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Cyber risks occur at every point where an individual or business uses technology, including computers, smart phones, tablets, email, and social media. Recent high profile data breaches have heightened already growing concerns about the threats that accompany a world where information is increasingly shared online. Last year, the NAIC formed the Cybersecurity (EX) Task Force to help coordinate insurance issues related to cybersecurity. This article, written by North Dakota Insurance Commissioner and Cybersecurity Task Force Chair Adam Hamm, discusses some of the steps being taken by insurance regulators to proactively address cybersecurity issues.

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Over the past 15 years, state insurance regulators have made great strides in streamlining the producer-licensing process and advances in technology have eliminated many of the hurdles. The recent enactment of the National Association of Registered Agents and Brokers (NARAB) Act of 2015 is a significant step to help simplify insurance producer licensing in the U.S. The NAIC supported the creation of a NARAB as it would create a “one-stop” mechanism for accessing nonresident markets while preserving important state market regulatory authorities and consumer protections. This article will summarize the Act and discuss recent developments.

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The CIPR recently released study titled “Usage-Based Insurance and Vehicle Telematics: Insurance Market and Regulatory Implications” takes a closer look at the technology of telematics, explores the changes in the insurance market and analyzes the implications of telematics for insurers, consumers and state regulators. This article will discuss the survey CIPR conducted of state insurance departments to assess the expanding use of telematics in the auto insurance market.
**CYBERSECURITY TAKES CENTER STAGE**

*By Adam Hamm, North Dakota Insurance Commissioner and NAIC Cybersecurity (EX) Task Force Chair*

I recall the times when I thought it was a nuisance having to shred documents containing personal information so somebody wouldn’t steal my identity by going through my trash each week. Now, I wish that was my only identity theft concern. With the proliferation of electronic communication, social media, emails and massive databases housing personal financial and health information, it’s enough to make anyone lose sleep at night. It makes all of us wonder what can be done to protect ourselves.

In this article, I will discuss some steps being taken by state insurance regulators to proactively address cybersecurity issues.

**DEFINING THE PROBLEM**

As people become more reliant on electronic communication, and as businesses collect and maintain ever more granular pieces of information on their customers, the opportunity for bad actors to cause difficulties for businesses and the public is exploding. Identity theft is a growing problem for consumers.

The statistics collected by the U.S. Bureau of Justice Statistics (BJS) confirm our fears related to identity theft. The BJS periodically collects information through a survey called the National Crime Victimization Survey. For purposes of the survey, the definition of identity theft includes three general types of incidents:

1. Unauthorized use or attempted use of an existing account.
2. Unauthorized use or attempted use of personal information to open a new account.
3. Misuse of personal information for a fraudulent purpose.1

The BJS report called *Victims of Identity Theft, 2012* (the most recent year available) shows:

- About 7% of persons age 16 or older were victims of identity theft in 2012.
- The majority of identity theft incidents (85%) involved the fraudulent use of existing account information, such as credit card or bank account information.
- Victims who had personal information used to open a new account or for other fraudulent purposes were more likely than victims of existing account fraud to experience financial, credit, and relationship problems and severe emotional distress.
- About 14% of identity theft victims experienced out-of-pocket losses of $1 or more. Of these victims, about half suffered losses of less than $100.
- More than half of identity theft victims who were able to resolve any associated problems did so in a day or less; among victims who had personal information used for fraudulent purposes, 29% spent a month or more resolving problems.2

The BJS also collects information on cybercrime. However, the most recent data available from them is for 2005. There is another vehicle for gathering information about cybersecurity threats to the financial sector. Perhaps the best way for insurers to share information on cyber activity is through the Financial Services Information Sharing and Analysis Center (FS-ISAC). The FS-ISAC is a resource for the financial sector on cyber and physical threat intelligence analysis and information-sharing. The FS-ISAC is a member-owned non-profit entity providing an anonymous information-sharing capability across the entire financial services industry. For more information on the FS-ISAC visit [www.fsisac.com](http://www.fsisac.com).

Identity theft for individuals and cybercrimes for business are closely interrelated. There are a number of reasons why a business might be hacked. Some of these reasons are more critical than others for guarding against identity theft. One type of cybercrime is hacking by an individual just to show he or she can successfully perpetrate the act. The motivation is simply the challenge of being able to break through the firewall of a business and cause some form of disruption.

This type of hacking often shows itself as a denial-of-service attack. The intent of the hacker is to disrupt or degrade the Internet connectivity or email system of a business. This is accomplished by “ping” attacks, port-scanning probes and by causing excessive amounts of data to arrive in a short period of time with the intent of disrupting service. From an identity theft perspective, this type of attack is relatively

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benign. The intent of the hacker is not to steal and sell or use identities, but rather to be a nuisance to the business.

Other hackers, sometimes known as “hacktivists,” are intent on using technology to deliver an ideological, political or religious message. Cyberterrorists are included in this category, as they use denial-of-service or Web defacement to damage a firm that fails to live up to the hacker’s ideological expectations. Others hack to expose perceived wrong-doing or to make confidential information available to the public.

Another source of hacking is the nation state. We know some nations support hacking activities for various reasons. A rogue nation state might be interested in cyber warfare as a way to disrupt the economy of another nation or to do harm to its people. Other nations might simply be interested in spying on businesses in another nation or gaining information and insight from government websites. Sometimes, nation states target businesses to hack where access to trade secrets and business processes is the desired goal.

It is hacking for profit that is the cause of greatest concern. It could be an individual or an organized criminal gang who is engaged in hacking, with the goal to obtain personal financial and health information to exploit people and business for ill-gotten financial gain.

The bottom line is if you own a computer or a smart phone or other electronic equipment using the Internet, you are at risk. State insurance regulators are not going to be able to solve this broad public policy issue. However, state insurance regulators are in a position to help protect the public—policyholders, beneficiaries and claimants—by making sure that insurers implement the best practices for data security available.

From a state insurance regulator’s perspective, the problem can be defined in four ways:

- Regulators know consumer information is at risk and want to do whatever is within their regulatory power to assist insurance consumers when consumer information is compromised by a breach from an insurer, an insurance producer or the regulator.
- Regulators have authority to monitor the market activities of insurers and insurance producers and are actively overseeing the cybersecurity capabilities of insurers and insurance producers.
- Regulators need to work together to make sure state computer networks and the computer network at the NAIC are state-of-the-art when it comes to cybersecurity measures.
- Regulators need to exercise authority over the insurers involved in selling cybersecurity insurance products to individuals and businesses in the U.S.

The NAIC Cybersecurity (EX) Task Force

The NAIC Executive (EX) Committee recently appointed the Cybersecurity (EX) Task Force and asked it to serve as the central focus for insurance regulatory activities related to cybersecurity. I am honored to serve as chair of this new Task Force. The Task Force has a fairly aggressive work plan, which involves coordination with various NAIC groups working on certain aspects of cybersecurity.

The first project for the Task Force was establishing a set of guiding principles to plant a “flag in the ground” on cybersecurity. An initial draft set of eighteen guiding principles was released for public comment in March. After receiving and considering feedback from interested parties, the Task Force revised and combined some of the principles. The Task Force then adopted a final set of twelve guiding principles on April 16. These principles will serve as the foundation for protecting consumers personally identifiable information held by insurers as well as insurance producers and will guide state insurance regulators who oversee the insurance industry. A copy of the guiding principles can be found on the NAIC website.3

The Task Force will be working with the Property and Casualty Insurance (C) Committee on a proposal to add a cybersecurity supplement to the P&C Annual Statement. The purpose of this would be to get a clear picture of the size and breakdown of the cyber insurance market. The Committee recently adopted a motion to release the Annual Statement Supplement for public comment and asked for written comments to be submitted March 23. The Committee discussed the comments received during its March 29 meeting in Phoenix at the Spring National Meeting. Several states and interested parties made suggestions for im-

proving the draft Annual Statement Supplement. Commissioner Mike Chaney (MS), who chairs this Committee, convened a conference call to discuss the comments and suggested changes. The proposed supplement was then adopted during the call.

Additionally, the Task Force will be working with the IT Examination (E) Working Group. The Working Group plans to review existing guidance in the Financial Condition Examiners Handbook (Handbook) and will be working with the Task Force on improvements to the examination protocols for state financial examiners to check on the cybersecurity capabilities of insurers. Patrick McNaughton (WA) leads this Working Group.

Currently, every state is required to use specialists at companies when reviewing their data-security controls. These specialists generally have specialized training enabling them to successfully review insurer data security controls. These specialists typically have obtained the certified information systems auditor (CISA) designation, as well as the automated examination specialist certification from the Society of Financial Examiners (SOFE). Using these specialists is an accreditation requirement on all multi-state financial examinations.

The NAIC maintains the Handbook to provide guidance to financial examiners. The Handbook has an extensive section regarding the review of automated controls and uses the COBIT 5 standards, which are recommended and promoted by the Information Systems Audit and Control Association (ISACA). The standards are strict and robust with respect to evaluating and determining whether the general information technology controls at a company are operating as they should.

The difference between what a state financial examiner with data security skills and what a cybersecurity firm does is that the financial examiner ensures an insurer is evaluating its risks and hiring the necessary firms to examine its data and systems. A cybersecurity firm does actual penetration testing, monitoring, and ongoing reviews on behalf of the insurer.

