (The summary follows).

BARNETT BANK OF MARION COUNTY v. NELSON, ___ U.S. ___ (1996)

No. 94-1837.

Argued January 16, 1996
Decided March 26, 1996

A 1916 federal law (Federal Statute) permits national banks to sell insurance in small towns, but a Florida law (State Statute) prohibits such banks from selling most types of insurance. When petitioner Barnett Bank, a national bank doing business in a small Florida town, bought a state licensed insurance agency, respondent State Insurance Commissioner ordered the agency to stop selling the prohibited forms of insurance. In this action for declaratory and injunctive relief, the District Court held that the State Statute was not pre-empted, but only because of the McCarran-Ferguson Act's special insurance-related anti-pre-emption rule.

That rule provides that a federal law will not pre-empt a state law enacted "for the purpose of regulating the business of insurance" - unless the federal statute "specifically relates to the business of insurance." 15 U.S.C. 1012(b) (emphasis added). The Court of Appeals affirmed.

Held:

The Federal Statute pre-empts the State Statute. Pp. 4-17.

(a) Under ordinary pre-emption principles, the State Statute would be pre-empted, for it is clear that Congress, in enacting the Federal Statute, intended to exercise its constitutionally delegated authority to override contrary state law. The Federal and State Statutes are in "irreconcilable conflict," Rice v. Norman Williams Co., 458 U.S. 654, 659 , since the Federal Statute authorizes national banks to engage in activities that the State Statute expressly forbids. Thus, the State's prohibition would seem to "stan[d] as an obstacle to the accomplishment" of one of the Federal Statute's purposes, Hines v. Davidowitz, 312 U.S. 52, 67 , unless, as the State contends, Congress intended to limit federal permission to sell insurance to those circumstances permitted by state law. However, by providing, without relevant qualification, that national banks "may . . . act as the agent" for insurance sales, 12 U.S.C. 92, the Federal Statute's language suggests a broad, not a limited, permission. That this authority is granted in "addition to the powers now vested . . . in national [banks]," ibid. (emphasis added), is also significant. Legislative grants of both enumerated and incidental "powers" to national banks historically have been interpreted as grants of authority not normally limited by, but rather ordinarily pre-empting, contrary state law. See, e.g., First Nat. Bank of San Jose v. California, 262 U.S. 366, 368-369. Where, as here, Congress has not expressly conditioned the grant of power upon a grant of state permission, this Court has ordinarily found that no such condition applies. See Franklin Nat. Bank v. New York, 347 U.S. 373 . The State's argument that special circumstances surrounding the Federal Statute's enactment demonstrate Congress' intent to grant only a limited permission is unpersuasive. Pp. 4-11.

(b) The McCarran-Ferguson Act's anti-pre-emption rule does not govern this case, because the Federal Statute "specifically relates to the business of insurance." This conclusion rests upon the Act's language and purposes, taken together. The word "relates" is highly general; and in ordinary English, the Federal Statute - which focuses directly upon industry-specific selling practices and affects the relation of insured to insurer and the spreading of risk - "specifically" relates to the insurance business. The Act's mutually reinforcing purposes - that state regulation and taxation of the insurance business is in the public interest, and that Congress' "silence . . . shall not be construed to impose any barrier to [such] regulation or taxation," 15 U.S.C. 1011 (emphasis added) - also support this view. This phrase, especially the word "silence," indicates that the Act seeks to protect state regulation primarily against inadvertent federal intrusion, not to insulate state insurance regulation from the reach of all federal law. The circumstances surrounding the Act's enactment also suggest that the Act was passed to ensure that generally phrased congressional statutes, which do not mention insurance, are not applied to the issuance of insurance policies, thereby interfering with state regulation in unanticipated ways. The parties' remaining arguments to the contrary are unconvincing. Pp. 11-17.

43 F.3d 631, reversed.

(End of Summary)

Insurance Law as Relevant to Financial Institutions and the Gramm-Leach-Bliley Act

The American Bankers Insurance Association ("ABIA") had hoped that the Supreme Court's decision in the *Barnett Bank* case and the codification of that decision in the Gramm-Leach-Bliley Act ("GLBA") would end state efforts to regulate banks engaged in the sale of insurance. Instead, the Independent Insurance Agents and Brokers of America ("IIAA") and the National Association of Insurance Commissioners ("NAIC") sought to re-litigate the *Barnett Bank* case and re-interpret GLBA to allow States to take action against banks engaged in the sale of insurance.

The IIAA and NAIC undertook this effort on multiple fronts, including through a federal lawsuit that challenged a preemption opinion issued by the Office of the Comptroller of the Currency ("OCC") regarding certain provisions of West Virginia's insurance sales law. The IIAA and NAIC argued that the

OCC has misread the *Barnett Bank* case and GLBA, and, as a result, has applied the wrong preemption standard. According to the IIAA and NAIC, the "prevent or significantly interfere" preemption standard that appears in the *Barnett Bank* case and GLBA should be read narrowly and applied sparingly.

ABIA maintains that it is the IIAA and NAIC who have misread the decision in the *Barnett Bank* case and GLBA. The "prevent or significantly interfere" standard established in the *Barnett Bank* case and codified in GLBA should be read to override any action by a State that obstructs, hinders, impedes or frustrates the ability of a bank to engage in the sale of insurance.

The importance of this attempt to re-litigate the *Barnett Bank* case and re-interpret GLBA cannot be overstated. The *Barnett Bank* case was a watershed for the banking industry. It recognized the public benefits associated with national bank entry into insurance sales, and it stopped other discriminatory State insurance laws aimed at national banks. Congress subsequently codified the *Barnett Bank* decision in GLBA, and applied the *Barnett Bank* standard to all depository institutions and their affiliates.

I. The *Barnett Bank* Case, Including its Supporting Rationale, Defines when a State Law is Preempted.

In the 1996 *Barnett Bank* case the U.S. Supreme Court held that a federal banking law that permits national banks to sell insurance from small towns preempted a Florida insurance law that prohibited affiliations between financial institutions and insurance agencies. To determine whether preemption was appropriate, the Court examined the authority for national banks to sell insurance. The Court said that the authority was "a broad, not a limited, permission." The Court then said that the Florida statute is preempted, because it stood as "an obstacle to the accomplishment and execution of the full purposes and objectives of Congress" in permitting national banks to sell insurance. Further, the Court said that a state may not "prevent or significantly interfere" with a national bank's authority to sell insurance. The Court did not leave the meaning of the phrase "prevent or significantly interfere" solely to the imagination. Instead, the Court placed that phrase within the context of several other preemption cases previously decided by the Supreme Court. In those cases, the Supreme Court said that state laws that "unlawfully encroach", "destroy", "hamper", or "impair" the operation of a national bank are subject to preemption. Thus, when the phrase - "prevent or significantly interfere" - is read in conjunction with the entire decision, it is clear that this "*Barnett Bank* preemption standard" is a broad and flexible one intended to override any state law that stands as "an obstacle" to the exercise of a national bank's legitimate powers.

II. The GLBA Codified the *Barnett Bank* Decision in its Entirety.

In response to the discriminatory regulatory treatment of banks engaged in insurance sales by the States, Congress codified the decision in the *Barnett Bank* case in GLBA - including all favorably cited preemption standards - not just four words taken from the case. The relevant provision of GLBA provides that -

In accordance with the legal standards for preemption set forth in the decision of the Supreme Court of the United States in Barnett Bank of Marion County N.A. v. Nelson, 517 U.S. 25 (1996), no State may . . . prevent or significantly interfere with the ability of a depository institution . . . to engage . . . in any insurance sales, solicitation, or crossmarketing activity. (emphasis added)

The terms used in the introductory clause of this provision clearly indicate that Congress intended to codify the entire decision in the *Barnett Bank* case, not just the phrase "prevent or significantly interfere." The word "accordance" means "conformity" or "agreement." Therefore, the phrase "prevent or significantly interfere" must be read to conform or agree with the "decision" in the *Barnett Bank* case. The word "decision" is commonly understood to mean the entire opinion of a court, not just one part of the opinion, or just certain words taken from an opinion. The introductory clause also includes a citation to the decision in the *Barnett Bank* case. That citation is to the entire decision, not a portion of the decision.

The extensive legislative history of the GLBA supports this reading of the statute. Congress actively debated and voted on GLBA between 1997 and 1999. Over the course of those three years, the text of the preemption standard for State insurance sales laws evolved from a "prevent or restrict" standard to the codification of the entire decision in the *Barnett Bank* case. This occurred through the addition of what are now the introductory clause, the substitution of the phrase "prevent or significantly interfere" for the phrase "prevent or restrict," and the insertion of a rule of construction. That rule of construction provides that "Nothing in this paragraph shall be construed . . . to limit the applicability of the decision of the Supreme Court in Barnett Bank of Marion County N.A. v. Nelson, 417 U.S. 25 (1996). . . ."

Furthermore, as the text of GLBA was refined to codify the entire *Barnett Bank* decision, the Committee Reports accompanying the bill expressly linked the preemption standard for State insurance sales laws with the decision in the *Barnett Bank* case. Three statements from those reports are illustrative. First, in a November 1997 report, the House Committee on Commerce reported that even the phrase "prevent or restrict" was intended "to be *parallel to the analysis* of the United States Supreme Court in Barnett Bank of Marion County, N.A. v. Nelson, 116 S. Ct. 1103 (1996)..." (emphasis added) That Report also noted that the "prevent or restrict" standard "does not intend, by implication or otherwise, *to expand or narrow* the scope of the Barnett ruling." (emphasis added)

Second, a Senate Banking Committee Report in 1999 supporting the preemption language in the final bill states that the preemption standard for State insurance sales laws is a codification of the *Barnett Bank* decision and all of the case law embodied in that decision:
There is an extensive body of case law related to the preemption of State law. For example, in Barnett Bank of Marion County, N.A. v. Nelson, 116 S. Ct. 1103 (1996), the U.S. Supreme Court noted that Federal courts have preempted State laws that "prevent or significantly interfere" with a national bank's exercise of its powers; that "unlawfully encroach" on the rights and privileges of national banks; that "destroy or hamper" national banks' functions or that "interfere with or impair" national banks' efficiency in performing authorized functions.

Finally, the Conference Report accompanying GLBA acknowledged that the House and Senate had "parallel" provisions related to the operation of State law, and stated that the preemption standard for State insurance sales laws was the *Barnett Bank* case:

With respect to insurance sales, solicitations, and cross-marketing, States may not prevent or significantly interfere with the activities of depository institutions, *as set forth in Barnett Bank of Marion County N.A. v. Nelson, 517 U.S. 25 (1996). . . .* (emphasis added)

These statements leave no doubt that Congress intended to codify the entire *Barnett Bank* case in GLBA and to apply that entire case to all banks and their affiliates engaged in the sale of insurance.

III. Federal Courts have Accepted a Broad Reading of *Barnett Bank*.

Recent litigation in which *Barnett Bank*'s "prevent or significantly interfere" standard played the central role supports a broad reading of the preemption standard in the *Barnett Bank* case. In *Association of Banks in Insurance (ABI) v. Duryee,* the Federal District Court of the 5th District of Ohio said that preemption under *Barnett Bank* is not limited to state laws that prohibit bank-affiliated insurance agencies from engaging in an authorized insurance agency activity, but also is warranted when the statute harms bank operations; increases a bank's costs of operating; requires a bank to operate inefficiently; or places obstacles in front of banks - all principles it derived from the *Barnett Bank* case. In other words, according to the court, preemption is appropriate where a state requirement prevents a bank from operating like a bank - that is, a profit-making enterprise.

The United States Court of Appeals for the Sixth Circuit fully affirmed this broad reading of *Barnett Bank*'s preemption standard, noting that the phrase "prevent or significantly interfere" means much more than what the intervenors in that case had argued:

The intervenors' attempt to redefine "significantly interfere" as "effectively thwart" is unpersuasive, however. . . . The intervenors are asking this court to interpret "significantly interfere" in a way that would render the two prongs of the *Barnett Bank* standard redundant. Moreover, immediately after laying out the "prevent or significantly interfere" standard, the *Barnett Bank* opinion cited two cases that do not support the intervenors' interpretation of the standard. *See McClellan v. Chapman,* . . . (considering whether state statute would "impair the efficiency of national banks" or would "destro[y]" or "hampe[r]" national bank's functions); *First Nat'l Bank v. Kentucky*, . . . (considering whether state law would "interfere with or impair [national banks'] efficiency in performing the functions by which they are designed to serve [the Federal] government"). (emphasis added)

It is this reading of the *Barnett Bank* preemption standard that is incorporated fully into GLBA as the Section 104 preemption standard and upon which the OCC has relied in its preemption opinion letters.

IV. Since Passage of GLBA, the States have been on Notice that Their Bank-Insurance Sales Laws are Subject to Preemption Under *Barnett Bank* and GLBA.

Following enactment of GLBA, only a few states responded to eliminate or revise discriminatory State insurance sales laws. For example, two months after enactment of the GLBA, the Texas Department of Insurance issued a bulletin describing interim guidelines temporarily suspending enforcement of several insurance agent licensing statutes pending legislative action. The Department recognized that "[b]ased on provisions of the [GLBA], several provisions of the Texas Insurance Code are preempted as applied to depository institutions and other affiliated entities who wish to exercise powers granted under federal law to engage in the business of insurance in Texas." The Michigan Insurance Bureau issued a similar letter last year.

The NAIC also recognized the need for action. It established a working group to amend the NAIC's model Unfair Trade Practices Act to recognize the GLBA preemption standards, and invited banking interests, insurance interests, and the OCC to participate in the process. That collaborative effort was designed to ensure that any amendments to the model act that might later be adopted by a state were consistent with GLBA. The result was a final product that all parties agreed provides the states with a useful template to guide them in the enactment of state insurance sales laws that will clearly be protected from federal preemption. Moreover, in the two preemption opinion letters it has issued, the OCC made it clear that it would not preempt state laws consistent with the NAIC model.

Additionally, ABIA has provided the NAIC with a list of laws in 30 states that are inconsistent with GLBA. In its letter to the NAIC, ABIA asked the NAIC to encourage those states to remedy those laws. ABIA also noted that while there are three avenues available for resolving noncompliant state laws - state administrative/legislative action; federal regulatory action (preemption opinions); and litigation - ABIA preferred state administrative/legislative action.

In spite of these efforts, most states have not eliminated or revised offending laws, and despite the urging of the ABIA, the NAIC has expended no further efforts to encourage States to do so. This has left the banking industry with no choice but to ask the OCC for preemption opinions. <u>It is state inaction; therefore, not the OCC's eagerness to "act unilaterally," that has led to the OCC's preemption letters in West Virginia and Massachusetts.</u>

Moreover, it should be emphasized that the OCC's preemption letters are merely <u>opinion</u> letters. As stated in the OCC's preemption letters, "Federal courts, rather than the OCC, are the ultimate arbiters of whether Federal law preempts State law in a particular case."

Gramm-Leach-Bliley Act- (*Gramm-Leach-Bliley Financial Services Modernization Act)* This was enacted November 12, 1999. It repealed part of the Glass-Stegall Act of 1933. It opened up competition among banks, securities companies and insurance companies. Commercial banks are now permitted to own insurance companies and engage in securities underwriting through federally regulated subsidiaries. A complex piece of legislation, the act marks the culmination of efforts dating to the early 1980s to modernize the U.S. Financial services industry.

Glass-Stegall Act- A Federal law enacted by Congress in 1933 forcing a separation between commercial banking and investment banking. This act required commercial banks to dispose of their securities affiliates. Since then, the name Glass-Steagall has been more commonly used when referring to the four sections of the banking act (Sections 16, 20, 21, and 32) pertaining to underwriting and sale of securities.

Summary

The entire framework for State "functional regulation" of bank-insurance sales activities as set forth in GLBA is based upon a delicate balance between two principles: the preservation of state insurance regulatory powers and the establishment of limits on those powers to ensure that states cannot unfairly discriminate against banks engaged in the sale of insurance. To achieve that balance, Congress included in GLBA a preemption standard based upon the entire *Barnett Bank* decision. The statutory text of GLBA and the supporting legislative history lead to no other conclusion. The IIAA and the NAIC are seeking to turn that balance on its head by re-litigating the *Barnett Bank* case and, thereby, effectively amending GLBA. The states have been on notice since enactment of GLBA in November 1999 that not only was *Barnett Bank* the law of the land, but that its application has been broadened to all depository institutions.

The OCC has not rushed to judgment in issuing its recent preemption letters. It has issued them within the legal authority and spirit of the GLBA. Working through the NAIC, the OCC has given the states ample time and consultation to address preemption issues relating to existing laws and laws yet to be enacted. At some point, however, states should no longer be able to delay addressing noncompliant state laws and should be put on formal notice - through a preemption opinion issued by a federal regulator - that noncompliant laws are subject to Federal preemption. In West Virginia and, subsequently, in Massachusetts, the OCC has taken that action. The OCC has the authority to do so, and its interpretation of the preemption standard to be applied is consistent with GLBA.

CHAPTER 2 State Regulation and Safe Harbors

GLBA provides 13 areas or "safe harbors," within which the states can regulate insurance sales, solicitation, and cross marketing practices of banks and their subsidiaries and affiliates. Those 13 safe harbors cover advertising practices, licensing requirements, various notices and disclaimers, tying, restrictions on paying fees to non-licensed employees, and other potentially coercive sales practices. A state law concerning insurance sales, solicitation, and cross-marketing activities that does not fit within the safe harbors is treated in one of two ways, depending on when the law was enacted. The traditional *Barnett* preemption principles apply to all state laws for insurance sales, solicitation, and cross-marketing activities that do not fit within one or more of the safe harbors. State laws regulating those activities enacted on or after September 3, 1998 are subject to the *Barnett* preemption principles and a new antidiscrimination standard.

State Regulation Safe Harbors

Application of those principles can create novel and complex legal issues that the Comptroller's Office reviews case by case. In 2001 the Comptroller's Office published its first opinion letter, analyzing whether a state's insurance sales laws would be preempted pursuant to the *Barnett* standards as incorporated in section 104 of GLBA. The letter can be found at 66 *Federal Register* 51502 (Oct. 9, 2001). That letter contains a comprehensive discussion of how the standards apply. Questions about whether particular provisions of state insurance sales laws apply to national banks will continue to be address by the Office of Comptroller of the Currency.

Permissible National Bank Insurance Activities

Questions periodically arise concerning the permissibility of national banks to engage in specific insurance activities. Banks should consult with the OCC's Law Department or their own legal counsel if any questions arise. Examples of insurance activities permissible for national banks and their subsidiaries include:

Insurance Activities as Agent

• *Selling insurance as agent from a "place of 5,000" consistent with 12 USC 92*. A national bank may act as a general insurance agent and sell most types of insurance from any office located in a community of 5,000 or less. No geographic restrictions limit the bank's ability to solicit and serve its insurance customers. A national bank is not generally authorized to sell title insurance under 12 USC 92, but may sell title insurance to the extent permitted under GLBA, as discussed later. In some states, insurance agency activities authorized under 12 USC 92 may be characterized as managing general agency (MGA) activities.

• *Selling title insurance, as authorized under GLBA*. Under GLBA, a national bank or its operating subsidiary may sell title insurance in a state where a state bank is permitted to sell title insurance, but only in the same manner and to the same extent as the state bank. Also, a national bank and its subsidiary may conduct title insurance activities that the national bank or the subsidiary was actively and lawfully conducting before November 12, 1999. Neither a national bank nor its operating subsidiaries may offer, sell, or underwrite title insurance, if a state law was in effect before November 12, 1999 that prohibits those activities in that state. Although financial subsidiaries are not subject to those title insurance sales restrictions, they may not underwrite title insurance.

• *Selling crop insurance, as authorized under 12 USC 92 and 12 USC 24a*. A bank's sales of crop insurance are permitted from a "place of 5,000" consistent with 12 USC 92. Under 12 USC 24a, a national bank is authorized to sell crop insurance as agent through the bank's financial subsidiary.

• *Selling insurance as agent without geographic limitation through a financial subsidiary, as authorized under 12 USC 24a*. Financial subsidiaries of a national bank are authorized under 12 USC 24a to act as an insurance agent for all types of insurance, in any state.
• *Selling credit-related insurance as agent under 12 USC 24(Seventh)*. Pursuant to 12 USC 24(Seventh), national banks or their subsidiaries may sell credit-related insurance products, including:
credit life insurance (as defined in 12 CFR 2.2(b));
involuntary unemployment insurance (protects the bank if the borrower becomes involuntarily unemployed);

- *vendors single interest insurance* and *double interest insurance* (insures the bank or the bank and the borrower, respectively, against loss or damage to personal property pledged as loan collateral);
- *mechanical breakdown insurance* (protects a loan customer against most major mechanical failures during the loan's life); and,
- *vehicle service contracts* (protects the value of loan collateral from mechanical breakdown for the term of the contract).

Insurance Activities as Principal

• *Providing insurance as principal (underwriter or reinsurer).* GLBA permits national banks and their subsidiaries to provide insurance as principal (underwriter or reinsurer) for any product that the Comptroller's Office had approved for national banks prior to January 1, 1999, or that national banks were lawfully providing as of January 1, 1999. Included among the various types of insurance that national banks and their subsidiaries may provide as principal are credit-related insurance, municipal bond insurance, safe deposit box insurance, self insurance of business risk insurance, and private mortgage insurance.

Insurance Activities as Finder

A national bank may act as a finder to bring together potential purchasers and sellers of insurance. As a finder, a national bank may receive a fee to identify potential parties, inquire about interest, introduce or arrange meetings of interested parties, and otherwise bring parties together for a transaction that the parties themselves negotiate and consummate.

Acting as finder. Insurance finder activities are authorized for national banks under 12 USC 24(Seventh) as part of the business of banking. Some state laws may treat finder activities as activities that constitute acting as an insurance agent under state law. Where a state law characterized finder activities as activities of an insurance agent, national banks must comply with the applicable state insurance licensing and other requirements. The Comptroller's Office has also permitted banks acting as finders to provide extensive billing services to process insurance forms.

Bank Structures for National Bank Insurance Activities

A national bank may structure its insurance activities using one or a combination of legal entities. These include conducting insurance activities through the bank directly, a related insurance entity, or an unaffiliated third party. Each structure has certain benefits and efficiencies; a bank's choice will likely depend upon its resources and strategic preferences. Each of these structures must comply with appropriate legal requirements. Certain variable life insurance products are securities registered with the Securities Exchange Commission (SEC). These products are sold through broker/dealers whose functional regulator is the SEC. The SEC may use self-regulatory organizations, such as the National Association of Securities Dealers Regulation (NASDR) and the New York Stock Exchange (NYSE), to fulfill its regulatory responsibility.

Bank Direct Sales

In many states, a national bank must obtain a license - that is, the bank is the "licensed agency," and individuals working in the bank are licensed agents. Other states may require only that the individual be licensed. A bank that conducts its own insurance sales or operations may be able to exercise more control over the insurance activities than it would if it used a separate corporate or third-party structure. No formal application with the Comptroller's Office is required, if insurance activities are conducted directly through the bank.

Investment in an Insurance Entity

A national bank may choose to invest in an insurance entity, either through a controlling interest in an operating subsidiary or a financial subsidiary or a non-controlling interest in another enterprise. A bank's investment in an insurance entity may involve acquiring an existing entity or starting up a *de novo* entity. National banks planning to invest in an insurance entity should consult 12 CFR 5 for the appropriate corporate filing procedures with the OCC. A national bank may also use a holding company affiliate to offer insurance products and services to its clients. Several factors may influence a bank's decision to invest in an insurance entity. Establishment of a separate corporation for insurance activities may minimize the potential legal liability to the bank from financial losses arising from the subsidiary's insurance activities. In addition, in the event that the bank purchases an existing insurance entity, the necessary expertise and an existing customer base can be acquired immediately.

Operating Subsidiary

National banks are authorized to conduct insurance activities in an operating subsidiary. A national bank's operating subsidiary may be structured as a corporation, a limited liability company, or a similar entity. The parent national bank must own more than 50 percent of the voting (or similar type of controlling) interest in the operating subsidiary, or may hold 50 percent or less if the parent bank otherwise controls the subsidiary and no other party controls more than a majority interest in the subsidiary. See 12 CFR 5.34 for additional information.

Financial Subsidiary

GLBA permits national banks to own financial subsidiaries that may engage in many activities financial in nature or incidental thereto, including insurance agency activities. Financial subsidiaries are authorized to act as an insurance agent for all types of insurance, including title insurance, from any location, and are not confined to a "place of 5,000." See 12 CFR 5.39 for additional information.

