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Insurance Topics We Will Be Watching in 2013

January 30, 2013

We end the first month of the year with a report on major insurance topics that we will be watching in 2013.

Many of these developments can be traced to discrete events or market or political forces. This year, those events and forces include the lasting impact of Superstorm Sandy, pressures created by the continuing low interest rate environment and sluggish economic growth, federal-state tensions and the emergence of international standards in the regulation of insurance, governments searching for more tax revenue, and the pervasiveness of technology (increasingly in the form of mobile devices) for all aspects of human interaction. Where helpful, we have identified these forces and how they affect the industry.

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Federal Role in Insurance Continues to Develop Slowly

While Dodd-Frank paved the way for an increased federal role in the regulation of insurance, to date, there has been only a modest level of federal activity. Set forth below is a review of the activities of the Federal Insurance Office (FIO) and a brief note on the potential reauthorization of the Terrorism Risk Insurance Program Reauthorization Act (TRIPRA), set to expire in 2014.

Federal Insurance Office. Despite the somewhat modest mandate set for FIO under Dodd-Frank, FIO has still struggled to ramp up and meet its obligations. Many had speculated that FIO's long-awaited report on how to modernize and improve regulation of the insurance industry would be forthcoming on the heels of the 2012 presidential election. However, the report remains unissued and is now more than a year beyond the due date set under Dodd-Frank. In addition, FIO has also missed deadlines on two reports related to reinsurance activities: (1) a report describing the global reinsurance market and the role that market plays in supporting insurance in the U.S. (due September 30, 2012); and (2) a report describing the impact of the Nonadmitted and Reinsurance Reform Act on state regulators' access to reinsurance information for regulated companies in their jurisdictions (due January 1, 2013).

Part of FIO's statutory mandate is to represent the U.S. in the International Association of Insurance Supervisors (IAIS). Michael McRaith, the Director of FIO, has participated in IAIS activities in the past year and has been appointed as a member of the Executive Committee for the North America region. In Congressional testimony earlier this year, Director McRaith described FIO's work with the IAIS' Financial Stability Committee and also indicated that FIO has been providing technical input to the IAIS ComFrame. More recently, Director McRaith was appointed to head the Technical Committee of the IAIS.

FIO is also charged with the authority to recommend insurers to the Financial Stability Oversight Council (FSOC) to be designated as systemically important financial institutions (SIFI(s)) that are subject to heightened supervision and other regulatory requirements. FSOC has not yet designated any insurance entities as SIFIs and there is little public information on what, if any, role FIO has played in FSOC's deliberations with respect to insurance-focused SIFIs. FIO has indicated that it is playing a role in attempting to shape the IAIS version of group supervision of systemically important insurers. The IAIS has published a proposal to identify global systemically important insurers (G-SII(s)) and is reportedly working to identify its list of G-SIIs by the end of the first quarter of 2013. Director McRaith has indicated that FIO is working with IAIS to align IAIS' work on G-SIIs with the FSOC's work on SIFIs.

Looking ahead to 2013, it remains to be seen whether FIO can gain some traction in meeting its mandate under Dodd-Frank, and stake its claim as a player in the insurance marketplace both domestically and abroad. Perhaps the clearest sign of progress to date for FIO has been its activity in the IAIS Executive Committee and Director McRaith's appointment to lead the Technical Committee. One factor that appears to be somewhat limiting to FIO's development is its internal resources. Director McRaith testified in May that FIO's staff was not complete, but that FIO hoped to ultimately build to a staff of 15. We understand that many of the positions on FIO's staff have been filled, but a few remain open. We will be on the lookout for the "tardy" reports in 2013, which should give us a better barometer of the direction that FIO will be heading in the near term. In addition, the ability of FIO to coordinate efforts among the IAIS and the FSOC with respect to the methodology and designation of systemically important insurance groups will be a test for FIO in 2013.

Federal Terrorism Insurance Program. We also note that TRIPRA is inching closer to termination. It must be reauthorized before its expiration at the end of 2014. Congress previously extended the program in 2005 and then re-authorized the program in 2007 for a seven year period. Last Fall, during a hearing conducted by a subcommittee of the House Financial Services Committee on the eleventh anniversary of the 9/11 terrorist attacks, strong support was shown for the extension of TRIPRA; however, it remains to be seen whether TRIPRA will be extended, and on what terms. One potentially new issue that may be addressed during the re-authorization process is whether the coverage will extend to coverage for "cyber" terrorism.

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De-Risking and Low Interest Rates

1. De-Risking of Products: More to Come?

A fundamental aspect of variable annuities is the shifting of investment risk from the insurer to the contract owner by passing through the investment experience of the assets held in one or more separate investment accounts. During the last decade, however, many insurers engaged in what some have characterized as an "arms race" of adding more, and more generous, optional guarantees to their products – death benefits with roll-ups and step-ups, guaranteed minimum account value benefits, guaranteed minimum income benefits, guaranteed lifetime withdrawal benefits, etc. These optional guaranteed benefits sold very well – perhaps too well in some cases. In any event, insurers took on more and more risk with these guarantees.

The severe downturn in the stock markets and sustained ultra-low interest rates exposed these risks and made these products and their guarantees very expensive for insurers to hedge. Consequently, during the past several years, companies have been busy trying to "de-risk" the products in various ways, including cutting back benefits, increasing charges, imposing more investment restrictions, designing underlying mutual fund options with "imbedded hedges" or low volatility features that will reduce hedging costs for the insurer, limiting or refusing new premiums, and in some cases stopping sales or selling off blocks of business. Some companies have even been offering buy-backs to contract owners with certain guaranteed benefits, where the contract owner is offered an amount equivalent to a significant percentage of the guaranteed benefit amount if they surrender the contract.

Similarly, insurers have outstanding untold fixed or general account products with what now seems like relatively generous guaranteed minimum interest rates on cash values, some as high as 4% or more. Carriers are examining ways to limit their risks on these products as well, limiting or suspending the privilege of making additional premiums, changing the maximum annuity commencement dates, terminating low balance contracts, offering to exchange to other contracts.