The IT Examination (E) Working Group regularly revises its guidelines and standards. The Working Group has used the draft principles assembled by the Task Force to determine the Working Groups next steps to ensure the Handbook guidance includes a more robust look at cybersecurity. The Working Group is going to compare the National Institute of Standard Technology (NIST) framework to its existing framework to be sure there are no gaps between the two frameworks.

When financial regulators conduct a risk-focused examination of an insurer, they look at how the insurer identifies and defines its risks, as well as the steps taken to mitigate identified risks. The financial examiner will also weigh what the CEO and board members have to say regarding these risks. Often, the financial examiner finds data security and cybersecurity are not high enough on the list of risks identified by insurer management. The Cybersecurity (EX) Task Force, working together with the IT Examination (E) Working Group, plans to change that dynamic in the future.

The Task Force will also be looking to create a survey of the states to assess state cyber vulnerabilities. Work on this project is expected to occur over the summer. The Task Force plans to be able to discuss results of the survey during the Fall National Meeting.

Another important project for the Task Force is the creation of a Consumer Bill of Rights. I expect it will cover existing regulations and statutes regarding the security breach notification. It will also outline state insurance regulators’ expectations of insurers if they experience a cybersecurity issue. Consumers deserve to know insurers are protecting their sensitive financial and health information. They also deserve to know when a breach occurs so they can take steps to safeguard themselves from identity theft or other fraud. Now that the guiding principles have been adopted, plans call for work on the Consumer Bill of Rights to begin.

The Task Force also plans to stay abreast of what is happening in the Financial and Banking Information Infrastructure Committee (FBIIIC), the Cybersecurity Forum for Independent and Executive Branch Regulators and the FS-ISAC. Plans call for the Task Force to host a webinar to receive information from the FS-ISAC. The webinar will cover the benefits of information sharing through the FS-ISAC.

The NAIC maintains numerous model laws, regulations and guidelines. Some of them deal with issues related to cybersecurity. The Task Force will review several model laws and regulations to update them with regard to privacy and cybersecurity. Among the models under consideration are: the NAIC Insurance Information and Privacy Protection Model Act (#670); the Privacy of Consumer Financial and Health
**CYSBERSECURITY TAKES CENTER STAGE (CONTINUED)**

*Information Regulation (#672); and the Standards for Safeguarding Consumer Information Model Regulation (#673).*

The Task Force may also take a look at the *Insurance Fraud Prevention Model Act* (#680). No definite timeframe has been set for this work. It is important to note the Model #670 and Model #672 were created in response to the federal Gramm-Leach-Bliley Act. They provide the basis of the annual privacy notifications for the insurance sector. Careful attention must be paid to these important models.

**CONCLUSION**

These days, everyone who owns a computer is at risk. Hackers with a variety of motivations spend their days trying to stay one step ahead of the firms who sell cybersecurity tools. Sound firewalls and robust network security are able to turn away most hacking attempts, but we know no system is perfect. As such, I am proud to say state insurance regulators are stepping up to do their part to attempt to make the electronic world safer.

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**ABOUT THE AUTHOR**

Adam Hamm was appointed Insurance Commissioner by Governor John Hoeven in October 2007, elected to a four-year term in November 2008 and reelected to a second four-year term in November 2012. He has a strong and varied background that includes experience both in public service and in the private sector.

Mr. Hamm’s dedication to serve the public began with his work as a prosecutor at the Cass County State’s Attorney’s office. Hamm has also worked as an attorney in private practice advocating for North Dakota businesses and individuals. He is a graduate of Sam Houston State University and received his Juris Doctorate Degree, with Distinction, from the University of North Dakota School of Law in 1998.

Mr. Hamm is currently the immediate Past President of the NAIC, and chairs its new Cybersecurity Task Force. He also serves on numerous NAIC committees, including the Executive Committee, the Accreditation Committee and the Government Relations Leadership Council. Additionally, he was selected by his fellow insurance commissioners to serve on the U.S. Financial Stability Oversight Council (FSOC). In this role, he represents the interests of all the nation’s state insurance regulators.
**NARAB II SIGNED INTO LAW**

*By Shanique (Nikki) Hall, CIPR Manger*

On Jan. 12, 2015, the National Association of Registered Agents and Brokers Reform Act of 2015 (NARAB II) was enacted as part of H.R.26, the Terrorism Risk Insurance Program Reauthorization Act of 2015. The Act requires the establishment of a national clearinghouse to streamline market access for nonresident insurance producers. The NAIC supported the creation of a National Association of Registered Agents and Brokers (NARAB) as it would create a one-stop mechanism for accessing nonresident markets while preserving important state market regulatory authorities and consumer protections. This article will summarize NARAB II and discuss recent developments.

**PRODUCER LICENSING AND NARAB**

People who wish to sell, solicit or negotiate insurance in the United States must be licensed as a “producer.” The term producer includes insurance agents and insurance brokers. There are currently more than 2 million individuals and more than 500,000 business entities licensed to provide insurance services in the United States. State insurance departments oversee producer activities as part of a comprehensive regulatory framework designed to protect insurance consumer interests in insurance transactions.

Traditionally, a producer must have a license from his/her home state and then must obtain nonresident licensing in other states in order to sell, solicit or negotiate insurance in such other states. Prior to the late 1990s nonresident licensing was done via paper forms because Web-based processing was still in its infancy. Producers licensed in one state generally had to meet the separate licensing requirements for each state in which they wanted to sell insurance. While the licensing requirements in each state were similar, there were differences in the application and review process. This became administratively burdensome as it imposed significant time and monetary costs on producers, their affiliated agencies and each state insurance department.

A provision in the federal Gramm-Leach-Bliley Act of 1999 (GLBA) sought to streamline producer licensing by requiring the states to enact certain reforms to the nonresident insurance producer-licensing process. The provision was designed to create a new organization called NARAB if greater state producer-licensing uniformity or reciprocity was not achieved by November 2002.1 The GLBA enactment sparked a nationwide movement to implement sweeping reforms to simplify and bring more efficiency to the producer-licensing process.

In February 2000, the NAIC adopted the *Producer Licensing Model Act* (#218) to help the states comply with GLBA’s reciprocity provision. Subsequently, the NAIC membership determined a majority of states had satisfied the GLBA reciprocity requirements. As a result, the GLBA version of NARAB was not created. However, while the licensing process was made easier over the years (e.g., with advancements in technology and the use of the National Insurance Producer Registry2 (NIPR) to submit applications) the nationwide uniformity and reciprocity for insurance producer licensing desired under GLBA was never fully realized. Several large states have not yet become reciprocal.

The absence of these major markets inhibited the implementation of national licensing reciprocity and the ability of agents to obtain nonresident licenses in all 50 states. This led to renewed calls for NARAB and new versions of the bill have been introduced many times in the U.S. Congress over the past 15 years (Figure 1 on the following page).

**NARAB II**

The recently enacted National Association of Registered Agents and Brokers Reform Act of 2015 amends the federal law that was part of the GLBA but never came into effect. For this reason, it is often referred to as NARAB II. It creates NARAB as an independent, non-profit corporation controlled by its board of directors. NARAB will act as a central clearinghouse allowing an insurance producer licensed in his/her home state to sell, solicit or negotiate in every other state in which the producer intends to do business, provided the producer is licensed for those lines of business in his/her home state and pays the state’s licensing fee.

NARAB II eliminates the need for insurance producers to apply for nonresident licenses; i.e., a producer will be able to become a member of NARAB and thereafter be able to become authorized to act as a producer in other states, without the need to meet the licensing requirements of those states. The stated purpose of the legislation is to provide “a mechanism through which licensing, continuing education, and other nonresident insurance producer qualification requirements and conditions may be adopted and applied...”

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1 The GLBA required at least 29 jurisdictions to achieve the prescribed goals of producing licensing uniformity and reciprocity by November 2002 to preclude the creation of NARAB.
2 The NIPR was established by the NAIC as a nonprofit affiliate in 1996 to develop and operate as a national repository for producer-licensing information. The NIPR is part of an ongoing effort to streamline and modernize the various processes involved with producer licensing. It is an electronic system that tracks ongoing licensing changes from state to state. Currently, the NIPR receives data from all 50 states, Puerto Rico and the District of Columbia.
plied on a multi-state basis without affecting the laws, rules, and regulations, and preserving the rights of a State, pertaining to certain specific producer-related conduct.

Here’s how it works:

- NARAB will exist as a new non-governmental, membership-based agency formed in the District of Columbia as an independent nonprofit corporation. NARAB will likely establish a portal, mechanism, or central clearinghouse that enables individuals and business entities to satisfy membership requirements that will allow market access in nonresident states.

- NARAB will be governed by a 13-member board of directors (subject to presidential appointment and Senate confirmation), consisting of eight current or former3 U.S. state insurance commissioners and five insurance industry representatives with professional expertise in producer licensing. The law specifies NARAB’s board of directors shall be appointed by the president within 90 days of its enactment. One of the state insurance commissioners appointed will be designated to serve as the board’s initial chairperson. The board of directors will not be compensated.

- NARAB is not funded with federal funds. The board of directors will establish and collect membership fees to cover the costs of its operations. These fees are not yet determined and will be established by the board.

- Through NARAB membership, a producer may obtain authority to do business outside his/her home state. An individual or entity licensed in his/her home state can obtain licensing in all 50 states by becoming a member of NARAB.

- Membership and participation in NARAB is entirely optional and voluntary; producers are not required to become NARAB members. Producers may continue to obtain their licenses state by state if they wish to do so. However, a producer or entity must first become a member of the organization in order to take advantage of its benefits. Once approved for membership, a producer may use NARAB to obtain the authority needed to operate in any jurisdiction and do so in an efficient manner.