Non-controlling Investment

In 12 CFR 5.36, it provides that national banks may own, either directly or indirectly, a *non-controlling* interest in an enterprise. The enterprise may be a corporation, limited partnership, limited liability company, or similar entity. A non-controlling investment represents another structural option that banks may consider as a vehicle to offer insurance products and services. National banks that make non-controlling investments must meet the following four part test;
Activities of the enterprise must be part of, or incidental to, the business of banking, or otherwise authorized for a national bank.
The bank must be able to prevent the entity from engaging in activities that do not meet this standard or otherwise be able to withdraw its investment.
The bank's loss exposure must be limited with no open-ended liability.
The investment must be convenient or useful to the bank in carrying out its business and may not be a mere passive investment unrelated to the national bank's business.

Holding Company Affiliate

Some banking organizations structure their insurance activities directly under the holding company. GLBA permits a broader range of insurance activities under this structure including broader insurance underwriting authority. A national bank may contract with the holding company affiliate to offer insurance products and services to its client base. Such transactions between a bank and a holding company affiliate must comply with the standards of Section 23B of the Federal Reserve Act. In other words, such transactions must be on terms and under circumstances that are substantially the same, or at least as favorable to the bank, as those prevailing at the time for comparable transactions with or involving other nonaffiliated companies; or in the absence of comparable transactions, on terms and under circumstances that in good faith would be offered to or would apply to, nonaffiliated companies. Generally, this requirement means that the transactions must be conducted on an arm's-length basis, and the bank must receive at least fair market value for any services it provides to its affiliate.

Arrangements with Unaffiliated Third Parties

Banks may elect to enter into agreements with third parties that have no affiliation with the bank. These arrangements can provide banks with expertise and services that otherwise would have to be developed in-house or purchased. Depending upon the type of insurance being sold, the expected volume of business, and the size of the bank, banks may find that using unaffiliated third parties to be more advantageous than establishing bank-direct or bank-affiliated insurance programs. Additionally, some banks may elect to offer more specialized products through an arrangement that may or may not involve common ownership or affiliation.

Distribution Methods

Within the authorized structures, banks may use various methods to distribute their insurance products. The sales force could involve fully dedicated agents or part-time agents. Part-time agents generally are part of a bank's platform program and may be authorized to sell bank and insurance products. These agents may have multiple employers, which may include the bank, an insurance agency, and a securities broker. Distribution methods may include face-to-face customer meetings, seminars, telemarketing, direct mail, referrals, the Internet, and other electronic media.

Agency Activities and the Role of the Insurance Agent

No one in the insurance business deals more closely with the public than insurance agents. Consumer confidence in the insurance industry depends on the demonstrated knowledge, experience, and professionalism of the insurance agent with whom a customer chooses to do business. An agent is someone who has been authorized by an insurance company to represent it. The insurance company (or insurer) underwrites and issues policies. The agent's role includes:
Describing the insurance company's policies to prospective customers.
Soliciting applications for insurance.
Providing service to prospects and policyholders.
Collecting premiums (when authorized) from policyholders and applicants.

Agents are most commonly described in terms of the contractual relationship between the agent and an insurance company. An *exclusive* agent is an individual who represents only one insurance company and is often, but not always, an employee of that insurer. A *general* agent is usually contractually awarded a specific geographic territory for an individual insurance company. General agents build their own agency and usually represent only one insurer. Unlike exclusive agents, who usually receive a salary in addition to commissions, general agents are paid by commissions only. An *independent* agent can work alone or in partnership or corporate affiliations. Under a contractual agreement, independent agents represent many different insurers in the life, health, and property and liability fields. All of their compensation is from commissions.

Managing General Agency (MGA) and the Role of an MGA

An MGA is a wholesaler of insurance products and services to insurance agents. An MGA receives contractual authority from an insurer to assume many of the insurance company's functions. The MGA may provide insurance products through local insurance agents. The MGA may also provide diversified services, including marketing, accounting, data processing, policy maintenance and service, and monitoring of claims. Many insurance companies prefer the MGA distribution and management system for the marketing and underwriting of their insurance products, because it avoids the high cost of establishing a branch office. Most states require that an MGA be licensed.

Finders Activities and the Role of the Finder

A national bank may act as a finder to bring together potential purchasers and sellers of insurance. As a finder, a national bank may receive a fee to identify potential parties, inquire about interest, introduce or arrange meetings of interested parties, and otherwise bring parties together for a transaction that the parties themselves negotiate and consummate.

Reinsurance and the Role of the Reinsurer

Reinsurance is insurance for insurers. As individuals and businesses purchase insurance as protection from the consequences of loss, so do insurers. Reinsurance allows an original insurer, also called the direct writer or ceding company, to reduce its underwriting risk by transferring all or part of the risk under an insurance policy or a group of policies to another company or insurer, known as the reinsurer. The original insurer may retain only a portion of the risk and reinsure the balance with a second company. The reinsurer then assumes that portion of the risk and receives a portion of the premium. In establishing a reinsurance arrangement, the insurer should seek a reinsurer that shares its underwriting discipline and that operates under comparable standards. The same is true for reinsurers seeking partners among insurers. Banks that have captive reinsurance subsidiaries that reinsure all or part of private mortgage insurance for real estate loans also must conduct their activities in compliance with the requirements of the Real Estate Settlement Procedures Act (RESPA), 24 CFR 3500.

Regulation and Supervision

The Office of the Comptroller of the Currency is responsible for supervising the safety and soundness of the national banking system. This responsibility encompasses evaluating the consolidated risk profile of the national bank, including determining the potential material risks posed to the bank by the functionally regulated activities of a national bank's subsidiaries and affiliates. The Comptroller's Office will assess the risks posed to the bank from its insurance related activities by using a risk assessment process that is consistent with GLBA's functional regulation requirements. The assessment is integrated into the OCC's normal supervisory process and embraces the supervision by risk approach in determining the necessity, frequency, and depth of the analysis. The assessment is conducted at the bank level, and it is anticipated that the OCC's examinations of FRAs will be infrequent. This section contains information on the OCC's supervisory process involving functionally regulated activities. It identifies the risks and significant legal requirements applicable to national banks' insurance activities. The OCC's assessment process is detailed in the "Risk Assessment Process" section of this booklet.

Functionally Regulated Activities

The Gramm-Leach-Bliley Act (GLBA) codified the concept of "functional regulation," recognizing the role of the state insurance commissioners, the Securities and Exchange Commission (SEC), and the Commodities Futures Trading Commission as the primary regulators of insurance, securities, and commodities activities, respectively. As the primary regulator of national banks, the Comptroller's Office has the responsibility for evaluating the consolidated risk profile of a bank. This responsibility includes determining the potential material risks posed to the bank by functionally regulated activities conducted by the bank or by a Functionally Regulated Affiliate (FRA), such as an affiliate insurance agency. A key component of this assessment is evaluating a national bank's systems for monitoring and controlling risks posed by functionally regulated activities conducted in the bank or an FRA. The Comptroller's Office is also responsible for determining compliance with applicable legal requirements under the OCC's jurisdiction.

The state insurance regulators are responsible for enforcing individual state's laws on the insurance companies and their associated agencies and agents doing business in the state. States regulate, among other things, licensing insurance agents or agencies, the financial stability of insurance companies, marketing and trade practices, the content of insurance policies, and the setting of premium rates. Each state has its own legal requirements and supervisory methods. State insurance regulators refer to the National Association of Insurance Commissioners (NAIC) model laws for guidance in drafting state regulations. The NAIC consists of principal insurance regulatory authorities from each state and its primary function is to develop uniform standards for the insurance industry. State insurance regulators have discretion in implementing the NAIC's recommendations given the NAIC has no authority over its individual members.

The assessment of risk at individual national banks must adhere to GLBA requirements that limit the OCC's authority to obtain reports directly from and examine an FRA, unless certain conditions exist. GLBA does not limit the OCC's authority to obtain reports from or examine the national bank itself. If the risk assessment identifies potential significant risk to the bank from the FRA's insurance activities, the Comptroller's Office will seek additional information or reports from the appropriate functional regulator. If such information or report is not made available, the Comptroller's Office may seek to obtain it from the FRA if the information or report is necessary to assess:
A material risk to the affiliated national bank;

Compliance with a federal law the Comptroller's Office has specific jurisdiction to enforce with respect to the insurance entity; or
The system for monitoring and controlling operational and financial risks that may pose a threat to the safety and soundness of the affiliated national bank.

GLBA does not, however, limit the OCC's authority to seek information on an FRA in the possession of the bank or from sources other than the FRA to the extent needed to evaluate the risks an FRA poses to the bank.

OCC Limits

GLBA also imposes limitations on the OCC's ability to directly examine insurance activities conducted by FRAs. The Comptroller's Office may directly examine the FRA only when:
• There is reasonable cause to believe that the company is engaged in activities that pose a material risk to the affiliated national bank;
• After reviewing relevant reports, a reasonable determination is made that an examination of the company is necessary to adequately inform the Comptroller's Office of the system for monitoring and controlling operational and financial risks that may pose a threat to the safety and soundness of the affiliated national bank; or
• Based on reports and other information available, there is reasonable cause to believe that the company is not in compliance with federal law that the Comptroller's Office has specific jurisdiction to enforce against the company, including provisions relating to transactions with affiliates, and the Comptroller's Office cannot make such determination through examination of the national bank.

Before an examiner requests information from or conducts an examination of an FRA or an unaffiliated third-party insurance provider. Although GLBA limits on bank regulators' ability to examine and obtain reports technically apply only to affiliated entities, the Comptroller's Office will generally apply the same principles when seeking information from an unaffiliated third-party insurance provider.

GLBA functional regulation limitations on obtaining reports and examinations do not apply to insurance activities conducted directly by the bank. In those arrangements, the state insurance regulator is responsible for functional regulation of the bank's insurance activities. The Comptroller's Office is responsible for supervising the safety and soundness of those insurance activities and for evaluating compliance with banking law requirements. Effective functional supervision places a premium on close cooperation and coordination among the various regulators. The Comptroller's Office has entered into information sharing agreements with many state insurance departments to assist in this coordination and is working toward entering into agreements with all states.

Large bank EIC's and ADC's with portfolio responsibilities maintain open channels of communication with their state insurance regulatory counterparts and work directly with them on institution-specific issues. These efforts can result in strengthening regulatory oversight and reducing the burden of overlapping jurisdiction on the regulated entities. This includes the coordination of supervisory activities, communication of critical issues, and exchange of necessary information. The Comptroller's Office might receive a request for information from another functional regulator, in which case a response can be given or forwarded to another, more appropriate, functional regulator for information.

Regulatory Risk Assessment

The OCC's primary supervisory focus, with respect to a bank's insurance activities, is assessing the material risks that those activities may pose to the national bank and the effectiveness of the bank's oversight systems for monitoring and controlling those risks. The bank's insurance activities can pose direct risks to the bank's earnings, capital, liquidity and reputation, if not properly managed. The risk assessment by the OCC takes into consideration items discussed in the course under the sections, "Applicable Legal and Regulatory Requirements," "Risks," and "Risk Management Processes." The OCC's risk assessment process is consistent with GLBA functional regulation requirements. Also, this business line risk assessment conforms to the OCC's supervision by risk approach and is integrated into the bank's normal supervisory process for evaluating the bank's overall risk profile. The risk assessment process consists of a preliminary risk assessment that determines whether the insurance activities pose a material risk to the bank and what, if any, additional supervisory efforts are warranted in making this risk determination. If additional supervisory efforts are necessary, the OCC examiner selects the appropriate steps from the "Additional Risk Assessment" section. The risk assessment process anticipates that the OCC's examinations of an FRA or unaffiliated third-party insurance provider will be infrequent;

nevertheless, the process does establish protocol in the event such an examination is considered. The risk assessment of the bank's insurance activities generally will include a bank level evaluation of the nature of the activities, strategic plans, financial significance to the bank's earnings, capital and liquidity, risk management systems, and compliance with banking laws. Comptroller's Office examiners use sources, such as routine meetings with bank management, regular reviews of existing bank reports, information obtained from state insurance regulators, and any applicable Comptroller's Office reports to aid in the development of the consolidated bank assessment of risk. Comptroller's Office examiners review and update data on the OCC's electronic information systems during the bank's normal supervisory cycle or as requested. The "Risk Assessment Process" section of this book contains more information on how the risk assessment is conducted.

Applicable Legal and Regulatory Requirements

Potentially relevant statutory, regulatory, and Comptroller's Office policy requirements may apply to a national bank when insurance activities are conducted through the bank, FRAs, or unaffiliated third parties. The Comptroller's Office risk assessments of insurance activities encompass evaluating national banks' risk management functions. This includes determining the effectiveness of banks' systems for ensuring compliance with applicable legal and regulatory requirements. Following is a summary of these requirements that add to the statutory provisions discussed in the "National Bank Insurance Powers" section.

Insurance Customer Protections - 12 CFR 14

National banks must comply with the OCC's insurance consumer protection rule published under 12 CFR 14, which implements section 305 of GLBA. This regulation applies to retail sales practices, solicitations, advertising, or offers of any insurance or annuity product by a depository institution or any person engaged in such activities at an office of the institution or on behalf of the institution. Refer to the section "Bank Insurance Activities- Insurance Customer Protections" for a more detailed discussion of this regulation.

Privacy Rule - 12 CFR 40 and the Fair Credit Reporting Act

A national bank and its financial and operating subsidiaries that provide insurance to consumers must comply with the privacy provisions under Title V of GLBA. Pursuant to the requirements of GLBA, the OCC, the Federal Reserve Board, the Federal Deposit Insurance Corporation, and the Office of Thrift Supervision have issued an interagency rule that governs the privacy of consumers' nonpublic personal information. National banks are subject to the OCC's privacy rule. However, functionally regulated financial and operating subsidiaries that offer insurance to consumers are not covered by the OCC's privacy rule, but must comply with state privacy requirements. The interagency privacy rule implements the provisions of GLBA that require each bank (and other types of financial institutions, including insurance agents and insurance underwriters) to notify its customers about the bank's privacy policies and to provide consumers with an opportunity to opt out of information sharing between the bank and certain nonaffiliated third parties. Similarly, a bank's insurance subsidiary would have to provide its customers with its own privacy and opt out notices, although the rule would permit a company-wide notice where it accurately reflects each institution's practices. The rule requires that these privacy and opt out notices be provided to individual consumers who establish a customer relationship with the bank, generally not later than the time the customer relationship is established. Unless an exception applies, these notices also must be provided to any other consumer, even if not a "customer" of the bank, before the bank discloses that consumer's nonpublic personal information to a nonaffiliated third party. While the privacy rule applies to the sharing of information by a bank with nonaffiliated third parties, affiliate sharing of certain consumer information is subject to the Fair Credit Reporting Act (FCRA). In general, if a bank wants to share with its insurance subsidiary information from a credit report or from a consumer application for credit (such as assets, income, or marital status), the bank must first notify the consumer about the intended sharing and give the consumer an opportunity to opt out of it. The same rules would apply to an insurance company that wants to share information from credit reports or from applications for insurance. Failure to provide notice and opt out may turn the bank or insurance company into a consumer reporting agency. Affiliate sharing notices should be included in the bank's or insurance company's privacy notice.

Consumer Reporting Agency

As stated above, the failure of a bank or its affiliate insurer to provide notice and opt-out information may cause the entity to morph into a consumer reporting agency. Here are the rather serious ramifications of becoming one of those.

Federal Prohibitions on Tying - 12 USC 1972

Tying the availability of credit from the bank to the purchase of insurance offered by the bank or a bank affiliate is illegal. Under 12 USC 1972, a bank is prohibited (subject to certain exceptions) from requiring a customer to obtain credit, property, or services as a prerequisite to obtaining other credit, property, or services. This standard applies whether the customer is retail or institutional, or the transaction is on bank premises or off. The Comptroller's Office has extended these protections to cover national bank operating subsidiaries

Restrictions on Transactions with Affiliates - 12 USC 371c, 371c-1

A national bank is subject to certain quantitative and qualitative restrictions on transactions with affiliates as prescribed by sections 23A and 23B of the Federal Reserve Act, 12 USC 371c and 371c-1. These legal restrictions apply to transactions between a bank (or its subsidiaries) and affiliates conducting insurance activities. They also apply to transactions between a bank and its own financial subsidiary. The principal requirements of 12 USC 371c are as follows. The statute provides that for any one affiliate, the aggregate amount of covered transactions may not exceed 10 percent of the bank's capital stock and surplus. For all affiliates, the aggregate amount of covered transactions may not exceed 20 percent of the bank's capital stock and surplus. In addition, an extension of credit to an affiliate and a guarantee, acceptance, or letter of credit issued on behalf of an affiliate, must meet specific collateral requirements. Further, under section 371c any covered transaction must be made on terms and conditions that are consistent with safe and sound banking practices. Section 371c also prohibits the purchase of low-quality assets by a bank (or its subsidiaries) from an affiliate. Generally low-quality assets are defined as substandard, doubtful, loss, other assets especially mentioned, or delinquent.

The principal requirement of 12 USC 371c-1 is that transactions covered by that statute must be on terms and under circumstances that are substantially the same, or at least as favorable to the bank, as those prevailing at the time for comparable transactions with or involving other nonaffiliated companies; or in the absence of comparable transactions, on terms and under circumstances that in good faith would be offered to or would apply to, nonaffiliated companies. Generally, this requirement means that the transactions must be conducted on an arm's-length basis, and the bank must receive at least fair market value for any assets it sells, or services it provides, to its affiliate. A covered transaction under 12 USC 371c is an extension of credit to an affiliate; a purchase of, or investment in, affiliate securities; a purchase of assets from an affiliate; the acceptance of affiliate securities as collateral for a loan to any borrower; or the issuance of a guarantee, acceptance, or letter of credit on behalf of an affiliate. Transactions covered by 12 USC 371c-1 include covered transactions under 12 USC 371c, the sale of securities or other assets to an affiliate, including assets subject to an agreement to repurchase, and the payment of money or the furnishing of services to an affiliate under contract, lease, or otherwise.

Advisory Letter 96-8, "Guidance on Insurance and Annuity Sales Activities"

Certain standards from Office of Comptroller of the Currency Advisory Letter 96-8 under the "Risk Management" section are mentioned in this book. Other portions of Advisory Letter 96-8 were superseded by GLBA's requirements on the applicability of state laws, customer privacy, and customer protections. Advisory Letter 96-8 has since been rescinded by the OCC.

Risks

The Comptroller's Office assesses banking risk relative to the potential that events, expected or unanticipated, may have an adverse effect on the bank's earnings and capital. The primary risks associated with insurance activities are **transaction, compliance, strategic, reputation, and credit** risk. These are separate risks from those normally associated with insurance underwriting and reinsurance risks, such as mortality risk, adverse selection, excess capacity, and poor underwriting results that affect an insurer’s success in business. All of these risks can pose direct risks to the bank's franchise value if not managed properly. For example, inferior product delivery, ineffective controls, and poor planning can

result in potential legal costs and loss of business. The following is a more detailed discussion of the primary risks associated with a bank's insurance activities.

Transaction Risk

Transaction risk is the risk to earnings or capital arising from fraud, error, and the inability to deliver products and services, maintain a competitive position, and manage information. Increasing or high transaction risk exists in a bank whose ability to transact business is impeded by inefficient operating systems or poor internal controls. Ineffective operating systems can result in poor product delivery, including unacceptable levels of errors and exceptions or general systems failures. Banks with low transaction risk typically have efficient delivery systems, including capable staffs, strong information systems and processing, viable backup systems, and appropriate insurance coverage for errors and omissions.

A bank's insurance activities, which may include the issuance of binders and policies, the forwarding of premiums, the filing of claims, and electronic product delivery, pose transaction risk to the bank if they are not performed efficiently and accurately. Transaction risk is elevated for banks that internally process premium payments and loss claims, including the potential liability for late or non-remittance of payments to the underwriter. For insurance sales, underwriting, or reinsurance activities, examiners assess transaction risk by evaluating the adequacy of the bank's risk management over insurance application, processing, and delivery systems and controls. They consider the volume and type of policies issued, the capabilities of systems and technology in relation to current and prospective volume, contingency preparedness, and exposures through the claims and payment processing systems.

Compliance Risk

Compliance risk is the risk to earnings or capital arising from violations of or noncompliance with laws, rules, regulations, internal policies and procedures, or ethical standards. Compliance risk exposes a bank to the possible loss of business, fines, payment of damages, and voidance of contracts. The regulatory framework for bank insurance activities is complex, consisting of both federal and state legal requirements. Banks, particularly those with multi-state programs, must research carefully and understand fully the compliance requirements for each state in which they conduct insurance activities. Moreover, this regulatory framework addresses both safety and soundness and consumer protection provisions. It is crucial that banks comply with all applicable regulatory requirements. Banks without adequate policies, training, management information systems, and audit/compliance programs are subject to high compliance risk, because of the lack of effective systems for self-regulating this business line.

Significance of Complaints

A pattern of complaints is a lagging indicator of compliance problems. Conversely, banks that clearly incorporate authority and responsibility into their risk management programs and develop strong compliance systems are likely to exhibit low compliance risk. OCC Examiners assess compliance risk by evaluating the comprehensiveness of a bank's compliance program relative to the complexity of the bank's insurance activities. Examiners consider the volume and nature of complaints received, violations of law cited, and enforcement actions taken by banking and functional regulators, and the quality and effectiveness of the audit/compliance program.

Strategic Risk

Strategic risk is the risk to earnings or capital arising from adverse business decisions, improper implementation of decisions, or lack of responsiveness to industry changes. Strategic risk in insurance activities may be high in banks that, in an effort to remain competitive, rapidly and aggressively introduce new products and services without fully performing due diligence reviews or implementing the infrastructure to support the activity.

Culture Club

A culture that focuses almost exclusively on production and income can motivate undesirable sales and underwriting practices if appropriate risk management systems are not in place. Conversely, banks with

low strategic risk would likely exhibit a corporate culture that includes appropriate planning, due diligence, implementation, delivery networks, and risk management systems.

Management's knowledge of the economic dynamics and market conditions of the insurance industry, including the cost structure and profitability of each major insurance line, can help limit strategic risk. The bank's structure and managerial talent must support its strategies and degree of innovation in offering new or nontraditional products. Strategic risk may vary depending on whether the bank acquires an existing insurance agency, underwriter, or reinsurer with established systems and controls or starts a new one. Examiners assess strategic risk by determining whether bank management: has performed adequate due diligence reviews of the insurance companies whose products will be offered, underwritten, or reinsured; evaluated the feasibility and profitability of each new insurance product and service before it is offered; and established appropriate systems and controls. Examiners also assess the adequacy of the bank's infrastructure to support agency, underwriting, and reinsurance activities.

Reputation Risk

Reputation risk is the risk to earnings or capital arising from negative public opinion that can affect the bank's ability to establish new business and retain existing relationships. Reputation risk associated with insurance sales can arise from inappropriate sales recommendations, deficient underwriting and reinsurance practices, poor service, violations of law, or litigation. Also, adverse events surrounding the insurance companies whose products are sold or underwritten through the bank may increase reputation risk. Reputation risk can be minimized by appropriate implementation and policing of the bank's insurance activities, to include effective due diligence in selecting products and their providers, as well as adequate policies, procedures, training, audit, and management information systems. Banks that are entering into or expanding insurance activities without acquiring the necessary expertise or implementing the necessary risk management systems may experience high or increasing reputation risk.

High Anxiety

A focus on production and an anxiety for income may motivate undesirable sales or underwriting practices without the necessary systems and controls. Inappropriate sales recommendations or deficient underwriting or reinsurance practices, and violations of law could subject the bank to significant reputation risk and litigation, including class-action lawsuits which can give rise to significant potential liability. Banks with low or stable reputation risk are typically those that exercise caution in introducing new insurance products and services, or those that have been in insurance activities for some time and expand their product line gradually and only after performing the appropriate due diligence review. Examiners assess reputation risk by evaluating the quality of the bank's risk controls including the due diligence process and oversight functions for ensuring appropriate sales, underwriting, and reinsurance practices. Examiners also consider any current or pending litigation and analyze customer complaint information.

Credit Risk

Credit risk is the risk to earnings or capital arising from an obligor's failure to meet the terms of any contract with the bank or to otherwise fail to perform as agreed. Credit risk is found in all activities for which success depends on counterparty, issuer, or borrower performance. Banks relying on third parties to facilitate their insurance activities are exposed to credit risk, if the vendor is unable to meet the contractual requirements. Credit risk exists in credit-related insurance sales, underwriting, and reinsurance activities, if the insurance carrier fails to honor a claim. The insurance carrier's claims paying ability depends on its financial strength and willingness to pay. In many credit-related insurance sales, the bank is named as the beneficiary to receive insurance proceeds for debt repayment in the event of the borrower's death, unemployment, or disability. If the insurance company fails to pay benefits under the credit-related policy, the bank's credit risk exposure increases as debt repayment becomes uncertain. Banks involved in underwriting credit-related insurance and reinsurance are exposed to credit risk from the probability that claims will be presented for payment or will not be honored by another underwriter. The credit quality of the primary insurance company and duration of the contracts are key variables. Before establishing a relationship with a primary underwriter or a reinsurer, the bank should conduct an independent financial analysis and review of the insurance carrier's ratings. Credit risk may be reduced partially by the support provided by state insurance guaranty associations or funds. Examiners assess credit risk in the bank's insurance activities by evaluating the significance of exposures, loss experience,

and controls over the associated activities. The OCC examiner of insurance activities coordinates with the examiner responsible for assessing credit underwriting standards when determining risk exposures.