With no end in sight to the low interest rate environment, we look for these and perhaps other de-risking initiatives to continue in 2013.

2. Pension Plan Buyouts

In 2012, we witnessed the two largest transfers of pension obligations in U.S. history – the Prudential transactions with General Motors and Verizon. The documentation for a pension buyout includes a definitive purchase agreement, which memorializes the terms of the agreement, and a group annuity contract, which requires the purchaser to transfer a contribution amount to the insurer in exchange for the insurer's irrevocable commitment to make annuity payments to annuitants and their beneficiaries. The annuity payments mirror the payments made, or to be made, under the pension plan. Each pension plan participant receives an annuity certificate describing the payments to which such participant is entitled under the group annuity contract. The insurer typically allocates the contribution amount to a separate account, and the insurer's liabilities under the group annuity contract are supported by the separate account.

Transferring pension obligations allows a company to remove a large and growing liability from its books. Such a transfer reduces future volatility in earnings and required contributions for the employer, and it moves the pension obligations to insurance companies, which are in the business of managing credit, interest and longevity risk. Due to the universal appeal of achieving these goals, we expect to see other companies of varying sizes undertaking pension buyouts in 2013.

3. Increased Interest by Insurers in Alternative Investments

The continuing low interest rate environment can be expected to foster interest in alternative, less traditional investments to enable insurance companies to maximize returns and support product crediting rates. Specifically, investment sectors such as timber, energy, entertainment, industrial products and construction, which currently represent a relatively small portion of insurers' invested assets in comparison to more traditional investment sectors, may become increasingly attractive.

An analysis by the National Association of Insurance Commissioners (NAIC) Capital Markets Bureau includes a detailed sector breakdown of year-end 2010 insurer bond and capital stock investments and shows areas of potential growth. Whereas finance-related industries represented 12.1% of total industry bond exposure and 18.2% of total unaffiliated common stock holdings as of year-end 2010, hotels and casinos represented only 0.1% of bond exposure, and forest products, paper and packaging accounted for only 0.3% of common stock investments. The New York insurer investment law (which applies to all insurers domiciled and licensed in New York), for example, generally would not permit the type of alternative investments described above to qualify as minimum capital and surplus investments; however, these types of investments can qualify as general investments (for life insurers) and reserve and surplus investments (for property/casualty insurers). Life insurers may invest in obligations and preferred shares of American institutions and equity interests as general investments within certain defined single issuer and aggregate limitations. While property/casualty company reserve investments are somewhat more constrained, many alternative investments would qualify as surplus investments or, in the case of both life and property/casualty insurers, leeway investments subject to certain statutory limitations.

Regulatory Reform

1. An Important Year for the Future of Principles-Based Reserving

The Valuation Manual containing a life insurance principles-based reserving (PBR) methodology was adopted by the NAIC at the end of last year, allowing PBR to move forward to state legislatures after a decade of work in developing the current iteration of PBR.

PBR is founded on a desire to modernize the life insurance reserving methodology so that it has less of a formulaic approach and is more focused on the specific product design and model. The goal of PBR is to "right size" the reserves for specific products with the hope of also addressing the widely-viewed redundant reserves that result from the NAIC's Regulation XXX and Actuarial Guideline 38. However, opposition to PBR was strong. California, Guam, Maryland, New Mexico, New York, North Carolina, Oregon and Wyoming voted against the Valuation Manual's adoption, and Minnesota and Oklahoma abstained. Critics of the Valuation Manual pointed to PBR's potential for lowering reserves for insurance companies at a time when the general economy is still fragile, and some insurance companies are facing financial stresses due to the guarantees they have issued. An additional concern, which was shared by many states that voted for the Valuation Manual, was that the new valuation model would require a tremendous amount of resources to understand, test and implement. Even states that have voted for the adoption of PBR, including Texas and Delaware, have stated that before they will ask their lawmakers to move on it, they will spend time conducting their own research on what PBR really means and evaluating and testing the new model. Several states admit that this process could potentially take years to complete.

PBR will not be instituted until it is adopted by 42 states and state adoption reflects 75% of total life insurance premium written in the U.S. This means that New York and California, two of the most vehement objectors to PBR, which have large volumes of life insurance premium written in their states, could, with one other state, derail the process. At the moment, it appears that the fate of PBR depends on the results of the states' review and testing of the new valuation model.

At this point, it is too early to tell what PBR will really mean for life insurers. Since PBR only changes reserving methodology for newly written business, the true financial impact of PBR will only be fully recognized many years after its adoption. In addition, if rating agencies do not incorporate PBR in their rating methodologies, insurers may not realize the full effect of PBR in lowering reserves and freeing up deployable capital.

2. Governance

In 2012, we saw the NAIC clarify the risk-related duties of directors and senior management of insurers and insurance holding companies, but a New York case diminished the job security of those very individuals charged with managing risk.

In the Fall of 2012, the NAIC adopted the Risk Management and Own Risk and Solvency Assessment (ORSA) Model Act, which is to become effective on January 1, 2015. Broadly speaking, the ORSA Model Act applies to domestic insurers that have annual direct written and unaffiliated assumed premium of more than $500 million or are part of an insurance group that has annual direct written and unaffiliated assumed premium of more than $1 billion. Insurers subject to the Act must "maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks." They must also perform an ORSA at least annually and at any time "there are significant changes to the risk profile of the insurer" or its insurance group. Starting in 2015, the insurer must file an ORSA Summary Report annually in accordance with the NAIC's ORSA Guidance Manual. The Guidance Manual was recently revised to require the insurer (i) to identify the entities in the group that are included in the ORSA Summary Report and the accounting basis used in preparing the report, (ii) to provide a comparison to the prior year's report by disclosing material changes and a comparison of risk capital, (iii) to conform the ORSA Guidance Manual to the ORSA Model Act, and (iv) to add a glossary of relevant terms (*e.g.,* double gearing, scenario analysis). The ORSA Model Act also contains extensive confidentiality provisions.

