By John M. Huff, NAIC President & Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration

† INTRODUCTION

I am energized and honored to have been chosen to lead the NAIC in 2016. I am also humbled by the enormity of the tasks we face as the nation’s insurance regulators. State-based insurance regulation has a 145-year history of consumer protection. Effective regulation of insurer solvency is the cornerstone of consumer protection as insolvent insurers do not pay claims. While solvency may have been the initial focus of regulation, consumer protection efforts have evolved along with the industry. Insurance regulators provide consumer education about insurance products, mediate disputes between consumers and their insurance companies, and ensure insurance companies fulfill the promises made in insurance contracts. Insurance regulators also work to foster competitive insurance markets, assuring consumers have a wide selection of insurance products to meet their risk management needs. As the NAIC President, I am committed to further strengthening our state-based regulatory system.

The state-based national system of insurance regulation consists of 56 independent jurisdictions. Collectively, we regulate more than $8.3 trillion of insurer assets and $1.8 trillion in premiums. Almost 12,000 dedicated state insurance regulators help the chief insurance regulator fulfill their obligations to the public. While insurance regulation is state-based, there are many ways in which regulatory activity is coordinated. It is the NAIC that is the mechanism for this regulatory coordination. The NAIC also provides the platform for a transparent collaboration with stakeholders. Input from consumers, state legislators, regulated entities, other stakeholders, and regulators is actively sought to ensure sound public policy decisions are made.

I am anticipating a busy and issue-packed year in 2016. At the end of the year, I hope collectively we will have reached new heights in consumer protection, while promoting healthy competition in our 56 insurance markets. After all, state regulation is successful because we know best how to balance the needs of consumers and the insurance industry.

† CHALLENGES AND OPPORTUNITIES OF BIG DATA

The insurance industry is, and always has been, a data-driven industry. Insurers and insurance advisory organizations have a long history of collecting data, which is used by actuaries to predict future losses based on past experience. However, the raw data itself is of limited value. It must be converted to meaningful information to drive the ever-important decisions about what price to charge and how best to manage risks. Data can also help insurers learn more about the customers they serve.

The amount of consumer data has grown exponentially in just a few years. Today, almost everyone has a smartphone, newer cars are equipped with data ports and sensors and most households have a computer or tablet or other mobile device. We are reading, sharing, storing and interacting with immense amounts of online data every day. Those interactions result in additional data that can be mined for the most granular of insights into our everyday lives. According to Gartner, "Big Data is high-volume, high-velocity and high-variety information assets that demand cost-effective, innovative forms of information processing for enhanced insight and decision making." While the definition is interesting, it is not of much use as a practical matter. As insurers collect more granular information from policyholders and from other sources, what regulators need is greater insight into what data is available to the insurance industry and how it is being used.

The challenge for insurance regulators related to big data is to sort out whether it is beneficial or harmful to consumers. My initial impression is big data can be both. Are insurers using telematics to attract high-end customers or to make auto insurance more affordable and available to everyone? Does big data lead to more accurate pricing, therefore resulting in better solvency of insurance companies? Regulators also need to know the impact big data is having on competition. Does it foster or impede competition? Will we find ourselves with more or fewer insurers in the markets we regulate?

An example of a regulatory challenge related to insurer use of big data is the controversy surrounding price optimization. It seems everyone has their own definition of price optimization and a corresponding opinion about whether certain practices included in their definition are appropriate for purposes of pricing or underwriting. Gathering data about the consumer’s propensity to shop for coverage or propensity to make an insurance claim can provide valuable insight into consumer behavior. However, just because the information is available does not mean it should be used to take advantage of a consumer by charging the person more for coverage than another similarly situated individual.