CHAPTER 3 Risk Management Processes

This section describes how national banks should manage the risks associated with insurance activities. It is what the federal government looks for in the case of banks selling insurance- procedural practices. This is a primer on risk audit standards and the examination of risk structure at a bank. The board and senior bank management should develop and implement effective risk management processes that effectively assess, control, and monitor the risks emanating from a bank's insurance activities. An effective risk management system is characterized by a board and senior management that are actively involved in the development and maintenance of effective supervision and sound risk management processes. Evaluating the effectiveness of the bank's risk management processes is a key component of the OCC's risk assessment.

Program Management Plan

A bank's board of directors is responsible for overseeing insurance activities conducted directly by the bank or through contractual arrangements with third parties, including bank subsidiaries, affiliates, or unaffiliated providers. In carrying out this responsibility, the board should adopt an appropriate program management plan to guide the bank's insurance activities. Aspects of the plan may be articulated in the bank's strategic plan for insurance activities or in other board-approved directives. The comprehensiveness of the plan should be commensurate with the complexity of the bank's insurance activities. This plan should articulate the board's risk tolerance and establish the necessary systems for controlling the program's risks. Annually, the board should reevaluate the plan for appropriateness and effect any necessary changes. At a minimum, the plan for insurance activities should address:

Program objectives, strategic direction, and risk tolerance standards. The bank board of director's plan should address the insurance program's objectives and establish the strategies for achieving them. The plan should describe the insurance program, including risks associated with the activities, and the board's risk tolerance levels.

Organizational structure and authority. The plan should establish the organizational structure for insurance activities and clearly delineate program authority, responsibility, and accountability. Depending upon the size of the bank, this structure may be an individual, a group of individuals, or a committee.

Policies and procedures. The plan should require establishing appropriate policies and procedures commensurate with the structure and complexity of insurance activities. These guidelines should ensure that the program's objectives are met without compromising customers' best interests.

Risk management system. The plan should reflect the board's commitment to risk management and a sound internal control system. It should outline a comprehensive risk management system that is appropriate for the bank's structure, complexity, and diversity of operations. A risk management function should include, as appropriate, senior managers, line managers, and personnel from compliance, audit, legal operations, human resources, information systems, and product development.

Management information systems (MIS). The plan should establish the appropriate MIS necessary for the board to oversee properly the bank's insurance activities. Board MIS should provide sufficient information to evaluate and measure the effect of actions taken. Also, the plan should provide for appropriate senior management MIS that may include sales volumes and trends, profitability, policy exceptions, customer complaints, and other data outlining compliance with laws and policies.

Bank Risk Assessment

The board and senior management must have processes in place to identify the risks associated with the bank's insurance activities. These processes should also determine how those risks will be measured and what controls and monitoring systems are needed. The bank should clarify the risk measurement and reporting processes it expects from bank managers and third-party providers. Over time, risks may vary because of changes in the bank's strategies, product lines, personnel, or economic environment. The bank's risk assessment should adapt to the changes and adequately address the risks. Internal and independent risk assessment should be comprehensive. Staff assigned to manage risk should identify the types of risk and estimate the levels of risk created by the bank's insurance activities. The assessment should consider the differences in bank direct activities and third-party relationships.

Risk Identification

Depending upon the size of the institution, a risk management function may have responsibility for identifying the risk in insurance activities. This function (or person in a smaller institution) should be independent and objective. When insurance activities are performed exclusively by third parties, bank management should ensure that the third-party activities are consistent with the bank's corporate strategic goals. The bank should identify the strategic purposes and risks associated with the third-party activity to ensure that the standards are consistent with those employed by the bank and to ensure that they are within the bank's risk tolerance levels.

Risk Measurement

Management must decide what measurement system is appropriate for gauging the risks in insurance activities. Models may be used in quantifying the risks. Management could incorporate insurance risks in existing models measuring credit and operational risks. A model is only as good as the quality of its data and the expertise of its users. Banks must continually assess and validate models used in this process. Office of the Comptroller of Currency's Office Bulletin 2000-16, "Risk Modeling," provides guidance on validating computer-based financial models. For third-party relationships, management should receive sufficient information and reports that allow for effective measurement of risk.

Risk Monitoring

For both third-party and bank direct activity, bank management should be accountable for understanding the insurance products offered and the sales process and for assuring compliance with insurance laws, regulations, and rules. A control self-assessment program should be implemented. This program should include identification of performance criteria, internal controls, reporting needs, and contractual requirements. The bank may want to use internal auditors, compliance officers, and legal counsel to help analyze the risks associated with third-party relationships and establish the necessary control and reporting structures.

Risk Controls

A function of insurance is to eliminate risk for individuals and businesses. Unpredictable events which put individuals at risk are a predictable expense for the population as a whole. Through insurance coverage, a risk of loss is pooled with similar risks and converted to a regular expense for the individual or business by means of payment of premiums.

There are many examples of risk; a homeowner faces a large potential for variation associated with the possibility of economic loss caused by a house fire. A driver faces a potential economic loss if his car is damaged. A larger possible economic risk exists with respect to potential damages a driver might have to pay if he injures a third party in a car accident for which he is responsible. Historically, economic risk was managed through informal pooling agreements. Over time, these agreements were replaced by the insurance function. The cooperative concept became formalized in the insurance industry. Under a formal insurance arrangement, each insurance policy purchaser pools his or her risk with all other policyholders. An insurance contract covers a policyholder for economic loss caused by a peril named in the policy. The policyholder pays a known premium to have the insurer guarantee payment for the unknown loss. In this manner, the policyholder transfers the economic risk to the insurance company. Risk is the variation in potential economic outcomes. It is measured by the variation between possible outcomes and the expected outcome: the greater the standard deviation, the greater the risk.

By extension, the same applies to the risks faced by banks. Risk controls, including policies, procedures, processes, and systems, are necessary to maintain risk at levels consistent with the bank's risk tolerance levels. The bank should have a comprehensive set of controls for managing the insurance-related risks affecting the national bank.

Adequate Policies and Procedures

Policies and procedures should be developed and implemented that comprehensively address the bank's insurance activities. The level of detail contained in a bank's policies and procedures will depend on the structure and complexity of the bank's program. For example, an insurance program involving nationwide product distribution and heavy sales volumes will require more elaborate policies and procedures than a bank's program that is limited credit life insurance sales to its loan customers.

Effective Due Diligence Processes

A third-party provider (affiliated or unaffiliated) may perform many of a national bank's insurance activities. Before entering into a relationship with a third party, a bank should establish a comprehensive program for managing the relationship. The program should be documented and should include appropriate due diligence for selecting providers, products, and services, and ongoing oversight of the relationship. The relationship should be supported with binding written agreements, and bank counsel should review all contracts before entering into a third-party relationship. If the relationship is with a third-party provider that is an affiliate, the relationship must be consistent with the requirements of sections 23A and 23B of the Federal Reserve Act, 12 USC 371c and 371c-1. The requirements of sections 23A and 23B of the Federal Reserve Act, 12 USC 371c and 371c-1, are summarized under the "Restrictions on Transactions with Affiliates - 12 USC 371c, 371c-1" section of this study guide.

Processes for Identification and Selection of Third Parties

Selecting a competent and qualified third-party provider is essential to managing third-party risk. An effective due diligence process should be used to identify and select a third party that will help the bank achieve its strategic goals. The bank should obtain information, as appropriate, on the firm's investment and business approaches, professional resources, financial strength, historical performance, regulatory history, personnel turnover, and other relevant factors. The due diligence process normally will consider the following factors:

Background. When the third party was established, its ownership and affiliation, the history of regulatory actions, personnel turnover, and other relevant factors.

Financial strength. The provider's current, past and projected financial performance, financial audits, credit ratings and analyses issued by nationally recognized independent credit rating agencies.

Experience. The provider's capability to render the necessary expertise, operational and technical support for the products and services under contract, and management depth and quality, and training support for all employees. Consider any subcontractors used and their effects on the prime provider's capabilities.

Reputation. The provider's business reputation, complaint records and methods of resolving complaints, commission structure, product pricing, the payment of claims, and the current regulatory/litigation environment.

Business strategies and goals. The provider's business strategies and goals and whether they complement the bank's philosophies and risk appetite. Consider the provider's human resource policies, customer service philosophies, policies for managing costs and improving efficiency, and ethics.

Effectiveness of risk management processes. The provider's policies and procedures, diversification guidelines, concentration limits, internal compliance and audit programs, contingency planning and disaster control systems, and the internal control environment.

Written plans. The provider's written business resumption, recovery, continuity, and contingency plans; and whether they meet the bank's expectations and requirements.

Management information systems (MIS). The provider's MIS capability in meeting the bank's information needs in a timely and comprehensive manner. MIS should cover client data, sales activity, product performance, financial, compliance, and complaint information.

Products and services. Whether the variety of offerings meet the bank's criteria for its client base, products' underlying insurance underwriters possess the financial strength for paying claims, and product pricing is reasonable compared with similar product offerings from other vendors. Bank management should review a sample of marketing materials, particularly those using the bank's name, to ensure materials are appropriate.

Guidelines for Written Contracts

Bank management should ensure that expectations and obligations of each party are clearly defined within a binding written agreement or contract with each third-party provider. The document should address the following issues:

Scope of the relationship. The types of insurance products or services that will be provided, software support and maintenance, training of employees, and customer service guidelines.

Activities provided. Agency or other insurance related activities that will be provided and whether they will be conducted on or off bank premises. The contract should describe, as applicable, the terms governing the use of the bank's space, compensation, human resources, and equipment. When dual employees are used, responsibilities and duties should be articulated clearly.

Expectations and responsibilities. The means for monitoring ongoing performance and measuring the success of the third-party arrangement, including compliance with legal requirements.

Management information reports. The types, frequency, and materiality of management information reports expected by bank management.
Compensation and costs. Full descriptions of compensation, fees, and calculations for services provided, including charges based upon the volume of activity and fees for special requests. The contract should state clearly who is responsible for paying legal, audit, and examination fees associated with the insurance activity. The cost and responsibility for purchasing and maintaining hardware and software should be addressed.
Indemnification. Provisions that release the bank from any potential liability. Such provisions can reduce the likelihood that the bank will be held liable for claims citing negligence of the third party. The bank may also consider limiting the third party's liability. If so, management should determine whether the proposed limit is in proper proportion to the amount of loss the bank might experience from the third party's failure to perform.
Insurance coverage. Requirements for insurance coverage. The third party should maintain adequate insurance, including appropriate errors and omissions coverage, and should notify the bank of material changes to coverage.
Dispute resolution. The process (arbitration, mediation, etc.) for resolving problems between the bank and the third party.
Default and termination. What constitutes default, identity of remedies, and allowance for opportunities to cure defaults. The contract should include a provision that enables the bank to terminate the contract upon reasonable notice and without penalty, in the event the Comptroller's Office or another regulator formally objects to the third-party arrangement. The contract should state termination and notification requirements with timeframes to allow for the orderly conversion to another provider. It should also provide for timely return of the bank's data and other resources.
Customer complaints. Identity of the person(s) responsible for responding to and resolving complaints. The third party should forward to the bank copies of any complaints it receives from the bank's customers and copies of all follow up correspondence on those complaints.

Guidelines for Qualifications and Training

Banks should have knowledgeable, experienced, and qualified personnel to ensure that insurance activities are carried out in a manner that provides customers with competitive products, sound advice, and accurate information. Personnel should be familiar with the bank's policies and procedures to ensure compliance with its internal guidelines and applicable legal requirements. Timely and regularly scheduled training can keep personnel aware of the latest innovations in financial products, changes in bank policies, and developments in applicable laws or regulations. To achieve these goals, management should:
Clearly define responsibilities of personnel authorized to sell insurance products and the scope of the activities of any third party involved in the sales program.
Verify that sales personnel are licensed and in good standing under applicable state and federal laws. Ascertain whether individuals have been subject to any disciplinary action.
Ensure that continuing education requirements are met.
Limit the involvement of tellers and individuals not qualified to sell insurance to directing customers to qualified personnel who can provide authoritative information.

For third-party relationships, the bank should ensure that the vendor has processes in place to meet qualification and training requirements.

Guidelines to Prevent Inappropriate Recommendations or Sales

Customers interested in purchasing insurance products may have particular needs based on their financial status, current insurance coverage, or other circumstances. Customers inexperienced in dealing with financial products, particularly those products involving an investment risk, may also require more detailed information about the products offered. Sales programs should have effective guidelines to prevent inappropriate recommendations or sales. For example, management should communicate clearly to its sales personnel that it is unacceptable to recommend and sell new or replacement insurance policies to customers on the basis of commissions to the seller rather than on the benefits of the policy. Such "twisting" is inappropriate and a violation of most states' laws. For bank direct activities, the bank is responsible for day-to-day supervision of the sales practices and management including the appropriateness of products for each customer. In arrangements with third parties (bank subsidiaries, bank affiliates, and unaffiliated entities), the bank oversees the third party and ensures that the vendor

has policies and procedures to prevent inappropriate recommendations and sales. Day-to-day supervision of third-party sales practices is the responsibility of the third party.

Appropriate Employee Compensation Programs

Incentive compensation is commonly used to sell insurance and may increase customer awareness of the availability of the products offered by a bank. The sales program should have a compensation structure in place that does not encourage inappropriate sales practices. Sales should reflect the customer's best interest and the policy's benefits, not the commission derived from the transaction. Management should communicate clearly to the bank's sales personnel that it is unacceptable to engage in high-pressure sales tactics, sell duplicative or unnecessary insurance, or recommend and sell new or replacement insurance policies to customers for reasons other than the customers' benefit. Sales personnel who engage in such practices should be penalized, either through the compensation program or by termination, as appropriate. The bank is responsible for day-to-day supervision of the bank's employee compensation programs. For third-party relationships (bank subsidiaries, bank affiliates, and unaffiliated entities), it is the bank management's task to ensure that the vendor has policies and procedures in place to ensure that its employee compensation programs are appropriate. Any performance-based compensation should be:
Conformed to applicable legal requirements.
Approved by appropriate legal counsel.
Addressed in a governing document or contract.

These documents should discuss formally the performance-based compensation, including the basis of calculation and circumstances under which the fees will or will not be payable.

Any bank employee referral program should meet applicable legal requirements. For example, under 12 CFR 14, certain bank employees, including tellers, may receive a one-time nominal fee of a fixed dollar amount for each customer referred for insurance products. The payment of this referral fee cannot depend on whether the referral results in a transaction.

Risk Monitoring

Risk monitoring is necessary to evaluate the performance of the bank's risk strategies and control processes over insurance activities. Bank management responsible for risk monitoring should perform frequent, independent reviews of compliance with risk policies, procedures, and control systems. Noncompliance with established policies and procedures should be addressed through fully documented corrective action plans and communicated to affected persons. The frequency of monitoring should be determined based on the nature, complexity, and diversity of insurance activities and operations.

Ongoing Oversight of Third-Party Relationships

After entering into an arrangement with a third party (bank subsidiary, bank affiliate and unaffiliated entities), management should monitor the third party's activities and performance. Management's oversight program should be documented properly to facilitate the monitoring and management of the risks associated with third-party relationships. Management should dedicate sufficient staff with the necessary expertise to oversee the third party. The extent of a bank's oversight activities will vary depending on the nature of the arrangement. At a minimum, the bank should monitor the third party's financial condition, its controls, and the quality of its service and support. The monitoring of these areas may include:
Evaluation of the third party's financial condition. Perform a comprehensive financial analysis at least annually, and more often depending upon the complexity of the third-party arrangement. Significant relationships with third parties should require audited financial statements.
Financial obligations to subcontractors. Ensure that the third party's obligations are met in a timely manner.
Insurance coverage. Review adequacy of the third party's coverage.
Review audit reports. Review audit (e.g., internal audits, external audits, security reviews) and examination reports, if available, and follow up on any deficiencies noted.
Policies relating to internal controls and security. Ensure that these policies continue to meet the bank's minimum guidelines and contract requirements.
On-site quality assurance reviews. Perform reviews, targeting adherence to specified policies and procedures, when practicable and necessary.

Coordinated audits and reviews. Coordinate with user groups.
Compliance. Review compliance with applicable banking laws, including consumer protection legal requirements.
Third party's business resumption contingency planning and testing. Review to ensure that all bank services can be restored within an acceptable time. For many critical services, annual or more frequent tests of the contingency plan are typical. Review any results of those tests and ensure that recovery times meet bank requirements.
Third-party personnel. Monitor changes in key personnel allocated to the bank.
Reports documenting the third party's performance. Review service level agreements regularly. Determine whether contractual terms and conditions are being met, and whether any revisions to service-level agreements or other terms are needed.
Performance problems. Document and follow up on performance problems in a timely manner.
Bank's strategic plan and goals. Evaluate the third party's ongoing ability to support and enhance its strategic plan and goals.
Training. Ensure that adequate training is provided to bank employees.
Customer complaints on the products and services. Review those provided by the third party and any complaint information available from the OCC, and the resolution of those complaints.
Customer satisfaction. Consider using mystery shopper, customer callback, or other customer satisfaction programs.
Periodic meetings with contract parties. Discuss performance and operational issues.
Documentation and records maintenance. Document and maintain records on contract compliance, revision, and dispute resolution.

Customer Complaints

Even the most well-managed insurance program can be subject to customer complaints. Both customers and the bank will benefit, if the bank has an orderly process for assessing and addressing customer complaints and resolving compliance issues. A process that keeps track of customer complaints also helps the bank to identify and monitor any systemic problems in its sales program that could harm its franchise. This process should include maintaining records on the number, nature, and disposition of customer complaints received by a bank, subsidiary, or affiliated or unaffiliated third party. Management should also ensure that an effective process exist through which it receives information about complaints or other concerns about the bank's insurance sales, so that it may implement corrective measures. The bank's systems must be sufficient to monitor compliance with its policies, applicable federal and state laws, and Comptroller's Office guidance.

Compliance and Audit Programs

Banks develop and implement policies and procedures that ensure that insurance activities are conducted in compliance with applicable laws and regulations, internal policies and procedures, and guidelines. Compliance procedures also provide for a system to monitor customer complaints and their resolution. When applicable, compliance procedures should call for verification that third-party sales are being conducted in a manner consistent with the governing agreement with the bank. Personnel performing the audit or compliance review of the bank's insurance activities must be qualified and should have the necessary expertise to perform the assigned tasks. Audit and compliance personnel engage in ongoing training to keep abreast of emerging developments in banking, securities, and insurance laws and regulations. There should be an independent review of the insurance program. Independence may be established, if the audit or compliance personnel: determine the scope, frequency, and depth of their own reviews; report their findings directly to the board of directors or an appropriate committee of the board; have their performance evaluated by persons independent of the insurance activity; and receive compensation that is not connected to the success of insurance product sales. An audit and compliance function is essential to effective risk management and internal control monitoring. Any deficiencies in internal controls and risk management processes should be addressed through written corrective action plans and monitored effectively for adequate follow-up and resolution.

CHAPTER 4 Insurance and Risk Review

The following risk assessment process is applicable when the risks of a national bank's insurance activities are evaluated. Whether conducted by the bank directly or through affiliated or unaffiliated third parties, the purpose of the review is to determine whether the bank's insurance activities pose a material risk to the bank. The review is normally based on supervisory information obtained during routine meetings with bank risk managers or during the Office of the Comptroller of the Currency's regularly scheduled monitoring of bank information reports. The risk assessment conforms to the OCC's supervision by risk approach and is generally integrated into the normal supervisory process for evaluating the bank's overall risk profile. The risk assessment process consists of a preliminary risk assessment that will determine whether insurance activities pose a material risk to the bank and what, if any, additional supervisory efforts are warranted in making this risk determination. If additional supervisory efforts are necessary, the OCC examiner will then select the appropriate steps from the additional risk assessment process. The risk assessment process anticipates that the OCC's examinations of a Functionally Related Affiliate or unaffiliated third-party insurance provider will be infrequent; nevertheless, the process does establish protocol in the event the risk assessment indicates that such an examination may be needed.

RISK ASSESSMENT PROCESS

The process is detailed in the next three sections under "Preliminary Risk Assessment," "Additional Risk Assessment, " and "Risk Assessment Conclusions."

The risk assessment process is consistent with GLBA functional regulation requirements limiting the OCC's authority to obtain reports directly from and examine a Functionally Regulated Affiliate (FRA), unless certain conditions exist. If the risk assessment identifies potential significant risk to the bank from the FRA's insurance activities, the Comptroller's Office seeks additional information or reports from the appropriate functional regulator. If such information or report is not made available, the Comptroller's Office may seek to obtain it from the FRA, if the information or report is necessary to assess:
A material risk to the affiliated national bank;
Compliance with a federal law the Comptroller's Office has specific jurisdiction to enforce with respect to the insurance entity;
The system for monitoring and controlling operational and financial risks that may pose a threat to the safety and soundness of the affiliated national bank.

Direct Examination of FRA's

These limitations do not restrict the Comptroller's Office from seeking information on insurance activities conducted directly by the national bank, nor from obtaining information on an FRA from the bank or from sources other than the FRA to the extent needed to evaluate risks an FRA poses to the bank. GLBA also limits the OCC's ability to directly examine insurance activities conducted by FRAs. The Comptroller's Office may directly examine the FRA only when:
There is reasonable cause to believe that the company is engaged in activities that pose a material risk to the affiliated national bank;
After reviewing relevant reports, a reasonable determination is made that an examination of the company is necessary to adequately inform the Comptroller's Office of the system for monitoring and controlling operational and financial risks that may pose a threat to the safety and soundness of the affiliated national bank; or
Based on reports and other information available, there is reasonable cause to believe that the company is not in compliance with federal law that the Comptroller's Office has specific jurisdiction to enforce against the company, including provisions relating to transactions with affiliates, and the Comptroller's Office cannot make such determination through examination of the national bank.

The OCC examiner seeks approval from his or her chain of authority before contacting the functional regulator for additional information on an FRA's or unaffiliated third party's insurance activities. These examination limitations do not apply to insurance activities conducted directly by the bank. In these arrangements, the state insurance regulators and the Comptroller's Office have joint jurisdiction. The

state insurance regulator is responsible for functional regulation of the bank's insurance activities. The Comptroller's Office is responsible for supervising the safety and soundness of these activities and for evaluating compliance with banking law requirements. These examination limitations also do not apply to unaffiliated bank service companies subject to the Bank Service Company Act (BSCA) that provide insurance or insurance-related services to a bank. The OCC's supervisory focus in these examinations is on the bank service company's effect on the bank's safety and soundness.

Insurance Activities and FRA's

The preliminary risk assessment of the FRA or unaffiliated third-party conforms to the OCC's supervision by risk approach and is integrated into the normal supervisory process. The preliminary risk assessment is used to determine whether the national bank's insurance activities conducted in the bank, an FRA, or an unaffiliated third party pose a material risk to the bank.

Preliminary Risk Assessment

The preliminary risk assessment is meant to determine what, if any, additional supervisory efforts are warranted in making the risk determination on the part of OCC examiners.

Step 1: Level and Types of Risk
A preliminary assessment is developed as to the level and types of risks posed to a national bank by insurance activities conducted by the bank, an FRA, or an unaffiliated third party. This risk assessment should determine whether the activities pose material risk to the bank. This assessment will be used in deciding whether additional supervisory efforts are necessary and, if appropriate, to establish the scope of the additional risk assessment. This is the list of procedures the OOC examiner follows:
1. Review the related findings in the OCC's electronic information systems that were prepared during the last supervisory cycle.
2. Contact the OCC's Customer Assistance Group to obtain any insurance related complaints (1-800-613-6743 or customer.assistance @occ.treas.gov).
3. Examiners can obtain from the bank the following information and reports applicable to insurance activities:
Board of director minutes and information reports.
Oversight committee minutes and information reports.
Risk management information reports.
Compliance and audit program reports.
Fiscal and interim financial reports.
Litigation reports.
Client complaint information.
4. Examiners discuss the following with the bank's risk managers;
Significant risk issues and management strategies relating to insurance activities.
Significant changes in strategies, services, and distribution channels.
Significant changes in organization, policies, controls, and information systems.
External factors affecting insurance activities and strategies to address these issues.
5. Develop a preliminary risk assessment and for perspective and strategy coordination. These items are taken into consideration:
The nature of the bank's insurance activities. In general, agent activities present less risk to the bank than underwriting.
The bank's strategic plan for its insurance activities.
The significance of current and planned earnings from insurance activities relative to the bank's earnings.
The sensitivity of insurance revenues relative to changing market or other external conditions.
The amount of capital necessary to support insurance activities.
The impact on the bank's liquidity from insurance activities either through direct funding requirements or from reputation risk.
Information obtained from the OCC's electronic information systems.
Any risk management deficiencies identified previously by the OCC, functional regulators, or the bank's risk control functions.