Separately, at the end of 2012, the NAIC adopted the Valuation Manual to be used in conjunction with PBR. With respect to governance, the Manual's stated purpose is not to expand the existing fiduciary duties of directors and senior management, but to "emphasize and clarify how their duties apply to" the PBR function of insurers. Under the Valuation Manual, the Board's role is to establish a process where the Board (i) receives and reviews risk reports, (ii) works with senior management to obtain additional information and answers to questions, and (iii) determines what else is necessary (*e.g.*, correcting material weaknesses in internal controls) so that the Board can rely on the PBR and valuation functions of the insurer. The Valuation Manual calls for an unusually high level of specificity regarding the PBR function in the minutes of Board meetings, which is likely to confound corporate secretaries seeking to conform with current practices for minute-taking. The Valuation Manual also provides guidance that senior management should (a) establish an adequate PBR infrastructure, (b) ensure the consistency of the PBR elements with those of other risk assessment processes and risk tolerances of the company, and (c) address any significant or unusual findings or issues.

While regulators have increased expectations for insurers' compliance and risk management functions, New York State's highest court ruled last year that New York common law does not protect a compliance officer from being fired for confronting a manager with a violation – something the compliance officer considered to be simply doing his job. In *Sullivan v. Harnisch,* 969 N.E.2d 758 (N.Y. 2012), the New York Court of Appeals upheld the dismissal of a suit brought by a fired chief compliance officer (CCO) for wrongful termination. The Court refused to recognize an exception to the "employment at will" doctrine, under which employers may terminate employees at any time unless it would result in a constitutional, statutory or contractual violation. According to the Opinion, as the CCO of an investment adviser registered under the federal securities laws, it was Sullivan's responsibility to administer the company's policies and procedures to prevent violations of federal law and regulations. Sullivan discovered that the CEO was involved in front-running, *i.e.,* he sold securities for himself and his family ahead of clients of the firm in order to make a greater profit than the clients. A few days after Sullivan insisted that the front-running stop and be reversed, the CEO fired Sullivan. The court held that Sullivan could be terminated at will because he had no employment contract, and he did not fall under the one exception to New York's at will doctrine, which involves attorneys. In the case establishing the exception, the employee was an attorney who was fired because he insisted that his law firm report the professional misconduct of another attorney at the firm in compliance with the applicable disciplinary rules. The court focused on the ethical obligations of attorneys, finding that the associate's responsibilities as a member of the bar were inseparable from his responsibilities as an associate. Thus, the associate could not be fired under the at will doctrine. The *Sullivan* court found, to the contrary, that (i) Sullivan's position at the company was not inseparable from his duties as CCO since he had other duties, and (ii) compliance officers are not subject to self-regulation like attorneys.

It remains to be seen whether the decision has any far-reaching impact. First, the Court held that Sullivan did not identify a specific company policy that was violated by the firing, while most company codes of conduct are intended to provide protection against retaliation for reporting violations. Second, state and federal whistle-blower laws may provide protection for disclosure of violations by CCOs or risk managers. Third, the Court appeared to be influenced by the fact that the CCO

had other roles in the company, including serving as Chief Financial Officer, rather than serving exclusively in a compliance role. Fourth, the Court's Chief Judge issued a strongly worded dissent in which he described the public policy folly in the majority's view: "The message that will be taken from the majority's decision is self-evident: if compliance officers (and others similarly situated) wish to keep their jobs, they should keep their heads down and ignore good-faith suspicions or evidence they may have that their employers have engaged in illegal and unethical behavior, even where such violations could cause or have caused staggering losses to their employers' clients."

3. Update on Reinsurance Collateral Reform

State activity to adopt collateral reduction measures will continue in 2013. These measures permit U.S. ceding insurers to take full credit for reinsurance ceded to qualified non-U.S. reinsurers based upon less than 100% collateralization (which has been historically required). Amendments to the NAIC's Credit for Reinsurance Model Act permit reduced collateral for reinsurance ceded to non-U.S. reinsurers that meet certain specified requirements (including minimum capitalization and financial strength ratings) domiciled in "qualified jurisdictions," as determined by the commissioner. Such reinsurers would be eligible for "certified reinsurer" status, and would be permitted to post reduced collateral based on a sliding scale.

At the NAIC Fall National Meeting, staff reported that 11 states had adopted collateral reduction measures, with an additional 11 states indicating that they intended to adopt such measures. The 11 states that already adopted collateral reduction measures (California, Connecticut, Delaware, Florida, Georgia, Indiana, Louisiana, New Jersey, New York, Pennsylvania and Virginia) represent approximately 40% of the directly written premium in the U.S. We will be watching for more states to pass such measures this year. In November, the NAIC adopted revised state accreditation standards that permit states to adopt reduced collateral requirements, provided that such requirements are substantially similar to the Amended Credit for Reinsurance Model Act and Regulation. The revised accreditation standards, which were adopted on an expedited basis, also permit states to maintain their existing full collateral requirements – adoption of the Amended Credit for Reinsurance Model Act and Regulation is optional.

New York and Florida are the only two states that have actually approved any reinsurers for reduced collateral. The efforts of two NAIC working groups are expected to assist other states in their implementation activity. First, the Reinsurance Financial Analysis (E) Working Group (R-FAWG) is charged with providing "advisory support and assistance to states in the review of reinsurance collateral reduction applications." Although R-FAWG has been described as an "advisory body," because its procedures manual will be a regulatory-only document, it remains unclear to what extent R-FAWG will influence individual state insurance department decisions on certified reinsurer applications. Second, the Qualified Jurisdiction (E) Drafting Group will attempt to finalize the process for the review of non-U.S. jurisdictions for recognition as qualified jurisdictions. It is expected that certain jurisdictions (Bermuda, Germany, Switzerland and the U.K., *i.e.,* those jurisdictions approved by New York and Florida for reduced collateral) will receive some form of expedited review.