* NARAB II “doesn’t pass” denotes NARAB was passed in the House on these occasions, either as a stand-alone measure or as part of other reforms, but did not pass in the Senate.


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3 The president has to offer Board membership to all sitting commissioners before he can select former commissioners.
To become a member of NARAB, an insurance producer must be licensed in his/her home state, not have an active license suspension or revocation in place at the time of application, successfully pass a criminal background check and pay membership fees (which will be established by the NARAB board of directors).

Once NARAB accepts the membership application from a qualified producer, the producer is authorized to engage in producer activities (i.e., the sale, solicitation, and negotiation of insurance) in that jurisdiction, provided the producer is licensed for those lines of business in his/her home state and pays the state’s licensing fee.

The states generally will not be able to impose additional market access or discriminatory requirements on nonresident producers. Nonresident jurisdictions may not impose any licensing, application, or market entry-related requirements on NARAB members. The states are also prohibited from requiring any NARAB member to register as a foreign corporation.

The new law requires NARAB to establish continuing education (CE) requirements as a condition of membership that are comparable to the CE requirements of a majority of states.

NARAB is granted some disciplinary enforcement powers. However, state regulators will continue to regulate marketplace conduct, oversee the actions of producers, investigate complaints, protect consumers, and take action against those who violate the law.

The provisions of the bill take effect on the later of: 1) the expiration of the two-year period beginning on the day of the enactment of NARAB; or 2) once NARAB is incorporated.

**CONCLUSION**

Over the past 15 years, state insurance regulators have made great strides in streamlining the producer-licensing process and advances in technology have eliminated many of the hurdles. The recent establishment of NARAB is a significant step to help simplify insurance producer licensing in the United States. However, there is considerable work that must be completed in order to establish a successful NARAB. Once the board of directors is formed, it will need to raise capital to get the organization up and running, hire staff and establish standards and procedures for admission of members/producers.

On March 27, 2015, the NAIC submitted a list of recommendations to the President for the eight state insurance positions. The recommendations included state insurance commissioners who expressed interest in serving on the NARAB board of directors, and comprised a diverse geographic and political cross section of commissioners with the necessary expertise and commitment to effectively carry out the responsibilities. The CIPR will continue to provide additional updates on NARAB II as information becomes available.

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**ABOUT THE AUTHOR**

Shanique (Nikki) Hall is the manager of the NAIC Center for Insurance Policy and Research. She joined the NAIC in 2000 and currently oversees the research, development, production and editorial aspects of the CIPR’s four primary work streams; the CIPR Newsletter, studies, events and website. Ms. Hall has more than 20 years of capital markets and insurance expertise and has authored copious articles on insurance regulatory matters affecting state regulated insurance companies. She began her career at J.P. Morgan Securities in the Global Economic Research Division where she worked closely with the chief economist to publish research on the principal forces shaping the economy and financial markets. Ms. Hall has a bachelor’s degree in economics and an MBA in financial services. She also studied abroad at the London School of Economics.

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**THE FINANCIAL STABILITY OVERSIGHT COUNCIL INSURER SIFI DESIGNATION PROCESS: OVERVIEW, CHALLENGES AND REFORM**

*By Dimitris Karapiperis, CIPR Research Analyst III*

**INTRODUCTION**

Eight years have passed since the advent of the global financial crisis, and the issue of systemic risk and systemically important financial institutions (SIFIs) is still being hotly debated. The main controversy is centered on the identification of SIFIs among non-bank financial institutions and particularly insurance companies. Notwithstanding the merit of identifying those financial institutions posing systemic risk, the suitability and wisdom of the enhanced regulatory and supervisory requirements to which non-bank SIFIs are subject due to their systemic importance are still points of contention.

Questions abound regarding whether these measures applied to SIFIs are targeted towards remediating the factors believed to contribute to systemic risk or creating a permanent regulatory infrastructure whose mission is to simply manage said systemic risk. In a crisis with the banking sector at its core, the controversial inclusion of insurance companies among those companies whose activities could be a source of systemic risk has been questioned and challenged by state insurance regulators and the insurance industry. While all designations of insurers as SIFIs have elicited strong reactions, guidance may be provided by the U.S. courts following MetLife’s decision to legally challenge the Financial Stability Oversight Council (FSOC) decision to designate the insurer as a SIFI.

**FINANCIAL STABILITY OVERSIGHT COUNCIL PROCESS FOR NON-BANK FINANCIAL COMPANIES**

To prevent a repeat of the excessive risk-taking that led to the failures of the financial system, the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank) was enacted in 2010.\(^1\) The notion of broader, macroprudential supervision was introduced to keep systemic risk in check and protect financial stability. Central to the concept of macroprudential supervision is the need to recognize those financial institutions whose failure or distress could threaten the financial stability of the United States.

To that end, pursuant to Title I of Dodd-Frank, the FSOC was established to identify financial firms of systemic importance and designate them as SIFIs, as well as monitor the overall stability of the nation’s financial system and promote regulatory cooperation.\(^2\) Those institutions designated as SIFIs would theoretically become subject to more stringent regulatory standards under the Board of Governors of the Federal Reserve System. The treasury secretary, whose vote is mandatory for a SIFI designation, chairs the FSOC. The heads of eight regulatory agencies—Board of Governors of the Federal Reserve System, Office of the Comptroller of the Currency (OCC), Consumer Financial Protection Bureau (CFPB), U.S. Securities and Exchange Commission (SEC), Commodities Futures Trading Commission (CFTC), Federal Deposit Insurance Corporation (FDIC), Federal Housing Finance Agency (FHFA), and National Credit Union Administration Board (NCUA)—and one independent member with insurance expertise, appointed by the President, also have voting rights on the FSOC. Five non-voting members also sit on the FSOC, including the directors of the Federal Insurance Office (FIO) and Office of Financial Research, a state banking supervisor, a state insurance commissioner, and a state securities commissioner.\(^3\)

To aid in the definition of a SIFI, the FSOC, as authorized by section 113 of Dodd-Frank, determines whether a non-bank financial institution is a SIFI if its material financial distress, or its nature, scope, size, scale, concentration, interconnectedness or the mix of its activities could pose a threat to the financial stability of the country. Title I of Dodd-Frank defines a non-bank financial company as one that is predominantly engaged in financial activities—including insurance, investment banking and asset management—other than bank holding companies and certain other types of firms.\(^4\)

According to FSOC rules and regulations regarding non-bank financial companies, released in April 2012, SIFIs are drawn from a population of non-banking financial institutions with at least $50 billion in consolidated assets, $30 billion in credit default swaps where the company is the reference entity, $3.5 billion in derivative liabilities, $20 billion in total debt outstanding, 15-to-1 leverage ratio and 10% short-term debt-to-asset ratio. These six quantitative thresholds in this first stage of the process help filter through the initial set of companies meriting further evaluation. A non-bank financial company will be moved on to the next stage if it meets both the total consolidated assets threshold and any one of the other thresholds.\(^5\)

While these thresholds are specifically designed to be uniform, transparent and readily calculable by all, the FSOC has clarified the universe of selected companies may go beyond\(^6\)

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\(^2\) United States Senate. Committee on Banking, Housing, and Urban Affairs. “Brief Summary the Dodd-Frank Wall Street Reform and Consumer Protection Act.”


\(^4\) United States Senate. Committee on Banking, Housing, and Urban Affairs. “Brief Summary the Dodd-Frank Wall Street Reform and Consumer Protection Act.”

those meeting the quantitative thresholds. The FSOC has reasoned the thresholds may not adequately measure unique risks posed by particular companies, and, therefore, it has retained the discretion to consider companies not captured in Stage 1 for any reason.

The companies captured in the first stage, and any others subsequently added by the FSOC, are then analyzed in the next stage of the process, based on six overarching framework categories to determine a company’s potential systemicness. The company-specific factors in the second stage include both quantitative and qualitative measures such as size, interconnectedness, substitutability, leverage, liquidity risk and maturity mismatch, and existing regulatory scrutiny. The first three factors are oriented towards assessing the likely impact of companies’ financial distress on financial stability, while the remaining three focus on the degree of vulnerability of the companies to possible financial distress.

When evaluating a non-bank financial company using the six measures in Stage 2, the FSOC is examining a number of statutory considerations, including the amount and nature of the company’s financial assets; the amount and nature of the company’s liabilities, including the degree of reliance in short-term funding; the extent of the company’s leverage; the extent and nature of the transactions and relationships with other significant financial institutions; the importance of the company as a source of credit for households (with an additional emphasis on low-income, minority communities) and businesses, as well as a source of liquidity for the financial system; the extent to which assets are managed rather than owned by the company; and the degree to which the company is already regulated by one or more primary financial regulatory agencies.

During the public comment period regarding these rules, the FSOC acknowledged a number of commenters pointed to the differences between insurance companies and other types of non-bank financial institutions, suggesting the focus should be on the unregulated, non-traditional activities undertaken by insurers instead of their well-regulated core activities, which do not pose any systemic risk. Furthermore, it was stressed products and services of regulated, traditional insurance companies are highly substitutable, adding insurers operate without significant leverage or reliance on short-term debt and, even more importantly, are subject to high levels of existing regulatory scrutiny.

