We are pleased to provide the latest issue of the Center for Insurance Policy and Research (CIPR) Newsletter. Our goal is to provide thought leadership and information for an audience including U.S. and international regulators, state and federal policy makers, lawmakers, academics, researchers and consumers on the latest regulatory activities and key issues, trends and risks that affect the insurance industry. We want to provide you with insight into the major challenges that face the regulatory community and to promote a greater understanding of a wide range of national and international developments in the insurance world.

This issue includes eight articles we hope are of great interest to our readers. We begin with a discussion of the Own Risk and Solvency Assessment (ORSA) by CIPR Manager Shanique Hall and Kris DeFrain, Director of the NAIC Research and Actuarial Department of the Regulatory Services Division. This timely article discusses a key element in our effort to modernize the U.S. approach to the regulation of insurance groups.

Sara Pankow, NAIC Research Analyst and Sara Robben, NAIC Statistical Advisor write about the recently enacted Biggert-Waters Flood Insurance Reform Act and summarize some of the key observations from the recent CIPR Flood Insurance Summit. NAIC International Intern Justin Mohn provides an overview of political risk insurance (PRI) and addresses why demand for PRI is on the rise.

I contribute two articles to this edition. The first describes lender-placed insurance (LPI) which has become a hot topic in recent months. The NAIC has begun reviewing LPI as more placements are occurring in the recent economic downturn. I also discuss cyber risk management and how insurers are offering innovative insurance products to meet businesses’ risk management needs.

NAIC Market Analysis Manager Randy Helder provides a comprehensive overview of the market conduct analysis framework. In recent years, the regulation of market conduct of insurance entities has been maturing toward a more rigorous and systematic process. The NAIC Research and Actuarial Department provides data at a glance. This quarter we take a look at insurance-related gross domestic product and insurance employment trends as well as revenue and budgetary statistics.

We close with an update to an article featured in previous editions of the CIPR Newsletter. CIPR Research Analyst Dimitris Karapiperis writes about the recent revisions to life insurance reserves for universal life policies with secondary guarantees and Actuarial Guideline XXXVIII (AG 38).

I hope you enjoy the newsletter and tell your friends about it. Your comments and suggestions for improvement are always welcome.

Eric Nordman
CIPR Director

<table>
<thead>
<tr>
<th>Inside this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurers, Are You Ready? The Own Risk and Solvency Assessment (ORSA) is On Its Way</td>
</tr>
<tr>
<td>Biggert-Waters Flood Insurance Reform Act of 2012</td>
</tr>
<tr>
<td>Political Risk Insurance: Insuring Against Man-Made Risk</td>
</tr>
<tr>
<td>Lender-Placed Insurance</td>
</tr>
<tr>
<td>The Market Conduct Analysis Framework</td>
</tr>
<tr>
<td>Research and Actuarial Department: Data at a Glance</td>
</tr>
<tr>
<td>Managing Cyber Risk</td>
</tr>
<tr>
<td>Revised AG 38 Adopted By NAIC</td>
</tr>
</tbody>
</table>

http://cipr.naic.org
**INSURERS, ARE YOU READY? THE OWN RISK AND SOLVENCY ASSESSMENT (ORSA) IS ON ITS WAY**

By Shanique (Nikki) Hall, CIPR Manager; and Kris DeFrain, FCAS, MAAA, CPCU, Director, Research and Actuarial Services

**INTRODUCTION**

Aligning insurance supervision with insurance business practice, insurance regulators across the globe have been working toward a common goal of improving the processes for understanding and measuring risks inherent in the business of insurance. The International Association of Insurance Supervisors (IAIS) is promoting a concept called Own Risk and Solvency Assessment (ORSA) as a key component of regulatory reform. An ORSA will require insurance companies to issue their own assessment of their current and future risk through an internal risk self-assessment process and it will allow regulators to form an enhanced view of an insurer’s ability to withstand financial stress.

The ORSA concept is now embedded in the IAIS standards and is in various stages of implementation in the United States, Europe and other jurisdictions. Resulting from the NAIC Solvency Modernization Initiative (SMI), large- and medium-size U.S. insurance groups and/or insurers will be required to regularly conduct an ORSA starting in 2015. Solvency II, the regulatory regime that is being implemented in Europe, will require nearly all European Union-domiciled insurers to be subject to Solvency II requirements once it becomes effective in the next few years. An ORSA is a key part of Solvency II. The Australian Prudential Regulatory Authority (APRA) will require life and property/casualty insurers to have an Internal Capital Adequacy Assessment (ICAAP), which is similar to Solvency II’s ORSA, in place by Jan. 1, 2013. Other jurisdictions—including Japan, Canada, Bermuda and Switzerland—are implementing similar changes.

While the overall concept of ORSA is similar among jurisdictions, specific definitions and requirements differ by country. This article will discuss the purpose and general characteristics of an ORSA and summarize some of the major policy developments in the United States. The article will also contrast how the U.S. ORSA initiative compares to the ORSA under development in the European Union (EU).