Superstorm Sandy Aftermath

1. Insurance Coverage Issues

Superstorm Sandy can be expected to generate some of the same types of coverage disputes that arose in the aftermath of Hurricane Katrina. For example, since homeowners' policies routinely exclude coverage for flood damage, there will inevitably be disputes as to whether particular damage was caused by wind or by water. This is particularly likely where homeowners did not have flood insurance and need to show that damage was caused by wind in order to receive any recovery. Superstorm Sandy can also be expected to generate disputes under business interruption coverage. Issues likely to arise include whether the claim is precluded by a water damage exclusion, the necessity of suspending business operations at the insured premises, when the business did or reasonably could have resumed its operations, the proper measure of any loss of income, and the availability of extra expense coverage.

Similarly, plaintiffs' attorneys may once again assert aggressive theories to avoid the impact of property insurance flood exclusions. For example, one of the post-Katrina theories pursued by coastal plaintiffs was that property damage caused by "storm surge" was a form of water damage not excluded by the water damage exclusions in homeowners' policies. In New Orleans, some plaintiffs argued that flood exclusions applied only to naturally caused flooding and did not apply to the flooding allegedly caused by negligence in connection with the city's levee system. Yet another theory urged in Louisiana was that the state's valued policy law required paying policy limits if any part of the total loss of a property was caused by wind, even though most of the loss was caused by flood. These theories were rejected by both state and federal courts, but those losses will likely not deter a new round of aggressive litigation theories post-Sandy.

As noted below, at least some regulators are monitoring claims processing and may weigh in on some of the coverage issues that arise.

2. Regulatory Actions

Temporary Suspension of Premium Collection and Policy Cancellation. In the wake of Superstorm Sandy, four states asked insurers to temporarily suspend or relax policy standards for premium collection and cancellation, termination or non-renewal of insurance policies. Of these four states, New York and Rhode Island issued the strictest requirements. Specifically, the New York Department of Financial Services imposed a moratorium on all cancellations, terminations and non-renewals in designated counties for at least 30 days beginning October 26, 2012. This moratorium has been extended six times, and the latest extension keeps the moratorium in effect, albeit with a limited geographical scope, until February 13, 2013. New York is also closely monitoring insurers' processing of claims in areas affected by Superstorm Sandy, and has posted online the "New York State Insurers' Report Cards" with statistics on individual companies' claims handling.

The Rhode Island Insurance Division, through the issuance of an Insurance Bulletin, required all insurers operating in the state to provide prompt and immediate relief to those policyholders impacted by the disaster, including the temporary suspension of premium payments and vacancy provisions under the policies of those temporarily displaced. The Insurance Bulletin provides that a 90-day suspension period from the date of loss is deemed reasonable, so long as reasonable requests for extensions are granted. Connecticut and New Jersey merely encouraged forbearance. Specifically, the Connecticut Insurance Department released a bulletin encouraging insurers to grant policyholders an extended grace period for the payment of any premium due, to allow continuing insurance coverage to those policyholders affected by the storm. New Jersey, by executive order, directed insurers to take into consideration the difficulties related to Superstorm Sandy and, therefore, to exercise appropriate forbearances on the collection of premiums, policy cancellations and documentation.

Adjuster Licensing. Due to the large number of claims that arose from Superstorm Sandy, several states relaxed insurance adjuster licensing requirements. New Jersey and New York are issuing temporary public adjuster permits to applicants sponsored by licensed public adjusters. Similarly, West Virginia entered an order permitting licenses for emergency adjusters, so long as such adjusters are supervised by an adjuster licensed in the state or an insurance company authorized to do business in the state. The Connecticut Insurance Department instituted a Catastrophe Adjuster Licensing Program, but the program only permits insurers to seek permission to handle catastrophe claims; claims company requests will not be honored. The Delaware Department of Insurance does not require an adjuster's license for the adjustment of a particularly unusual or extraordinary loss, or a series of losses, resulting from a catastrophe common to all such losses, provided that such adjuster furnishes to the Commissioner written notice within 10 calendar days of any catastrophic adjustment work. Finally, the Rhode Island Insurance Division issued an alert declaring Superstorm Sandy a catastrophic event. Such a declaration triggered the state's emergency adjuster statute, which permits emergency licenses to be granted to experienced adjusters for a period of up to 180 days.

3. Legislative Actions

Earlier this month, the New Jersey Assembly's Financial Institutions and Insurance Committee approved a bill, Assembly Bill 3642,

to address certain issues that arose following Superstorm Sandy; specifically, the bill is intended to address perceived confusion surrounding what is and is not covered under a homeowners' insurance policy. The bill would require that homeowners' insurers provide policyholders with a consumer information brochure that includes a one-page summary of the policy. This one-page summary must include the notable coverages and exclusions under the policy, as determined by the Commissioner of Banking and Insurance, and the information must be presented in a "simple, clear, understandable and easily readable way."

Some industry representatives have expressed concern that the one-page summary could make insurers vulnerable to potential lawsuits if there are any inconsistencies between the summary and the policy itself. To alleviate this concern, the Committee added the following language to the bill: "The summary shall not be considered a replacement for the terms of the policy of insurance, shall not have the effect of altering the coverage afforded by the policy, and shall not confer new or additional rights beyond those expressly provided for in the policy. The summary shall expressly state that the summary is only provided as guidance to the homeowner in understanding the terms of the policy of insurance."

In New York, several bills have also been recently proposed to address issues that arose in the wake of Superstorm Sandy. Of particular relevance is Assembly Bill 2287, which would require a provision in the homeowners' bill of rights stating that the policy provisions "may be modified or changed pursuant to state or federal law" when a state of emergency is declared. New York has also proposed a bill, Assembly Bill 1092, that codifies many of the claims handling practices that New York required post-Sandy, including that an insurer acknowledge receipt of a claim and commence investigation of the claim within six business days of receiving notification. Also of relevance is Senate Bill 1760, which would limit deductibles for windstorms. Specifically, Senate Bill 1760 provides that such a deductible may not be approved unless the deductible is only applicable to losses incurred in a hurricane that causes wind speeds of 125 mph or greater within the state. The proposed bill also provides that the maximum deductible may not be greater than $1,500 and must be stated in the policy in numerical terms.