In Stage 2 of the process, the FSOC analyzes companies that have triggered the Stage 2 thresholds using additional public information and regulatory information. During this stage of the process, the FSOC also begins the consultation with the company’s primary financial regulatory agencies. At the conclusion of Stage 2 of the process, the FSOC votes on whether to move the company to Stage 3 of the process. If the FSOC votes to move the company to Stage 3 of the process, then it informs the company it has entered Stage 3 and can request information directly from the company. During that time, the FSOC may request additional material and information concerning the companies’ enterprise risk management (ERM) framework and procedures, strategic plans, counterparty exposures, resolvability, potential acquisitions or disposals, and any planned or anticipated changes in their business model or orientation that may affect the country’s financial stability.

Stage 3 builds on Stage 2 analysis using the additional quantitative and qualitative information submitted by the companies under consideration. Among the qualitative factors are considerations that could mitigate or aggravate the potential of the non-bank financial company to pose a threat to the country’s financial stability, such as the company’s resolvability, the opacity of its operations, its complexity and, once again, the extent and nature of its existing regulatory scrutiny. Once the three-stage review process is completed, the FSOC decides, by a two-thirds vote of its members, whether a company should be designated as a SIFI and subject to Board of Governors supervision. At that time, the FSOC provides the company with a written notice of proposed determination and explanation of the status basis. The FSOC also notifies the company’s existing regulators and its subsidiaries. The SIFI designation is then revisited on an annual basis, with the decision whether to renew or rescind put to a vote again.

A company disagreeing with the FSOC determination may request a hearing to contest the proposed designation in accordance with section 113(e) of the Dodd-Frank Act and § 1310.21(c) of the rule.

**Insurer SIFI Designations**

**American International Group**

In July 2013, the FSOC for the first time exercised its authority under Title I of the Dodd-Frank Act and designated American International Group (AIG) as a SIFI in a 9-0 vote (one

(Continued on page 11)

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8 Ibid.
9 Ibid.
10 Ibid.
11 United States Senate. Committee on Banking, Housing, and Urban Affairs. “Brief Summary the Dodd-Frank Wall Street Reform and Consumer Protection Act.”
member recused) subjecting the insurer to consolidated supervision and enhanced prudential standards. Although the FSOC’s designation of AIG as a SIFI was not unexpected by state regulators, given the company’s role in the financial crisis, the NAIC objected to the language and the rationale offered by the FSOC for this decision.

The rationale provided by the FSOC pointed to the potential for a run-like scenario for certain withdrawable insurance products and a possible broader loss of public confidence in the insurance industry as a result. However, as the NAIC contended, the insurance industry proved very resilient during the crisis, and no insurer, including AIG, suffered a run or the same loss of confidence experienced by the banking sector.

The FSOC also noted the size of AIG’s market presence in certain P/C and surplus lines, and fears about the ability of AIG’s policyholders to find similar coverage in the event AIG exits the market. State insurance regulators countered that while it may be true the exit of a major insurer could be disruptive, there is a proven history in the insurance market of a robust, competitive market with the capacity to absorb the business of failing insurers and attracting new capital.

**Prudential Financial**

In September 2013, the FSOC designated Prudential Financial, Inc. as the second non-bank financial institution SIFI in a 7-2 vote, with S. Roy Woodall Jr., independent member having insurance expertise, and Edward J. DeMarco, acting director of the FHFA, voting against, and contrary to the advice of John M. Huff, director of the Missouri Department of Insurance (DOI) and the state regulator FSOC representative. The dissenting independent member of the FSOC with insurance experience argued the FSOC’s underlying analysis used scenarios antithetical to a fundamental and expert understanding of the insurance business, the insurance state regulatory framework, and the state insurance company resolution and guaranty fund systems.

The non-voting commissioner’s dissent was based on the FSOC’s misapplication of bank-like concepts to insurance products and their regulation. The NAIC voiced again state regulators’ concerns about the unknown consequencs of such designation and the potential disruption in the insurance marketplace. The NAIC also reiterated its conviction that traditional, core insurance activities do not pose a systemic threat to the financial system, and encouraged the FSOC to instead focus on highly leveraged, thinly capitalized, or unregulated activities of non-banks as it exercises its authority.

**MetLife**

In December 2014, the FSOC, in a 9-1 vote, decided to designate MetLife as a SIFI, the third insurer and fourth non-bank financial company to be designated. In its decision, the FSOC explained MetLife is such a significant participant in the U.S. economy and in financial markets, and it is interconnected to other financial firms through its insurance products and capital markets activities. The FSOC also explained that a substantial portion of MetLife’s liabilities included the option of surrendering in exchange for cash, and some policies also let policyholders borrow against the accumulated cash value. In the event of mass surrenders, MetLife would be forced to liquidate its relatively illiquid asset portfolio disrupting trading or funding markets. Therefore, the FSOC reasoned, material financial distress at MetLife could be damaging to the economy by severely impairing financial intermediation or financial market functioning.

The sole dissenting vote in FSOC’s decision was cast by the independent member with insurance experience who argued the decision to designate MetLife was flawed. The FSOC used the event of material financial distress as the sole justification for its determination without fully considering other factors to assess the insurer’s systemicness in the absence of distress. Furthermore, the independent member pointed to the implausible and contrived scenario of mass surrenders and forced asset liquidation charging the FSOC failed to appreciate fundamental aspects of insurance and annuity products and, more importantly, the existence of robust state insurance regulation.

The non-voting state insurance regulator representative, North Dakota Insurance Department Commissioner Adam Hamm, also expressed his dissent, taking issue with the FSOC’s persistent attempt to diminish the state insurance regulatory framework and its effectiveness in reducing the

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(Continued on page 12)

18NAIC Statement on FSOC’s Prudential Designation, September 19, 2013.
19Ibid.
22Ibid.
likelihood of failure, as well as the impact on the financial system from an insurer’s material financial distress. The commissioner also objected to the FSOC’s unfounded criticism of risk-based capital (RBC) considered in isolation from all other regulatory tools and the purely speculative outcomes related to the liquidation of assets based in large part on hypothetical and highly implausible claims of significant policyholder surrenders. He stressed the tools currently at the disposal of state insurance regulators are either equally or more effective than the Fed’s enhanced prudential standards would be in addressing many of the risks identified by the FSOC.  

**Reaction to Designations**

Following their designations as SIFIs by the FSOC, AIG made no attempt to fight it, while Prudential unsuccessfully challenged its designation in an evidentiary hearing. Prudential appealed the designation and asked for a hearing as it was entitled under Dodd-Frank guidelines. When the FSOC reaffirmed its original decision following the closed door hearing Prudential had requested, the insurance company decided not to pursue a legal challenge.

MetLife also launched an appeal, becoming the second insurer to exercise its right to challenge the proposed SIFI designation in a hearing before the FSOC. After losing the appeal, despite presenting what MetLife called substantial and compelling evidence, the insurer, in January 2015, filed a lawsuit in the United States District Court for the District of Columbia, charging it would be irreparably harmed if the designation was allowed to stand. The CEO of MetLife stated the company had hoped to avoid litigation, pointing to the fact the company has always been a big supporter of robust regulation, and it has operated under a stringent state regulatory system for decades without any problems. MetLife’s lawsuit marked the first time a SIFI designation has been challenged before a federal judge.

**MetLife’s Legal Complaint**

MetLife’s legal challenge contests both the specifics of the SIFI designation and the general process in the process followed by the FSOC for insurance companies. The insurer rejected the idea it could pose a threat to the country’s financial stability and argued the conclusion reached by the FSOC was arbitrary and capricious. Furthermore, MetLife charged the FSOC’s process effectively denied the company its due process rights and violated the constitutional separation of powers because FSOC members acted and functioned interchangeably as lawmakers, prosecutors, investigators and judges at the same time. MetLife also charges the FSOC made a series of critical errors fatally undermining the reasoning in its designation of MetLife as a SIFI. First and most important of the errors was the FSOC’s failure to understand, or give meaningful weight to, the comprehensive state insurance regulatory regime that supervises every aspect of MetLife’s U.S. insurance business, despite statutory and regulatory requirements that specifically direct the FSOC consider existing regulatory scrutiny. The second error, according to MetLife’s lawsuit, was the FSOC fixation on the company’s size and so-called interconnectedness—two factors when considered alone would most certainly lead to the designation of virtually any large financial company—while ignoring other statutorily mandated considerations that weighed sharply against designation.

The third error was the FSOC’s reliance on vague standards and assertions, unsubstantiated speculation, and unreasonable assumptions inconsistent with historical experience and accepted principles of risk analysis. At the same time, the FSOC ignored tools used by federal regulators to assess the potential impact of severely adverse economic conditions in other contexts, including the Fed stress tests. The fourth error, according to MetLife, was the FSOC refusal to give the company access to data and materials used by the FSOC in its determination, depriving MetLife of a meaningful opportunity to refute the assumptions made, in violation of due process rights.

MetLife also contended in the lawsuit it is not predominantly engaged in financial activities, and the FSOC designation authority is limited in Section 113(a)(2) of the Dodd-Frank Act to U.S. non-bank financial companies. MetLife derives more than 15% of its revenues from, and more than 15% of its assets are related to, insurance activities in foreign markets. Also, MetLife notes despite the FSOC having an obligation to consider reasonable alternatives to the SIFI designation such as following an activities-based approach, it elected not to do it. In a more general criticism, MetLife argued the FSOC designation process was opaque.