**ORSA: WHAT IS IT?**

In essence, an ORSA is an internal process undertaken by an insurer or insurance group to assess the adequacy of its risk management and current and prospective solvency positions under normal and severe stress scenarios. An ORSA will require insurers to analyze all reasonably foreseeable and relevant material risks (i.e., underwriting, credit, market, operational, liquidity risks, etc.) that could have an impact on an insurer’s ability to meet its policyholder obligations.

The “O” in ORSA represents the insurer’s “own” assessment of their current and future risks. Insurers and/or insurance groups will be required to articulate their own judgment about risk management and the adequacy of their capital position. This is meant to encourage management to anticipate potential capital needs, and to take action before it’s too late. ORSA is not a one-off exercise; it is a continuous process and should be a fundamental part of the risk-management system for an insurer. Moreover, there is no mechanical way of conducting an ORSA; how to conduct the ORSA is left to each insurer to decide, and actual results and contents of an ORSA report will vary from company to company. The output will be a set of documents that demonstrate the results of management’s self-assessment.

**ORIGIN OF ORSA**

The origin of the term ORSA can be traced to insurance sector reforms introduced by the Financial Services Authority (FSA), the United Kingdom’s financial regulatory agency. In response to a rash of insolvencies, the FSA developed a new solvency framework in the early 2000s, and implemented it in approximately 2004. Many of the FSA reforms were designed to ensure that insurers have enough capital to cover potential risks. According to the FSA, the overall aim of the reforms were to reduce “the probability of prudential failure, in a cost-efficient way that creates greater transparency in the arrangements for setting regulatory capital levels, while at the same time promoting a strong culture of risk management.”

(Continued on page 3)

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One of the FSA reforms required firms to develop internal models to analyze their overall risk position. In 2005, the FSA implemented the Individual Capital Adequacy Standards (ICAS). ICAS required insurers to undertake a risk-based capital assessment to better understand their risk profile and to improve policyholder protection. ICAS is essentially a firm’s assessment of its own risk profile in order to determine the level of capital required to mitigate the specific risks inherent in their business. To integrate the ICAS into the operations of the business and broaden it from more of a compliance exercise to an internal assessment process “owned” by the insurer, the FSA developed the concept of an Own Risk and Capital Assessment that was based on the ICAS concept.

The ICAS regime will be replaced by Solvency II, which was initiated in 2000 by the European Commission to implement a fundamental change to European insurance regulation. Solvency II builds on the Own Risk and Capital Assessment framework; changing the “C” (capital) to “S” (solvency) to make it more consistent with the named reforms (Solvency II). Solvency II aims to create a more harmonized, risk-oriented solvency regime, resulting in capital requirements that are more reflective of current and future business risks. A key feature is the requirement that all firms undertake an ORSA to demonstrate “sound and prudent management of the business” and assess overall solvency needs.

In 2010, the ORSA concept was adopted as part of the IAIS Insurance Core Principles (ICPs). The IAIS adopted 26 revised ICPs in October 2010 to accommodate new approaches to insurance supervision, including the adoption of ICP 16—Enterprise Risk Management (ERM). ICP 16 says an insurer should perform an ORSA to regularly assess the adequacy of its risk management in supporting the current, and the expected future, solvency positions. ICP 16 applies to “insurance legal entities and insurance groups with regard to the risks posed to them by non-insurance entities.”

As a result, an ORSA is now a worldwide standard. In order to comply with the ICPs, all IAIS members are asked to apply ICP 16 in their legal frameworks and supervisory practices. Moreover, the ICPs are used by the International Monetary Fund (IMF) and World Bank in the Financial Sector Assessment Program (FSAP) review. Conducted worldwide, the FSAP is designed to address financial sector stability issues through an evaluation of the regulatory rules and practices measured against the internationally recognized standards and codes. For insurance, the ICPs form the basis for the assessment of regulators’ observance of international standards.

A key difference between ORSA and the ICAS predecessor is that ORSA includes qualitative assessments of the insurer’s governance, whereas the ICAS focused mainly on the firm’s quantitative capital requirements. Under ICAS, firms were required to undertake regular assessments of the amount and quality of capital adequate for its size and nature of business (its ICA). In contrast, an ORSA includes qualitative requirements for measuring financial position, as well as a review of risk-management practices. In addition, ORSA results lead to actual company action plans. According to ICP 16.11.1, “Every insurer should undertake its ORSA and document the rationale, calculations and action plans arising from this assessment.”

Moreover, to address concerns arising from the global financial crisis and American International Group intervention, ORSA reaches beyond the regulated insurance entity and includes risk affecting the insurance group, even where the affiliates are not insurance entities. According to ICP 16.13, the insurer’s ORSA should encompass all reasonably foreseeable and relevant material risks, as well as risks arising due to membership of a group.

**NAIC U.S. ORSA**

In light of the recent financial crisis, U.S. insurance regulators began to modify their supervisory framework. In 2008, the NAIC launched the Solvency Modernization Initiative—a critical self-examination to update the U.S. insurance solvency framework. SMI focuses on key issues such as capital requirements, governance and risk management, group supervision, statutory accounting and financial reporting, and reinsurance. As part of the SMI, the NAIC re-evaluated risk-based capital (RBC) in the United States and determined that RBC will continue to form the backstop function for insurer solvency to: (1) guarantee regulator action; and (2) provide the legal authority to intervene without extensive litigation.