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4 Gartner is one of the world’s leading information technology research and advisory companies.
I believe insurance regulators have an obligation to help educate consumers to better prepare for retirement. Many studies show that financial literacy is lacking for many consumers. I would like to see individuals of all ages become more educated in order to adequately plan for retirement. At the same time, I want to ensure insurance consumers are protected in the marketplace. Rest assured state insurance regulators will continue to diligently monitor the marketplace, pursue and address fraud and other unlawful practices, and help to strengthen consumer protection laws.

While educating and protecting consumers, we also need to make sure we do not stifle innovation. I would like to identify and address areas in current laws and regulations that could unnecessarily stifle innovation or that do not take advantage of new technologies to benefit consumers, such as laws that do not recognize electronic signatures. Regulators should also work with consumer groups and the insurance industry to help identify new or redesigned projects to be affordable and meet the needs of consumers, thereby meeting the changing needs for future retirement security.

I am committed to expanding our outreach to help consumers get smart about their insurance choices and improve their overall financial literacy. It is one of my priorities for 2016. A comfortable retirement is something we all should be able to enjoy. It is our job to help people achieve a comfortable retirement armed with the knowledge and resources to make it last a lifetime.

**Cybersecurity**

Recent high-profile data breaches have led regulators to work toward strengthening insurer defenses against cyber attacks. Managing cybersecurity risk has become more important as critical consumer personal, financial and health information is increasingly stored in electronic form. As people become more reliant on electronic communication, and as businesses collect and maintain even more granular pieces of information on their customers, the opportunity for bad actors to cause difficulties for businesses and the public is exploding.

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In 2015, insurance regulators made great progress toward development of a comprehensive framework for the insurance community to address the challenges of cyber risk management. The NAIC Cybersecurity (EX) Task Force, under the able leadership of North Dakota Insurance Commissioner Adam Hamm and South Carolina Insurance Director Ray Farmer, accomplished a lot. The Task Force developed the Principles for Effective Cybersecurity Insurance Regulatory Guidance. The guiding principles present a framework for protection of sensitive personal information necessary for business purposes. Insurers, insurance producers, insurance regulators and the NAIC all collect certain personal financial or health information that if accessed by an unauthorized person might lead to adverse consequences. The 12 principles promote careful protection of sensitive personal information and demand accountability when the information is accessed by unauthorized persons.

The second major project of the Task Force was development of the NAIC Roadmap for Cybersecurity Consumer Protections. The roadmap supplements the guiding principles by providing clarifying details on consumer protection. Generally, the roadmap suggested the consumer is entitled to: 1) know what information is collected; 2) know about the insurer’s privacy policies; 3) know the insurer is taking appropriate measures to protect sensitive data; 4) receive notice if the data is compromised; 5) receive information about consumer rights; and 6) receive free identity theft coverage for at least one year. One of the 2016 projects is to draft a model law incorporating the consumer protection elements of the roadmap. The model is intended to include standards for insurers and insurance producers regarding their obligation to safeguard sensitive personal financial and health information and remedies if they do not.

The Cybersecurity (EX) Task Force also worked with the Property and Casualty Insurance (C) Committee and the Financial Condition (E) Committee to develop the Cybersecurity and Identity Theft Coverage Supplement for insurer financial statements to gather financial performance information about insurers writing cyber-liability coverage nationwide. The NAIC also updated its Financial Condition Examiners Handbook to make sure the guidance it contains is consistent with the National Institute of Standards and Technology (NIST) cybersecurity framework. This is important because other financial regulators use the NIST framework to measure compliance of banks and securities firms.

In 2016, I expect the Cybersecurity (EX) Task Force to continue its important work on cybersecurity matters, including completing its work on a model law incorporating the consumer protections from the roadmap and pertinent parts of the 12 guiding principles. To address the need for a uniform approach, I expect the Task Force will propose the new model be made part of the NAIC accreditation standards. This is warranted because the possibility of a cyber-breach is accompanied with substantial costs to the victimized firm. The known remediation costs associated with one of the major 2015 breaches exceeded $250 million. A major cyber breach could absolutely threaten the solvency of an insurer.