(Continued on page 13)
IMPLICATIONS OF SIFI DESIGNATIONS

If a non-bank financial company is designated as a SIFI, it is subject to consolidated supervision by the Federal Reserve (Fed) and enhanced prudential standards as spelled out by the Fed in its regulatory rulemakings. The enhanced regulation expected by the Fed may include a combination of measures including, but not limited to, increased capital requirements, increased reporting, stress testing, debt-to-equity ratio requirements, stricter credit exposure limits, early remediation requirements, and “living wills” documenting resolution and liquidation plans.

In the bank-centric world of federal financial regulation, state insurance regulators considered calls for bank-style oversight of insurers particularly misplaced and ironic considering the state-regulated insurance industry served as a model of stability in 2008 when the federal banking and mortgage system nearly collapsed.

While Dodd-Frank gives the Fed the authority to subject insurance companies designated as SIFIs to the same regulatory capital rules banks have to follow, the recognition of the critical differences between banks and insurers motivated the Fed to work towards adapting the rules to insurers’ unique business model and risk profile. The Fed has reached out to the large insurance holding companies under its regulatory charge to get their assistance in creating a more appropriate capital regulatory framework.

In order to better tailor capital requirements for insurance companies, the Fed sent out a quantitative impact survey (QIS) in October 2014 to collect data from insurers in order to get a baseline understanding of the insurance industry’s capital levels. The Fed had asked insurance companies to submit all the information to the agency by the end of 2014. 29

FSOC EFFORT TO REFORM

The criticisms to insurer SIFI designations submitted by the dissenting voting and non-voting members of the FSOC, as well as those outlined in MetLife’s legal complaint, are widely shared by the insurance industry, state insurance regulators and members of Congress. In addition, the FSOC has been subject to criticism relating to its lack of transparency, a concern that has been shared by Congress, public interest groups, the industry and state insurance regulators.

In an effort to respond to some of these criticisms, the FSOC announced in January 2015 its intent to change the SIFI designation process. In February, FSOC members voted to implement a series of changes and formalize certain practices relating to its process for reviewing non-bank financial companies for potential designation. 30

The chairperson of the FSOC, Treasury Secretary Jacob J. Lew, said the newly adopted changes will help increase the transparency of the designation process and strengthen the work of the FSOC in general. He stressed the fact the FSOC is a new organization and as it grows and matures, it must continue to be flexible and adjust its processes as needed to fulfill its mandate. 31

The FSOC changes meant to supplement its rule and interpretive guidance regarding non-bank financial company determinations fall in three main categories: 32 1) Engagement with companies under consideration. The FSOC will inform companies earlier when they come under review, and provide additional opportunities for companies under consideration and their regulators to productively engage with the members of the FSOC. 2) Transparency to the broader public regarding the designations process. The FSOC will make more information available to the public about its designation work, while ensuring sensitive, nonpublic information remains protected. 3) Engagement during the FSOC’s annual reevaluations of designations. The FSOC will create a clearer and more robust process for the annual reviews of its designations. This new process is designed to enable more engagement between designated companies and the FSOC, with ample opportunity for companies to present information and to understand the FSOC analysis. 33

Commissioner Hamm has indicated the changes are a good first step. However, he remains concerned the FSOC has not fully addressed the concept of an “exit ramp” to designation nor has it made fully clear to the public or regulators the specific activities of such firms that have led to the designation of these companies. The NAIC, in written testimony to the Senate Banking Committee, indicated the failure to provide an “exit ramp” contributes to, rather than reduces risks to, the financial system.

(Continued on page 14)

31 Ibid.
33 Ibid.
Given the experience during the financial crisis, identifying which activities could threaten the stability of the U.S. economy is profoundly important. At the same time, it would be judicious to be cautious about presuming non-bank financial companies as systemically risky and particularly insurance companies, which have enjoyed a less turbulent history than their banking counterparts.

The proposed reforms of FSOC’s designation process, if implemented, are expected to enhance transparency and accountability allowing for increased consideration of the relevant views of the affected insurance companies and their primary regulators. However, establishing a clear path towards de-designation via an exit ramp should help insurance companies and their primary regulators understand better the changes they need to make in their operations and activities to eliminate any potential for posing a threat to the financial stability of the country.

**Conclusion**

Dimitris Karapiperis joined the NAIC in 2001 and he is a researcher with the NAIC Center for Insurance Policy and Research. He has worked for more than 15 years as an economist and analyst in the financial services industry, focusing on economic, financial market and insurance industry trends and developments. Karapiperis studied economics and finance at Rutgers University and the New School for Social Research, and he developed an extensive research background while working in the public and private sector.

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**About the Author**

Dimitris Karapiperis joined the NAIC in 2001 and he is a researcher with the NAIC Center for Insurance Policy and Research. He has worked for more than 15 years as an economist and analyst in the financial services industry, focusing on economic, financial market and insurance industry trends and developments. Karapiperis studied economics and finance at Rutgers University and the New School for Social Research, and he developed an extensive research background while working in the public and private sector.
RECENTLY ADOPTED AG 48 TO BRING UNIFORMITY TO CAPTIVE REINSURANCE TRANSACTIONS

By Shanique (Nikki) Hall, CIPR Manager*

Over the past several years, the NAIC and state insurance regulators have been keenly focused on the life insurance industry’s use of captive insurance companies to finance reserves required under current regulations. These reserves are commonly referred to as “XXX reserves” for certain term life insurance policies and “AXXX reserves” for certain universal life insurance policies. In cases where reserves are viewed as excessive or redundant, life insurers have increasingly turned to captive reinsurers to finance the redundant statutory reserves on these products.

After several years of work, the NAIC and state insurance regulators made significant strides last year towards bringing more uniformity to captive reinsurance transactions. In December 2014, Actuarial Guideline XLVIII (AG 48) was adopted by the NAIC Executive (EX) Committee and Plenary. AG 48 defines the rules for new life XXX and AXXX reserve financing transactions executed after Jan. 1, 2015 and is a key item needed to implement the XXX/AXXX Reinsurance Framework (Framework) as adopted in 2014. The Framework sets forth an action plan specific to life insurance reserve financing transactions until principle-based reserving (PBR) requirements become fully effective. Once adopted and implemented, PBR is expected to eliminate the reserving incentive for these transactions.

Life-insurer Owned Captives
The XXX/AXXX excess reserve financing market started in the early 2000s. It has since grown in popularity to become a common part of many life insurers’ capital management programs.1 In 2011, the NAIC first undertook its investigation into certain types of life insurer-owned captives. Regulatory concerns led to the establishment of the NAIC Captive and Special Purpose Vehicle Use (E) Subgroup in 2012. The Subgroup, which has since been disbanded, was charged to study insurers’ use of captives and special purpose vehicles (SPVs) to transfer insurance risk, other than self-insured risk, in relation to existing state laws and regulations, and to establish appropriate regulatory requirements to address concerns identified in this study. At the end of this study, the Subgroup adopted a white paper, Captive and Special Purpose Vehicles: An NAIC White Paper2, on the use and regulation of captives.

The white paper revealed insurers were creating these captives because the XXX/AXXX reserves established were too high—sometimes three to four times the actual value of the reserves. Because of this, insurers looked for better, more economical ways to handle these reserves and thus, they created captives and SPVs. The result to the companies was an economic gain because they were able to back the excess reserves with non-traditional assets and other instruments not typically allowed as assets in our statutory financial regulatory system. This created an unlevel playing field amongst insurers.

Another core concern identified in the white paper was a lack of transparency and consistency in the regulation of captives. While both insurers and captives are subject to solvency regulation, the financial regulatory systems for captives is significantly different than for insurers. This is largely because captive laws were originally intended to only address the risks of self-insurance. Also worth noting is insurance company-owned captives have since become more unique. As regulators have said, “If you’ve seen one captive, you’ve seen one captive.” One of the differences is insurers are required to file a uniform financial statement that is shared with all regulators. There is shared information between regulators, including financial data and state action information. Conversely, captives share specified information only with their state regulator—there is an option to share information, but only upon regulatory request.

Two important bodies of work resulted from the NAIC study: 1) regulators sought to clarify when they should use the national state-based financial regulatory system for the regulation of captives; and 2) regulators sought to identify adjustments to the regulatory system to no longer provide incentives to insurers to use captives for XXX/AXXX reserves. As it pertains to the latter, regulators decided they wanted to adjust the system but also did not want to forbid these captives, since they did not want to encourage movement of these captive reinsurance transactions off-shore.

XXX/AXXX Reinsurance Framework
The NAIC retained Rector & Associates, Inc. (Rector) to develop regulatory responses for the use of captives to finance XXX/AXXX reserves. Rector worked with multiple parties to devise a XXX/AXXX Reinsurance Framework which was based on significant input from state insurance regulators and the insurance industry. The Framework was adopted in August 2014 by the NAIC Executive (EX) Committee in concept. Subsequent to the Executive Committee action, a number of NAIC groups have been working to de-

* The author would like to thank Dan Daveline, Kris DeFrain and Todd Sells for their valuable comments and suggestions to this article.
2 The Captive and Special Purpose Vehicles: An NAIC White Paper was formally adopted in 2013 and can be accessed at: www.naic.org/store/free/SPV-OP-13-ELS.pdf. (Continued on page 16)
Recently Adopted AG 48 to Bring Uniformity to Captive Reinsurance Transactions (Continued)

The Framework is prospective and only applies to financing arrangements involving term life insurance business subject to Regulation XXX and universal life insurance business subject to Actuarial Guideline 38 (more commonly known as Regulation AXXX or AG 38). These are the business lines that have been identified by the life insurance industry as having the most self-evident reserve redundancies and are the most commonly financed lines. The Framework does not change the statutory reserve requirements applicable to a ceding insurer. Rather, the Framework addresses the types of security that can back those reserves in connection with reserve financing transactions.