(Continued on page 4)
Regulators decided that additional capital assessments evaluating prospective solvency should be added to the system. Additional capital assessments will be included in ORSA to complement RBC as a financial regulatory safeguard. The *NAIC ORSA Guidance Manual*, which was adopted by the NAIC Executive (EX) Committee and Plenary in March 2012, provides information for insurers on performing its ORSA and documenting risk policies and procedures.

Pursuant to the *NAIC ORSA Guidance Manual* and the newly adopted Risk Management and Own Risk and Solvency Assessment Model Act (#505), an insurer and/or the insurance group of which the insurer is a member will be required to complete an ORSA “at least annually to assess the adequacy of its risk management and current, and likely future, solvency position.” The ORSA will apply to any individual U.S. insurer that writes more than $500 million of annual direct written and assumed premium, and/or insurance groups that collectively write more than $1 billion of annual direct written and assumed premium.

While the *NAIC ORSA Guidance Manual* is deliberately non-prescriptive, because each ORSA will be unique and will vary depending on risks that are unique to that insurer/group, insurers subject to the ORSA requirements are instructed to examine their own risk profile in three major sections. Section 1 – Description of the Insurer’s Risk Management Framework, should be a high-level summary of its own risk-management framework, including risk appetite, tolerance and limits and internal controls. Section 2 – Insurer’s Assessment of Risk Exposure, should include detail showing the insurers’ process for assessing risks (both qualitative and quantitative assessments should be performed) in both normal and stressed environments. Section 3 – Group Risk Capital and Prospective Solvency Assessment, should demonstrate that current and future capital is sufficient to support the identified risks.

Companies must keep the ORSA up-to-date through an annual update and review. All foreseeable and materials risks should be included in the assessment. Insurers will need to develop processes to perform a self-assessment in the stressed environment using either a stress test methodology or stochastic model.

To avoid duplicative international regulatory requirements, an internationally active insurer may be able to satisfy the ORSA filing requirements, or sections, by providing the most recent and substantially similar report provided by the insurer or another member of an insurance group, of which the insurer is a member, to a supervisor or regulator of a non-U.S. jurisdiction.

When the NAIC Executive (EX) Committee and Plenary adopted Model #505 on Sept. 12, 2012, it was expected that each jurisdiction would adopt risk-management and ORSA requirements into state law prior to 2015. Model #505 provides the requirements for completing an annual ORSA and provides guidance and instructions for filing an ORSA Summary Report.

According to Model #505, the ORSA Summary Report should demonstrate that each entity’s capital—both regulatory and economic—is sufficient to cover the risks inherent in the entity’s business plan. If the insurer does not have the necessary capital to meet its current or projected risk capital requirement, then it should describe the management actions it has taken (or will take) to remediate any capital adequacy concerns.

In July 2012, the NAIC ORSA (E) Subgroup completed an ORSA Feedback Pilot Project. The project was a review of confidential ORSA Summary Reports from 14 volunteer insurance groups. The goal of the project was to provide feedback to the industry, identify revisions to the *NAIC ORSA Guidance Manual*, and identify areas to develop guidance for regulators. The project also served to help guide the development of enterprise risk management education materials for state insurance regulators. Based on the ORSA (E) Subgroup’s observations, they will evaluate the need for revisions to the *NAIC ORSA Guidance Manual* and finalize a pilot project report with key observations that will be made available to the public. The pilot program is expected to be repeated in 2013.

**How ORSA Fits Into The U.S. Solvency System**

A cornerstone of the U.S. solvency system is the risk-focused surveillance process. In this process, the regulator studies and reports on an insurer’s financial condition, focusing on residual risks (not sufficiently mitigated through controls) in the insurer’s overall operations. The residual risks are determined after regulators obtain an understanding of the insurer’s overall operations, inherent risks and risk-mitigation strategies/controls. Regulators recently enhanced the risk-focused surveillance to better incorporate prospective risk assessment in identifying insurers that have, or will encounter, solvency issues and bring focus to the broader issues of the ability of management to identify, assess and manage (Continued on page 5)
the business risks of the insurer. An ORSA will fit readily into this process.

The information an ORSA contains will supplement the risk-focused examination process and provide regulators with a more dynamic view of each company’s risk profile. The NAIC ORSA Guidance Manual notes that the depth and breadth of the insurer’s risk-focused examination will hinge on the contents and discussions surrounding the ORSA Summary Report. As noted earlier, the ORSA Summary Report should include three major sections. Section 1 documents the company’s risk-management framework, while Section 2 documents the insurer assessment of risk exposures. In the risk-focused surveillance process, regulators currently perform certain elements of risk-management evaluation, which includes an assessment of risk and the insurer’s ability to manage or mitigate risks. As part of the enhanced risk-focused surveillance process, U.S. insurers are required to detail the risks they face and how they mitigate those risks. Section 1 and Section 2 of the ORSA Summary Report create a formalized risk-management reporting and quantification requirement in the enhanced risk-focused surveillance process.