Also considered by OCC examiners are the following examples of insurance activities that involve potentially higher risks:
Aggressive strategic plans and actions for expansion through acquisitions, mergers, and alliances.
Significant program expansions by increasing product lines, licensing more agents, using more aggressive and varied distribution networks, and broadening the geographic target market.

Sales programs involving riskier lines of business or significant concentrations of business.
Underwriting activities.
Manufacturing and marketing proprietary products.
Deficiencies in the bank's oversight supervision and risk management systems.
Negative findings from insurance regulators, auditors, compliance or risk managers.
Adverse publicity or significant litigation.

Step 2: Sufficiency of Assessment
It must be determined whether the preliminary risk assessment is sufficient in assessing:
Materiality of the risks posed to the bank from insurance activities.
Effectiveness of the bank's risk management systems.
Compliance with legal requirements under the OCC's jurisdiction.

Evaluation of Steps 1 & 2-If, Then…
If the examiners find that the preliminary risk assessment is sufficient in evaluating the bank's risks, risk management, and compliance associated with insurance activities, and the aggregate risk is not material, the examiner will STOP and proceed to the steps under the "Risk Assessment Conclusions" section.
If the preliminary risk assessment is insufficient in evaluating the bank's risks, risk management, and compliance associated with insurance activities, or the preliminary risk assessment indicates aggregate risk is potentially material, the examiner will continue with Step 3 for guidance on performing an additional risk assessment of the bank.

Step 3: Objectives, Scope and Work Plans
The objectives, scope, and work plans for the additional risk assessment of the bank to be completed are established.
1. Based on the preliminary risk assessment, examiners prepare a final planning memorandum that includes:
A preliminary business and risk assessment profile of insurance activities.
The objectives for the additional risk assessment.
The timing and projected workdays for the additional risk assessment.
The scope of the additional risk assessment to be completed. The selected steps should be consistent with the indications of risk identified during the preliminary risk assessment and focus on the identification of material risk to the bank from insurance activities. The steps to be used in this assessment should be selected from among those provided in the "Additional Risk Assessment" section.
Required examiner resources to complete the additional risk assessment.
The types of communication planned, such as meetings and final written products.

2. The following tasks are completed by OCC examiners after the planning memorandum has been approved by the appropriate OCC staff;
The examination staff is selected and assigned consistent with the objectives, scope, and time frames of the planned additional risk assessment.
Discuss the risk assessment plan with appropriate bank personnel and make suitable arrangements for on-site national bank accommodations and additional information requests.
Examiner staff schedules and assignment responsibilities are detailed.
Close consultation is held, and any needed authorization obtained from the OCC chain of authority before completing the additional risk assessment.

Additional Risk Assessment

This additional risk assessment is used when:
The preliminary risk assessment is insufficient in evaluating the bank's risks, risk management, and compliance associated with insurance activities conducted in the bank, an FRA, or an unaffiliated third party, or
The preliminary risk assessment indicates aggregate risk is potentially material.

The selected steps are consistent with the indications of risk identified during the preliminary risk assessment and focus on the identification of material risk to the bank from insurance activities.
Examiners consult and obtain authorization from the OCC chain of authority before completing the additional risk assessments.

Quantity of Risk Assessment: Transaction Risk

Step 1: Quantity of Transaction Risk
Examiners identify and estimate the quantity of transaction risk posed to the bank from insurance activities.
1. Bank information reports relating to transaction processing and reporting in insurance activities are analyzed. The following structural assessment factors are considered:
The volume, type, and complexity of transactions, products, and services offered through the insurance program. It is determined whether the bank insurance unit internally processes premiums and claims.
The condition, security, capacity, and recoverability of systems.
The complexity and volume of conversions, integrations, and system changes.
The development of new markets, products, services, technology, and delivery systems to maintain a competitive position or gain strategic advantage.
The volume and severity of operational, administrative, and accounting control exceptions and losses from fraud and operating errors.

2. An analysis and discussion is made with appropriate bank risk managers how the following strategic assessment factors affect the quantity of transaction risk in insurance activities:
The impact of strategic factors, including marketing plans and the development of new markets, products, services, technology, and delivery systems.
The impact of acquisition and divestiture strategies.
The maintenance of an appropriate balance between technology innovation and secure operations.

3. An analysis and discussion is made with appropriate bank risk managers how the following external assessment factors affect the quantity of transaction risk in insurance activities:
The effect of external factors including economic, industry, competitive, and market conditions; legislative and regulatory changes; and technological advancement.
The effect of infrastructure threats on the bank's ability to deliver timely support and service.
The ability of service providers to provide and maintain service level performance that meets the requirements of the insurance activities.

4. The results of the bank information systems examination activities are obtained. The examination staff makes an analysis and discussion of the conclusions and recommendations.

Step 2: Conclusion is Reached
A conclusion is reached on the quantity of transaction risks posed to the bank from insurance activities.

Compliance Risk

Step 1: Quantity Identified and Estimated
The quantity of compliance risk posed to the bank from insurance activities are identified and estimated.
1. The type and level of policy exceptions, internal control deficiencies, and law violations that have been identified and reported internally by the bank are obtained and analyzed. Information from the following sources is reviewed:
Board and committee minutes and reports.
Risk management division reports.
Compliance reports.
Control self-assessment reports.
Internal and external audit reports.
Regulatory reports.
Other Comptroller's Office examination programs.

2. The type and volume of litigation and consumer complaints related to insurance activities are obtained and analyzed.

3. Significant litigation and complaints with the appropriate bank risk managers to determine the risk to capital and the appropriateness of corrective action and follow-up processes are discussed.

Step 2: Insurance Customer Protections
Reference can be made to "Insurance Customer Protections," for the examination procedures necessary to review compliance with 12 CFR 14. These procedures can be used when they are viewed as

necessary to determine the level of compliance or the quality of the bank's compliance program, or when the Comptroller's Office has identified or suspects violations.

Step 3: Legal Requirements Compliance
Determination is made whether the bank is in compliance with the legal requirements on transactions with affiliates under sections 23A and 23B of the Federal Reserve Act, 12 USC 371c and 371c-1.

Step 4: Conclusion Reached
A conclusion is reached on the quantity of compliance risk posed to the bank from insurance activities.
The following assessment factors are considered by examiners, if applicable:
The nature and extent of business activities, including new products and services.
The volume and significance of noncompliance with policies and procedures, laws, regulations, prescribed practices, and ethical standards.
The amount and significance of litigation and customer complaints.

Strategic Risk

Step 1: Strategic Risk Identified and Estimated
Strategic risk posed to the bank from insurance activities are identified and estimated.
1. An analysis of the bank's strategic plan for insurance activities is made by considering the following assessment factors;
The magnitude of change in established corporate mission, goals, culture, values, or risk tolerance.
The financial objectives as they relate to the short- and long-term goals of the bank.
The market situation, including product, customer demographics, and geographic position.
Diversification by product, geography, and customer demographics.
Past performance in offering new products and services.
Risks and performance in implementing innovative or unproven products, services, or technologies.
Merger, acquisition and alliance plans, opportunities, and past experience.
Potential or planned entrance into new businesses, product lines, or delivery channels, or implementation of new systems.

2. The strategic plan is discussed with appropriate bank risk managers and the impact of external factors on strategic risk is assessed. The following are considered:
Economic, industry, and market conditions (impact on projected revenue).
Legislative and regulatory change.
Technological advances.
Competition.

Step 2: Conclusion Reached
A conclusion is reached on the quantity of strategic risk posed to the bank from insurance activities.

Reputation Risk

Step 1: Identify and Estimate Reputation Risk
An identity and estimate is made as to reputation risk posed to the bank from insurance activities.
1. The affect of the following assessment factors on reputation risk is discussed with the appropriate bank risk managers:
• The volume and types of insurance activities.
• Merger and acquisition plans and opportunities.
• Potential or planned entrance into new businesses, product lines, or technologies (including new delivery channels), particularly those that may test legal boundaries.

2. The affect of the following external factors on reputation risk from insurance activities is discussed with the appropriate risk managers from the bank:
The market's or public's perception of the corporate mission, culture, and risk tolerance of the bank and the insurance activities.
The market's or public's perception of the bank's and the insurance entity's financial stability.
The market's or public's perception of the quality of products and services offered by the bank and the insurance entity.
The impact of economic, industry, and market conditions; legislative and regulatory change; technological advances; and competition.

Step 2: Conclusion Reached
A conclusion is reached on the quantity of reputation risk posed to the bank from insurance activities.

Credit Risk

Step 1: Credit Risk Posed
Credit risk posed to the bank from insurance activities is identified and estimated.
1. Obtain and analyze bank information relating to credit exposures in insurance activities. The focus is on the bank's credit-related insurance, underwriting, and reinsurance activities. Consider the following risk assessment factors:
Volume and trends in the book of business.
Significant concentrations in the book of business, including individual, industry, geographic, and product concentrations.
Financial strength and claims payment ability of counterparties.
Loss experience and anticipated losses.
Adequacy of the bank's allowance for loan and lease losses.
Duration of insurance contracts.
Expertise and experience of personnel responsible for overseeing and managing credit risk.
Economic and other external factors.
Findings from the latest examination conducted by the state insurance regulators.

2. An analysis is made of the effectiveness of the bank's due diligence process for selecting and ongoing monitoring of insurance carriers involved in the bank's credit-related, underwriting, and reinsurance activities. This effort is coordinated with the applicable steps under the "Quality of Risk Management Process" section.
3. The analysis of the above is coordinated with that of OCC examiners responsible for credit underwriting risk.

Step 2: Conclusion Reached
A conclusion is reached on the quantity of credit risk posed to the bank from insurance activities. If the bank is involved in reinsurance activities, then the decision is made by examiners to continue to **Step 3** for additional guidance.

Step 3: Additional Analysis- Reinsurance
Additional analysis on the credit risk associated with the bank's reinsurance activities is performed. This is accomplished by understanding more about the nature of the bank's reinsurance business.
The section titled, "Insurance Product Types," has more information on reinsurance.
1. The method(s) used for ceding risks in the bank's reinsurance business and the proportion of the methods relative to the reinsurance activities are determined. The following are considered:
Treaty reinsurance contracts require the reinsurer to underwrite part or all of a ceding company's book of business for one or more specific classes of business. Generally the reinsurer is bound automatically to reinsure any business the ceding company writes within these specific classes resulting in potentially greater risk than the method described next.
Facultative reinsurance contracts only require the reinsurer to underwrite individual policies of the ceding company rather than all risks within a particular class of business.
2. The loss basis structure of treaty and facultative reinsurance contracts are determined. Taken into account is whether the reinsurance activities operate under proportional or non-proportional agreements. For proportional based reinsurance, consideration is given whether the agreement involves quota share or surplus share arrangements. Under quota share agreements, determination is made as to the percentage basis assumed in the bank's reinsurance business. Under the surplus share agreements, determination is made as to the share proportion of the individual risk reinsured. For non-proportional (or excess of loss) agreements, determination is made of the reinsurer's obligation to the primary insurer that is a predetermined amount of risk above the primary insurer's risk retention amount.
3. Whether the bank's reinsurance business uses retrocessions in transferring risk is determined. If retrocessions are used, the level of coverage obtained and the effectiveness of reducing the reinsurance loss exposures is determined.

Step 4: Conclusion Reached
A conclusion is reached on the quantity of credit risk posed to the bank from reinsurance activities.

Quality of Risk Management Assessment Policy

Step 1: Bank Policies Applicable
The adequacy and effectiveness of policies applicable to insurance activities is determined.
1. The bank board's program management plan for insurance activities is obtained. Portions of this plan may be contained within the bank's strategic plan for insurance activities or in other board directives.
2. The program management plan is reviewed to determine whether it is appropriate in guiding the bank's insurance activities. A determination is made whether the plan:
Was formally adopted by the board and receives annual board review and approval.
Establishes program objectives, strategic direction and risk tolerance standards.
Addresses organizational structure and authority.
Requires establishing appropriate policies and procedures.
Outlines a comprehensive risk management system appropriate for the bank's insurance activities.
Sets forth management information systems necessary for the board to oversee the activities properly.

3. Policy documents are reviewed to determine whether they:
Are approved formally by the board, or a designated committee(s).
Outline the program's goals and objectives, responsibilities, ethical culture, risk tolerance standards, and risk management framework consistent with the program management plan.
Address applicable law.
Address all significant products and services, including:
Product offering criteria.
A list and description of insurance products and services.
Compensation schedules.
Descriptions of marketing and distribution channels.
How new products and services are developed and approved.
Address the organizational structure and supervisory framework by establishing:
Organizational and functional charts.
Defined lines of authority and responsibility.
Delegation authority and approval processes.
Processes to select, employ, and evaluate legal counsel.
Standards for dealings with affiliated organizations.

Personnel practices.

Establish appropriate information reporting and risk monitoring processes that include:
Initial and ongoing due diligence reviews of third-party vendor, products, and services.
Written contracts with vendors.
Proper oversight of bank direct programs.
Customer complaint resolution procedures.
Risk management systems.
Policy exception tracking and reporting processes.
• Address information systems and technology applications, such as:
Accounting and other transaction recordkeeping systems.
Management information system requirements.
Systems security and disaster contingency plans.
• Establish a compliance program. Determine whether the policy includes:
A description of the program's purpose, responsibility, and accountability.
Operating and testing procedures.
Reporting and follow-up requirements and processes.
Educational material and resource references.

4. Evaluate the policy review process and determine whether changes in risk tolerance, strategic direction, products and services, or the external environment are reviewed adequately and effectively.
5. Through discussion with management and other examiners, parts of the policy requiring development or revision are identified. Considering:
Recently developed and distributed products and services.
Discontinued products, services, organizational structures, and information systems.
Recent updates or revisions to existing policies and procedures.

Step 2: Conclusion Reached

Draw a conclusion about the adequacy and effectiveness of the bank's risk management policies relating to insurance activities.

Processes

Step 1: Oversight of Insurance Activities
Determine the adequacy and effectiveness of supervision by the bank's board and senior management.
1. Determine how supervisory oversight of insurance activities is organized and whether clear lines of authority, responsibility, and accountability are established through all levels of the organization. Obtain and evaluate:
Bank bylaws and resolutions.
Strategic plan and business strategies, including those related to functionally regulated entities.
Board and management committees, charters, minutes, and reports.
Management structures, authorities, and responsibilities.
Other organizational structures.
2. If the board has delegated insurance supervisory oversight to one or more committees, review each committee's composition, charter, meeting frequency, attendance, information reports, and board reporting processes for consistency with board guidance and regulatory requirements.
3. Evaluate the bank's strategic planning process for insurance activities focusing on whether this planning process:
Is part of the bank's overall strategic and financial planning processes.
Considers all significant elements of risk that affect the insurance program, such as internal risk tolerance standards, the corporate ethical culture, available financial resources, management expertise, technology capabilities, operating systems, competition, economic and market conditions, and legal and regulatory issues.
Evaluates and determines the amount of capital necessary to support the business.
Includes monitoring how well the insurance program implements the strategic plan and reports performance to the bank's board or the designated oversight body.
4. Evaluate the appropriateness of board and senior management reports for overseeing the bank's insurance activities.
5. Evaluate the effectiveness of the bank's initial due diligence process when identifying and selecting an affiliated or unaffiliated third-party provider. Refer to the "Identification and Selection of Third Parties" under the "Risk Control" section of this book for factors that influence the selection process.
6. Evaluate the adequacy of the process used when establishing arrangements with affiliated and unaffiliated third-party providers. Refer to the "Guidelines for Written Contracts" under the "Risk Control" section of this course for factors that influence entering into a formal arrangement.
7. Evaluate management's effectiveness in overseeing and monitoring relationships with affiliated and unaffiliated third parties. Refer to the "Ongoing Oversight of Third Party Relationships" under the "Risk Monitoring" section of this book for factors that affect the decision-making process.
8. Evaluate the effectiveness of management's supervision of bank direct insurance programs ensuring that risks are controlled appropriately.

Step 2: Conclusion Reached
A conclusion is reached concerning the effectiveness of the bank's processes for managing risk posed to the bank from insurance activities.

Personnel: Insurance

Step 1: Policies, Practices, and Programs
A determination is made as to the adequacy and effectiveness of the bank's personnel policies, practices, and programs relating to insurance activities.
1. It is determined whether lines of authority and individual duties and responsibilities are defined and communicated clearly.
2. An evaluation is made as to the bank's recruitment and employee retention program by reviewing:
Recent success in hiring and retaining high-quality personnel.
Level and trends of staff turnover, particularly in key positions.
The quality and reasonableness of management succession plans.
3. The insurance activities compensation and performance evaluation program is analyzed by considering whether:

The compensation and performance evaluation program is appropriate for the types of products and services offered. Assess whether the compensation program provides incentive for improper sales practices.
The program is formalized and reviewed periodically by the board and senior management.
The program is consistent with the bank's risk tolerance and ethical standards.
Responsibilities and accountability standards are clearly established for the performance evaluation program.
The bank employee compensation program for insurance referrals conforms to legal requirements.
4. For bank direct insurance activities an evaluation is made of the effectiveness of management's efforts in ensuring that sales personnel are qualified, properly trained, and receiving appropriate supervision for their sales practices and other activities. For third-party relationships (bank subsidiary, affiliated and unaffiliated), assessment is made of the bank's oversight of the vendor's processes to meet qualification and training requirements.
5. The risk management training program is reviewed by considering:
The types and frequency of training and whether the program is adequate and effective.
The adequacy of financial resources allocated to risk management training.
Whether employee training needs and accomplishments are a component of the performance evaluation program.

Step 2: Conclusion Reached
Examiners must reach a conclusion on the effectiveness of the bank's personnel policies, practices, and programs relating to insurance activities.

Control Systems: Insurance Activities

Step 1: Adequacy and Effectiveness of Control Systems
A determination is made as to the adequacy and effectiveness of the bank's control and monitoring systems relating to insurance activities.
1. The types of control and monitoring systems used by the bank's board and senior management are determined and evaluated. Taken into consideration are:
Board and senior management risk monitoring processes.
Risk management groups.
Committee structures and responsibilities.
Management information systems.
Quantitative risk measurement systems.
Compliance programs.
Control self-assessment processes.
Complaint resolution process.
Audit program.
2. The extent to which the bank's board and senior management are involved in supervising insurance activities are established. The following are considered:
Types and frequency of board and senior management reviews used to determine adherence to policies, operating procedures, and strategic initiatives, including those related to functionally regulated entities.
Adequacy, timeliness, and distribution of management information reports.
Responsiveness to risk control deficiencies and effectiveness of corrective action and follow-up activities.
3. When the bank has a separate risk management function responsible for insurance activities, a review is made of its purpose, structure, reporting process, and effectiveness:
Size, complexity, strategic plans, and trends in insurance activities.
Independence and objectivity.
Quality and quantity of personnel.
Quality of risk assessment, transaction testing, monitoring systems, and reporting processes.
4. The bank's compliance program for insurance activities is considered, including:
Extent of board and senior management commitment and support.
Line management responsibility and accountability.
Formalization, transaction testing, reporting structures, and follow-up processes.
Qualifications and performance of compliance officer and supporting personnel.
Communication systems.
Training programs.
5. If the bank has implemented a control self-assessment program, information on the control self-assessments performed on insurance activities are obtained and evaluated.

6. The latest internal and external audit reports and follow-up reports pertaining to insurance activities are examined.
❋ The adequacy and effectiveness of the internal and external audit work on insurance activities is evaluated by considering:
The independence, qualifications and competency of audit staff.
The timing, scope, and results of audit activity.
The quality of audit reports, work papers (if reviewed), and follow-up processes.
❋ If the review of audit reports and work papers raises questions about audit effectiveness, the issues are discussed with appropriate examiners and determine is made whether the scope of the audit review should be expanded. Issues that might require an expanded scope include:
Unexplained or unexpected changes in auditors or significant changes in the audit program.
Inadequate scope of the insurance activities audit program.
Deficient audit work papers or work papers that do not support audit conclusions.
Inadequate coverage of high risk insurance activities.
Inappropriate actions by insiders to influence the findings or scope of audits.

Step 2: Conclusion Reached
Conclusions are drawn about the adequacy and effectiveness of the bank's control systems for managing risk posed to the bank from insurance activities. The findings and recommendations, if applicable, are forwarded to the examiner responsible for evaluating the bank's risk management, compliance, and audit programs.

Risk Assessment of Insurance Activities; Conclusions

These risk assessment conclusions are used when completing both preliminary and additional risk assessments on the bank's insurance activities conducted in the bank, an FRA, or an unaffiliated third party.

Step 1: Insurance and Banks Consolidated Risk Profile
A conclusion is reached as to the risks posed by insurance activities on the bank's consolidated risk profile.

1. The following concepts/ideas are used in making this conclusion:
Materiality of the risks posed to the bank from insurance activities.
The effectiveness of the bank's risk management systems for controlling risks posed to the bank from insurance activities. The bank's compliance with federal laws that the Comptroller's Office has specific jurisdiction to enforce, including provisions relating to transactions between affiliates and the national bank.
2. The large bank or community bank Risk Assessment System is completed (RAS).

Step 2: Summary of Risk
A summary document is prepared that includes the conclusions under **Step 1** and, if applicable, any other findings and recommendations for bank management.

Step 3: Findings Discussed with OCC
The review's findings are discussed with the OCC authority chain and findings are adjusted. Recommendations are made as needed. Based on those results, the appropriate next steps are;
1. Proceed to Step 4 if the preliminary or additional risk assessments conclude that the bank is not exposed to material risk from insurance activities and further supervisory efforts are not warranted.
2. The assessment is stopped and the circumstances discussed with the appropriate OCC supervisory personnel if the preliminary or additional risk assessments conclude that the bank is exposed to material risk from insurance activities and additional information is needed from the FRA or unaffiliated third party; or an examination of the FRA or unaffiliated party is necessary; or assessment findings should be referred to the functional regulators. The following information is reviewed:
Summary document prepared in Step 2.
The identity of the functional regulator and the name, address, and telephone number of the primary contact at the functional regulator (if applicable).
A detailed description of the information to be requested or the reason(s) for requesting the information or for conducting the examination activity consistent with GLBA requirements, plus a copy of the proposed request to be delivered to the functional regulator.

Step 4: Bank Oversight Committees
A meeting is arranged with appropriate bank oversight committees or the appropriate risk managers to communicate the review's conclusions and recommendations. Bank management reviews draft conclusions and report comments.

Step 5: Conclusion Memorandum
A conclusion memorandum is prepared. Supplement the conclusion memorandum, when appropriate, include:
The objectives and scope of completed supervisory activities.
Reasons for changes in the supervisory strategy, if applicable.
Overall conclusions, recommendations for corrective action, and management commitments and time frames.
Comments on any recommended administrative actions, enforcement actions, and civil money penalty referrals, if appropriate.

Step 6: Final Comments
Final comments for the bank report of examination are prepared;
Meeting Comptroller's Office report of examination guidelines.
Supporting review conclusions and recommendations.
Containing accurate violation citations.

Step 7: Update System
The OCC electronic information system is updated, including:
Matters requiring attention (MRA).
RAS.
Violations of law or regulation.
Core knowledge database.

Step 8: Recommended Strategy
A recommended supervisory strategy for the subsequent OCC supervisory cycle is prepared.

Step 9: Memo or Update
A memorandum or update of work programs is prepared with any information that will facilitate future risk assessments or examinations.

CHAPTER 5 Insurance Product Types

The following are the most common types of insurance sold in most states by licensed agents. However, many varieties of these products, as well as other products, are available through insurance companies. Therefore, examiners need to understand that, because products vary significantly in purpose and complexity, the selling agents need different knowledge, qualifications, and expertise. This discussion also includes reinsurance activities.