The purpose of the Framework is to “further an action plan to develop proposed changes to the insurer/captive regulations specific to XXX/AXXX transactions.” As part of the action plan, Rector introduced a draft “Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (Model #830).” Regulators refer to this actuarial guideline as AG 48.

AG 48
There are two means to implement the Framework—a long-term solution and a short-term solution. AG 48 is a short-term solution to regulate the use of captives for XXX/AXXX reserve financings until PBR requirements become generally effective. AG 48 was developed to serve as an interim step—it establishes a reserving methodology that will be in place until the XXX/AXXX Reinsurance Model Regulation is adopted and implemented. Regulators opted for a short-term solution of AG 48 which requires issuance of a “qualified” actuarial opinion if the Framework is not being followed.

AG 48 does not prohibit XXX/AXXX captive reserve transactions. Its intent is to “provide uniform, national standards governing XXX/AXXX reserve financing arrangements” so all companies and regulators will use the same approach, thereby providing a more level playing field than that which exists today. To meet the standards, a portion of a ceding insurer’s statutory reserve approximately equal to the PBR reserve must be secured by high quality types of assets. The portion of the statutory reserve exceeding the PBR-level may be backed by other forms of security, but only as approved by the ceding insurer’s domiciliary regulator. AG 48 does introduce new terms, such as Primary Security, which will be explained below.

The main components of AG 48 include the following:

- AG 48 applies to “covered policies” (those required to be valued under Sections 6 or 7 of the NAIC Valuation of Life Insurance Policies Model Regulation) ceded Jan. 1, 2015 and later. It will not apply to policies that were both issued prior to Jan. 1, 2015 and ceded as part of a reinsurance arrangement in existence as of Dec. 31, 2014. Policies already subject to a captive arrangement as of the end of 2014 would be grandfathered. Guidance has been included to allow the ceding company’s domiciliary regulator, after consulting with the NAIC Financial Analysis Working Group (FAWG), to exempt a transaction if such risks are “clearly outside the intent and purpose” of AG 48 or for other reasons specified in the guideline.

- AG 48 identifies specific assets, “Primary Securities” which must be used to support the “Actuarial Method” reserves, which are calculated using NAIC Valuation Model, chapter 20 (VM-20) with specified modifications. Primary Security includes numerous forms of security including cash, SVO-listed securities excluding any synthetic letter of credit, contingent note, credit-linked note or other similar security that operates in a manner

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1. Back the remainder of the statutory reserve with other assets and forms of security identified as acceptable by regulators.

2. In general, reserve financing arrangements are those where the security/assets backing part or all of the reserves have one or more of the following characteristics: such security/assets (1) are issued by the ceding insurer or its affiliates; and/or (2) are not unconditionally available to satisfy the general account obligations of the ceding insurer; and/or (3) create a reimbursement, indemnification or other similar obligation on the part of the ceding insurer or any if its affiliates (other than a payment obligation under a derivative contract adopted in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance arrangement).

3. Actuarial Method is the methodology used to determine the Required Level of Primary Security (the dollar amount determined by applying the Actuarial Method to the risks ceded with respect to Covered Policies.)
similar to a letter of credit; as well as, funds-withheld and modified coinsurance transactions, commercial loans in good standing (CM3 quality and higher), policy loans and derivatives used to hedge risk.

- AG 48 allows “other security” approved by the regulators to back the excess of statutory reserves over the Actuarial Method reserves which can include any asset acceptable to the ceding company’s domiciliary state and even security not typically considered an asset, such as letters of credit

- Each reinsurance arrangement subject to AG 48 requires analysis by the appointed actuary on a treaty by treaty basis, and requires the appointed actuary to issue a qualified opinion if one or more of the requirements are not met.

- AG48 was adopted with an effective date of 1/1/2015 and is included in the NAIC Accounting Practices and Procedures Manual.

**SUMMARY**

The adoption of AG 48 is viewed as an interim step in developing a more comprehensive approach to the use of captive reinsurers for XXX/AXXX reserves. As a second stage solution, the NAIC Reinsurance Task Force will create a new model regulation incorporating AG 48 principles, and amend the existing Credit for Reinsurance Model Act (Model #785) to allow for the new regulation. Although some in the life insurance industry believe a level of redundancy will continue to exist under PBR, under the new regulation, companies will be required to fund the full statutory (PBR) reserve with assets that meet the requirements of AG 48, which would appear to eliminate the reserving incentive to use captives to finance reserves.

**ABOUT THE AUTHOR**

Shanique (Nikki) Hall is the manager of the NAIC Center for Insurance Policy and Research. She joined the NAIC in 2000 and currently oversees the research, development, production and editorial aspects of the CIPR’s four primary work streams; the CIPR Newsletter, studies, events and website. Ms. Hall has more than 20 years of capital markets and insurance expertise and has authored copious articles on insurance regulatory matters affecting state regulated insurance companies. She began her career at J.P. Morgan Securities in the Global Economic Research Division where she worked closely with the chief economist to publish research on the principal forces shaping the economy and financial markets. Ms. Hall has a bachelor’s degree in economics and an MBA in financial services. She also studied abroad at the London School of Economics.

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6 Other Security is any asset, including asset meeting the definition of Primary Security, acceptable to the Commissioner of the ceding insurer’s domiciliary state.
The Terrorism Risk Insurance Program Reauthorization Act (TRIPRA) of 2015 was signed into law by President Obama Jan. 12, 2015. A full analysis of the revisions to the Terrorism Risk Insurance Program (the Program) can be found in the February 2015 CIPR Newsletter. As Congress debated the Program’s reauthorization, members of Congress, industry and media frequently requested information regarding the size of the market and insurers writing the terrorism risk coverage. Marsh has periodically issued a report surveying Marsh clients that estimates take-up rates and costs by company size, industry and region. However, industry-wide data regarding terrorism risk insurance has not been available.

In TRIPRA, Congress explicitly called for the collection of certain data elements that will aid in analyzing the effectiveness of the Terrorism Risk Insurance Program (TRIP).

TRIPRA calls for the following information to be collected during the calendar year beginning on January 1, 2016:

A. Lines of insurance with exposure to such losses;
B. Premiums earned on such coverage;
C. Geographical location of exposures;
D. Pricing of such coverage;
E. The take-up rate for such coverage;
F. The amount of private reinsurance for acts of terrorism purchased; and
G. Such other matters as the Secretary considers appropriate.

(Continued on page 19)

1 www.naic.org/cipr_newsletter_archive/vol14_tria.pdf

### Figure 1: Direct Premium Per Line of Business Covered by TRIPRA

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Direct Premium Earned</th>
<th>Direct Premium Earned (Less Deductible)</th>
<th>Deductible Amount (20%)</th>
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<tbody>
<tr>
<td>Fire</td>
<td>$12,686,553,958</td>
<td>$10,149,243,166</td>
<td>$2,537,310,792</td>
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<tr>
<td>Allied Lines</td>
<td>$12,562,801,388</td>
<td>$10,050,241,110</td>
<td>$2,512,560,278</td>
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<td>$18,101,760,389</td>
<td>$14,481,408,311</td>
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<td>Workers Compensation</td>
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<td>$42,809,199,602</td>
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<td>Aircraft</td>
<td>$1,539,651,975</td>
<td>$1,231,721,580</td>
<td>$307,930,395</td>
</tr>
<tr>
<td>Boiler and Machinery</td>
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<td>$1,152,432,989</td>
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<td>Products Liability</td>
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<td>$662,999,612</td>
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<tr>
<td>Commercial Multiple Peril (non-liability portion)</td>
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<td>$19,279,563,696</td>
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<tr>
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<td>$13,755,842,357</td>
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<tr>
<td>Other liability - occurrence</td>
<td>$34,548,829,354</td>
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<td>$6,909,765,871</td>
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<tr>
<td>Other liability - claims-made</td>
<td>$19,716,623,820</td>
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</tbody>
</table>

TOTAL TRIPRA-COVERED LINES  $198,353,295,436  $158,682,636,349  $39,670,659,087

TOTAL PROPERTY CASUALTY MARKET* $498,656,524,146

Percent of Total Statewide (including D.C.) Premiums Earned attributable to TRIPRA covered-lines of business 39.78%
TRIPRA states the Secretary of the Treasury shall coordinate with the appropriate state insurance regulatory authorities to determine if the information to be collected is available from state insurance regulators. State regulators, through the NAIC Terrorism Insurance Implementation Working Group, are considering adding a supplement to the Annual Statement Blank in order to capture some of this data. Regulators are currently working with industry representatives to determine which data elements might be feasible for the industry to capture in 2015, to be collected by regulators in 2016.

This data would greatly assist state insurance regulators, the Federal Insurance Office, Congress, industry and consumers in determining the size of terrorism coverage relative to the total property and casualty market. The data would also identify the major writers of terrorism coverage.

Currently, regulators can only determine the size of each line of business covered under the Program. The Program covers most lines of commercial insurance, but excludes mortgage and title insurance, financial guaranty, medical professional liability, flood, federal and private crop, reinsurance, commercial auto, burglary and theft, surety, professional liability (except directors and officers coverage) and farmowners multiple peril.\(^3\) Approximately forty percent of total property/casualty insurance premiums are currently covered under the Program.