I also expect continued collaboration among state insurance regulators and other financial regulators through the Financial and Banking Information Infrastructure Committee (FBIIC). Insurers must become key players in sharing threat information through one of the information sharing and analysis centers.

I look forward to the first submission of data from insurers required by the Cybersecurity and Identity Theft Coverage Supplement. This information should provide us with insight on how this important market segment is developing and what, if anything, regulators need to do to help it grow in ways that do not threaten the solvency of any insurer choosing to participate in the market place for this important risk management product.

PBR FOR LIFE INSURERS

The NAIC has made great progress in recent years in the continued transition to principle-based reserving (PBR) in the life insurance area. As insurance products have changed over time, the use of the traditional formula-based approach to determine the necessary reserves to support today’s more complex products has proven less than optimal. The traditional formula-based approach results in some products having excessive amounts of conservatism built into reserve requirements, while other products result in inadequate reserves. Over the past several years regulators have refined the PBR concepts so that they are now ready to replace the formula-based approach for some life insurance products, primarily those involving certain term insurance policies and universal life insurance policies.

There are two key components necessary to implement the change from formula-based reserves to PBR: 1) changing the NAIC Valuation Manual; and 2) convincing state legislatures to adopt changes to the Standard Valuation Law (SVL). Changes were also made to the Valuation Manual in 2012 to make the reserving process more dynamic and in touch with today’s insurance products. Changes were made to the SVL

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and to date, 39 states representing 71% of the required premium have adopted the revised SVL. There must be at least 42 states representing 75% of the applicable premium with substantially similar terms and provisions before the legislation becomes effective. We are close to meeting the thresholds established in the model. The NAIC stands ready with technical resources to assist states through the transition. I expect states will reach the thresholds in 2016 so the PBR concept can begin to be implemented in 2017.

◆ CHANGES IN HEALTH INSURANCE MARKETS
The markets for health insurance face many uncertainties as the various provisions of the federal Patient Protection and Affordable Care Act (ACA) continue to unfold. Regardless of one’s political persuasion, it is undeniable that the ACA has changed how health care is delivered in the U.S. There are a number of very positive developments for consumers. More people now have health insurance coverage. Caps on annual and lifetime benefits have been eliminated, along with preexisting condition exclusions. Enhancements have been made to coverage of preventative health care services like immunizations and wellness visits. Health plans providing dependent coverage must now allow coverage for adult children up to age 26.

Changes have been made in how individuals and families access information on health care and new tools have been developed to help people be more effective shoppers. Among these improvements are standardization of definitions and standardization of the summary of benefits and coverage (SBC) explanations. The number of rating factors insurers use to price individual health insurance coverage has been limited to age, smoking status, geographic location and whether coverage is for an individual or family. Some of the rate classifications have rating constraints such as the 3-to-1 ratio for age rating. This has the effect of reducing the cost for people in the 50–64 age range at the expense of younger, healthier consumers.

There have also been some significant headwinds. It seems the ACA is having a difficult time living up to the “affordable” part of its name. Health insurance rates have been rising in most states because the cost of underlying health care continues to rise. This is occurring in spite of measures contained in the ACA designed to constrain insurer profits, such as the medical loss ratio (MLR) standards.

Last year there were two significant court challenges to the ACA. The first involved a constitutional challenge to the ACA claiming the language in the law prohibited the federal government from providing subsidies to participants in federal health insurance exchanges. In a 6-to-3 decision, the interpretation of the provision allowing subsidies for people participating in either state or federal health insurance exchanges was upheld by the Supreme Court. The second involved the requirement for employers to provide coverage for contraceptives to employees and dependents. In the Hobby Lobby case (Sebelius, Sec. of HHS v. Hobby Lobby Stores, Inc.), the Supreme Court held that the federal Religious Freedom Restoration Act allows certain closely held for-profit entities to exclude contraceptive benefits if the owner has a religious objection to providing contraceptive coverage.