Credit Life and Other Credit-Related Insurance

Credit Life Insurance

Credit life insurance is an add-on product offered to customers taking out a loan. Credit life insurance includes credit life, health and accident insurance, sometimes referred to as credit life and disability insurance, and mortgage life and disability insurance. These policies are issued on the life of the debtor and pay off consumer debt if the borrower dies or becomes disabled or unemployed before repayment. Mortgage life, disability, and unemployment policies make payments for a specified period of time or provide for a lump-sum payment, depending on the terms of the contract. The OCC's regulation governing credit life insurance and the disposition of credit life insurance income is 12 CFR 2. This regulation sets forth the principles and standards that apply to a national bank's sales of credit life insurance and the limitations that apply to the receipt of income from those sales by certain individuals

and entities associated with the bank. Additionally, banks must comply with certain disclosure requirements in connection with the sales of credit life insurance.

Crop Insurance

Crop insurance, which includes both multiple peril crop insurance and hail/fire insurance, gives farmers a financial risk management tool to protect against excessive losses from crop failures or low yields. Historically, the federal government provided subsidies and price supports to the agriculture industry as a "safety net" to reduce the inherent production and price risk for the producer. Some minimal catastrophic coverage was required to participate in these programs. However, these programs, including federal crop insurance, were phased out under the Federal Agricultural Improvement and Reform Act of 1996. The void is being filled by crop insurance policies that are underwritten by private insurance companies.

Flood Insurance

The Comptroller's Office issued 12 CFR 22 to implement the requirements of the National Flood Insurance Act of 1968 and the Flood Disaster Protection Act of 1973. The regulation addresses requirements to purchase flood insurance where available, exemptions, escrow requirement, and required use of standard flood hazard determination form, force placement of insurance coverage, determination fees, notice of special flood hazards and availability of federal disaster relief assistance, and notice of servicer's identity. A national bank is permitted to force place flood insurance if insurance is required by law and loan collateral is not covered by flood insurance or is covered in an amount less than that required by OCC's regulation. If a borrower fails to obtain flood insurance within 45 days after notification, the bank must purchase insurance on the borrower's behalf. The bank may charge the borrower for the cost of premiums and fees incurred in purchasing the insurance. Force placed flood insurance is not subject to the requirements of 12 CFR 14.

Life Insurance

The function of life insurance is to create a principal sum or estate, either through the death of the insured or through the accumulation of funds set aside for investment purposes. It is most commonly used to protect a person and his or her dependents against the undesirable financial consequences of premature death. Life insurance can be categorized into two broad types, temporary (term) and permanent insurance. There are numerous variations of Insurance Activities these products. However, life insurance products generally fall within one or a combination of the following categories.

Term Life Insurance

Term life insurance is a basic type of insurance that offers death benefits only and generally has no cash value or savings element. Because term insurance provides only mortality protection, it provides the most coverage per premium dollar. However, premiums generally increase with the age of the policyholder. Most term life insurance policies are renewable for certain periods or until the policyholder attains a specified age. Additionally, many are convertible to permanent life insurance without the insured having to show evidence of insurability. Term life insurance is commonly used in conjunction with a home mortgage, in which case the beneficiary is usually a family member, not the lienholder.

Permanent Life Insurance

Whole Life

The cash value (essentially a savings account) of a whole life insurance policy, accrues according to a guaranteed, predetermined rate of return by the insurance company. These policies are also referred to as "general account" products because the general assets of the life insurance company support the cash value. Most types provide lifetime protection to age 100. If the insured is still living at that age, the policy "endows," and the guaranteed cash value equals the face amount of the policy. Also, cash value can be borrowed under the policy's loan provisions. Premiums and death benefits are guaranteed for the duration of the policy. Because premiums are constant, the cost is much higher in the early years than equal

coverage under a term life insurance policy. However, the cost relationship reverses in later years as the cost of term life insurance rises with the age of the insured.

Combination Policies

Combination policies usually combine term insurance with a base whole life policy by using an attachment or rider. This combination provides for additional death benefits without a significant increase in premium cost.

Universal Life

Another form of permanent life insurance, universal life is an interest-sensitive form of life insurance, designed to provide flexibility in premium payments and death benefit protection. Policyholders can adjust the premiums, cash values, and level of protection, subject to certain limitations, over the life of the contract. Additionally, unlike whole life, the interest credited to the cash value of universal life policies is based upon current interest rates, subject to an interest rate floor. Universal life has a pure insurance component (mortality protection) and a professionally managed investment component. The policyholder can pay maximum premiums and maintain a high cash value. Alternatively, the policyholder can make minimal premium payments in an amount large enough to cover mortality and other expense charges, thus not accumulating as much cash value.

Variable Life

Variable life is a form of whole life insurance with the critical difference being that the policy's cash value is invested in a segregated account comprised of equity and other securities. Premiums may be placed in the insured's choice of stock, bond, or money market funds offered through the insurance company. The death benefit and cash value of the policy depend upon the performance of the underlying investment portfolio, thus shifting the investment risk to the policyholder. There is generally, however, a minimum guaranteed death benefit. The policy allows for tax-deferred appreciation of the accumulated assets. Because variable life policies are classified as securities, life insurance agents selling these policies must also be registered representatives of a broker-dealer licensed by the National Association of Securities Dealers Regulation (NASDR) and registered with the Securities and Exchange Commission (SEC).

Variable Universal Life

Variable universal life combines the flexible premium features of universal life with the investment component of variable life. These products also are classified as securities and subject to SEC and NASD requirements.

Accident and Health Insurance

Accident and health insurance, generally referred to merely as "health insurance," is defined as insurance against loss by sickness or accidental bodily injury. The loss may be lost wages caused by the sickness or accident, or it may be expenses for doctor bills, hospital bills, medicine, and so forth. Included within this definition is insurance that provides lump sum or periodic payments, such as disability income insurance and accidental death and dismemberment in the event of loss occasioned by sickness or accident. Although these types of insurance can be written for individual coverage, most coverage is underwritten on a group basis to make premiums cost effective.

Group Life and Health Insurance

Many people are covered under group policies usually sponsored through their employers. Group plans provide low-cost insurance, and coverage is offered to everyone in the group regardless of their age or health status. Group plans have some disadvantages. There is no guarantee that the plan will be continued, and if an employee is terminated or resigns, the coverage will end. It is possible to convert group coverage to individual coverage; however, converting can be expensive for the insured.

Disability and Employment

Disability insurance is designed to replace a portion of a borrower's income, when the borrower is disabled by a covered condition. Similarly, unemployment insurance provides a portion of income, for a limited period of time, to a policyholder that subsequently becomes unemployed.

Property and Liability Insurance

Property insurance insures the policyholder against physical damage to or loss of personal or commercial property, such as homes, automobiles, and business property. Most property insurance policies require the insured to share in the loss in the form of a deductible or coinsurance. Liability insurance protects the insured against loss resulting from being found legally liable for an injury to another person or damage to property of others. Most liability policies provide for payment of sums that the insured becomes legally obligated to pay (for the medical expenses of those injured and any damage to property of others), subject to limits. It is also typical of insuring agreements to promise defense of the insured and to reserve the right to make an out-of-court settlement. Professional liability insurance protects the insured from loss brought about by a failure to use due care and the degree of skill expected of a person in a particular situation. Malpractice insurance and errors and omissions insurance are examples of professional liability insurance.

Reinsurance

Reinsurance is a device whereby an original insurer reduces its underwriting risk by transferring all or part of the risk under an insurance policy or a group of policies to another company or insurer. Reinsurance can provide the original insurer protection against catastrophic unexpected losses. In addition, reinsurance can enable an insurance company to expand its underwriting capacity, stabilize its underwriting results, and finance its expanding volume. The original insurer is called the direct writer, ceding company or cedant, and the recipient of the transferred risk is known as the reinsurer. The original insurer typically retains only a portion of the risk and reinsures the balance with a second underwriter. The reinsurer assumes a portion of the risk and in return receives a portion of the premium from the ceding company. State insurance regulators generally conduct examinations every three to five years, but may examine a company when deemed necessary. The examinations focus primarily on solvency of reinsurers and their cedants and the collectability of the reinsurance asset. A reputable reinsurer will be licensed (not all states require licensing), well capitalized, and prompt-paying. Most insurers are licensed in one or more states to write insurance or reinsurance business. A licensed reinsurer typically must satisfy at least the same financial, reporting and examination requirements applied to primary insurers by the state insurance regulators. Some states have more stringent financial standards for reinsurers than for original insurers.

The *credit for reinsurance* laws, regulations, and standards typically provide that a ceding insurer cannot treat reinsurance recoverables as an asset on its financial statements unless the reinsurer meets certain tests. In general, a ceding insurer can take credit if the reinsurer is licensed or accredited in the ceding insurer's state of domicile. A large number of states and the NAIC model law on credit for reinsurance recognize well-capitalized reinsurers domiciled in another state with substantially similar laws, as well as reinsurers that maintain large trust asset accounts in the U.S. If the reinsurer does not meet those standards, the ceding insurer must treat the recoverable as a liability that can be reduced only by acceptable security-usually a letter of credit, trust fund, or amounts withheld by the ceding insurer. The requirements vary, but both the NAIC model law and the versions of the model law enacted in many states reflect a movement toward higher and more uniform standards.

Reinsurance Contracts

There are two basic methods of reinsuring or "ceding" risks to a reinsurer. The more common method is *treaty reinsurance*, which accounts for about 80 percent of the placements in the U.S., and the less common is *facultative reinsurance.* Under a treaty reinsurance contract, the reinsurer underwrites part or all of a ceding company's book of business for one or more specific classes of business. The reinsurer is generally automatically bound to reinsure any business the company writes within these specified classes. Under a facultative reinsurance contract, the ceding company cedes risk under individual policies to a reinsurer, rather than all risks within a particular class. This method reduces the ceding company's exposure to a loss on an individual risk basis, because each facultative certificate is separately negotiated. Whether treaty or facultative, reinsurance contracts can be structured on a proportional or non-proportional (excess of loss) basis. Proportional reinsurance allows for a sharing of risk, or it may result in an increase to the primary insurer's surplus, thus allowing the primary insurer to write more

business. In **quota share agreements,** the ceding company and the reinsurer share in the premiums and losses of each policy the company cedes on a fixed percentage basis. A facultative certificate written on a quota share basis would work similarly, but on an individual risk, rather than a whole book basis. **Surplus share agreements** allow the company greater flexibility in ceding risks to the reinsurer. The ceding company selects the proportion of liability it wishes to retain on any one risk or policy and may then cede multiples, known as lines, of its retention to the reinsurer. Losses and premiums are divided between the ceding company and the reinsurer in the proportion each shares in the individual risk. These agreements are generally issued only on a treaty basis.

Non-proportional or excess of loss agreements require that the primary insurer pay, and be solely responsible for, claims arising from a given book of business up to a predetermined amount, known as retention. The reinsurer is obligated to reimburse the primary insurer's claims up to another predetermined amount above retention. Thereafter, the primary insurer is solely responsible for claims in excess of the reinsurer's tier of losses on a given book. When assessing risks, examiners should consider whether the reinsurer is operating under a proportional or non-proportional agreement. Retrocessions are reinsurance agreements that protect reinsurers for business they have assumed. These agreements, in effect, are reinsurance for reinsurers. Generally reinsurers will use retrocessional agreements to cover a larger number of reinsurance agreements to obtain the coverage needed. For example, if a reinsurer has reinsurance contracts with 12 insurance companies, only four retrocession agreements may provide needed coverage. These agreements are usually worded broadly to ensure intended coverage of all losses, and to avoid conflicts with terminology used in the various underlying reinsurance contracts.

Insurance Customer Protections

Part 14 of 12 CFR implements section 305 of GLBA. Banks must comply with the insurance consumer protection rule published under 12 CFR 14. This regulation applies to retail sales practices, solicitations, advertising, or offers of any insurance product or annuity by a depository institution or any person that is engaged in such activities at an office of the institution or on its behalf. The Comptroller's Office does not consider debt cancellation contracts or debt suspension agreements as insurance; consequently, they are not governed by 12 CFR 14. Part 14 applies to "covered persons." A covered person includes a bank; a person that sells, solicits, advertises, or offers an insurance product or annuity to a consumer at an office of the bank; or a person that sells, solicits, advertises, or offers an insurance product or annuity to a consumer on behalf of the bank. To determine compliance with this rule, a *consumer* is an individual who purchases, applies to purchase, or is solicited to purchase from a covered person insurance products or annuities primarily for personal, family, or household purposes. Small businesses are not consumers under this regulation. A person is acting *on behalf of* the bank when the person represents that the sale is *on behalf of* the bank; when the bank refers a customer to a seller of insurance, and the bank has a contractual relationship to receive commissions or fees derived from the sale of an insurance product or annuity resulting from that referral; or when documents evidencing the sale, solicitation, advertising, or offer of the insurance product or annuity identify or refer to the bank. An *office* is the premises of a bank where retail deposits are accepted from the public.

The rule prohibits misrepresentation- Banks often disseminate information to bank customers and the general public describing insurance products that are available from the bank, its subsidiaries or affiliates, or unaffiliated third parties. Banks also communicate with their customers about how to obtain more information on insurance products. To comply with 12 CFR 14, those communications must not suggest or convey any inaccurate information and should be designed with care to avoid misunderstanding, confusion, or misrepresentation to the bank's customers. Covered persons, including banks, may not engage in any practice or use any advertisement at any office of, or on behalf of, the bank or a subsidiary of the bank that could mislead any person or otherwise cause a reasonable person to reach an erroneous belief for:
The uninsured nature of any insurance product or annuity offered for sale.
An insurance product or annuity that involves investment risk, (the fact that there is an investment risk, including the potential that principal may be lost and that the product may decline in value).

The fact that the approval of an extension of credit (when insurance products or annuities are sold or offered for sale) may not be conditioned on the purchase of an insurance product or annuity from the bank or its affiliates and that the consumer is free to purchase the product from another source.

The rule also requires the following affirmative disclosures, except when the disclosures would not be accurate:

In connection with the initial purchase of an insurance product or annuity, the following disclosures must be provided orally and in writing before completion of the initial sale to the consumer.
The insurance product or annuity is not a deposit or other obligation of, or guaranteed by the bank or an affiliate of the bank.
The insurance product or annuity is not insured by the FDIC or any other agency of the United States, the bank, or an affiliate of the bank.
If there is an insurance product or annuity that involves an investment risk, there is investment risk associated with the product, including the possible loss of value.
In connection with an application for credit in which an insurance product or annuity is solicited, offered, or sold, banks must disclose that the bank may not condition an extension of credit on either:
The consumer's purchase of an insurance product or annuity from the bank or any of its affiliates; or
The consumer's agreement not to obtain, or a prohibition on the consumer from obtaining, an insurance product or annuity from an unaffiliated entity.

In most cases, these disclosures must be made orally and in writing at the time the consumer applies for an extension of credit that is associated with an insurance product or annuity that is solicited, offered, or sold. There are various exceptions to this requirement for mail, telephone, and electronic transactions;
Mail - Oral disclosures are not required if the sale of the insurance product or the application for credit is taken by mail.
Telephone - If the sale is conducted by telephone, a covered person may provide the written insurance disclosures by mail within three business days beginning on the first business day after the sale. A covered person may also provide the written credit disclosure by mail if the covered person mails it to the consumer within three days beginning the first business day after the credit application is taken.
Electronic disclosures - A covered person may provide the written insurance and credit disclosures through electronic media if the customer affirmatively consents to receiving the disclosures electronically, and the consumer can download the disclosures in a form that can be retained later, such as by printing or storing electronically.

All disclosures must be readily understandable and meaningful. Disclosures must be conspicuous, simple, direct, readily understandable, and designed to call attention to the nature and significance of the information provided. Examples of meaningful disclosures include plain language headings, easy-to-read typeface and type-size, wide margins, boldface or italics for key words, and distinctive type styles. Disclosures are not meaningfully provided in the electronic context if the consumer can bypass the visual text of the disclosures before purchasing the product.

Certain short form disclosures may be used in visual media and, as appropriate, in other circumstances. For example, a covered person may use the following disclosures in visual media:
• NOT A DEPOSIT
• NOT FDIC-INSURED
• NOT INSURED BY ANY FEDERAL GOVERNMENT AGENCY
• NOT GUARANTEED BY THE BANK
• MAY GO DOWN IN VALUE

Banks must also obtain written acknowledgement from the consumer that he/she received the required disclosures. The acknowledgement must be received at the time the consumer receives the disclosures or before the initial sale. Banks must, to the extent practicable, keep the area where it conducts its insurance and annuities transactions physically segregated from areas where retail deposits are routinely accepted from the general public. In addition to physical segregation, the rule also requires the bank to identify the areas where the sales activity occurs and to distinguish those areas from the areas where the bank's retail deposit-taking activities occur. (The area where retail deposits are routinely accepted generally means traditional teller windows and teller lines.) Any person accepting deposits from the public, in an area where such transactions are routinely conducted in the bank, may refer a consumer who seeks to purchase an insurance product or annuity to a qualified person who sells that product. If the bank has a referral fee program, the referral fee paid to this person may not be more than a one-time, nominal fee of a fixed dollar amount that does not depend on whether the referral results in a transaction.

Examination Procedures 12 CFR 14

These examination procedures are used when Comptroller's Office personnel are performing the additional risk assessment. These procedures are used, when they are necessary to determine the level

of compliance with 12 CFR 14, to determine the quality of the bank's compliance program, or because the Comptroller's Office has identified or suspects violations.

The objective is to determine the bank's level of compliance with 12 CFR 14, Consumer Protection in Sales of Insurance.

1. Samples are selected of initial sales of insurance and annuities and credit applications when insurance or an annuity is solicited by the applicant, or offered or sold to the applicant by the bank or covered person (include sales made and loan applications received by telephone, mail, and electronic media). Samples are also selected of advertisements and promotional materials for the sale of insurance and annuities.

2. The samples are reviewed, along with consumer complaint information, and audit findings to determine whether:

a.) Before completion of the initial sale, consumers received and acknowledged receipt of information disclosing the fact that the insurance or annuity [12 CFR 14.40(c)(1) and (c)(7)]:

Is not a deposit or other obligation of, or guaranteed by, the bank or an affiliate of the bank [12 CFR 14.40(a)(1)].

Is not insured by the Federal Deposit Insurance Corporation or any other agency of the United States, the bank or a bank affiliate [12 CFR 14.40(a)(2)].

May involve investment risk, including the possible loss of value, if applicable [12 CFR 14.40(a)(3)].

b.) At the time the consumer applied for credit, the consumer received and acknowledged (at that time or at the time of the sale) receipt of information disclosing the fact that the bank may not condition a credit extension on [12 CFR 14.40(c)(1) and (c)(7)]:

Purchase of an insurance product or annuity from the bank or any of its affiliates [12 CFR 14.40(b)(1)].

Agreement not to obtain, or a prohibition on the consumer from obtaining, an insurance product or annuity from an unaffiliated entity [12 CFR 14.40(b)(2)].

c.) Advertisements and promotional materials include the disclosures described in 2a, [12 CFR 14.40(d)].

d.) The bank led the consumer to believe that in obtaining a loan from the bank, the consumer must purchase insurance or an annuity from the bank or its affiliates, or the consumer must agree not to purchase insurance or an annuity from a nonaffiliated [12 CFR 14.30(a)].

e.) The bank led the consumer to believe that the insurance product was backed by the federal government or bank, was insured by the FDIC, or when an investment risk existed, that the product did not involve an investment risk [12 CFR 14.30(b)].

f.) The bank considered the status of the consumer as victim of domestic violence, or provider of services to victims of domestic violence, as a criterion in any decision for insurance underwriting, pricing, renewal, scope of coverage, or payment of claims [12 CFR 14.30(c)].

3. The disclosures in 2a and 2b are reviewed by OCC staff, and a determination is made whether they were conspicuous, simple, direct, readily understandable, designed to call attention to the nature and significance of the information provided, and provided in a meaningful form [12 CFR 14.40(c)(5) and (c)(6)].

4. Through discussions with insurance sales personnel and a review of the bank's training program, it is determined whether sales personnel provide, and are trained to provide, disclosures orally and in writing prior to completion of the initial sale and at the time a consumer applies for credit (in connection with insurance solicitations, offerings, or sales) [12 CFR 14.40(c)(1)].

5. Through discussions with management and on-site inspection, a conclusion is reached whether the bank physically segregates and identifies such areas within the bank where it conducts insurance product and annuity transactions and where it conducts retail deposit-taking activities [12 CFR 14.50(a)].

6. A review is made of the bank's compensation program for insurance referrals and a sample of employee compensation records (employees who accept deposits from the public in an area where such transactions are routinely conducted in the bank and make referrals to others for the sale of insurance products or annuities) is selected. Verification is made that such employees receive no more than a one-time, nominal fee of a fixed dollar amount for each referral, and that payment of this fee does not depend on whether the referral results in a transaction [12 CFR 14.50(b)].

7. A sample of people who sell or offer for sale any insurance product or annuity in any part of the bank or on its behalf is selected. Then it is determined whether each person has always been qualified and licensed appropriately under applicable state insurance licensing standards for the specific products they sell or recommend [12 CFR 14.60].

Conclusions

After OCC personnel audit a bank's insurance sales activities, a written summary is drawn up with conclusion and findings. If necessary, needed corrective actions are recognized as to which policies or internal controls appear to be deficient or when violations of law or regulation are identified.

1. Findings and violations from the preceding procedural steps are identified to assess the bank's level of compliance with 12 CFR 14, Consumer Protection in Sales of Insurance.
2. For those violations found to be significant or a pattern or practice, determination is made as to their root cause by identifying weaknesses in:
Internal controls.
Audit/independent compliance review.
Training.
Management oversight.
3. Action needed to correct violations and weaknesses in the institution's compliance system is identified.
5. A determination is made as to whether any items identified during this examination could evolve into supervisory concerns before the next on-site examination, with consideration given as to whether the bank has plans to increase monitoring in the affected area, or anticipates changes in personnel, policy, outside auditors or consultants, or business strategy.
6. The effect on aggregate risk and direction of risk for any concerns identified during the review is ascertained using the following criteria;
Risk categories: compliance, transaction, reputation.
Risk conclusions: high, moderate, or low.
Risk direction: increasing, stable, or declining.
7. A conclusion must be reached about the reliability of the compliance management system for Consumer Protection in Sales of Insurance and conclusions provided to the OCC authority chain.
8. Conclusions and sanctions (if any) are recommended concerning:
• A summary of violations and recommended CMPs or enforcement actions, if any.
• Recommended corrective action.
• The quantity of risk and quality of risk management.
• Recommended MRAs.
MRAs should cover practices that:
Deviate from sound fundamental principles and are likely to result in financial deterioration, if not addressed.
Result in substantive noncompliance with laws.
MRAs should discuss:
Causative factors contributing to the problem.
Consequences of inaction.
Management's commitment for corrective action.
The time frame and person(s) responsible for corrective action.
9. Findings are discussed with management. A commitment(s) for corrective action as needed is obtained. Included in the discussion is:
• The quantity of risk and quality or risk management.
• Violations of 12 CFR 14.
• MRAs.

Privacy Rule - 12 CFR 40 and the Fair Credit Reporting Act

Banks must provide their customers an annual privacy notice in addition to the initial privacy notices discussed previously in this text. All privacy notices must be clear and conspicuous, and must be provided so that each intended recipient can reasonably be expected to receive actual notice. The notices must be in writing (unless the consumer agrees to electronic delivery) and must describe the types of nonpublic personal information collected and disclosed, the types of affiliated and nonaffiliated third parties with whom the information may be shared, and, if applicable, the consumer's right to opt out and thereby limit certain information sharing by the bank.

Banks generally may not, directly or through an affiliate, disclose a consumer's nonpublic personal information to any nonaffiliated third party unless the consumer is given a reasonable opportunity to direct that such information not be disclosed, i.e., to opt out. Before a bank may disclose nonpublic personal information about a consumer to a nonaffiliated third party, the bank must provide the consumer with an initial privacy notice and an opt-out notice. GLBA contains a number of specific exceptions to these opt-out requirements, however, to ensure that banks can continue to disclose information to nonaffiliated third parties to conduct routine business. These exceptions include, for instance, the disclosure of information by banks to third parties who are providing services to the bank or to their customers as the bank's agent.

The interagency rule also provides that a bank generally may not disclose a credit card, deposit, or transaction account number of a consumer to any nonaffiliated third party for use in telemarketing, direct mail, or other marketing through electronic mail to the consumer. The rule also limits the redisclosure or

reuse of information obtained from other nonaffiliated financial institutions. Functionally regulated subsidiaries that sell insurance must comply with state laws and regulations that govern the handling of consumer information, such as health information, in connection with insurance activities. Under GLBA, state insurance authorities are expected to promulgate privacy regulations that apply to insurance companies. States could, for example, adopt the NAIC's model privacy regulation that requires all licensees of a state insurance Comptroller's department to obtain specific consumer authorization (opt in) before disclosing health information. The disclosure of certain consumer information may also trigger requirements under the Fair Credit Reporting Act (FCRA). Although the FCRA imposes no limits on a bank's disclosure to third parties of information about the bank's transactions and experiences with its customers, the FCRA governs the sharing of credit reports and other information that meets the statutory definition of "consumer report." The FCRA provides that banks and other entities may share such information among their affiliates without being considered consumer reporting agencies if they provide their consumers with notice about the sharing and an opportunity to opt out. Banks engaged in insurance sales activities should consider the applicability of the FCRA and any regulations that may be promulgated before disclosing "consumer report" information.