An individual insurer must pay a 20% deductible before federal assistance becomes available under the Program. In the aggregate, 20% of the direct earned premium under the TRIP-covered lines was approximately $39.7 billion in 2014 (Figure 1 on previous page). Although the distribution of losses among insurance companies cannot be determined, federal assistance following a covered terrorism event would likely begin somewhere below $39.7 billion.

**About the Author**

Jennifer Gardner is a manager in the NAIC Research and Actuarial Department. Jennifer joined the organization in 2011. She conducts economic and statistical research for the NAIC and its members. She is responsible for publishing various statistical reports including the Report on Profitability By Line By State and the Competition Database Report. She provides support for numerous NAIC working groups and assists the state insurance departments in data collection related to catastrophe. Jennifer earned a bachelor’s degree in business administration with an emphasis in finance from the University of Missouri-Kansas City. Prior to joining the NAIC Research and Actuarial Department, Jennifer worked on the State Based Systems (SBS) products and services within the NAIC.

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By Dimitris Karapiperis, CIPR Research Analyst III

The NAIC Center for Insurance and Policy and Research recently released a study titled “Usage-Based Insurance and Vehicle Telematics: Insurance Market and Regulatory Implications.” The CIPR study takes a closer look at the technology of telematics, explores the changes in the insurance market and analyzes in-depth the implications of telematics for insurers, consumers and state regulators.

The study examines how the U.S. auto insurance industry is undergoing a fundamental change with the introduction of vehicle telematics technology. Telematics-supported usage-based insurance (UBI) programs hold the promise of more efficient pricing of risks and widespread benefits accruing to insurers, consumers and society in general. Many U.S. insurers currently have telematics-based UBI policies available offering significant discounts to consumers who, according to recent market surveys, seem overwhelmingly favorable to the technology and the value it can offer. As the population becomes more accepting of technology and as the generation that has grown up surrounded by technology in their everyday life grows, it is likely that the percentage of policyholders ready to adopt telematics will increase dramatically.

By deploying telematics UBI programs, insurers are able to capture multiple data points on vehicle usage and operational characteristics, as well as driver behavior, to better understand and adequately model risky behavior. Using causal risk factors allows insurers to calculate premiums accurately reflecting true risks and thus offer significant discounts to those policyholders who consent to operate their vehicles within prescribed risk-minimizing parameters. Insurers also benefit from the superior fraud detection telematics can provide. Telematics UBI also helps to significantly reduce accident- and vehicle theft-related costs for insurers who then can pass a percentage of the savings along to their policyholders.

Along with the benefits, both consumers and regulators have a number of serious concerns regarding the use of telematics UBI ranging from privacy and transparency issues to how driving data is used in pricing. It is critical all information about data collection, use, ownership, storage, protection and dissemination is made available to state insurance regulators when a filing incorporates telematics-based UBI.

CIPR conducted a survey of state departments of insurance to assess the expanding use of telematics UBI in the auto insurance market and gauge the acceptance and readiness of the state regulatory system to allow for this new technology while protecting policyholders.

The study in its entirety can be found on the CIPR website at www.naic.org/cipr_special_reports.htm.

\* CIPR Telematics UBI State Survey

Introduction

In order to find out more about what actions states may have taken or contemplated related to the use of telematics UBI in auto insurance, CIPR staff developed a 10-question web-based survey in May of 2014 inviting all U.S. jurisdictions to participate. The high response rate in the survey, with 47 jurisdictions providing answers, allowed for a comprehensive assessment of the growth of telematics and the readiness of the state regulatory system to ensure a viable, fair and dynamic auto insurance market.

Survey Results

Approximately 89 percent of the responders answered telematics-based UBI auto insurance is available in their states, closely reflecting recent market studies (Figure 1.) Eight of the jurisdictions noted they have 12 or more companies offering telematics UBI programs to their consumers. Another 15 states responded they have at least five but less than 12 domiciled insurers with a telematics UBI program. Ten states noted the number of companies offering telematics UBI programs in their jurisdiction were less than five. The remaining nine jurisdictions could not provide a precise number of companies active in telematics because legislation permitting such programs was only recently passed in their state and/or they do not have systems in place to accurately track how many companies offer telematics.

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The follow-up to the first question was an open-ended inquiry seeking to explore the reasons a telematics program may not be available in a specific jurisdiction. Smaller jurisdictions—such as Guam, Puerto Rico and the Virgin Islands—noted the lack of interest by their domiciled insurers to make telematics-based UBI policies available in their local markets.

However, the California Department of Insurance pointed to the state’s legal mandate to preserve drivers’ privacy and control of their vehicles’ data and to the need for transparency and stability in premium rating factors behind the department’s restrictive approach to telematics programs. At this point in time, only rating factors specified in statute or regulation are allowed in California and currently, none of the common telematics UBI PAYD behaviors, other than mileage, are among these factors. The only data telematics UBI programs available to California can use is mileage driven.

The third question in the survey asked state regulators to provide information of any specific legislation introduced relating to the usage of telematics and/or dealing with privacy concerns and rating issues. Six states responded affirmatively, noting the passage or introduction of unique legislation intended to establish a regulatory framework for telematics-based UBI.

During the 2006 legislative session, the legislature of the commonwealth of Virginia passed a bill addressing the use of recording devices in vehicles for the purpose of pricing auto insurance. Two new statutes, §46.2-1088.6 and §38.2-2213.1, were introduced defining what a telematics is and how it can be used and specifying the pricing of a policy with or without telematics. In the event an insurer chooses to not allow access to his data to an insurer, the legislation prohibits retaliatory action by the insurer, such as reducing coverage, raising premium, applying surcharges and placing in a less favorable tier.

The legislature of the state of Washington in its 2012 session passed House Bill 2361 dealing with automobile UBI and exempting certain UBI information from public inspection. The legislation covers the usage of the data captured by a telematics device as defined in statute RCW 46.35.010 and the usage-based determination of rates or premiums. In addition, it ensures that all information about the UBI methods and/or processes of the insurer remains confidential.

The state of Illinois passed legislation in the 2011 session relating to trade secrets and commercial or financial information. The 5 ILCS 140/7 statute provided protection to insurer proprietary trade secrets, allowing insurers to make their telematics solution available to consumers.

The General Assembly of the state of Delaware passed House Bill 56w/SA3 in the 2014 session enacted into law in May 2014. The legislation prescribes certain regulations for telematics devices prohibiting the use by insurers of vehicle personal data for anything other than consideration for premium discounts. The law also requires disclosure to the insured of others who may gain access to their data, and otherwise prohibits insurance companies from releasing such data to others.

The state of Montana noted its legislature will consider legislation in the 2015 session. The senate in North Carolina has passed SB 180, allowing enhancements to auto insurance, but it has not been enacted to date. Also, California pointed again the existence of legislation specifically restricting insurer use of a telematics device.

Eight jurisdictions (Arizona, Arkansas, Iowa, Kansas, Maine, Missouri, Nebraska and Texas) responded that their existing legal and regulatory framework adequately covers telematics UBI programs providing guidance on ratings and confidentiality protection for insurers’ UBI solutions.

The fourth question inquired if the existing laws affect the development, availability and use of telematics-based UBI. Ten jurisdictions that had given a negative answer in the previous question responded their legal requirements may potentially hinder insurers’ efforts to offer telematics solutions.

The state of Maryland pointed to the Insurance Article §11-307(a), which requires all auto insurers to file with the Commissioner all rates and supplementary rating information for use in the state. The Maryland Insurance Administration is responsible for reviewing the rating criteria to ensure no insurer has rating criteria that would otherwise amount to a violation of the Insurance Article. The rating criteria and supporting documentation is subject to public disclosure pursuant to §11-307(c) of the Article. According to the Maryland Insurance Administration, the public disclosure requirements for the telematics rating criteria have (Continued on page 22)

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1. Existing California regulation restricts insurer use of a technological device for the collection of driving data, such as mileage.
2. HB 816: Recording devices in motor vehicles; access to recorded data. Amending § 38.2-2212; adding §§ 38.2-2213.1, 46.2-1088.6, and 46.2-1532.2. (Patron–May, CH 851), Commonwealth of Virginia.
3. SB 90: Recording devices in motor vehicles; access to recorded data. Amending § 38.2-2212; adding §§ 38.2-2213.1, 46.2-1088.6, and 46.2-1532.2. (Patron–Watts, CH 889), Commonwealth of Virginia.
4. The 5 ILCS 140/7 statute provided protection to insurer proprietary trade secrets, allowing insurers to make their telematics solution available to consumers.
5. Ibid.
7. Ibid.
been a point of contention with some insurers. At the same time, there is no indication it has actually deterred any insurer from filing a telematics plan.

Similarly, Iowa Insurance Division noted complete rating information is required under Iowa Code §515F.5 on rate filings. The state law requires all insurers to file their rates or rating plans, every manual, minimum premium, class rate, rating schedule and all relevant factors. Furthermore, all filings and supporting information should be open to public inspection.

The Office of Insurance Regulation of the state of Florida added that public disclosure requirements and review of all aspects of auto insurance rates are required in accordance with statute §627.0651. The New York Department of Financial Services referred to state Insurance Laws §2305 and §2307 on rates and ratings plans and policy forms, respectively. The laws require prior approval for all forms, rates and rating rules, and public disclosure of the filing and supporting information following approval. Also, New York’s Freedom of Information Act means that no specific protection is guaranteed or afforded to any filed algorithms by insurers offering telematics UBI.