Section 3 of the ORSA Summary Report documents how the company combines the qualitative elements of its risk-management policy and the quantitative measures of risk exposure in determining the level of financial resources it needs to manage its current business and its longer-term business. For U.S. regulators, RBC models are among multiple tools available to evaluate an insurer’s ability to fulfill its obligations to policyholders. The NAIC RBC system was adopted by most of the states in the 1990s in order to “provide a capital adequacy standard that is related to risk, raises a safety net for insurers, is uniform among the states, and provides regulatory authority for timely action.” A separate RBC formula exists for each of the primary insurance types: life, property/casualty, health and fraternal.

RBC provides a legal-entity view of required capital and a group capital view in some situations (e.g., for parent insurance companies), whereas the ORSA will more often provide a group view of capital. An ORSA will also enhance regulators’ ability to determine an insurer’s prospective solvency position and understand actual, projected and target levels of risk capital in excess of the required regulatory minimum levels. This will allow regulators to key in on each insurer’s top risks more efficiently and allocate resources to the most critical areas for regulatory review. It is important to note that, while the ORSA forms part of the supervisory process, it does not create an additional capital requirement; rather, it allows for extensive regulatory assessment of the group capital position.

**ORSA: Key Differences Among the U.S. and EU**

The scope and general purpose of an ORSA is relatively similar across jurisdictions. The concept supports a robust company risk-management framework and the approaches are not rules-based or static formula-based. However, while there are similarities, the two approaches are not identical. The following summarizes some of the key differences between the U.S. ORSA and EU Solvency II ORSA.

**Management/Board:** Currently, the U.S. ORSA and the Solvency II ORSA require a different degree of involvement of management in the ORSA process. The European Insurance and Occupational Pensions Authority (EIOPA) Chairperson Gabriel Bernardino has noted that ORSA changes the viewing angle from bottom-up to top-down and that ORSA will change the way boards of directors approach the risk- and capital-management processes. In the EU ORSA consultation paper, it states that “The undertaking should ensure that its administrative, management or supervisory body takes an active part in the ORSA process by steering how the assessment is performed and challenging its results.”

The NAIC ORSA Guidance Manual requires the management board to decide on the adequacy of the firm’s ERM system and capital, based on their own assessment of the firm’s future plans, risk and risk capacity. However, the NAIC ORSA Guidance Manual does not clearly define or distinguish the role and responsibilities of the board of directors and senior management for the holistic ERM processes.

**Proportionality and Exemptions:** In the EU, all (re)insurers with gross premium income exceeding €5 million are subject to Solvency II. All EU-domiciled insurers in this threshold, including small insurers, will be subject to an ORSA requirement.

(Continued on page 6)
In the United States, insurance groups will be exempted from the ORSA requirement if their premium income writing is less than $1 billion per year, as well as individual insurers with less than $500 million in annual premium. This is expected to capture at least 80% of the U.S. insurance market, while relieving a large number of smaller insurers from the ORSA requirement. In addition, an insurer may make an application to the domiciliary commissioner for a waiver from the requirements of the ORSA based on unique circumstances. U.S. regulators consider the extensive financial reporting requirements to effectively be a proportionate “mini ORSA” for smaller insurers.

**Legal Entity and Group Reporting:** Under Solvency II, both the legal entity and the group will be required to perform an ORSA. In the United States, an insurer, or the insurance group to which the insurer is a member, is required to perform an ORSA for “however a company/group manages its business,” which could be legal entity, a subgroup of entities in the group or the group as a whole. U.S. regulators view the ORSA as reporting of business practice and, thus, want the reporting to reflect how the business is actually managed for risk-management purposes.

**Regulatory Action:** Actions regulators will take based on information in the ORSA is unclear. If a company reports in their ORSA that their available capital is insufficient to meets its prospective capital needs, U.S. regulatory action could range from additional scrutiny during the regulatory process to public reports detailing the inadequacy of the firm’s risk-management practices. If a company reports in their ORSA that there are risks not contemplated in their regulatory requirements, under Solvency II, an additional capital requirement may be assessed, while the NAIC would consider the issue in the assessment of the overall financial condition.

**Summary**
An ORSA will help regulators better understand the prospective risks to each insurer’s plan and judge the adequacy of capital for the risks identified. An effective ORSA can provide useful insights into the capital and efficiency of the business and management actions needed in the future. It will enable companies to evaluate the long-term capital efficiency of particular products and assist in the design of new policies. Regulators will use the results of the ORSA to form an opinion of an insurer’s risk management and prospective solvency. This allows regulators to use the ORSA as an “early warning” device and to work with the insurance group to strengthen the insurer’s risk-management, solvency-assessment and capital-management processes where necessary.