4. Impact on the National Flood Insurance Program

Superstorm Sandy will place further financial strain on the National Flood Insurance Program (NFIP). The five-year extension passed by Congress in June of 2012 was aimed at ending longstanding subsidies for flood insurance by phasing out subsidies for second homes, business properties, severe repetitive loss properties and substantially improved or damaged properties, raising the annual cap on premium rate increases from 10% to 20% and requiring the Federal Emergency Management Agency (FEMA) to incorporate historical flood loss obligations into calculations for setting premiums, bringing premiums more in line with actuarially justified estimates. The first increases, for second homes, took effect January 1. The effective date of the remaining increases has yet to be determined by FEMA but will be sometime after July 1, 2013.

Although the NFIP has authority to borrow from the U.S. Treasury when claims exceed its funds, such borrowing is supposed to be repaid from future premiums. Prior to Hurricane Katrina, the NFIP had statutory authority to borrow up to $1.5 billion to cover such shortfalls. Hurricane Katrina claims necessitated raising the borrowing authority to more than $20 billion, with little likelihood of repayment from subsequent premiums. Despite the NFIP re-authorization legislation's provisions designed to reduce program shortfalls, the damage from Superstorm Sandy necessitated increasing the program's borrowing authority by $9.7 billion this month. In voting for this funding, however, new House Financial Services Committee Chairman Jeb Hensarling stated that the Committee would begin considering legislation "to transition to a private, innovative, competitive, sustainable flood insurance market."

Governments Searching for Tax Revenues

1. Unclaimed Property Challenges – Still Intensifying

The unclaimed property challenges facing life insurance companies continue to intensify as we enter 2013. More companies are coming under unclaimed property audits and market conduct exams and are being subject to litigation

regarding unclaimed insurance benefits. In the audit and market conduct exam arena, state officials are now targeting not only the top 40 life insurers, but also small to mid-sized life insurance companies. Multiple auditors are competing to sign up states and initiate audits. And new litigation suits filed by the State Treasurer in West Virginia challenge whether insurers are required to undertake death matches.

Following on the heels of Verus Financial, LLC, two other unclaimed property auditors are expanding their roles in the life insurance area. During 2011 and 2012, regulators focused primarily on the largest (top 40) insurance companies, and some of the industry's largest players entered into multistate unclaimed property audit and market conduct settlements. Represented by Verus, state treasurers and insurance regulators asserted that insurers have engaged in improper handling of life insurance policies and annuity contracts by failing to proactively identify death claims and locate missing beneficiaries. Verus claims that insurers consult certain government databases — *e.g.,* the Social Security Administration's Death Master File (DMF) — to terminate annuity payments when annuitants die, but do not consult these same databases to determine whether life insurers or annuity contract owners have died in order to pay their beneficiaries. Verus further asserts that insurers throughout the industry have failed to timely escheat death benefits and matured policy/contract proceeds.

Recently, however, two other unclaimed property auditors have thrown their hats into the ring, Unclaimed Property Clearinghouse (UPCH) and Kelmar Associates, LLP (Kelmar). Indeed, some companies are being targeted by multiple auditors, with each auditor representing a separate group of states. While both UPCH and Kelmar have significant unclaimed property experience, UPCH and Kelmar seem to be largely following in the footsteps of Verus and taking similar positions.

Meanwhile, state insurance commissioners continue to resist any suggestion that the NAIC should develop model regulations to codify expectations of state insurance regulators regarding unclaimed insurance benefits, and instead have indicated that they intend to pursue settlements of market conduct exams of at least the top 40 life insurers. Whether the NAIC will consider model regulations in this area in 2013 remains to be seen.

The State of West Virginia, which has largely stayed on the sidelines during the multistate audits, has recently entered the fray by filing approximately 70 separate lawsuits against life insurance companies. The State Treasurer, John Perdue, who is acting as the named plaintiff in the actions on behalf of the State, has retained an outside plaintiffs' firm to represent the State in these cases. The complaints, which are all virtually identical, except for the name of the defendant and its purported market share, allege that insurers have an affirmative duty under the West Virginia unclaimed property statute to search the DMF and escheat policy proceeds if the proceeds cannot be paid to a beneficiary. The State alleges that this duty arises from an obligation of "good faith" under the West Virginia unclaimed property statute. The State is seeking escheatment of policy proceeds and penalties for willful breach of the unclaimed property statute.

With these new developments in unclaimed property audits, market conduct exams and litigation, unclaimed property issues are moving into a new phase and expanding beyond the Verus audits of the largest companies.

2. Tax Reform and Risks to Life Products

The potential impact of tax reform efforts on life insurance and annuity products is an issue that we continue to monitor closely. In the past, changes in the taxation of such products have been proposed to restrict or eliminate the current exclusion of inside build-up from income. To date, however, legislative tax reform proposals under consideration do not include proposals to change the taxation of these products. Separately, the imposition of federal estate and gift taxes – a key driver in the decision to purchase life insurance and annuity products and how to structure their ownership – has seen increased attention as part of Congress's "fiscal cliff" negotiations. The scheduled 2012 expiration of favorable tax rates and exemptions was avoided by the enactment earlier this month of the American Taxpayer Relief Act, which made permanent the larger estate and gift tax exemptions ($5,000,000 per person, indexed for inflation), but increased the maximum tax rate from 35% to 40%.

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3. Tax Challenges Facing Property/Casualty Insurers

Pending Federal Cases. A number of federal tax cases involving insurance characterization and reserve issues are pending. For example, there are eight captive cases making their way through the U.S. Tax Court, the U.S. Court of Federal Claims and U.S. District Court. One case has been tried, and briefs have been filed. In this case (*Rent-A-Center, Inc. and Affiliated Subsidiaries v. Commissioner*), the IRS argues that the insurance transactions of a Bermuda domiciled insurance company (that made an election to be taxed as a U.S. domestic company) were a sham, were not conducted at arm's length, did not comport with commonly accepted notions of insurance, and lack risk transfer and risk distribution. Another case, *Securitas Holdings Inc. and Subsidiaries v. Commissioner,* is scheduled for trial in March.