Hawaii revised statutes §431:10C-207 regarding discriminatory practices and §431:14-103(a)(1) dealing with the making of rates are the legal questions facing insurers offering telematics-based UBI, according to the Hawaii Insurance Division. Discriminatory practices are prohibited, so no insurer can base any standard or rating plan, directly or indirectly, on a person’s driving experience, physical handicap and other factors like age, race, creed or ethnicity. Also, rates cannot be excessive, inadequate or unfairly discriminatory.

Michigan Department of Insurance and Financial Services pointed to a set of statutes in chapter 500 of the Insurance Code of 1956 that could affect the availability and use of telematics UBI in the state. Statute §500.2109 requires rates not be excessive, inadequate or unfairly discriminatory. Statute §500.2110a allows insurers to use factors for rating if universally applied, and statute §500.2111 lists factors such as miles driven, vehicle characteristics relating to automobile theft prevention devices and major driving hazards that can be applied by an insurer only on a uniform basis throughout the state. Statute §500.2403 deals with the use of the rate that has or will have the effect of destroying competition among insurers, creating a monopoly or causing a kind of insurance to be unavailable to a significant number of applicants who are in good faith entitled to procure the insurance through ordinary methods.

The Bureau of Insurance of the state of Maine noted the revised statute §2303 of Maine’s Insurance Code that prescribes the establishment of classifications or modifications of classifications or risks based on such factors as individual experience is not prohibited provided such classifications and modifications apply to all risks under the same or substantially similar circumstances or conditions. Also, revised statute §2304-A was referred regarding public disclosure of any filing and any other supporting information after the filing becomes effective.

The Nevada Division of Insurance responded by noting the state is a prior approval state for all personal lines of insurance, meaning all UBI models have to be filed with the state and receive prior approval.

California Department of Insurance points to the state's Insurance Code 1861.02, where the mandatory rating factors are identified, and to the California Code of Regulations, Title 10, Chapter 5, Subchapter 4.7, Section 2632.5, where the allowable optional rating factors are listed. (None of the common PAYD factors are included.) Section 2632.5 also specifies the use of a technological device is strictly limited for the purpose of collecting vehicle mileage information.

The next open-ended question to state regulators asked how state departments of Insurance monitor and supervise the ratemaking process for auto insurance, particularly in the presence of telematics UBI plans.

Almost all the jurisdictions have a requirement for filing of rates and rating systems. Rates also must be actuarially supported and not excessive, inadequate or unfairly discriminatory. Prior approval is a requirement shared by most jurisdictions. A number of jurisdictions have an exception to prior approval requirement except when a flex rate method is used. However, telematics-based UBI programs generally cannot use the flex rate filing and must seek prior approval.

Guam responded by noting the existence of a tariff system for auto insurance in the territory. Any admitted insurer in

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the jurisdiction of Guam must file for any rate adjustment that deviates from the tariff.

The survey’s sixth question inquired how states evaluate the level of competition in the presence of UBI programs in their jurisdictions.

The Division of Insurance of the commonwealth of Massachusetts in its response recognized UBI has the potential to create an uneven playing field in competitive markets due to the holding of telematics patents by insurers. However, it was noted that because annual mileage is already easily tracked in Massachusetts, the use of telematics-based UBI becomes less compelling as a competitive tool. The Division of Insurance reiterated rate filings are carefully reviewed to understand the type and extent of discounts offered in the market for UBI policies.

The Bureau of Insurance of Virginia emphasized it is purely consumers’ decision to participate in a telematics plan, and there is no indication the presence of telematics in the state has had any adverse effects in Virginia’s competitive insurance market.

New York’s Department of Financial Services said state regulators work with insurance companies in implementing their individual telematics UBI programs. Pursuant to New York Insurance Law, all such programs are required to meet certain standards which must be approved by the Department prior to their implementation. Montana’s Office of the Commissioner of Securities and Insurance in its response stressed the fact the telematics UBI market is still in its early development. Because UBI is relatively new in Montana and the interest for UBI by consumers is not known, it is difficult, noted the Office of the Commissioner of Securities and Insurance, to accurately assess how competition has changed in the presence of telematics UBI. Ultimately, the personal auto insurance market in the state is greatly driven by rate levels, said the Office of the Commissioner of Securities and Insurance, and concluded by underscoring that while privacy is valued by a great number of consumers in the state, the better drivers in the state will likely try a telematics plan at some point in the future.

Michigan’s Department of Insurance and Financial Services, in its response, highlighted the high degree of competition in the state’s insurance market, with more than 100 insurers offering auto insurance plans. Therefore, consumers can choose the auto insurance plan with the best price and best service for their varying situations. The Department of Insurance and Financial Services noted Michigan law does not require insurers offering telematics UBI programs be competitive beyond this scenario. For example, regulators would not mandate any of the insurers to offer such programs nor consider telematics UBI are not acceptable rating plans because only one or a handful of insurers use them. To our question if a state has any specific concerns regarding the marketing and use of telematics UBI products, 23 jurisdictions answered in the affirmative, listing their concerns, while 20 jurisdictions responded they presently have no particular concerns. Four jurisdictions provided no answer (Figure 2.)

The survey listed four reasons for concern, thought to be more common according to prior research, for regulators to choose and an option to add on that, expand or elaborate. The four concerns listed were: 1) claims management; 2) pricing fairness between UBI consumers and those who wish to not participate; 3) privacy issues; and 4) data ownership and portability. While the issue of privacy figured prominently in most of the responses, states’ answers varied in their nuance and choice of concerns that often went beyond the four listed issues.

The Delaware Department of Insurance stated its concerns regarding telematics span all four choices, but more time is needed following the implementation of HB 56 in May 2014 to see if any particular issues emerge and/or consumers submit any complaints. The state of New Hampshire also noted all four issues are of concern, with a particular emphasis on privacy. Furthermore, the state Department of Insurance stressed that telematics programs are monitored to make sure they all strictly voluntary.

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17 House Bill # 56 w/SA 3. State of Delaware 147th General Assembly.
The Insurance Division of the Department of Business Regulation of the state of Rhode Island pointed to all four issues as equally concerning and added that currently, telematics programs are offered solely as an option to consumers. Insurers may offer discounts only and may not surcharge risks or use to non-renew. Similarly, Indiana Department of Insurance responded all four are concerns shared by Indiana regulators, adding another concern is the issue of transparency to the policyholders. The Maryland Insurance Administration also said all four issues are regulatory concerns, adding that equally concerning are if appropriate disclosures regarding how the program works to consumers are made and the accuracy of the data transmitted to the insurer via the device. All four issues were also concerns noted by the Department of Insurance of the state of Arizona.

The Georgia Office of Insurance and Safety Fire Commissioner answered that when telematics UBI programs were first introduced, there were some privacy concerns, but because the use of UBI is strictly voluntary, these concerns are reduced as the consumers have to consent to participate in the program.

The Florida Office of Insurance Regulation added the accuracy of the algorithms used to create UBI scores as a serious regulatory concern in addition to the concerns about privacy, data ownership, and portability and claims management. The New York Department of Financial Services shared its main concerns were with claims management and data ownership and portability, while the Connecticut Insurance Department pointed to privacy and data concerns.

The Montana Office of the Commissioner of Securities and Insurance stressed concerns regarding disclosure of how the data collected may be used, privacy issues, underwriting and renewal. The Department of Insurance and Financial Services of Michigan noted it is concerned about classifications used are not unfairly discriminatory. The Insurance Division of the state of Hawaii, the Bureau of Insurance of the state of Maine and the Washington Office of the Insurance Commissioner noted concerns with pricing fairness, privacy, and data ownership, and portability. Finally, the North Dakota expressed concerns with rebating issues with telematics UBI plans.

To the question if a jurisdiction has enacted or proposed any legislation regarding any of the concerns with telematics UBI, state departments of insurance responded either by noting the same telematics-related legislation discussed earlier or by saying that no additional legislation is required. Only the state of New Hampshire pointed to new state statutes whose main intent is to deal with privacy issues. The Insurance Department added that although these statutes did not specifically address UBI devices, they did encompass them.

The last question of the survey inquired if any of the jurisdictions has received a consumer complaint connected with a telematics UBI program. Two state departments of insurance, Maryland and New Jersey, answered in the affirmative. The Maryland Insurance Administration has received two complaints with regard to UBI programs. The first complaint was directly related to advertisement of the UBI program. Here, the insured felt the insurer failed to disclose the program required a subscription to an outside service (i.e., OnStar, Ford SYNC, In-Drive). The second complaint alleged the insurer did not properly inform the insured how long the device was required to be installed in the vehicle in order to receive a discount. The Department of Banking and Insurance of New Jersey said it received two complaints, one related to the applicable rating discount and the other related to the mechanics of using the telematics device.

**ABOUT THE AUTHOR**

Dimitris Karapiperis joined the NAIC in 2001 and he is a researcher with the NAIC Center for Insurance Policy and Research. He has worked for more than 15 years as an economist and analyst in the financial services industry, focusing on economic, financial market and insurance industry trends and developments. Karapiperis studied economics and finance at Rutgers University and the New School for Social Research, and he developed an extensive research background while working in the public and private sector.

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18 HB1567, HB1619, HB1324. 2014 Session of New Hampshire Legislature.