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<table>
<thead>
<tr>
<th>EU Solvency II ORSA and U.S. ORSA — Key Differences</th>
<th>European Union</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Management/Board</strong></td>
<td>Role and responsibilities of board of directors and senior management defined.</td>
<td>Role and responsibilities of board of directors and senior management under discussion.</td>
</tr>
<tr>
<td><strong>Proportionality</strong></td>
<td>All (re)insurers subject to Solvency II</td>
<td>Group &gt; $1B or entity &gt; $500M (all others have significant financial reporting deemed proportionate)</td>
</tr>
<tr>
<td><strong>Legal Entity and Group Reporting</strong></td>
<td>Both legal entity and group</td>
<td>Based on how a company manages its risks (legal entity, subgroup, enterprise)</td>
</tr>
</tbody>
</table>

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Biggert-Waters Flood Insurance Reform Act of 2012

By Sara Pankow, NAIC Research Analyst II; and Sara Robben, NAIC Statistical Advisor

Floods are the most common natural disaster in the United States. In 1968, the U.S. Congress enacted the National Flood Insurance Program (NFIP), primarily because flood insurance was nearly unavailable from the private insurance markets following frequent widespread flooding along the Mississippi River in the early 1960s. The NFIP is an important component of the federal government’s efforts to limit the damage and financial impact of floods. Although state insurance departments regulate most insurance, the NFIP is a federal program managed by the Federal Emergency Management Agency (FEMA). State insurance regulators collaborate with the NFIP and FEMA to ensure that consumers are sufficiently protected and informed.

Since 2008, the NFIP had been operating under numerous stopgap extensions (17) and shut down twice for several weeks. On July 6, 2012, President Barack Obama signed into law the Biggert-Waters Flood Insurance Reform Act of 2012, extending the NFIP for five years through Sept. 30, 2017. This long-term extension is critical to provide stability to the program, which protects more than 5.5 million consumers throughout the country. In addition to the five-year program reauthorization, the legislation includes many program reforms.

On Aug. 14, 2012, the NAIC’s Center for Insurance Policy and Research (CIPR) held a summit on the recently enacted flood reauthorization bill and future challenges of the NFIP. Speakers from many different perspectives, including academia, state and federal governments, consumer groups and the industry, met to share their knowledge on flood insurance. This article will summarize some of the NFIP reforms, as well discuss key observations of the summit.

NFIP Reforms

The Biggert-Waters Flood Insurance Reform Act of 2012 phases out subsidies for vacation and second homes, as well as businesses, severe repetitive loss properties or substantially improved/damaged properties. Under the new legislation, rates for these properties will increase by 25% per year until premiums meet the full actuarial cost, attempting to move the NFIP toward risk-based pricing. Properties not currently insured by the NFIP or any lapsed policy also will be subject to full actuarial rates.

In determining chargeable premium rates, the reform requires the rates be adequate on the basis of actuarial principles to cover the average historical loss-year obligations incurred by the National Flood Insurance Fund and allows for the use of historical loss data, including catastrophic loss years. However, the law does add the flexibility of installment payments for policyholders, whereas previously payments for NFIP policies required full payment of the insurance annually. The new legislation requires FEMA to develop an installment plan to allow policyholders that are not required to have their premium escrowed every month with their lender to pay their flood insurance premium in installments.

The NFIP reform also requires a premium rate adjustment to any property located in an NFIP-participating area to accurately reflect the current risk of flood. The determination of this risk is made after the effective date of any revised or updated flood insurance rate map (FIRM). The legislation requires any increase in the risk premium be phased in over a five-year period at a rate of 20%. This differs from the previous NFIP program, which placed a 10% cap on an increase-of-risk premium. However, there are some properties located in areas that were not previously designated as a special flood area. At some point in the future, these locations may become designated as such areas. For such properties, the chargeable risk premium rate will be phased in over a five-year period at a rate of 20% following the effective date of the remapping.

In addition to the premium rate adjustment reform, the legislation imposes minimum deductibles on flood claims. The minimum annual deductible for a pre-FIRM property is $1,500 if the property is insured for $100,000 or less, and $2,000 for a property insured for more than $100,000. The minimum annual deductible for post-FIRM properties is $1,000 for properties insured for $100,000 or less, and $1,250 for properties insured for more than $100,000.

The law includes language, supported by the NAIC, requiring FEMA, at a state’s request, to participate in state-sponsored non-binding mediation to resolve insurance claim disputes. Non-binding mediation has a proven record that will allow the NFIP, insurance companies and policyholders to settle claims quickly outside the expensive and time-consuming litigation process.