Regulators continue to monitor the House v. Burwell case, which could eliminate the cost-sharing subsidy without appropriations. We know the law of the land requires Americans to purchase health insurance coverage or face a tax penalty. The tax penalty has reached meaningful levels where it is becoming a real incentive for individuals and families to encourage personal responsibility. Americans who fail to maintain minimum essential coverage are required to pay an annual tax penalty of the greater of $695 or 2.5% of household income starting in 2016. This is expected to nudge more people into purchasing health insurance in lieu of paying the tax penalty.

Mergers and acquisitions in the health insurance markets are a fact of life. This is an area where insurance regulators must remain vigilant. Maintaining a competitive balance is important in health insurance markets as it is in other market segments. Regulators must be mindful of how a merger will impact the delivery of health care and whether it makes the insurer more nimble or instead harms consumers by limiting competition and consumer choice.

The topic of network adequacy has also become timely. The ACA requires qualified health plans (QHPs) sold on the Exchanges to meet network adequacy standards. Through 2016, many state standards have been deemed sufficient. However, for 2017 the federal government is considering the establishment of federal standards that would be applied in all states that use the Federal Exchange. These one-size-fits-all standards would be applied unless the state has established its own standards based on the NAIC Managed Care Plan Network Adequacy Model Act (H74) (Model Act). The Model Act has recently been amended to strengthen protections for consumers while balancing the need for health insurers to promote quality and reduce costs. It provides significant latitude for states to establish appropriate

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network adequacy measures that take into account the state’s geography, density and markets, which work to enhance the benefits for consumers. I hope the federal Center for Medicare & Medicaid Services (CMS) will concur.

Another challenge is the struggle of the health insurance co-ops created under the auspices of the ACA. Closures of co-ops in Arizona, Colorado, Iowa, Kentucky, Louisiana, Michigan, Nevada, New York, Oregon, South Carolina, Tennessee and Utah give pause to the future financial challenges for remaining co-ops. In addition to those already ceasing to write policies, several other state co-ops are being closely monitored by regulators. Will the remaining co-ops be successful? Only time will tell. It is one of the important issues at the top of minds for insurance regulators in 2016.

**Private Flood Insurance vs. The NFIP**

Floods are the most common natural disaster in the U.S. and all 50 states have experienced floods or flash floods in the past five years. Since the 1960s the only way for the public to insure against flood loss is to purchase a policy from the National Flood Insurance Program (NFIP). State insurance regulators are keenly aware of the devastating effects floods have on consumers. Regulators believe it is critical that flood insurance is available and affordable to protect homes, businesses and personal property. Insurance consumers should have access to multiple options in order to find the best balance between coverage and price. I believe facilitating increased private sector involvement in the sale of flood insurance will help promote the consumer choice and spur competition.

There appears to be limited interest at this time from admitted insurers. However, several surplus lines insurers have expressed interest in providing flood insurance coverage equivalent to or broader than the offerings of the NFIP. It is not unusual for new coverage offerings to first appear in surplus lines markets. As the industry becomes more comfortable with the ability of the surplus lines market to write private flood insurance coverage profitably, the interest of admitted insurers will grow. We appear to be in the early stages of this market development.

One of the barriers to private flood insurance market growth has been the negative reaction of lenders to surplus lines coverage of flood risk. One of the stated principles of the federal Biggert-Waters Flood Insurance Reform Act of 2012 (Biggert-Waters) is to provide opportunities for growing the private market as an alternative to the NFIP. Yet Biggert-Waters allows banking and housing regulators and the government-sponsored enterprises (GSEs) to apply their own requirements related to the financial solvency, strength, or claims-paying ability of private insurers. This is an area where they have no expertise to make these insurance regulatory decisions. As a result, there is regulatory duplication and the overlap is constraining the private market development.