Federal Prohibitions on Tying

Under 12 USC 1972, federal law prohibits certain tying arrangements. The statute's implementing regulation (12 CFR 225.7) provides some exceptions to the statutory tying restrictions for banks, including national banks. The exceptions permit certain tying arrangements for national banks and are applicable to national bank operating subsidiaries. For purposes of the federal tying prohibitions, a national bank financial subsidiary is considered a subsidiary of the bank holding company and not the bank, as provided in 12 USC 1971 (also see 12 CFR 5.39(h)(6)). Thus, the general tying restrictions applicable to national banks and their operating subsidiaries are not applicable to financial subsidiaries. A financial subsidiary is subject to the limited tying prohibition in 12 CFR 225.7(d) involving tying electronic benefit transfer services to other point-of-sale services. Tying arrangements may violate other laws, including the federal antitrust laws, in addition to antitying provisions.

OCC Bulletin 95-20, "Tying Restrictions," describes measures banks can take that help to ensure compliance with the tying prohibitions.
The measures include:
Monitoring to eliminate impermissible coercion when offering customers multiple products or services.
Training bank employees about the tying prohibitions, including providing examples of prohibited practices and sensitizing employees to the concerns raised by tying.
Involving management in reviewing training, audit, and compliance programs, and updating any policies and procedures to reflect changes in products, services, or applicable law.
Reviewing customer files to determine whether any extension of credit is conditioned impermissibly on obtaining an insurance product from the bank or affiliates.
Monitoring incentives, such as commissions and fee splitting arrangements, that may encourage tying.
Responding to any customer allegations of prohibited tying arrangements.

In situations involving sales of insurance in connection with extending a loan, banks must also comply with the requirements of 12 CFR 14. In summary, Part 14 prohibits engagement in any practice that would lead a consumer to believe that an extension of credit is conditional upon:
The purchase of an insurance product or annuity from the bank or any of its affiliates.
An agreement by the consumer not to obtain, or a prohibition on the consumer from obtaining, an insurance product or annuity from an unaffiliated entity.

Tying prohibitions do not prevent bank sales personnel from *informing* a customer that insurance is required to obtain a loan or that loan approval is contingent on the customer obtaining acceptable insurance. In such circumstances, sales personnel may indicate that insurance is available from the bank and may provide instructions on how the customer can obtain additional information. However, the bank should clarify to the customer that the bank's decisions on a loan application are independent of the customer's decision on where to obtain insurance. Tying concerns are equally pertinent and potentially more acute if a type of insurance that is unrelated to, or not required in connection with, a pending loan application is offered to a loan applicant as part of the loan application process. In that situation, banks should use great care to dispel any impression that the unrelated products are being mentioned because of a potential connection to the bank's credit decision. The bank should ensure that, if such offers are permitted, they are monitored adequately by the bank's compliance system.

CHAPTER 6 Comparison- Bank & Insurance Regulatory Frameworks

The National Association of Insurance Commissioners (NAIC) and the Federal Reserve System (FRS) joint Troubled Company Subgroup (Subgroup) was formed in 2000. The Subgroup's initiative was conducted by staff from several state insurance departments, the NAIC, the Board of Governors of the Federal Reserve System (Federal Reserve Board) and the Federal Reserve Bank of Boston under the auspices of the NAIC's Financial Condition (E) Committee. The Subgroup, which was originally established under the NAIC Coordinating with Federal Regulators Working Group now reports up through the NAIC Financial Analysis Working Group (FAWG) of the NAIC Financial Condition (E) Committee. The Subgroup's objective was to compare insurance and banking regulatory frameworks for identifying and supervising companies in weakened financial condition, and was one of four joint subgroups established by the NAIC and the FRS to address implementation of the Gramm-Leach-Bliley Act (GLB Act) enacted in November 1999. Unless otherwise noted, the banking supervisory framework presented in this paper is the approach used by the FRS as it pertains to state member banks and bank holding companies (BHCs). The FRS also has supervisory responsibility for certain U.S. bank branches and certain other U.S. banking offices of foreign banking organizations (FBOs); however, the scope of this summary does not include FBO supervision. Additionally, the scope of this summary was generally limited to financial soundness monitoring and the supervision of financially weakened institutions. Comparisons of frameworks for identifying and correcting issues pertaining to compliance with consumer protection regulations were also beyond the scope of this summary.

GLB and Sector Integration

The GLB Act facilitated the already growing integration of the insurance, banking and securities sectors by permitting wider latitude for insurance companies, banks and securities firms to operate within a single financial holding company (FHC), and mandated the coordinated supervision of entities within an FHC by the financial sector regulators. The joint efforts of the insurance and banking supervisors over the past several years have provided a foundation for effective communication and coordination between the state insurance departments and the FRS consistent with the GLB Act. Topics include-

1) Regulatory financial reporting frameworks;
2) Off-site surveillance and monitoring including "early warning systems" for identifying supervised companies having weak or deteriorating financial conditions;
3) On-site examinations;
4) Corrective action plans;
5) Enforcement powers;
6) Risk-based capital (RBC) frameworks;
7) Resolution processes for failing and failed insurance companies and banks; and
8) The FRS's role as umbrella supervisor for FHCs.

Summary of Resolution Procedures

Separately, in connection with this initiative, staff of the Federal Deposit Insurance Corporation (FDIC) presents a summary of that agency's resolution procedures to the NAIC task force members. In comparing the two frameworks of law, regulation, policy and procedures, the Subgroup members and other discussants stressed that the specific supervisory approaches taken for any given financially weakened insurance or banking company are dependent upon the specific facts and circumstances as well as upon the respective supervisory frameworks.

The Subgroup found that the frameworks for identifying and supervising financially weakened companies used by state insurance regulators and the FRS have many similarities. For example, both the state insurance departments and the FRS:

generally require supervised institutions to file detailed quarterly financial condition and income reports, related supplementary information, and information identifying affiliated entities of an insurer or a bank;
conduct routine off-site monitoring of supervised companies other than small, noncomplex BHCs, in part based upon information contained in regulatory reports, and also using market information, to assist in early identification of financially weakened companies and in allocating on-site examination resources;

have minimum capital standards, including an RBC framework that requires regulatory intervention when capital of a supervised insurance company or insured bank falls below a designated level. State insurance departments and certain bank regulators are responsible for handling insurance company and bank insolvencies, respectively; insolvencies of insurance holding companies and BHCs are handled under federal bankruptcy laws.
impose limitations on and reporting requirements related to certain transactions within holding company systems, including certain acquisitions of or by a supervised entity;
may require a financially weakened, supervised company to develop written corrective action plans and submit progress reports on compliance with plans; and
may take various other supervisory actions against a financially weakened company, including imposing restrictions on activities.

Phases of Supervisory Activities

The Subgroup also identified three broad phases of supervisory activities as follows:
Conducting both off-site monitoring of financial condition using financial statement and market information analysis, and on-site examinations;
Implementing corrective action plans for financially weakened companies; and
Undertaking insolvency proceedings (generally the responsibility of the FDIC for bank insolvencies).

The **Tables A and B** at the end of this Section contain summary information regarding the insurance and banking regulatory processes for identifying and supervising financially weakened insurance and banking organizations.

BACKGROUND ON THE GLB ACT

The GLB Act amendments to the Bank Holding Company Act of 1956 (BHC Act) authorized a qualifying bank holding company (BHC) to operate as an FHC and to engage in a diversified range of financial activities, including insurance sales, insurance underwriting, securities underwriting and dealing, acting as a futures commission merchant, and engaging in merchant banking. To qualify as an FHC, each of the BHC's depository institution subsidiaries must be well capitalized and well managed and each of the BHC's insured depository subsidiaries must have received at least a "Satisfactory" Community Reinvestment Act (CRA) rating in its most recent CRA examination. A CRA rating is an indicator of how well the depository institution has met its legal requirement to serve its community, in accordance with applicable laws and regulations. CRA examinations are conducted by a depository institution's primary federal banking regulator.

Allowed Insurance Activities

Those insurance activities that are permitted to be conducted by an FHC include-
Insuring, guaranteeing, or indemnifying against loss, harm, damage, illness, disability, or death;
Providing and issuing annuities; and
Acting as principal, agent, or broker for the foregoing activities.

Permissible activities also include those that the Federal Reserve Board and the Secretary of Treasury jointly determine to be financial in nature or incidental to financial activities, or that the Federal Reserve Board determines are complementary to a financial activity and do not pose a substantial risk to the safety and soundness of depository institutions or the financially system generally. Under the GLB Act, state regulation of insurance is preserved. A state law applicable to insurance may be preempted, however, if it prevents or restricts a depository institution or a depository institution affiliate from engaging in any activity authorized under the GLB Act. For instance, state laws relating to insurance sales, solicitation and cross-marketing activities may not prevent or significantly interfere with the ability of a bank or bank affiliate to engage in insurance sales activities.

With limited exceptions that existed prior to the passage of the GLB Act, insurance underwriting activities of an FHC may only be conducted by the FHC parent company or by a nonbank subsidiary of the FHC. A bank and its subsidiaries are generally precluded from insurance underwriting, other than the underwriting of credit life and credit health products. As set forth in the GLB Act, general insurance sales may be conducted by an FHC parent company or a nonbank subsidiary of the FHC, or by a financial subsidiary of a bank. The GLB Act did not change the authority for national or state-chartered banks to sell or underwrite insurance directly. Federal banking laws, however, generally continue to limit insurance

underwriting activities of banks to credit-related underwriting activities. Most state banking laws now permit state-chartered banks to sell general insurance.

The Federal Reserve Board is the umbrella supervisor of BHCs, including FHCs. In accordance with the GLB Act, the Federal Reserve Board is to rely to the fullest extent possible on reports of examination made by the applicable functional securities and insurance regulators, including for any licensed insurance company and any other subsidiary that the Federal Reserve Board finds to be comprehensively supervised by a federal or state authority. If information that is needed to assess the risk of a functionally regulated subsidiary of a banking organization is not available from the functional regulator, the Federal Reserve Board may examine a functionally regulated subsidiary of a BHC only if: the Federal Reserve Board has reasonable cause to believe that such subsidiary is engaged in activities that pose a material risk to an affiliated depository institution; the Federal Reserve Board reasonably determines, after reviewing relevant reports, that examination of the subsidiary is necessary to adequately inform the Board of the systems for monitoring and controlling operational risks that may pose a threat to the safety and soundness of a depository institution subsidiary of the BHC; or, based on reports and other available information, the Federal Reserve Board has reasonable cause to believe that the subsidiary is not in compliance with the GLB Act or any other federal law that the Federal Reserve Board has jurisdiction to enforce against such subsidiary, and the Federal Reserve Board cannot make such a determination through examination of the affiliated depository institution or the bank holding company.

FRAMEWORKS FOR SUPERVISING BANKS AND INSURANCE

The primary objective of insurance regulation is to correct market failures that would otherwise cause insurers to incur an excessive risk of insolvency or engage in market abuses that hurt consumers. Significant state insurance department regulatory resources are employed to monitor market behaviors, compliance, and solvency. Each state, the District of Columbia, and the U.S. territories are responsible for regulating the insurance business within their own jurisdictions (the fifty states, the District of Columbia, and the U.S. territories are collectively referred to as "states" in this document). Each state maintains its own insurance department, which operates under the supervision of a commissioner, director, or superintendent who is either appointed or elected. Some states have combined the regulation of insurance, banking, and securities, activities under one department or office.

NAIC Insurance Supervision

The NAIC, formed in 1871, is a private, non-profit, voluntary association of the chief insurance regulatory officials of the 50 states, the District of Columbia, and the four U.S territories (American Samoa, Guam, Puerto Rico, and the Virgin Islands). The NAIC provides its members with a forum for discussing common interests and for working cooperatively on regulatory matters that transcend the boundaries of their own jurisdictions. The NAIC is not a regulatory body or a trade association, but is instead an organization whose members consist solely of insurance regulators for the purpose of facilitating communication and interaction among insurance regulators to enhance insurance regulation and establish national standards, where appropriate.

State Solvency Efforts

The NAIC coordinates and assists state solvency efforts in a number of ways, including:
Maintaining extensive insurance databases and a computer network that are assessable to all state insurance departments;
Analyzing and informing regulators as to the financial condition of insurance companies;
Coordinating examinations and regulatory actions with respect to financially weakened companies;
Establishing and certifying states' compliance with minimum financial regulation standards through the NAIC's Financial Regulations Standards and Accreditation Program (Accreditation Program);
Providing financial, reinsurance, actuarial, legal, computer and economic expertise to state insurance departments;
Valuing securities held by insurers;
Analyzing and listing nonadmitted 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 regulators, state legislators, Congress, U.S. government agencies, insurance regulators in other countries, and the general public.

A nonadmitted insurer (as mentioned in #7 above) is a company not licensed by a state to sell insurance policies within the state. Alien insurers are those formed according to the legal requirements of a foreign country. In order for an alien insurer to conduct operations and sell its products in a particular state, the insurer must conform to the state's rules and regulations governing insurance companies. A nonadmitted alien insurer may be allowed to write on a surplus lines basis if it complies with the state's eligibility requirements. To assist states in their review of nonadmitted alien insurers, the NAIC produces a Quarterly *Listing of Nonadmitted Alien Insurers* (the Listing). If an insurer appears in the Listing, it has filed specified documents with the NAIC International Insurers Department (IID) and, based upon these documents and other information, appears to fulfill the criteria for eligibility set forth by the NAIC. Several states utilize the Listing to some capacity within their respective state statutes or regulations in relation to their eligibility requirements.

NAIC Objective

The objective of the NAIC is to serve the public interest by assisting state insurance supervisory officials, individually and collectively, in achieving the following fundamental insurance regulatory objectives:
1) protect the public interest, promote competitive markets and facilitate the fair and equitable treatment of insurance consumers;
2) promote the reliability, solvency and financial solidity of insurance institutions; and
3) support and improve state regulation of insurance.

The primary means for NAIC members to be actively involved in the association is through the NAIC committee system. Each commissioner serves, or delegates to state insurance department staff, the responsibility to serve on various NAIC committees, task forces and working groups. The NAIC is committed to conducting its business openly, subject to the discretion of the chairpersons of committees, subcommittees, tasks forces, working groups and subgroups, who may determine those situations in which public discussions would not be appropriate.

Financial Regulation Standards

In June 1989, the NAIC adopted the Financial Regulation Standards (the Standards), that established baseline sound practices for an effective regulatory system in each insurance department. The Standards are applied through a formal, voluntary certification program administrated by the NAIC. The objective of the Accreditation Program is to provide a process whereby solvency regulation of multi-state insurance companies can be enhanced and adequately monitored by the states. The Standards are grouped into three areas: 1) laws and regulations; 2) regulatory practices and procedures; and 3) organizational and personnel practices. Under this Accreditation Program, an independent team of experienced consultants reviews each insurance department's compliance with the Standards at least every five years. All states have enacted legislation designed to achieve compliance with the Standards, and as a result, insurance department budgets and staffing have increased significantly. As of 2018 all fifty states, the District of Columbia and Puerto Rico are currently accredited..

Insurance companies are chartered by individual jurisdictions and receive a certificate of authority (that is, a license) to conduct business from each jurisdiction in which the company desires to underwrite insurance. This has been the case since 1792, when chartered insurance companies were first required by the states to limit company activities and investments, and to file financial statements. The power of a state to regulate insurance was established in 1869 in *Paul v. Virginia*, where insurance was declared a local matter rather than commerce between the states. By 1870, many of the states had appointed a state official to oversee insurance. In 1944, the U.S. Supreme Court in *United States v. South-Eastern Underwriters Association* ruled that insurance was "commerce" and subject in its interstate activity to regulation by the Congress and the statutory restriction of the Sherman Act prohibition against restraint of trade. In 1945, however, Congress enacted the McCarran-Ferguson Act, which included a limited exception from certain antitrust laws for certain insurance-related activities. The McCarran-Ferguson Act generally made insurance subject to state control and withheld the application of federal statutes to the extent that state law regulated such business, except in instances where the federal law specifically relates to insurance.

The states issue a number of different insurance company license types, including life and health, and property and casualty licenses. The states also issue insurance producer license types, including broker,

independent agents, managing general agents, and general agent licenses. An independent agent is a contractor who represents more than one insurance company when placing a client's business. A general agent is a person appointed by one insurer who is responsible for insurance agency operations in a particular geographical area, including the sale of life and health insurance, recruiting and training agents, and providing administrative support.

Reinsurer Regulation

Reinsurers may either be authorized or licensed to write reinsurance business depending on the states laws and regulations. Under state insurance law, provided the owner meets certain criteria through the regulatory approval process, there are very few outright restrictions on a licensed insurer's ownership by, or affiliation with, other financial or non-financial companies. An exception is the general prohibition on foreign government ownership of an insurer. State insurance law does not provide for consolidated supervision of the insurance holding company or the parent holding company. However, an insurance company is subject to state restrictions and disclosures regarding inter-affiliate relationships, and change in ownership is subject to state insurance department approval. Under state law, a licensed insurance company is generally authorized to own subsidiaries that conduct insurance or insurance-related business activities, including real estate management and real estate development. Investments in higher risk activities are limited by state statutes and indirectly through statutory RBC minimum standards.

State insurance regulators have recognized a growing need to more fully coordinate their regulatory efforts with other state insurance regulators, including efforts for sharing confidential supervisory information. Historically, there has been significant coordination with respect to supervising financially weakened companies; similar efforts are also underway to focus on holding company systems or insurance groups that are financially strong. In 2000, the NAIC formed the Insurance Holding Company (E) Working Group (IHCWG) in an effort to document a framework for information sharing and coordination of regulatory processes for analyzing insurance holding companies and their insurance subsidiaries. The NAIC *Framework for Insurance Holding Company*

Regulation (Framework) is the result of the IHCWG's work. The Framework provides guidance for state insurance regulators to understand the holding company structure of insurers operating in their state, as well as to coordinate their supervisory approaches for reviewing holding company transactions that may impact insurance subsidiaries domiciled in multiple jurisdictions. Currently, this Framework is in the implementation stage.

Banking Regulation Framework

The FRS is the primary federal banking regulator for state member banks. It also has supervisory authority for all U.S. bank holding companies. In the U.S., commercial banks are either federally chartered by the Comptroller of the Currency (OCC) as national banks, or are chartered by a state. National banks are supervised by the OCC and are members of the FRS. State-chartered banks that are members of the FRS are referred to as state member banks, and are supervised by both the applicable state banking department(s) and the FRS. A state bank that does not choose to become a member of the FRS is referred to as a state nonmember bank and is supervised by both the applicable state banking department(s) and the FDIC. The OCC, FRS and FDIC are the primary federal bank supervisors for national banks, state member banks and state nonmember banks, respectively. A "dual banking system" exists in the U.S. whereby state-chartered banks have both a federal bank and a state bank regulator(s). A state-chartered bank may be subject to supervision in all states in which it operates. Therefore, the FRS actively coordinates its supervision of state member banks with the applicable state banking department(s).

Prior Federal Reserve Board approval is required for a company to initially become a BHC or for an existing BHC to acquire control of, or more than five percent of a class of voting securities of, additional BHCs or banks. Relevant federal statutes state that control of a BHC or bank exists when a company has (i) ownership, control, or power to vote 25 percent or more of the outstanding shares of any class of voting securities of the BHC or bank, directly or indirectly or acting through one or more other persons; (ii) control in any manner over the election of a majority of the directors, trustees, or general partners (or individuals exercising similar functions) of the BHC or bank; or (iii) the power to exercise, directly or indirectly, a controlling influence over the management or policies of the BHC or bank. A company includes corporations, partnerships, associations, certain trusts, and similar organizations. Also, non-financial firms generally are prohibited from controlling banks and thus are prohibited from owning 25 percent or more of the voting stock of a bank.

FRS Authority

The Federal Reserve System (FRS) has supervisory authority over BHCs, including those that are FHCs, and supervises these entities on a consolidated basis. The FRS supervisory approach reflects the "source of strength" doctrine, which asserts that a BHC should serve as a source of financial and managerial strength to its subsidiary banks, within certain constraints. This doctrine was reconfirmed in the GLB Act, except that the Act indicates that the FRS cannot require a BHC that is an insurance company, or an insurance company that is an affiliate of a depository institution, to provide funds or other assets to the affiliated depository institution if the state insurance authority makes a determination, in writing, that such action would have a material adverse effect on the financial condition of the insurance company.

The FRS is comprised of 12 regional Federal Reserve Banks under the general oversight of the Federal Reserve Board, which is located in Washington, D.C. The Federal Reserve Board and its staff develop FRS regulations and policies. The Federal Reserve Board is an independent government agency overseen by 7 board members, including the Federal Reserve Board Chairman and Vice Chairman, all of whom are appointed by the president and confirmed by the Senate. Each Federal Reserve Board member is appointed to serve a 14-year term, or if replacing a board member whose term has not yet expired, to serve the remainder of the previous board member's 14-year term. The Federal Reserve Board Chairman has a 4-year term, and may be reappointed.

In carrying out responsibilities for the comprehensive supervision of BHCs, including FHCs, the FRS coordinates and cooperates, as appropriate, with the other bank and thrift regulators, including the OCC, the FDIC, the Office of Thrift Supervision (OTS), and state banking departments. The Federal Financial Institutions Examination Council (FFIEC), whose members consist of the FRS, OCC, OTS, FDIC and National Credit Union Administration (NCUA), is an organization that fosters uniform depository institution regulatory reporting and consistent supervisory policy among those federal agencies. Moreover, federal and state bank and thrift supervisors share certain databases and other supervision tools and resources in order to develop coordinated and consistent regulation of supervised entities. Additionally, in carrying out its role as the consolidated supervisor for BHCs, including FHCs, the FRS also relies on and coordinates its supervisory activities with, as appropriate, the Securities and Exchange Commission (SEC) and the Commodity Futures Trading Commission, and state insurance and securities regulators.

CHAPTER 7 Tools for Identifying Financially Weakened Institutions

The NAIC reporting requirements have evolved considerably since its annual statement introduction in 1879. All states require an insurer to use the NAIC annual and quarterly statement reporting forms to satisfy their statutory financial statement filing requirements, except that states may exempt an insurer from this requirement, as appropriate. The complete annual statement filing currently includes a balance sheet, income statement, statement of cash flow, notes to financial statements, general interrogatories, and a significant number of supporting details in various exhibits, schedules and supplemental filings. General interrogatories are limited-scope questions regarding an insurer and its financial position and operations.

Insurance and Financial Reporting

Some of the more important exhibits and schedules provide information about: investment income and realized gains and losses; nonadmitted assets; Asset Valuation Reserve and Interest Maintenance Reserve; premiums and losses; expenses; long-term investments in bonds, preferred stock, common stock, real estate, mortgage loans, and other investments; derivatives; short-term investments; cash and cash equivalents; reinsurance; and transactions with affiliates. Supplemental filings are also required of most insurers, such as the actuarial opinion, the management's discussion and analysis, the annual audited financial report, and the RBC report. Other supplemental filings include specialty information such as the Medicare supplement report, the credit insurance report, and the long-term care report. Since 2003 insurers are also required to report affiliations with a BHC, bank, thrift or securities firm; to provide the names of each such affiliate; and to identify the relevant federal regulators of each insurer's financial institution affiliate. In addition to the annual statements, most insurers also are required to file the NAIC quarterly statement reporting form that contains key information on assets and liabilities; income and surplus; changes in investments; reinsurance; premiums written; losses and reserves.

Insurance company statutory financial reports are based on statutory accounting principles (SAP), which are designed to address the concerns of regulators. SAP stresses measurement of the ability to pay claims of insurers in the future, while generally accepted accounting principles (GAAP) stresses measurement of earnings of a business from period to period, and the matching of revenues and expenses for the measurement period (source: Preamble of the NAIC Accounting Practices and Procedures Manual). Conservatism serves as a major principle in SAP. For example, some assets are not allowed to be included in an insurer's surplus; these are referred to as nonadmitted assets. Another example of conservatism is the prohibition against discounting reserves, and the fact that specific tables approved by regulators are required to establish reserves for various life insurance products. Under GAAP, the experience expected by each insurance company, with provision for the risk of adverse deviation, is used to determine the reserves it will establish for its policies.