(Continued on page 8)
Additionally, the new legislation requires FEMA to establish a reserve fund to help meet future obligations of the NFIP in higher-than-average loss years. The reserve fund will phase in a reserve ratio or balance equal to 1% of the sum of the total potential loss exposure of all outstanding flood insurance policies in force during the prior fiscal year. Furthermore, the legislation authorizes FEMA to establish, increase or decrease the amount of aggregate annual insurance premiums to be collected to maintain the reserve ratio and to place an amount not less than 7.5% of the reserve ratio into the fund until it is fully capitalized. If the NFIP is not able to make the minimum contribution, it must report this to Congress. The reserve fund will be phased in at the beginning of the 2013 fiscal year.6

Establishing a reserve fund is important in light of the fact the NFIP has been operating under a deficit for a number of years. This deficit can be attributed primarily to the 2005 hurricane season (Hurricanes Katrina, Rita and Wilma), a time in which the NFIP had to borrow approximately $17 billion from the U.S. Treasury. The legislation includes a provision requiring FEMA to repay the flood insurance debt incurred to date. FEMA is charged with creating a debt repayment schedule and reporting its progress every six months. FEMA is also required to submit a report to Congress on the options available to the agency for eliminating the debt within 10 years.7

Another section of the legislation establishes a Technical Mapping Advisory Council to address map modernization issues. The council is to include representatives from FEMA, various federal agencies, state and local governments, as well as experts from private stakeholder groups. This council is responsible for suggesting improvements regarding accuracy, general quality, ease of use, and distribution and dissemination of flood insurance rate maps. Recommending mapping standards and guidelines for improving these maps are also included in the scope of this legislation. The council will also be required to provide standards for data accuracy, data quality, data currency and data eligibility, in addition to maintaining and recommending maintenance of flood insurance rate maps and flood insurance risk identification on an ongoing basis.8 Annual progress reports to Congress are required.

In line with the Technical Mapping Advisory Council, the National Flood-Mapping Program is to be established by FEMA to review, update and maintain flood insurance rate maps, including all areas within the 100-year and 500-year floodplains and residual risk areas. Additionally, FEMA is charged with enhancing communication and outreach to the states, local communities and property owners regarding mapping changes and mandatory purchase requirements. This program establishes a process for local communities to request a remapping based on the standards recommended by the technical mapping advisory council.9

The new law requires a number of reports and studies on a broad range of issues aimed at greater accountability, oversight and transparency. The U.S. Treasury Department’s Federal Insurance Office (FIO) is required to conduct a study on the current state of the market for natural catastrophe insurance and report to Congress no later than one year after the enactment of the bill. FEMA has been charged with an annual report regarding the NFIP financial conditions and a study of participation and affordability issues.

Another report that is of particular interest requires FEMA and the U.S. Government Accountability Office (GAO) to assess options for privatizing the NFIP. The legislation requires reporting on reinsurance assessment, by assessing the capacity of the private reinsurance, capital and financial markets to assist communities, on a voluntary basis, in managing the full range of financial risks associated with flooding by requesting proposals to assume a portion of the insurance risk of the NFIP.10 The GAO is also charged with conducting a study regarding business interruption and additional living expenses coverage, as well as investigation of reinsurance/privatization initiatives. The law contains definitive deadlines for select provisions that the NFIP must adhere to, and although FEMA will be working with Congress, it might be a challenge to meet all of the deadlines.11

† CIPR Flood Insurance Reform Summit

The CIPR Flood Insurance Reform Summit was hosted by Mississippi Insurance Commissioner Michael Chaney, chair of the NAIC’s Property and Casualty Insurance (C) Committee. Speakers included Edward Connor, deputy associate administrator for federal insurance, Department of Homeland Security, FEMA; Howard Kunreuther, professor of operations and information management and co-director of the Risk Man—

(Continued on page 9)
Biggert-Waters Flood Insurance Reform Act of 2012 (Continued)

management and Decision Processes Center, Wharton School of Business, University of Pennsylvania; Jeff Czajkowski, Travelers research fellow and Willis Re research fellow, Risk Management and Decision Processes Center, Wharton School of Business, University of Pennsylvania; Peter Kochenburger, director of graduate programs and associate clinical professor of law, University of Connecticut School of Law; Sonja Larkin-Thorne, NAIC funded consumer representative; Patty Templeton-Jones, chief operating officer, Fidelity National Insurance Services; Jennifer Rath, chair, Insurance Institute for Business and Home Safety (IBHS) Flood Committee; and Stuart Mathewson, Chair of the Flood Insurance Subcommittee and Co-chair of the Extreme Events Committee of the American Academy of Actuaries.

Providing the federal viewpoint, Connor summarized the newly passed reauthorization of the NFIP and focused on mandated rate increases. Connor stressed that, while these increases are necessary, they might be a shock to policyholders. Communication of the rate increases should be clear, provided in advance and as frequently as possible to alert the public and allow consumers time to adjust to the coming changes.

Connor also remarked on the provision that requires FEMA to establish a reserve fund to help meet the future obligations of the NFIP. Connor noted that this would be difficult to work on until the NFIP debt, currently estimated at more than $17 billion, is retired. The NFIP had been self-sustaining, to the extent that, if the program borrowed money from the U.S. Treasury, it was able to repay that debt. However, the 2005 hurricane season pushed NFIP’s debt to $20 billion. The NFIP was able to pay back $4.3 billion of the debt in interest and principal by renegotiating the interest rate with the Treasury and because of recent mild hurricane seasons. With revenue of $3.4 billion, Connor said the NFIP would need to be without flood losses for 35 years to repay the current debt.