A petition was recently filed in the U.S. Tax Court in a case involving residual value insurance (RVI), R.V.I. *Guaranty Co., Ltd and Subsidiaries v. Commissioner.* The IRS concluded that RVI policies that insure against market decline are not insurance for federal tax purposes. The IRS claims that RVI insurance provides coverage for a risk of loss that is more akin to an investment risk than an insurance risk. The IRS also argued that if the Court concluded that RVI was insurance, the taxpayer's losses that were contingent on events that had not occurred should be disallowed. The taxpayer responded to the reserve issue by stating that if such reserves were disallowed, for consistency its unearned premium reserve must be increased for its unexpired risks. The taxpayer also contends that RVI is insurance for federal tax purposes.

In *Acuity* (*Acuity, a mutual insurance company, and subsidiaries v. Commissioner*), a case filed in the Tax Court in August 2012, the IRS argues that the taxpayer has overstated its loss reserves and that its reserves are not a "fair and reasonable estimate of what the company will be required to pay." The taxpayer's actuary provided a range of reserves as well as a point estimate; the taxpayer set its reserves at the high end of the range, which was higher than the point estimate. The taxpayer argues, and has asked the Court to decide, that once the taxpayer's loss reserves are determined to be a fair and reasonable estimate, the taxpayer wins; the IRS does not get to substitute its estimate for that of the taxpayer's. The taxpayer is also asking the Court to decide the degree of force to be given the reserves as reported on the taxpayer's annual statement.

State Tax Issues. There is a clear trend across the country of state tax authorities attempting to impose corporate franchise or income tax on captive insurance companies. Some state tax authorities have challenged the statutory preemption of captive insurance companies from the corporate income or franchise tax. Specifically, state tax authorities are interpreting the statutory preemption in a very narrow way to limit preemption solely to insurance companies that file and pay a premium tax. Thus, in combined reporting states, the state tax authority may attempt to include the captive insurance company's income in the combined group's taxable income. Additionally, some state tax authorities have challenged the in-state related entities' reflection of their income in the corporate income or franchise tax filing using the state's discretionary authority (IRC § 482-type authority).

Despite this trend, captive insurance companies have several strong arguments — constitutional, statutory, and under the Nonadmitted and Reinsurance Reform Act — against state tax authorities attempting to impose corporate income tax on the captive.

Employee Benefits in Captives. In the past 12 years, the Department of Labor (DOL) has issued a number of Prohibited Transaction Exemptions (PTEs) that permitted the owners of captives to have their captives assume as a reinsurer risks relating to certain welfare benefit plans (*e.g.,* group term life) maintained by such owner for its employees. As a condition to most of these PTEs, plan benefits were required to be augmented. In the Fall of 2012, the DOL announced that it was reviewing the augmentation requirement. To date, only one PTE has been issued since the DOL's announcement. As more PTEs are issued, the DOL's new requirements will become clearer.

4. New FATCA Rules May Impact Insurers

On January 17, 2013, the U.S. Treasury and the IRS issued extensive final regulations that provide detailed rules governing the application of the Foreign Account Tax Compliance Act (FATCA). Under those rules, beginning January 1, 2014, any

payor of a "withholdable payment" must withhold what amounts to a penalty of 30% of the payment, unless the payee satisfies the FATCA reporting requirements or the payment or payee fits into a FATCA exception. "Withholdable payments" include any U.S. source payments of fixed or determinable annual or periodic income or "FDAP" income. FDAP income includes passive income such as interest, dividends, and royalties, as well as payments such as insurance premiums and compensation. In addition, beginning in 2017, withholdable payments will include the gross proceeds of certain asset sales.

FATCA contains two different sets of reporting requirements – one for foreign financial institutions (FFIs) and the other for non-financial foreign entities (NFFEs). The FFI rules require an FFI to enter into an agreement with the IRS to perform due diligence to identify account holders that are U.S. persons or entities with substantial U.S. ownership, to report information about such account holders and their accounts to the IRS, and to withhold on certain payments, including those made to recalcitrant account holders. Once an FFI is compliant with FATCA and provides the proper documents to its withholding agents, the withholding agents need not withhold on payments made to that FFI. But, if an FFI is not compliant, any withholdable payment will be subject to the 30% withholding. An insurance company generally will be an FFI only if it issues cash value insurance policies or annuity contracts.

A non-U.S. insurance company that is not an FFI generally will be an NFFE. NFFEs are not required to enter into an agreement with or to provide information directly to the IRS. Instead, NFFEs are required only to report to their withholding agents information with respect to the U.S. persons who own, directly or indirectly, more than 10% of the entity. These 10% holders are called "substantial U.S. owners," and an NFFE must provide their names, addresses, and taxpayer identification numbers to its withholding agents. If an NFFE has no substantial U.S. owners, it must report that fact to the withholding agents. The withholding agents then must report such information to the IRS. In the event an NFFE does not provide the required information to a withholding agent, the withholding agent must withhold 30% of any withholdable payment made to that NFFE.

The FATCA rules are complex and contain numerous exceptions and special rules. Implementation will require numerous system changes and new procedures. Both non-U.S. insurance companies and U.S. insurance companies, which may be withholding agents under the FATCA rules, should focus on these rules and how they apply to their particular circumstances.

NAIC Working Group Challenges Separate Account Insulation for Non-Variable Products

In January 2013, the NAIC's Separate Account Risk (E) Working Group (SARWG) released for comment an Exposure Document addressing whether non-variable insurance products should be allowed in "insulated" separate accounts, *i.e.,* where the assets in the separate accounts are not subject to the claims of general account creditors in a receivership or a rehabilitation. The Exposure Document places numerous types of non-variable products into six "Groupings" based on product attributes, and makes proposed recommendations that products in four of the Groupings simply should not be allowed in separate accounts insulated from general account claims. These four Groupings include (1) market value adjusted annuities; (2) deferred annuities, fixed and fixed income, and fixed credited interest rate products; (3) single premium, experience rated, and non-experience rated contracts; and (4) fixed indexed annuities. The other two Groupings include (1) guaranteed investment contracts, funding agreements, and group annuities; and (2) Corporate Owned Life Insurance (COLI) and Bank Owned Life Insurance (BOLI). The proposed recommendation for these two Groupings is mixed. The Exposure Document states that these types of products should be identified to the Financial Condition (E) Committee as products that should not be in separate accounts insulated from general account claims, but that further discussion is needed with input from industry and consumer representatives.