With the enactment of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (Dodd-Frank Act), the Federal Reserve assumed expanded responsibility as the consolidated supervisor of a significant number of insurance holding companies. As a result of the Dodd-Frank Act, the Federal Reserve is responsible for the consolidated supervision of insurance holding companies that own an insured bank or thrift, as well as insurance holding companies designated for Federal Reserve supervision by the FSOC. The insurance holding companies for which the Federal Reserve is the consolidated supervisor hold approximately one-third of U.S. insurance industry assets and vary greatly in size and in the types of products offered. After the passage of the Dodd-Frank Act, the Federal Reserve moved quickly to develop a supervisory framework that is appropriate for insurance holding companies that own depository institutions and promptly assigned supervisory teams to handle day-to-day supervision of those insurance holding companies. The Fed conducts its consolidated supervision efforts in a manner that is complementary to, and coordinated with, state insurance regulators, who continue their established oversight of insurance legal entities.

The Federal Reserve does not regulate the manner in which insurance is provided by these companies or the types of insurance that they provide. Those important aspects of the actual business of providing insurance are the province of the relevant state insurance supervisors. Regulatory issues of insurance holding companies are beyond the scope of this book.

Solvency Screening and Financial Analysis Systems

The fundamental objective of insurance company solvency monitoring is to ensure that companies meet regulatory standards and to alert regulators if actions need to be taken to protect policyholders. To accomplish this task, the state insurance regulators conduct financial analysis using regulatory financial reports, financial tools and other sources of information to detect problems that may jeopardize a company's long-term viability. These sources include SEC filings, corporate reports, external, independent certified public accountant (CPA) attestation reports, financial examination and market conduct reports, rate and policy form filings, consumer complaints, independent rating agency reports, correspondence from agents and insurers, and business media.

State insurance departments generally prioritize the review of their domiciliary companies based on a system of financial ratios and other screening tools, including those maintained by the NAIC. The NAIC has created a network of financial information systems and tools, such as the Financial Analysis Solvency Tools (FAST) System that includes the Insurance Regulatory Information System (IRIS), the Scoring System, and the Insurer Profiles System that are discussed below. The NAIC makes the information systems and tools available to state insurance regulators over the NAIC's Internet-State Interface Technology Enhancement (I-SITE). I-SITE provides a common user interface for more than 50 applications that are used to produce a wide variety of standard and custom reports. To be accredited, a state is required to conduct quarterly financial analysis on their domiciliary multi-state insurers. Most states conduct quarterly financial analysis on their single-state insurers as well. Typically, insurers with anomalous results, or those that have been previously identified for attention are subject to additional analysis.

The domiciliary state is relied upon as the primary solvency regulator. When there are concerns about the financial condition of an insurer, communications between the domiciliary state and the other states in which the company is licensed are increased. However, any state in which a company is licensed to conduct insurance business may perform its own monitoring, financial examinations, and may take regulatory action, as appropriate.

FAST System

The FAST System is a collection of analytical tools designed to provide state insurance regulators with an integrated approach to screening and analyzing the financial condition of insurance companies. The following are three key tools within the FAST System:

1) Insurance Regulatory Information System (IRIS)

IRIS has served as a baseline solvency screening system for the NAIC and state regulators since the mid-1970s. IRIS is designed to help regulators prioritize insurers for detailed financial analysis. The "statistical phase" of IRIS involves calculating a series of financial ratios for each insurer based on its annual statement data. The IRIS ratio results are available to the public. Because the ratios by themselves are not indicative of adverse financial condition, an experienced team of state insurance examiners and analysts (Analyst Team) reviews the IRIS ratio results and various other financial information in the "analytical phase" of IRIS, called the Analyst Team System (ATS). For the ATS, the Analyst Team meets annually at the NAIC Executive Headquarters to identify insurers that appear to require immediate regulatory attention in order to assist state insurance regulators in prioritizing their annual financial analysis reviews of insurers. The Analyst Team reviews a computer-selected priority listing of insurers that may be experiencing weak or declining financial results. It then validates the listing based on further analysis of those companies, and provides a brief synopsis of its findings in a document that can be accessed only by state insurance regulators and authorized NAIC staff.

2) Scoring System

The Scoring System is based on several financial ratios and is similar in concept to IRIS ratios. The Scoring System, however, includes a broader range of financial ratios and assigns a score to each ratio based on the level of solvency concern each result generates. The ratio results and scores are available only to state insurance regulators and authorized NAIC staff. The Scoring System is evaluated and updated, as appropriate, by the Financial Analysis Research and Development Working Group on an annual basis.

3) Insurer Profiles System

The Insurer Profiles System produces quarterly and annual profiles reports on property and casualty, life and health insurers. These profiles provide either a quarterly or annual five-year summary of a company's financial position. The Insurer Profile reports provide not only a snapshot of the company's financial statement, but also include analytical tools such as financial ratios and industry aggregate information that can be used in an analyst's review of the company. Insurer Profile reports can 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.

Peer Review Process

As a check and balance on the solvency screening efforts conducted by the states, a peer review process was created. The objective of the NAIC's peer review process conducted by the FAWG is to monitor whether domiciliary regulators are taking appropriate and effective supervisory action with respect to nationally significant insurers that are in financial difficulty. The FAWG is made up of commissioner appointed members from sixteen states.

On a quarterly basis, the NAIC's Financial Regulatory Services Division staff identifies nationally significant insurers for review using analytical criteria. Division financial analysts perform preliminary reviews of identified insurers and then select insurers that warrant more in-depth reviews. For those insurers, the FAWG will review the analysts' reports and then query the domiciliary state on various aspects of each insurer's financial condition and any regulatory actions being taken. If the FAWG determines that the domiciliary regulator is taking appropriate actions, then the FAWG may close the file or continue to monitor the company. If the FAWG determines that further measures are desirable, it will recommend the appropriate corrective action to the domiciliary state. If the domiciliary regulators fail to follow the FAWG's recommendation, the FAWG will alert other affected states accordingly and coordinate their supervisory response.

State Insurance Department Financial Examination Process

The purpose of a financial condition examination is to: 1) detect insurers with potential weaknesses; 2) determine compliance with state statutes and regulations; and 3) compile information needed for timely, appropriate regulatory action. On-site financial condition examinations of insurers are either full-scope or limited-scope examinations. The full-scope examination is considered a comprehensive examination with an overall objective to report on the company's financial position and affairs. A limited-scope examination, often referred to as a target examination, is conducted to review specific financial accounts and or specific areas of the company's operations.

State laws and regulations, as guided by the Accreditation Program, require the states to conduct a full-scope examination for each multi-state domestic company at least once every five years. Individual state statutes may require financial condition examinations more often, and several states impose a three-year requirement. Limited-scope examinations do not satisfy the NAIC Accreditation Standards to conduct financial condition examinations at least once every five years. However, failing to conduct limited-scope examinations for financial weakened companies may impact the results of the accreditation review. Frequently, full-scope examinations will be conducted as so called "zone examinations." A zone examination is a process to reduce the number of financial condition examinations of multi-state licensed insurers. The concept of zone examinations developed in response to the fact that states are entitled to conduct financial condition examinations on insurers that are licensed in their state regardless if they are domiciled elsewhere. As this ability could result in multiple examinations of the same company, the process of inviting representatives from other zones to participate evolved in order to reduce regulatory burden and increase efficiency.

Financial Condition Examinations

On-site financial condition examinations investigate a company's accounting methods and procedures, financial statement presentation, and validate what is presented in the annual financial statement assets, liabilities, capital and surplus line items, to ascertain whether the company is in good financial standing. The main thrust of the examination is to verify the company's solvency and determine whether the company has complied with state laws and regulations. In general, financial condition examinations shall at least encompass a review of all of the following matters:

1) company history;
2) management and control;

3) corporate records;
4) fidelity bonds and other insurance;
5) officers', employees', and agents' welfare and pension plans;
6) territory and plan of operation;
7) growth of company;
8) business in force by states;
9) mortality and loss experience;
10) reinsurance;
11) accounts and records; and
12) financial statements.

Examinations are conducted using a risk-based approach, whereby those areas identified as more likely to be prone to material financial reporting error are accorded greater attention during both the examination planning phase and the on-site examination. The state financial condition examination process also places emphasis on the quality of the company's internal control structure. This requires the state examiners to assess the internal control environment based on interviews with company management and personnel and other control testing procedures. On occasion, state insurance departments will engage outside experts to evaluate and test the effectiveness of internal controls (e.g., information system controls). The financial condition examination process also considers the work performed by external, independent CPAs as well as the work of internal auditors.

Regulatory Capital Framework for Insurance Companies

An insurer's capital and surplus provides a cushion against unexpected increases in liabilities and decreases in the value of assets, and are intended to absorb the costs of a rehabilitation or liquidation with minimal losses to policyholders and claimants. States require insurers to have a certain amount of capital and surplus to establish and continue operations. A state insurance department is authorized to take over, or "seize" an insurance company if the state can show to the applicable state court that the insurer will be unable to meet its obligations to policyholders.

Fixed minimum capital and surplus standards for licensing and operating an insurance company typically range in the area of $2 million to $5 million for a multi-line life and health or property and casualty insurer. Because of the limitations of fixed minimum capital standards, the NAIC adopted the Risk-based Capital (RBC) for Insurers Model Act. To be accredited, a state is required to adopt a substantially similar version of the Model Act, which contains separate formulas for life and health insurers and property and casualty insurers, and prescribes regulatory action to be taken if an insurer's Total Adjusted Capital declines below certain thresholds. The stated objectives of the NAIC RBC requirements are to provide a standard of capital adequacy that: 1) is related to risk; 2) raises the safety net for insurers; 3) is uniform among states; and 4) provides authority for regulatory action when actual capital falls below the standard. The model act specifies four levels of company and regulatory action, with more severe action required at lower levels.

The NAIC's life and health RBC formula encompasses six major categories of risk:
1) asset risk - affiliates;
2) asset risk - common stock;
3) asset risk - other;
4) insurance or pricing risk;
5) interest-rate risk and health credit risk and
6) business risk.

The risks addressed by the NAIC's property and casualty formula include:
1) asset risk - subsidiary insurance companies;
2) asset risk - fixed income;
3) asset risk - equity;
4) asset risk - credit;
5) underwriting risk - reserves; and
6) underwriting risk - net written premium.

Databases and Information Systems

The NAIC maintains a number of databases that state insurance regulators and NAIC staff use for financial analysis and other regulatory functions, including:

1) the Financial Data Repository (FDR);
2) the State Producer Licensing Database (SPLD);
3) Valuation of Securities (VOS);
4) Regulatory Information Retrieval System (RIRS); and
5) Special Activities Database (SAD).

The NAIC financial databases serve as the core resource of the solvency surveillance and other analysis activities of state insurance regulators and the NAIC. The FDR database contains the most recent 10 years of annual and quarterly financial statement information for the approximately 5,200 U.S. insurance companies. This database provides source data for reports on individual companies and for analytical tools, such as the FAST System. The VOS database contains credit quality designations and fair values for insurers' securities that are not rated and monitored by a Nationally Recognized Statistical Rating Organization (NRSRO). This database, combined with NRSRO ratings data, allows regulators to assess the relative credit risk of the securities owned and reported by insurers.

The SPLD database contains information on insurance companies, such as consumer complaints, and on nearly 3.5 million individual producers, including producer licensing and appointment information. RIRS database contains formally adjudicated regulatory actions taken by participating state insurance departments against insurance producers, companies and other entities engaged in the business of insurance. The SAD is a confidential database that contains information related to suspicious market activities and legal actions involving entities engaged in the business of insurance. The RIRS and SAD databases enhance state insurance regulators' ability to share information among state insurance departments on individuals or companies suspected of illegal or questionable activities and are tools to assist in the prevention of movement of these activities into new areas. State insurance regulators and NAIC staff also use an electronic mail system on the NAIC's computer network to communicate and coordinate supervisory developments with respect to examinations, regulatory actions, financially weakened companies, and a variety of other matters.

Banking (State Member Banks and BHCs)

All banks, including state member banks, are required to file quarterly regulatory reports known as FFIEC Call Reports consisting of consolidated balance sheets, income statements, RBC data and selected supplementary financial information. All BHCs are also required to file periodic regulatory reports.

Financial Reporting

Those BHCs with consolidated assets over $150 million, and BHCs below that threshold that are categorized by the FRS as "complex," are required to file consolidated balance sheets, income statements and RBC data, as well as parent company financial statements, on a quarterly basis. BHCs under $150 million that are non-complex BHCs are required to file parent company only financial statements semi-annually, but are not required to file fully consolidated financial reports. Additionally, all BHC are required to file periodic regulatory reports detailing certain intercompany transactions and balances between a bank and its nonbank affiliates; balance sheet and income statement data for certain of its domestic, non-functionally regulated nonbank subsidiaries and certain foreign domiciled bank and non-bank subsidiaries; and reports of new activities commenced. There are a number of other regulatory reports that must be filed by state member banks and BHCS. A complete listing of bank and BHC report forms and instructions are found on the Federal Reserve Board and the FFIEC websites (http://www.federalreserve.gov/ and http://www.ffiec.gov/, respectively).

Surveillance and Monitoring

The FRS off-site surveillance program is designed to monitor the financial condition and performance of individual state member banks and BHCs on a quarterly basis to facilitate identifying deterioration in the condition of companies between on-site examinations and inspections. Monitoring is accomplished, in part, through the use of automated screening systems and econometric models. These tools rely significantly on data reported on standardized regulatory reports and from the findings of on-site examinations. The surveillance program takes into consideration a number of aspects of banking performance, including capital adequacy, asset growth, loan quality and loan concentrations, liquidity, and capital markets activities. These surveillance results, produced by Federal Reserve Board staff, are distributed to the Federal Reserve Banks for further review, analysis, and follow-up. FRS Surveillance

screens incorporate the results of two econometric models, together known as the System for Estimating Examination Ratings (SEER). The SEER system developed by a FRS Surveillance Task Force was formerly known as the Financial Institutions Monitoring System (FIMS). The SEER models have been updated since they were first implemented, but a detailed description of the econometric frameworks used is contained in an article by Rebel Cole, Barbara Cornyn and Jeff Gunther in the Federal Reserve Bulletin, volume 81, number 1, January, 1995, pps. 1-15. The SEER risk rank model estimates the probability that a bank will become critically undercapitalized within the next two years. The SEER rating model estimates a bank's composite CAMELS rating based upon Call Report data and examination rating information. The surveillance screening results are strictly confidential.

To support off-site monitoring of bank performance and condition and on-site examinations, the FFIEC produces a quarterly Uniform Bank Performance Report (UBPR) for each commercial bank and FDIC-insured savings bank. These reports display current and historic balance sheet and income statement items, along with key performance ratios and peer group statistics. The FRS produces a similar report, the Bank Holding Company Performance Report (BHCPR), for BHCs over $150 million in consolidated assets. These UBPR and BHCPR reports are publicly available.

Bank Examinations and BHC Inspections

The FRS's safety and soundness examinations of state member banks and inspections of BHCs are focused on determining the financial condition and performance of an institution, and on evaluating management, internal controls and the risk management structure. The Federal Reserve is required to conduct a full-scope, on-site examination of every insured state member bank at least once during each 12-month period, with the exception that certain small institutions may be examined once during each 18-month period. The frequency of BHC inspections is determined by the size, condition, and complexity of the BHC.

Examiners assign a composite rating to a banking institution reflecting an assessment of the overall condition of the institution, including an assessment of relevant processes and risk management techniques. The rating system used for banks is known as CAMELS, an acronym for the components it evaluates: capital, asset quality, management, earnings, liquidity and sensitivity to market risk. Before 2005 BHCs were assigned a supervisory rating using a rating system known as BOPEC, which included evaluations of: bank subsidiaries ("B"); "other" (nonbank subsidiaries) ("O"); the parent company ("P"); consolidated BHC earnings ("E"); and consolidated BHC capital adequacy ("C"). A new BHC rating system was adopted in 2005 (SR letter 04-18, *Bank Holding Company Rating System,* at the Federal Reserve website). Under this system, a BHC is assigned an RFI/C(D) rating rather than a BOPEC rating. RFI/C(D) is an acronym for the components of: risk management ("R"); financial condition ("F"); potential adverse impact ("I") of nonbank affiliates on the affiliated depository institution(s); a composite BHC rating ("C") based on an evaluation and rating of the BHC's managerial and financial condition and an assessment of future potential risk to its subsidiary depository institution(s); and a rating for the depository institution(s) ("D") that will generally mirror the primary regulator's assessment of the subsidiary depository institution(s). Bank and BHC supervisory ratings and the reports of bank examinations and BHC inspections are strictly confidential.

FHCs are generally supervised similarly to any other BHC with a focus on understanding and assessing the quality of centralized risk management and control processes for key business lines, as well as understanding the intra-group exposures and risk concentrations across all business lines. To supervise a diversified BHC, the FRS relies to the extent possible on, and coordinates with, the appropriate functional regulators. Financial safety and soundness examinations and inspections generally include a review of compliance with a wide range of laws and regulations. In addition, the FRS also conducts consumer compliance examinations of state member banks to determine adherence with applicable consumer protection laws and regulations and assigns a compliance examination rating. Depository institutions, including state member banks supervised by the FRS, are also evaluated for their compliance with the CRA and assigned a separate CRA rating. An institution's CRA rating is publicly available.

Regulatory Capital Frameworks

Basel Capital Accord

The Basel Capital Accord (Basel I), the current international framework for bank capital adequacy, was adopted in 1988 by the G-10 group of central banks and other national supervisory authorities, working through the Basel Committee on Banking Supervision. The Basel Committee on Banking Supervision was established in 1974 comprising members from the central banks or other supervisory authorities of Belgium, Canada, France, Germany, Italy, Japan, Luxembourg, the Netherlands, Spain, Sweden, Switzerland, the United Kingdom, and the U.S. The FRS and the other federal banking agencies implemented an RBC approach for U.S. banking organizations in 1989. The fundamental objectives of Basel I are to promote the soundness and stability of the international banking system and to provide an equitable basis for international competition among banks. More specifically, Basel I sets forth RBC standards intended to assist in the assessment of capital adequacy of depository institutions. Other key objectives of the standards were to:
1) make regulatory capital requirements more sensitive to differences in risk profiles among banks;
2) factor off-balance sheet exposures into the assessment of capital adequacy;
3) minimize disincentives to holding liquid, low-risk assets; and
4) achieve greater consistency in the evaluation of the capital of the major banks throughout the world.[15]

Additional detail and background on the FRS's and the NAIC's RBC approaches can be found in the *Report of the NAIC and the Federal Reserve System Joint Subgroup on Risk-Based Capital and Regulatory Arbitrage*.

Under the Basel I framework, capital adequacy is assessed primarily in relation to credit risk with the other risks addressed implicitly. In 1996, Basel I was amended to take explicit account of market risk in trading accounts (i.e., the risk of loss due to a change in market prices, such as equity prices or interest or exchange rates).
Under the Basel I framework, a bank (and, in the U.S., generally a BHC with consolidated assets greater than $150 million) is required to have regulatory capital, as measured by combinations of equity, allowance for loan and lease losses (ALLL), qualified subordinated debt, and certain other instruments, at least equal to 8 percent of the amount of its risk-weighted assets. For the calculation, assets are weighted according to the level of perceived risk, and each off-balance sheet exposure is converted to an on-balance sheet equivalent, and then risk-weighted. Assets and off-balance sheet equivalents are generally risk-weighted at 100, 50, 20, or 0 percent. This measure is referred to as the total RBC ratio.

Another measure of capital adequacy used in the banking organization RBC framework is the Tier 1 RBC ratio. The Tier 1 RBC ratio is a more conservative measure that generally excludes debt instruments and the ALLL from the capital numerator. To be adequately capitalized, a U.S. banking organization must have a minimum Tier 1 RBC ratio of 4 percent. In addition, banking organizations are subject to a leverage ratio measure to evaluate capital adequacy. The leverage ratio, which is calculated as equity capital as a percentage of average balance sheet assets, is also used to evaluate capital adequacy. Currently, a revised RBC framework referred to as the Basel II Capital Accord is in the process of being implemented by U.S. and many foreign bank regulators. The objectives for reform include improving risk measurement and management; linking, more precisely, the amount of minimum regulatory capital to the amount of risk taken; further focusing the dialogue between supervisors and a banking organization on the measurement and management of risk and the connection between risk and capital; and increasing market discipline through enhanced transparency. Additional information pertaining to the Basel II Capital Accord may be found on the FRS public website (http://www.federalreserve.gov/) and the Bank for International Settlements public website (http://www.bis.org/index.htm).

Prompt Corrective Action (PCA)

As a result of the bank failures in the late 1980s and the rapid depletion of the federal deposit insurance fund, Congress mandated a PCA framework in the Federal Deposit Insurance Corporation Improvement Act of 1991 (FDICIA). This act requires federal bank regulators to administer timely corrective action to a bank when its capital position is deemed to have declined below certain threshold levels. The PCA framework specifies mandatory actions that regulators must take if capital ratios fall below certain thresholds, as well as discretionary actions that may be taken. The PCA regulations applicable to state

member banks are found at the Federal Reserve Board's Regulation H, Subpart D (12 C.F.R. 208.40 et seq.).

Under the PCA statute and accompanying regulations, a bank is assigned to one of five capital categories based primarily on the capital ratios reported in the quarterly FFIEC Call Reports. Four of the five PCA capital categories - "well capitalized," "adequately capitalized," "undercapitalized," and "significantly undercapitalized," are based on three capital adequacy ratios: the total RBC ratio, the Tier 1 RBC ratio, and the leverage ratio. The most severe capital category, "critically undercapitalized," is determined by a bank's tangible equity ratio, which measures the equity capital to assets ratios excluding intangible assets from the numerator and the denominator.

If a bank is deemed to be "undercapitalized," "significantly undercapitalized," or "critically undercapitalized" as defined in FDICIA based on its capital ratios, the bank must submit a capital restoration plan that is acceptable to its primary federal regulator, may not make any capital distribution, and may not pay a management fee to anyone that controls the bank. In addition, the bank may not increase its asset size, except under limited conditions, and may not make acquisitions or establish new branches or new lines of business, unless it meets certain conditions. Significantly undercapitalized and critically undercapitalized banks are subject to additional mandatory restrictions. The bank's primary federal regulator may also impose one or more of the discretionary restrictions enumerated in the statute and regulations through the issuance of a Prompt Corrective Action Directive to any undercapitalized, significantly undercapitalized, or critically undercapitalized bank. A bank may contest the issuance of such a directive through an agency appeal process. Under the PCA statute, a critically undercapitalized bank generally must be placed in conservatorship or receivership within 90 days of becoming critically undercapitalized.

In accordance with FDICIA, a BHC must guarantee its subsidiary bank's capital restoration plan and provide appropriate assurances of performance. Additionally, the cross-guarantee provision of FDICIA requires that, generally, any insured depository institution is liable for losses to the FDIC arising from the default of a commonly controlled insured depository institution. This provision was implemented, in part, to avoid the potential adverse effect of a bank shifting bad assets into a failing affiliate bank and thereby increasing the cost to the FDIC insurance fund.

Databases and Information Systems

The Federal Reserve Board maintains the National Information Center (NIC), a repository for both bank structure, financial, and confidential supervisory data for all commercial banks and BHCs. Additionally, the Central Document Text Repository (CDTR) is the repository for the electronic versions of commercial bank examination and BHC inspection reports, as well as other confidential supervisory documents. Front-end systems are available to authorized FRS staff for accessing these databases containing both publicly available and confidential supervisory information.

APPROACHES FOR SUPERVISING A FINANCIALLY WEAKENED COMPANY

The state insurance regulators and the FRS each have enforcement powers to support their ability to carry out their supervisory responsibilities, and both are subject to laws that require the regulator to take specified corrective action based on RBC thresholds for supervised insurers and supervised state member banks, respectively.

State Insurance Departments

Regulatory actions of an insurance department include activities that go beyond the monitoring and surveillance activities described above include:

Hearings/Conferences - These are sessions in which witnesses are requested to discuss, testify, or otherwise provide information to a state's insurance department with respect to a specific insurance company or group of companies. Hearings or conferences may be conducted either informally, involving only the department and insurance company personnel, or formally, involving the presence of an appointed hearing officer to conduct the session.

Implementation of a Corrective Plan - This involves the execution of a plan of action, reviewed and monitored by a state insurance department, for an insurer to correct a troubled or potentially troubled situation. This may include corrective plans required under RBC requirements.