One of my goals for 2016 is to overcome the lender reluctance to surplus lines flood insurance policies as acceptable evidence of flood insurance. While the surplus lines insurance market is not subject to rate and policy form review by states, flood insurance contracts issued by surplus lines insurers mirror the provisions of the policy issued by the NFIP. State insurance regulators oversee the surplus lines insurance marketplace by imposing capital and surplus requirements on eligible U.S.-based carriers and licensing and supervising surplus lines brokers. Surplus lines insurers domiciled in a U.S. state are regulated by their state of domicile for financial solvency and market conduct. Surplus lines insurers domiciled outside the U.S. may apply for inclusion in the NAIC Quarterly Listing of Alien Insurers. The carriers listed on the NAIC Quarterly Listing of Alien Insurers are subject to: 1) capital and surplus requirements; 2) a requirement to maintain U.S. trust accounts; 3) and character, trustworthiness and integrity requirements. There does not appear to be any good reason for lenders to hamper the development of the private flood insurance markets.

**International Issues**

For several years we have been hearing that Solvency II is coming. At long last it is here. Insurers in Europe and U.S. insurers writing in Europe now have to deal with the fallout. One of the features of Solvency II is the imposition of group capital standards on regulated entities operating in the European Union (EU). Solvency II also has the concept of equivalence embedded in it. This has led to many meetings and much dialog between European regulators and Team USA, which consists of state insurance regulators and representatives of the Federal Reserve, and the Federal Insurance Office (FIO).

The regulatory approaches in Europe are very different in purpose and scope. European regulators view stockholder protection as their primary mission, while U.S. regulators view policyholder protection as job one. To protect stockholders, Solvency II applies group capital standards at a high enough level to minimize the likelihood of a financial services

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4 https://www.floodsmart.gov/floodsmart/pages/flood_facts.jsp
group failing. Their view tends to require the firms to hold a very high level of capital to meet regulatory requirements. The U.S. approach to solvency regulation starts at the entity level and relies on the unique U.S. concept of statutory accounting to add elements of conservatism. Both systems have a risk-based capital (RBC) tool. However, the U.S. RBC levels are designed as a regulatory tool, rather than a target capital amount the entity must obtain. The U.S. system constructs regulatory walls around the legal entity insurer and has protected policyholders from raids on capital from other entities within the group. As such, the U.S. RBC is applied at the entity level rather than to the group as a whole.

EU insurance regulators and U.S. representatives, including state insurance regulators have been engaging in regulatory dialogues over the last 10 years on issues of mutual regulatory concern. In January 2012, they embarked on the EU-U.S. Mutual Regulatory Understanding Dialogue Project, with the objective of further enhancing understanding and cooperation between the two systems for the benefit of insurance consumers, business opportunity and effective supervision. With the involvement of technical experts from both continents, the project produced a report on commonalities and differences between the jurisdictions in key areas of supervision. A detailed project plan was developed in early 2013 and plans were laid to periodically update the plan as certain common objectives and initiatives are pursued over the next five years. The notion of measuring equivalence and the U.S. requirement for posting of reinsurance collateral by non-U.S. reinsurers were among the topics being discussed.

In late 2015, the FIO and the Office of the United States Trade Representative (USTR) jointly announced pursuit of a “covered agreement.” The notion of a covered agreement was included in Title V of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) as a unique stand-by authority for the U.S. Department of Treasury (Treasury Department) and the USTR to address, if necessary, those areas where U.S. state insurance laws or regulations treat non-U.S. insurers differently from U.S. insurers. A covered agreement can serve as a basis for preemption of state law under certain circumstances, but only if the agreement relates to measures substantially equivalent to the protections afforded consumers under state law.