The Working Group seems to be concerned that allowing non-variable products to be funded by insulated separate accounts would give owners of such products a preference or advantage over owners of general account products, and that there is no justification for such a preference. During an open conference call in January, when the Working Group voted to expose the document, the Group expressed the view that the same product should not be allowed to be issued out of both a separate account and the general account. The SARWG appears to be on a schedule to submit the document and its recommendations to the Financial Condition (E) Committee before or at the NAIC Spring Meeting.

At least two industry groups, the American Council of Life Insurers (ACLI) and the Committee of Annuity Insurers, are known to be working on comment letters to SARWG defending and justifying separate account insulation for at least some, if not all, of the categories of products in SARWG's Groupings. Nevertheless, it seems very likely that the SARWG will recommend that at least some of the Groupings should not be allowed to be supported by insulated separate accounts. Whether the Financial Condition (E) Committee will take different factors into account and reach different conclusions remains to be seen.

Application of the Volcker Rule and Derivatives/Swaps Rules to Insurers

1. The Volcker Rule: Waiting … and Waiting… for Final Regulations

Section 619 of Dodd-Frank – known as the Volcker Rule – generally prohibits any insurer that qualifies as a "banking entity" from (a) engaging in proprietary trading, or (b) investing in or sponsoring hedge funds and private equity funds ("covered funds"), subject to enumerated exceptions for "permitted activity." A "banking entity" includes any insurer that is an affiliate of an insured bank or thrift.

One of the explicit permitted activities in the Volcker Rule is investment activity for the general account of a regulated insurance company, and Dodd-Frank clearly indicates that the regulations implementing the Volcker Rule should "appropriately accommodate the business of insurance." Nevertheless, the proposed regulations (published in November 2011) are problematic for insurers in certain respects, and hopefully the final regulations in 2013 will be more accommodating to the business of insurance.

Specifically, the proposed regulations would exempt insurance company general account investment activity only from the ban on proprietary trading, and not from the restrictions on covered fund activity. Insurance industry commenters strenuously objected, arguing that the plain wording of the statute exempts general account investment activity from both the ban on proprietary trading and the restrictions on covered fund activity.

Similarly, the Volcker Rule provides that trading "on behalf of customers" is a permitted activity, exempt from both the proprietary trading and covered fund prohibitions. Insurance company separate account investment activity that is customer-driven should fall within the "on behalf of customers" exemption. However, the proposed regulations would not permit covered fund investments in separate accounts, and industry commenters also objected to this limitation.

In addition, industry commenters recommended certain revisions to the definitions of "general account" and "separate account" to better accommodate all aspects of the business of insurance. Finally, the proposed regulations would not accommodate certain specific types of separate accounts, such as those used for COLI and high net worth private placement products. Commenters requested revisions to cover these types of products.

The deadline for final regulations imposed by Dodd-Frank has long since passed, and we expect the final regulations in 2013. We are hopeful that it is not a question of whether those regulations reflect the industry comments, but rather the extent to which they do so.

2. Application of Derivatives/Swaps Rules to Insurers

Following the 2008 financial crisis, Congress enacted Dodd-Frank to, among other things, establish a comprehensive regulatory framework for swaps and security-based swaps. Among other things, the legislation was enacted to reduce risk, increase transparency, and promote market integrity within the financial system by imposing a myriad of requirements with respect to over-the-counter swap transactions, which were previously unregulated, and the entities that use them.

As market participants may be aware, the definition of "swap" contained in Dodd-Frank is very broad and, arguably, includes agreements, contracts and transactions that traditionally have not been considered swaps. This is particularly

true with respect to insurance. In July 2012, the Securities and Exchange Commission and the Commodity Futures Trading Commission (together, the "Commissions") adopted final rules to further define, among other things, the term "swap." As part of these final rules, which became effective on October 12, 2012, the Commissions adopted an "Insurance Safe Harbor" to clarify that traditional insurance products are not swaps.

The Insurance Safe Harbor consists of a "Provider" test, a "Product" test and an "Enumerated Products List." In order to satisfy the Insurance Safe Harbor, a product must be issued by an entity that meets the Provider test and either meets the Product test or appears on the Enumerated Products List.[1] Products that satisfy the Insurance Safe Harbor are excluded from the definitions of "swap" and "security-based swap."

Currently, direct insurance written for U.S. persons by commercial insurance companies and captive insurance companies located outside of the U.S. is ineligible for the Insurance Safe Harbor. This is because offshore insurance companies not offering reinsurance will only satisfy the Provider test if they (1) are listed in the NAIC's International Insurers Department (IID) Quarterly Listing of Alien Insurers; or (2) meet state law eligibility requirements. Many offshore commercial insurance companies and captive insurers are not IID listed, and most states do not impose eligibility requirements on them.

As a result, offshore commercial insurance companies and captive insurance companies face less legal certainty with respect to the insurance products that they offer in the U.S. than is available to domestic insurers. The implications of this lack of certainty are far-reaching. To the extent that products that offshore commercial insurance companies and captive insurance companies write are deemed swaps or security-based swaps, such products could be subject to real-time reporting obligations and the new Dodd-Frank requirements for swaps, which include, among other things, central clearing, electronic trade execution, recordkeeping and reporting obligations. Many of these requirements will take effect in 2013.

IT Innovation Leads to Increased Consumer Privacy Concerns

Technological innovation is creating new opportunities for the industry to interact with customers and new ways to reduce costs by outsourcing data processing and storage to the "cloud." But these new opportunities bring new risks with them—more opportunities for data breaches, and more ways in which customer data might be inadvertently, or purposefully, disclosed. Consumer health and financial data is increasingly stored on and transmitted through devices and networks over which insurance companies may have little or no control. And with cloud storage and similar outsourcing, how can you ensure the security of your customers' information when you do not know where that data is even being stored? The increasing use of mobile devices, social media and other cloud-based technology to communicate and even transact with both existing and potential customers has also brought increasing scrutiny from regulators and legislators concerned with protecting consumer privacy.