Restrictions on Activities - Such activities may include prohibitions, conditions, or limitations placed by a state insurance department on certain activities or transactions of an insurance company. Examples include requiring pre-approval by the department of specific activities or transactions. The ability to place restrictions on an insurance company depends, in part, on the laws or regulations of the particular jurisdiction.
Notice of Impairment - This is a formal regulatory communication from a state insurance department to an insurance company informing the insurance company that the company does not meet stated minimum statutory capital and/or surplus requirements and requiring the company to correct the deficiency by a certain date.
Cease and Desist/Suspension Order - This is a formal regulatory communication from a state insurance department ordering an insurance company to stop certain activities, such as the issuance of new insurance policies.
Supervision - This is an action taken by a state insurance department under its administrative or legal provisions, under which a supervisor is appointed by an insurance department or by a court to "supervise" the operations of an insurance company. The supervision may be "confidential" (i.e., unannounced or "drawer"), "announced" by the insurance department, or "voluntary" (i.e., assistance was requested or acknowledged by the insurance company).

The Federal Reserve System

The FRS employs a range of tools to identify and address a supervised bank or BHC exhibiting emerging problems or weakened financial condition in order to maintain a sound banking system, minimize potential losses to the FDIC insurance fund, and facilitate the institution's return to financial health, if possible. Routinely, a summary of examiner findings and expected actions is conveyed to the banking organization following each targeted review of a particular business line or business activity, as well as in an examination report that summarizes the key findings of the reviews conducted during the 12- to 18-month examination cycle. For those institutions whose problems warrant additional supervisory action, a range of informal and formal supervisory actions is available, in addition to the PCA measures for banks described above.

Informal corrective actions include resolutions adopted by an institution's board of directors and Memoranda of Understanding between the appropriate Federal Reserve Bank and an institution, whereby the institution's board agrees to implement the actions that the institution will take to correct deficiencies. Informal actions are not made publicly available by the FRS. The SEC requires publicly traded companies to make public disclosure of certain material information that may affect the securities markets. A publicly traded financial institution, therefore, may be required to disclose the existence of certain informal actions taken by the FRS if the actions are deemed to be material.

Formal corrective actions, including Written Agreements and Cease and Desist Orders, are authorized by the Federal Deposit Insurance Act (FDI Act) to correct violations of law and unsafe or unsound practices. These agreements and orders may require a depository institution, a BHC, certain other entities, and any institution-affiliated party, including any director, officer, employee or controlling shareholder to take affirmative action to correct deficiencies or to cease engaging in the violations or other unsafe or unsound practices. Written Agreements and Cease and Desist Orders are made publicly available. They may include measures designed to improve a bank's capital and asset quality by placing restrictions on dividends, requiring the employment of more qualified management and improved oversight by the bank's board of directors. Written Agreements and Cease and Desist Orders against BHCs may also include requirements for capital infusions to an undercapitalized FDIC-insured subsidiary bank; restrictions on additional debt, dividends, and inter-corporate transactions; and the termination of certain nonbank activities that constitute violations of law or unsafe or unsound banking practices.

In cases where specific violations or practices are likely to cause insolvency, cause dissipation of assets or earnings, weaken the condition of the institution, or prejudice the depositors' interests, the FRS may issue a Temporary Cease and Desist Order to address these violations or practices. A Temporary Cease and Desist Order requires the banking organization to take or cease specific actions and remains in effect pending the outcome of an administrative hearing on the issues. Temporary Cease and Desist Orders are generally not made public by the FRS. In the event that an institution does not consent to supervisory action, the FRS may issue a Notice of Charges to initiate litigation. The FRS is authorized by the FDI Act to suspend or remove institution-affiliated parties who have engaged in a violation of law, an unsafe or unsound practice, or a breach of fiduciary duty, which has caused a bank to suffer a financial loss or other

damages or has resulted in a gain to the individual, and that involves personal dishonesty or demonstrates continuing or willful disregard for the safety and soundness of the institution.

Notwithstanding these enforcement powers, the GLB Act prohibits the Federal Reserve Board from requiring an insurance company that is a BHC or an insurance company that is a subsidiary of a BHC to provide capital to a depository institution subsidiary of the BHC if the state insurance authority determines, in writing, that such a funds transfer would have a material adverse effect on the financial condition of the insurance company. Additionally, the GLB Act generally prohibits the Federal Reserve Board from taking enforcement action against an insurance company, unless the action is necessary to prevent or redress a practice that poses a material risk to an affiliated depository institution or to the domestic or international payments system, and it is not reasonably possible to protect against the material risk through action directed at the depository institution. These provisions are codified at 12 U.S.C. 1844(g) and 12 U.S.C. 1848a, respectively.

RECEIVERSHIP AND LIQUIDATION

Both state insurance regulators and banking regulators have statutory requirements for receiverships and liquidations of supervised entities. State receivership and liquidation laws vary to some degree. For a state insurance department to be accredited by the NAIC, a state must have laws that substantially conform to the NAIC Model Receivership Act.

State Insurance Supervisors

Delinquency proceedings are instituted against an insurance company by a state insurance department for the purpose of conserving, rehabilitating, reorganizing, or liquidating the insurance company. Among the various types of delinquency that may be permissible under state law are the following:
Conservation - This term has different meanings in different jurisdictions. The scope of conservation efforts can vary from a seizure of certain assets to rehabilitation.
Seizure of Assets - A state's legal or administrative provisions provide for an insurance department to take control of an insurer's assets, books, records, and business premises if the insurer is domiciled in the state, in order to conserve the company's assets for the benefit of its policyholders and creditors.
Rehabilitation - An insurance company may be placed in a rehabilitation status by an insurance department through a jurisdiction's legal or administrative proceeding. The rehabilitation process generally involves, sometimes under a court order, the transfer of operational authority from insurance company management to a rehabilitator with the objective of returning the company to a sound financial and operational condition. The court order could, among other matters, direct the rehabilitator to take possession of the assets and administer the assets and the operations of the insurance company under the supervision of the court or under a formal plan approved by the court with notice to the company's affected creditors.
Liquidation - In the event that rehabilitation of an insurer is unsuccessful, the insurance department may, through legal proceedings, place the insurer in liquidation. The liquidation process ordinarily would include the seizure and marshalling of the company's assets, a determination of the company's liabilities, and the distribution of the assets of the insurance company under the supervision of the court to address or redeem those liabilities.
Dissolution - An insurance department may petition a court for an order to dissolve or terminate the corporate existence of a domestic insurance company following its complete liquidation.

The nature, timing, and extent of regulatory action in any given troubled company situation depends, in part, on the applicable jurisdiction's laws and regulations to which the insurance company is subject, as well as the circumstances of the particular situation. State insurance law may use different terms to refer to essentially similar actions, and the actions that are available to an insurance department differ among the states. When an insurer is found to be insolvent and is ordered liquidated, the guaranty funds are the source of last resort to provide protection for the insurer's policyholders and claimants. Not all policy obligations, however, are covered. For those that are covered, statutory limits apply. Additionally, not all policyholders and claimants are covered.

Bank Supervisors

In the event that a commercial bank is formally declared insolvent by its chartering agency (a state banking department or the OCC), the chartering agency and the applicable federal regulator - the FRS, OCC, or the FDIC, in its supervision capacity - generally no longer have any responsibility for supervising

the bank. Federal statutes name the FDIC as receiver and outline the process of a bank receivership and liquidation as well as the prioritization of claims. The amount of FDIC insurance coverage of $100,000 per depositor is uniform nationwide in the event of a bank insolvency. Deposits of larger amounts have priority over all other non-depositor creditors.

In the event that all of a BHC's insured depository institutions are placed into receivership, the company is no longer a BHC, and, therefore, is no longer supervised by the FRS. The FRS generally has no role in the liquidation of a BHC or a company that was formerly a BHC. Such liquidations are administered in accordance with federal bankruptcy laws.

Summary

This section points out advances in the insurance and banking regulators' understanding of each other's approaches for identifying and supervising financially weakened institutions and enhances coordination between the state insurance departments and the FRS, consistent with the GLB Act mandates for supervision of FHCs. In addition, many other efforts between the FRS and the state insurance supervisors, including the implementation of Memoranda of Understanding now in place between most state insurance departments and the Federal Reserve Board for sharing appropriate confidential, supervisory information and consumer complaints, as envisioned in the GLB Act, have fostered effective coordination of supervisory activities. These accomplishments represent significant milestones in the achievement of effective cooperation between banking and insurance regulators.

Table A Summary of State Regulation for Identifying and Supervising Financially Weakened Insurers

Regulatory Response					
Phase[1]	Trigger Points	Explanation	Informal[2]	Formal[3]	Comments
1	Periodic (annual and quarterly) financial analysis of statutory financial statements	Annual Statements are filed by March 1 of each year. Quarterly Statements are filed within 45 days following each quarter-end. The annual statement review process tends to be the more comprehensive of the two periodic reviews, because of the amount and depth of information provided by the statement. The analytical tools described in the cells below are utilized throughout the reviews. In addition, the state insurance department analyst also consider other factors/conditions such as a prolonged devaluation in the stock or real estate markets; reinsurance recoveries; deterioration of parent company's public debt rating; and class action lawsuits.	Used in annual reviews, quarterly reviews and financial condition examination planning. Analysis results may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.	NA	The NAIC Accreditation Program provides timelines by which analysis of domestic insurers should be completed by state insurance departments.

[1]The term, "phase" in this table is used to refer to possible levels of progression relating to supervisory action as outlined in the NAIC Troubled Company Handbook.
[2]Powers confirmed by discretionary authority of a commissioner or department of insurance.
[3]Powers permissible by state statute or regulation.

Regulatory Response 1					
Phase[1]	Trigger Points	Explanation	Informal[2]	Formal[3]	Comments
1	Scoring System	The NAIC Scoring System ratios and scores provide an integrated approach to screening and analyzing the financial condition of insurers.	Used in annual reviews, quarterly reviews and examination planning. Analysis results may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.		Ratios and scores are confidential. Ratios address critical areas of an insurer's operations, such as leverage of capital, growth, underwriting and investment profitability, investment holdings and liquidity. Companies receiving highest scores receive immediate attention, which often leads to a more in-depth analysis.
1	Analyst TeamSystem (ATS) Review	The NAIC ATS is a multi-tiered process through which insurers are assigned levels of priority by a team of state analysts/examiners. The system is based on a series of tests applied to an insurer's financial results, which then assigns a "level" ranking. If an insurer receives a ranking in the top two levels, the company is reviewed by a team member who then validates or changes the assigned level.	Used in annual reviews and examination planning. Analysis results may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.		Like the Scoring System, the review process and results of the ATS are confidential. They are used by some states to gauge the financial soundness of non-domestic (foreign) insurers operating within the state.

Regulatory Response					
Phase[1]	Trigger Points	Explanation	Informal[2]	Formal[3]	Comments
1	Financial Condition Examination	An on-site examination may detect existing or potential financial problems or may be used to investigate problems arising from routine financial analysis.		Required by state law; state insurance commissioner has absolute power to conduct examinations as appropriate; insurer must respond to examination report comments and recommendations.	Examinations are conducted on either a full or limited-scope basis. Full-scope examinations are conducted every 3 - 5 years. Limited-scope examinations may be conducted more frequently, depending on circumstances.
1	Model Regulation Regarding Hazardous Financial Condition	This model is a Standard in the NAIC Accreditation Program. The purpose of this regulation is to set forth standards, which the state insurance department may use for identifying insurers found to be in an unsound financial condition and for authority to initiate action.	Standards considered and measured during analysis process; analysis results may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.	These standards provide the basis for a court petition to rehabilitate or liquidate.	All accredited states have passed laws substantially similar to the NAIC model. A state's rehabilitation and liquidation act may incorporate by reference its hazardous financial condition law.
1	Reinsurance Company Failure	An insurer's reinsurance program is closely monitored by a state insurance department's staff and measured by various financial ratios. A significant rating downgrade or failure of any reinsurer triggers a reaction from department staff to identify affected insurers and to assess potential impact on the insurer's solvency.	Analysis results may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.	May result in limited-scope examination.	Credit for reinsurance is heavily regulated through statutes, regulations, statutory accounting and reporting rules. These rules are part of the NAIC Accreditation Program.

Regulatory Response					
Phase1	Trigger Points	Explanation	Informal2	Formal3	Comments
1	Holding Company Filing	All insurers are required to register certain information with their domiciliary regulator, if part of a holding company system. Information must be disclosed regarding transactions, relationships and agreements with parent, subsidiary and affiliate (PSA) entities, among other information.	Analysis results may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meetings with management.	May result in limited-scope examination.	Filings are required pursuant to NAIC Insurance Holding Company System Model Act. All accredited states have passed laws substantially similar to the NAIC model.
1	Market Conduct Finding	All insurers periodically undergo some form of "market conduct" examination. As with financial condition examinations, these may be used to detect or investigate problems that impact existing as well as prospective policyholders. These examinations may also affect the insurer's financial stability.		State insurance commissioner has absolute power to conduct examinations as appropriate; insurer must respond to examination report comments and recommendations.	The NAIC continues to work toward developing standards of practice for conducting market conduct examinations.
1	Actuarial Opinion	All insurers are required to appoint "qualified actuary," as defined by the NAIC *Annual Statement Instructions Property and Casualty (P&C),* to provide an opinion on the adequacy of loss and loss adjustment expense reserves, if a P&C insurer; or policy reserves and other actuarially-determined reserves, if a life or health insurer.	Opinion statements or a change in actuary may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.		To the extent possible and appropriate, examiners may utilize the work of the appointed actuary, to validate reserve adequacy.

Regulatory Response					
Phase1	Trigger Points	Explanation	nformal2	Formal3	Comments
1	Independent Audit Report (Report on Significant Deficiencies in Internal Controls)	All insurers are required to obtain an opinion from an independent auditor on their annual financial statements. In addition, each insurer must submit a report prepared by the auditor describing significant deficiencies in the insurer's internal control structure identify during the annual audit. An insurer is also required to report a change in auditor to the insurance department of the state of domicile within five business days of the event.	Report findings or a change in auditor may lead to: 1) phone or e-mail inquiry; 2) letter requesting additional information; or 3) face-to-face meeting with management.	Associated with this filing are reporting requirements the independent, external auditor must fulfill if the insurer has materially misstated its financial condition. If internal control deficiencies are reported, the insurer must submit a remediation plan.	To the extent possible and appropriate, examiners may utilize the work of the independent auditor, following some re-testing.
2	Business or Corrective	Closer monitoring requires obtaining the	A business plan or	In some instances, state	Some state insurance

	Plan	insurer's business plan or corrective plan (including financial projections), depending on the severity of the situation. Two to three year plans are often requested. Financial analyst/examiners utilize these plans to monitor management's execution of the plan and to stimulate dialogue.	corrective action plan may be required under general supervisory authority.	law explicitly requires the insurer to file a business or corrective action plan. For example, if an insurer triggers a certain RBC action level, a Corrective Action Plan is required.	departments are moving to routinely request business plans and financial projections from domestic insurers, particularly life insurers

Regulatory Response					
Phase1	Trigger Points	Explanation	Informal2	Formal3	Comments
	Risk-Based Capital (RBC)	There are five action levels, which are determined by comparing a company's Total Adjusted Capital (TAC) to its Authorized Control Level (ACL) RBC as computed by the RBC formula. TAC is compared to ACL RBC because the ACL RBC is the level at which a state insurance commissioner may first take control of an insurer - that is, control of the insurer may be seized.		RBC standards and actions are statutory requirements.	The NAIC Risk-Based Capital for Insurers Model Act, or an act substantially similar, is required to attain state insurance department accreditation under the NAIC's Accreditation Program.
2	RBC Company Action Level	TAC of 150% to 200% of minimum RBC constitutes a company action level under which an insurer must prepare a report to the state regulator outlining the corrective actions the company intends to take. At this level, an insurer must submit a comprehensive financial plan to the regulator that identifies the conditions contributing to the company's financial condition. This plan must contain proposals to correct the company's financial problems and provide projections of the company's financial condition, both with and without the proposed		RBC standards and actions are statutory requirements.	

Regulatory Response					
Phase1	Trigger Points	Explanation	Informal2	Formal3	Comments
		corrections. The plan also must list the key assumptions underlying the projections and identify the quality of, and the problems associated with, the insurer's business. If a company fails to file this comprehensive financial plan, this failure to respond triggers the next action level.			
2	RBC RegulatoryAction Level	TAC of 100% to 150% of minimum RBC triggers a Regulatory Action Level initiative. At this level, an insurer is also required to file an action plan, and the state insurance commissioner is required to perform any examinations or analyses of the insurer's business and operations deemed necessary. The state insurance commissioner also issues appropriate corrective orders to address the company's financial problems	.	RBC standards and actions are statutory requirements.	

Regulatory Response					
Phase1	Trigger Points	Explanation	Informal2	Formal3	Comments
3	RBC AuthorizedControl Level	TAC of 70 to 100% of the minimum RBC triggers an Authorized Control Level. This is the first point that the law authorizes the regulator to take control of an insurer. This authorization is in addition to the remedies available at the company and regulatory action levels. It is important to note that the law grants the state insurance commissioner this power. This action level occurs at a point where the insurer may still be technically solvent according to traditional standards - that is, the company's assets may still be greater than its liabilities.		RBC standards and actions are statutory requirements.	
3	RBC MandatoryControl Level	TAC of less than 70% triggers a Mandatory Control Level that requires the regulator to take steps to place an insurer under control. This situation can occur while the insurer still has a positive level of capital and surplus; although a number of the companies that trigger this action level are technically insolvent (liabilities exceed assets).		RBC standards and actions are statutory requirements.	

Regulatory Response					
Phase1	Trigger Points	Explanation	Informal2	Formal3	Comments
3	Administrative Supervision	State insurance commissioner exercises varying levels of control over operations of an insurer, dependent upon the circumstances of the specific case. Ownership of company is not disturbed and directors remain in place. This phase usually involves submission of a corrective plan by the insurer. The state insurance		Statutory requirements relating to administrative supervision vary by state.	

		commissioner may appoint an on-site supervisor to monitor performance.			
4	Receivership	State insurance commissioner obtains a court order authorizing 1) seizure of a company; 2) appointment of the state insurance commissioner as receiver; and 3) vesting legal title to all assets of the company in the state insurance commissioner's name. Management and directors are removed. As receiver, the state insurance commissioner's actions are subject to supervision by the state court that issued the receivership order. State insurance commissioner typically appoints a special deputy receiver to manage the receivership. Receiver may attempt to rehabilitate the insurer or, if rehabilitation is not practical, the receiver will liquidate the company.		Statutory requirements relating to receivership vary by state.	Initial seizure order may be obtained ex parte in some situations. State insurance commissioner has broad discretion in administering the receivership.

Table B Summary of Federal Reserve System Framework for Identifying and Supervising Financially Weakened State Member Banks and Bank Holding Companies

This table highlights key elements of the FRS's supervisory framework pertaining to bank holding companies (BHCs) and state member banks. It does not purport to include all events that may trigger a supervisory response or the full range of applicable supervisory actions.

Event That May Trigger Supervisory Response	**Applicable Regulation/ Policy or Guidance**[1]	Supervisory Action and Time Frames for Action if Applicable
1) Quarterly surveillance results for state member banks	SR letter 00-7: System Bank Watch List Program	Reserve Bank staff investigates potential financial weaknesses and prepares or updates analyses for watch list banks identified through the FRS's quarterly surveillance process. The analyses address the sources of potential weakness and their potential effect on safety and soundness; assess the appropriateness of current supervisory ratings and on-site examination schedules; and detail future supervisory plans.
2) Quarterly surveillance results for BHCs	SR letter 95-43: Revised Bank Holding Company Surveillance Procedures SR letter 02-01: *Revisions to BHC Supervision Procedures for Organizations with Total Consolidated Assets of $5 Billion or Less* (Contains separate guidance for both BHCs $1 - $5 billion, and BHCs less than $1 billion in assets.)	Reserve Bank staff prepares or updates analyses for BHCs with assets of $1 billion or more identified by quarterly exception screens. The Reserve Bank analyses detail the sources of potential weakness, their effect on safety and soundness, and supervisory actions in response to surveillance screen results. For BHCs under $1 billion, (except small, non-complex BHCs), quarterly surveillance screens are also used to identify potentially significant changes in the conditions of these companies between on-site supervisory reviews.

[1] SR letters, the *Commercial Bank Examination Manual,* and the *Bank Holding Company Inspection Manual* provide guidance to Federal Reserve Banks for implementing their Federal Reserve Board-delegated responsibility for the supervision of banking organizations. SR letters are issued by Federal Reserve Board staff to the officers in charge of supervision at each Reserve Bank. These documents are accessible on the Federal Reserve Board's website at www.federalreserve.gov.

Event That May Trigger Supervisory Response	**Applicable Regulation/ Policy or Guidance**1	Supervisory Action and Time Frames for Action if Applicable
3) Risk assessments of BHCs, including FHCs, and banks are prepared by Federal Reserve Bank staff. Risk assessments include an analysis of the level of risk, the direction of risk, and management controls. The following risks are assessed for the consolidated organization, as well as for the major business lines: operational risk, credit risk, market risk, liquidity risk, legal risk, reputational risk, and overall risk. For FHCs, particular focus is on understanding intra-group exposures and risk concentrations across all business lines.	SR letter 97-24: *Risk-Focused Framework for the Supervision of Large Complex Institutions* SR letter 97-25: *Risk-Focused Framework for the Supervision of Community Banks* SR letter 99-15: *Risk-Focused Supervision of Large Complex Banking Organizations* SR letter 02-01: *Revisions to BHC Supervision Procedures for Organizations with Total Consolidated Assets of $5 Billion or Less* SR letter 00-15: *Risk-Focused Supervision Policy for Small Shell BHCs* SR letter 00-13: *Framework for Financial Holding Company Supervision*	Based on the risk assessment, supervisory staff determines the scope, objectives and dates for targeted on-site reviews of selected risk areas. Supervisory staff coordinates with functional and primary regulators when appropriate.
4) Significant market, economic or other external event affecting banking industry condition	FRS's role to maintain stability of the banking system as well as role of prudential regulator for banking institutions.	Conduct monitoring and targeted reviews of banking organizations, as appropriate, and develop action plans.
5) Bank examinations and BHC inspections	Federal Deposit Insurance Corporation Improvement Act of 1991 (FDICIA) requires full-scope on-site examinations of state member banks are required at least once during each 12-month period with the exception that certain small institutions can be examined once during each 18-month period. The frequency of BHC inspections is dependent on the size, condition, and complexity of the institution.	Institutions are required to respond to issues identified. A range of informal and formal supervisory actions that may be appropriate to address weaknesses identified include but are not limited to: • Written Agreement, • Cease and Desist Order, • Temporary Cease and Desist Order, and • Prompt Corrective Action (PCA) (see below portion of this chart regarding PCA).

Event That May Trigger Supervisory Response	Applicable Regulation/ Policy or Guidance1	Supervisory Action and Time Frames for Action if Applicable
6) FHCs whose depository institution subsidiaries become less than well capitalized or are not well managed	Formal corrective action is required under section 4(m) of the BHC Act	• Requires an agreement between the FHC and the FRS within 45 days of notification of deficiency. • Institution must submit a plan for corrective action. • Institution must correct deficiency within 180 days; FRS may extend the deadline based on reasonable cause.
7) Capital deterioration - Bank capital deterioration:	FDICIA PCA provisions apply to bank capital levels. These provisions do not apply to BHC capital levels.	
Well capitalized		No action required
Adequately capitalized		No action required
Undercapitalized	FDICIA PCA provisions apply to bank capital levels. These provisions do not apply to BHC capital levels.	Increase monitoring. The following conditions apply: • Capital restoration plan is required; • Parent BHC must guaranty bank's capital plan; • Cessation of dividends; and • Limitation on management fees paid to controlling persons.
Significantly undercapitalized	FDICIA PCA provisions apply to bank capital levels. These provisions do not apply to BHC capital levels.	Conditions (see above) for "Undercapitalized" banks apply. Mandatory and discretionary restrictions include: • Sale of shares to increase capital; • Sale or merger of bank; • Restrictions on transactions with affiliates; • Restrictions on interest rates; and • Restrictions on senior officer compensation.

Event That May Trigger Supervisory Response	Applicable Regulation/ Policy or Guidance1	Supervisory Action and Time Frames for Action if Applicable
Critically undercapitalized	FDICIA PCA provisions apply to bank capital levels. These provisions do not apply to BHC capital levels.	Conditions (see above) for "Undercapitalized" and "Significantly Undercapitalized" banks apply. The Federal Deposit Insurance Corporation (FDIC) may be appointed receiver within 90 days.
BHC capital deterioration	BHC Act	BHC capital deterioration may trigger informal or formal action such a Memorandum of Understanding, Written Agreement, or Cease and Desist Order.
8) Bank & BHC insolvency		
• Bank insolvency or other factors identified by the chartering agency (state banking department or OCC) that are likely to result in losses to the federal deposit insurance fund • BHC insolvencies	Federal Deposit Insurance Act N/A: BHC insolvencies fall under federal bankruptcy laws.	FDIC is generally appointed receiver. N/A