Providing an academic viewpoint, Kunreuther proposed that, rather than subsidizing premiums and increasing rates by 25% until premiums meet the full actuarial cost, the NFIP should immediately implement actuarially sound rates and offer a voucher so the consumer can see what the actual rate should be. This way, rates would immediately reflect risk, the vouchers would only go to those needing special treatment and homeowners would know their premiums would be stable. Another recommendation was to tie flood policies to the property, not the individual, possibly assessed through property taxes, although practical application might be difficult.

A January 2012 white paper drafted by the Wharton Risk Center, CoreLogic and SwissRe was also discussed by Czajkowski. The paper attempted to quantify what private insurance rates would look like and how risk-based premiums would be affected by mitigation efforts. The study found that NFIP premiums both underpriced and overpriced risks and that private market participation could increase take-up rates.

NAIC funded consumer representatives reflected that the new NFIP modernization act had many positives, and although it will be a hard message to convey, it is not anti-consumer to allow the program to charge actuarially sound rates. Kochenburger praised the updating of the flood maps and focus on mitigation; however, he said there was not enough focus on consumer education to inform homeowners. Larkin-Thorne noted that many lenders use the CoreLogic models to rate flood risk, which includes everything within a flood prone area, and so the cost of a NFIP policy can increase disproportionately if, for example, only 10% of a property is a flood hazard. Larkin-Thorne also stressed that flooding is not just a coastal problem, but a national problem. She noted that, even in the Midwest, 10% of homes are in floodplains.

Larkin-Thorne went on to say that she feels privatization is not the answer. She strongly encouraged empowering local governments to mitigate losses, even to the extent of allowing the states to reclaim high-hazard lands instead of allowing homeowners to continually rebuild and suffer losses. Long-term stability is critical, and Larkin-Thorne encouraged the use of guaranty funds and reinsurance to stabilize the NFIP. She concluded with a reminder of the importance of consumer education and agreed with the Wharton Risk Center’s suggestion on multi-year policies, tied to property taxes.

The final session was devoted to industry insight. Templeton-Jones spoke from a perspective of a monoline flood insurer; she recognized that, without rate increases, while burdensome on consumers, the health of the NFIP and real estate are at risk. One of the challenges with the NFIP reform law will be to improve communication with the public, especially related to rate increases and flood maps. She also stressed the importance of cooperation between agencies, companies and regulators to make the program a success.

(Continued on page 10)
Rath offered a perspective from companies that offer flood as an ancillary line. Rath noted that most companies that would have the capital and resources to enter the private market already write the NFIP business and sign a “non-compete” clause to not offer a private policy. Out of more than 2,000 property/casualty insurers, there are only 85 write your own (WYO) companies writing coverage due to the complexity, lack of data and low-frequency/high-severity risk of the line. Companies want to have the law of large numbers apply in order to have a good, viable rate, and would need a large amount of capital when insuring such a catastrophic risk. Another challenge she mentioned was a company’s inability to set building codes, as FEMA can, to help mitigate losses. Even if privatization occurs, FEMA and NFIP would still be needed as an insurer of last resort for the pool of high-hazard risks.

Finally, Mathewson stressed the actuarial principle that a rate should reflect the hazard of the insured risk. Rates are also required to be reasonable, not unfairly discriminatory and actuarially sound. He supported removal of subsidies and mentioned that, currently, NFIP excludes catastrophic event years like 2005 in its rate experience, which, if they were added, would double the rates. Mathewson agreed that some privatization would be beneficial and would bring more coverage, more data and more premiums into the program, and encouraged the use of reinsurance. He also reflected that, without debt forgiveness, building a reserve fund is not practical.

**SUMMARY**

In light of the reforms provided by the Biggert-Waters Flood Insurance Act of 2012, there are many challenges that exist as these changes are implemented. While premium rate reforms are necessary, policyholders will likely be surprised by the premium increases. The Wharton Risk Center has suggested implementing actuarially sound rates immediately and offsetting the increased cost to consumers by using a temporary voucher system. This approach would allow consumers with the actual rate increase information immediately, while offsetting the financial impact of the increase over a period of time. Regardless, clear and frequent communication between FEMA and flood insurance policyholders in advance of these changes is key in allowing consumers time to adjust. For many consumers, their home is the single-largest investment they will make in their lifetime. It is imperative for the consumer to understand the importance of purchasing flood insurance to protect their home in the event of a flood. It is also necessary to relay information regarding flood insurance to residents of inland, as well as coastal, states.

Repayment of the current debt, as well as establishing a reserve fund, could prove to be a difficult task. However, long-term stability of the NFIP is critical to the success of the flood insurance program. The use of reinsurance may contribute to making these reforms successful. Once the studies required by the legislation are complete, there will be some indication as to whether reinsurance and possible privatization of the NFIP would be beneficial. There is much work to be done to implement the reform of the NFIP, and it will take some time to put these reforms into practice.

More information on the Biggert-Waters Flood Insurance Reform Act of 2012 can be found at the U.S. Library of Congress, by searching for the bill summary for H.R. 4348. In addition, an NAIC executive summary can be found on the CIPR website.