Historically, in the area of reinsurance collateral, U.S. insurance regulators have required non-U.S. reinsurers to hold 100% collateral within the U.S. for the risks they assume from U.S. insurers. This is consistent with traditional U.S. approaches to policyholder protection, as reinsurers are ultimately providing security to primary insurers that are directly protecting U.S. policyholders. Requiring reinsurers to hold collateral in the U.S. is intended to ensure claim-paying capital is available and reachable by U.S. firms and regulators if needed. However, foreign reinsurers’ regulators and other stakeholders have objected to foreign insurers having to post collateral in the U.S. because this makes such capital unavailable for other purposes, including investment opportunities.

Recognizing the potential for variation in collateral requirements across states to make planning for collateral liability more uncertain and thus potentially more expensive, state regulators have been working together through the NAIC to reduce collateral requirements in a consistent manner commensurate with the financial strength of the reinsurer and the quality of the regulatory regime that oversees it. The NAIC passed amendments to the NAIC Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (Credit for Reinsurance Models) in 2011. Once implemented by a state, the amendments will allow foreign reinsurers to post significantly less than 100% collateral for U.S. claims, provided the reinsurer is evaluated and certified. Individual reinsurers are certified based on criteria that include, but are not limited to, financial strength, timely claims payment history, and the requirement a reinsurer be domiciled and licensed in a qualified jurisdiction.

In August 2013, the NAIC adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions, which established a comprehensive process for evaluating a jurisdiction’s oversight of reinsurers in order to determine whether it is a jurisdiction for purposes of reduced collateral. The 2011 amendments to the Credit for Reinsurance Models require an assuming insurer to be licensed and domiciled in a qualified jurisdiction in order to be eligible for certification by a state as a certified reinsurer. Bermuda, France, Germany, Ireland, Japan, Switzerland and the UK have been placed on the NAIC List of Qualified Jurisdictions.

The NAIC has also established a peer review system surrounding the certification of foreign reinsurers by states, which provides a foreign reinsurer an opportunity for a passport throughout the U.S. As of Aug. 1, 2015, 26 foreign reinsurers have been certified under this peer review system.

U.S. regulators were hopeful the EU/U.S. Insurance Dialogue Project would be sufficient to reach accord on rein-
Roadmap to the Future (continued)

surance collateral and other regulatory matters such as equivalence. Apparently the FIO and the USTR did not concur. At the time of this writing regulators are waiting to see what might be included in the proposed covered agreement. I remain hopeful an accord can be reached without preemption of state laws, as state insurance regulators are well on the way to implementing the reinsurance collateral solution and have recognized several of the European nations as qualified jurisdictions. Only time will tell.

Another work stream involves discussions on development of group capital standards for U.S. firms. Insurance regulators, working collectively through the NAIC, have been engaged with the Federal Reserve and FIO on development of a U.S. version of group capital standards. The Federal Reserve is obligated by Dodd-Frank to develop capital standards for the groups it oversees. State insurance regulators have regularly conducted group supervisions through the Insurance Holding Company System Regulatory Act (#440) and the corresponding Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450).

The NAIC adopted significant revisions to the model law and model regulation in 2010. The revisions included: 1) expanding the ability to evaluate any entity within an insurance holding company system; 2) enhancements to the regulators’ rights to access books and records and compelling production of information; 3) establishment of an expectation of funding with regard to regulator participation in supervisory colleges; and 4) enhancements in corporate governance, such as board of directors and senior management responsibilities. Additionally, regulators adopted an expansion to the Insurance Holding Company System Annual Registration Statement (Form B) to broaden requirements to include financial statements of all affiliates. A new Form F (Enterprise Risk Report) has also been introduced for firms to identify and report their enterprise risk.