California continues to lead the way among states. The California Attorney General started 2013 with "Privacy on the Go," a report on privacy recommendations for application developers and others in the smartphone arena. California, Maryland and Illinois have passed laws restricting employers' access to employees' social media accounts. At the federal level, Congressman Edward Markey introduced a bill entitled the Mobile Device Privacy Act, which would require new disclosures and place security requirements on companies that collect consumer information through smartphones and other mobile devices.

Big data opportunities may bring big headaches. How is it collected? Is it housed in the cloud? Who has access? What subcontractors ("data scientists") are accessing it and how are they accessing it? Is it secure? Once used, will it create the right result or create causes of action? Will slicing and dicing by data scientists result in competitive products or unfair discrimination actions?

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[1] For more information about the Insurance Safe Harbor, please see Sutherland's January 3, 2013 Legal Alert, "Insurance Safe Harbor Affords Little Certainty for Non-US Insurers, available at http://www.regulatoryreformtaskforce.com/files/upload/InsuranceSafeHarborAffordsLittleCertaintyforNonUSInsurers.pdf.

Congress has been working on cyber security legislation that could enable federal regulators to enforce security standards on "critical infrastructure" industries—usually defined to include healthcare and financial services businesses.

The number of reported data breach incidents in the U.S. in 2012 was up more than 50% from 2011. As the numbers and types of data breaches continue to increase, we expect legislators and regulators to continue to look for new ways to show they care about protecting consumers.

New Deal Structures Develop for XXX and AXXX

Since the NAIC's adoption of Model Regulation XXX and Actuarial Guideline 38 more than 10 years ago, we have seen several generations of XXX/AXXX funding structures. Current XXX/AXXX solutions include typical third-party letter of credit structures, internally funded solutions through a parent's senior debt financing, structured reinsurance, or the use of "other form[s] of security acceptable to the ceding insurer's regulator." During the past year, we continued to see more non-recourse, unfunded financing structures through the use of onshore captives.

In a typical recent excess reserve funding transaction, an insurer cedes a block of level term life policies (XXX) or universal life with secondary guaranty policies (AXXX) to a captive reinsurer. The captive will provide collateral for the excess reserves by obtaining a letter of credit naming the ceding insurer as the beneficiary. Alternatively, the captive will provide collateral in the form of SVO-rated trust certificates or other synthetic contingent obligations from a financing provider and use them as permitted assets of the reinsurer or in a credit for reinsurance trust established for the benefit of the ceding insurer. Under these structures, the collateral for the captive's excess reserve obligations are funded "synthetically" by the letters of credit, trust certificates or other contingent obligations, rather than by "hard" assets like Treasury securities. Under those transactions, the ceding insurer's ability to draw on such letter of credit or contingent obligation is usually conditioned on an order of draw (*i.e.,* the ceding insurer must use designated assets to pay reinsurance claims before drawing on the assets supporting the excess reserves) and the absence of any default by the captive or otherwise under the transaction documents. Those limitations and conditions make it unlikely that the letter of credit or the contingent obligation will be drawn upon by the ceding insurer. As a result of this lower risk of draw plus lower cost of capital for financing parties, current XXX/AXXX financings are usually non-recourse to the ceding insurer's parent and involve a lower cost than in prior years. These unfunded and conditional excess reserve financing structures, however, face significant regulatory challenges in some states due to their failure to meet all credit for reinsurance requirements.

Another current XXX/AXXX structure is through the use of a captive that is qualified as an accredited reinsurer in the ceding insurer's domiciliary jurisdiction. Since the captive is accredited in the ceding insurer's domiciliary jurisdiction, it can provide full reserve credit through its licensing status, thus alleviating the need to strictly follow the credit for reinsurance regulations and providing more flexibility in the funding solution. We have seen regulatory problems with this structure, because some states will not permit captives to be an accredited reinsurer. Additionally, captives formed in Iowa and the handful of states that have adopted limited purpose subsidiary laws similar to those in Iowa have enjoyed more flexibility in providing reserve credit, because such captives are often allowed to use a parental guaranty or a "synthetic" asset as an admitted asset to support the excess reserve liabilities.

In 2012, the NAIC formed a Captives & SPV Use Subgroup to study the use of captives and excess reserve funding arrangements in relation to existing state laws, with the goal of establishing appropriate regulatory requirements to address concerns identified by the study. The Subgroup held a series of conference calls, surveyed insurance departments with respect to the excess reserve funding transactions, and published a White Paper. The Subgroup agreed that it was inappropriate for captives to be used as a means to avoid the reserving requirements of statutory accounting and that conditional letters of credit or certain "synthetic" collateral were not consistent with the NAIC credit for reinsurance requirements. The Subgroup also found that a more appropriate accounting treatment for XXX/AXXX reserves should be pursued at the direct writing insurer level, as opposed to the use of captives, thereby eliminating the need for additional complex reinsurance transactions to address the perceived reserve redundancies. Considering the many issues and views raised by the White Paper, a resolution for XXX/AXXX reserve

funding needs is probably several years away. In the meantime, looking forward to what 2013 will bring, we believe that insurance companies will continue to seek available reserving financing solutions that they can obtain at acceptable cost levels, although some of those transactions will be clouded by regulatory uncertainty because of the many issues raised by the Subgroup.

Briefly Noted: Affordable Care Act and HITECH Act

Under the Patient Protection and Affordable Care Act and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), there are a number of developments of interest to insurers of health coverage, with varying definitions of health insurer and health coverage under many of the provisions. Among other things, we are monitoring the regulations and other guidance issued by the IRS and the U.S. Department of Health and Human Services (HHS) on various fees and taxes, such as the transitional reinsurance fee and the health industry or sector tax, on health insurers under the Affordable Care Act. In addition, we are advising health insurers on changes they may need to make to their privacy and security practices, breach notification policies, business associate agreements and other documents and policies in response to the final omnibus HITECH Act regulations issued by HHS.

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