In addition to these changes, U.S. insurance regulators are currently implementing a U.S. version of the international concept of the Own Risk and Solvency Assessment (ORSA). In an ORSA, every U.S. insurer (or its holding company group) will complete a self-assessment of its risk management, stress tests and capital adequacy on a yearly basis. Through the ORSA, U.S. regulators will be able to add to their existing assessment of group capital with analysis of the insurer’s own assessment of its group capital needs. In March 2012, the NAIC adopted the ORSA Guidance Manual which provides guidance to an insurer and/or the insurance group with regard to reporting an ORSA. In September 2012, the NAIC adopted the Risk Management and Own Risk and Solvency Assessment Model Act (#505). Model #505 sets out the legal framework for requiring a risk management framework and the filing of a summary report. Many states have already adopted the model law. ORSA pilot projects have been successful and it is expected the ORSA will be implemented by 2017.

● LTC Insurance Market Challenges

Long-term care (LTC) insurance refers to a wide range of services that meet the medical and non-medical needs of those who cannot care for themselves. People may need this type of care if they have a prolonged illness or disability. This care can encompass home health care, adult daycare, nursing home care or care provided in a group living facility. LTC insurance is one way, but not the only way, to pay for these long-term care needs. LTC insurance is designed to cover all or some of the services provided by medical, in-home care and social services personnel. In many cases family members provide primary care to aging parents when LTC insurance is not present.

The LTC market has evolved significantly. In the past decade those requiring LTC has grown from less than 3 million people to now more than 7 million. According to the U.S. Department of Health and Human Services (HHS), about 12 million of America’s senior citizens will require long-term care by 2020. As the baby boomers age, the demand for LTC services will continue to grow. The primary challenge for this segment of the population is to be able to figure out how to fund their LTC needs.

LTC insurance products were first developed in the 1960s following the creation of the Medicare program in 1965. These initial policies were intended to supplement payment for the primary form of LTC at the time—nursing homes. LTC insurance policies now incorporate a myriad of long-term care service alternatives including home health care, respite care, hospice care, personal care in the home, services provided in assisted living facilities, adult day care centers and other community facilities. Public programs, such as Medicare and Medicaid, also cover certain LTC services. As our population ages, the need for LTC support and services will become increasingly important and require innovative new approaches.

Insurers writing LTC insurance share in the senior’s dilemma. They do not have a crystal ball they can use to predict health care delivery costs in the future. In addition, insurers
that have been active for some time in the LTC insurance marketplace are supporting the burden of some inadequately priced business written in the past. When compounded with the low-interest rate environment limiting investment returns, the situation is quite challenging. These challenges have dampened the enthusiasm of insurers to participate in the long-term care insurance markets.

I believe current economic conditions are dictating short-term product trends. However, demographics will dictate long-term product trends. We are faced with an aging population which will result in a declining number of working-age people paying for each retiree going forward. People are living longer and all these factors lead to concern about the future viability of public programs such as Medicare and Medicaid. I expect these dynamics will drive increased demand for LTC insurance over the long run.

**CONCLUSION**

I hope this article has provided some insight into many of the challenges insurance regulators will face in 2016. I am optimistic these challenges are really opportunities for us to improve this industry, our insurance markets, and the quality of consumer protection state insurance regulators provide.

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**ABOUT THE AUTHOR**

Director John M. Huff, a native of Potosi, Missouri, was appointed Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration by Gov. Jay Nixon on Feb. 6, 2009. An attorney, he leads the department that protects consumers through the regulation of professionals and businesses that impact Missourians’ lives daily.

Director Huff was elected by his peers to serve as the 2016 President of the National Association of Insurance Commissioners, the national insurance standard-setting organization for the U.S.

In September 2010, he was appointed to the U.S. Financial Stability Oversight Council by the NAIC. Director Huff served two terms on the council and was the initial state insurance regulator appointee. The council was created by the 2010 Dodd-Frank Wall Street Reform and Consumer Protection Act.

Before entering public service, he spent 11 years as an executive with leading insurers and reinsurers, including Swiss Re and GE Insurance Solutions. Director Huff earned his bachelor’s degree in business administration from Southeast Missouri State University. He earned an MBA at Saint Louis University, and his juris doctor degree from the Washington University School of Law in St. Louis.
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