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13 http://thomas.loc.gov/home/thomas.php
14 www.naic.org/documents/cipr_events_2012_cipr_summit_overview.pdf
INTRODUCTION

Political risk insurance (PRI) is one of the many tools that companies can use to mitigate the risk factors that can be inherent to operating in the developing world. By allowing policyholders to protect themselves from specific risks deemed to be most threatening to their venture (i.e., expropriation of control for an electrical company investing in a foreign domestic firm), PRI can pave the way for much needed development and help to make otherwise dubious projects into competitive ones. Put simply: PRI protects companies from risks arising from actions either directly or indirectly resulting from their host country’s governance. Policies can be written to protect the holder from a number of eventualities, including currency inconvertibility and transfer restriction, expropriation and war, terrorism and civil disturbances. It can also be a tool used by investors to mitigate country risks associated with emerging market debt and equity investments, as well as the area of lending.¹

Fundamentally, insurance is the business of pooling policyholder dollars to protect against a future undesirable event. The motivations underlying PRI are not dramatically different from those of other forms of insurance, but the scale is much different. This article introduces readers to PRI and provides an overview of the types of PRI offered by insurers and the state of the contemporary PRI industry. This article also provides valuable insights offered by Country Risk Solutions CEO Daniel Wagner.

DEMAND FOR PRI ON THE RISE

Since the end of the World War II, the world has been dealing with globalization at an increasingly quickened pace. Multinational corporations (MNCs) from dozens of nations currently pursue opportunities in their established markets and in places only recently realized as opportunities for trade and development. To better envision this global marketplace, consider the business done by U.S. MNCs and investors. In 2010, U.S. MNC expenditures totaled approximately $621 billion and U.S. MNCs made use of the services of some 34 million employees (just less than half of those being employed abroad).²

The 21st century, while still young, has seen its share of the uncertainty and risk. Wagner notes that there is a general failure to acknowledge that “…the globalization process, while further enriching the world’s most prosperous nations, appears to have contributed to the further marginalization of at least one-third of the world’s people…”³ The Correlates of War project reports that no fewer than 25 wars have occurred between 2000 and 2007.⁴ The financial crisis of 2007–2008 kicked off a wave of financial reforms and social movement, and the effects can still be felt across the developing and developed world alike to this day. Unrest as a result of ethnic and social factions ousted long-standing governments in Tunisia and Yemen, spawned protests throughout the Middle East and precipitated civil war in Libya and (more recently) Syria, in what has become known as the Arab Spring.

Qualitative judgments regarding the legitimacy and morality of these events aside, it is risky for executives to seek expansion in the affected territories. Why open a mine when it could be lost to fighting? Why accept a contract to build a highway when the government enlisting that service might very well be gone tomorrow as a result of revolution or peaceful election? Why invest directly in a domestic company if new regulations might be passed to render that investment worthless?

That being said, there are absolutely reasons to engage with these nations. Africa, while still plagued in some areas by the deprivations of war and poverty, is setting the stage to be an enormous potential growth region. Foreign Policy magazine reports that the region will exhibit a workforce to rival any individual country, including the powerhouse markets of China and India.⁵ The report goes on to detail that the African workforce is better educated than ever before and eager for jobs that will provide a good wage. The potential for mutually beneficial economic relationships between MNCs and the growth areas of Africa is high, if the associated risks can be effectively addressed. Tools for risk management are critical to businesses seeking to invest and operate in regions where stability is less than certain.

(Continued on page 12)

POLITICAL RISK INSURANCE (CONTINUED)

◆ WHAT IS POLITICAL RISK INSURANCE?
Political risk insurance is defined as:

“...a tool for businesses to mitigate and manage risks arising from the adverse actions—or inac-
tions—of governments. As a risk mitigation tool, PRI helps provide a more stable environment for invest-
ments into developing countries, and to unlock better access to finance...”

One of the primary factors in this definition is that the ac-
tion triggering payment is prompted by a political action (though the specifics of what triggers a policy are deter-
mined by the policy’s language). Even in the field of political science, scholars sometimes cannot say affirmatively whether government action brought about a series of cir-
cumstances, and studies have noted that the level of ambi-
guity inherent in political events can lead to disputes be-
tween insurers and policyholders over whether an insured action has taken place. Take, for example, the scenario out-
lined in one report. In the case of currency inconvertibility or transfer restriction policy, it would not trigger a policy if a local business simply stopped making a payment on its obli-
gation, as this could be due to a number of factors pertain-
ing to their own credit supply or business choices. In order to trigger the terms of some currency inconvertibility or transfer restriction policies, payment must continue into the account over a period of months.

At a basic level, PRI works in a fashion similar to many other forms of insurance. A policy is written to cover losses in the event of a finite event. Several features distinguish PRI from other insured risks. For one, PRI addresses strictly noncom-
mercial risks. Wagner states that “usually, answering the simple question of whether an action was in an insured’s control or a government’s control will determine whether a risk can be covered by PRI.” There is also a lack of hard data from which to draw conclusions, in addition to the fact that events leading to the payment of a policy are harder to define in actuarial terms.

PRI is characterized by this uncertainty to the extent that distinguishing between actual and perceived risk is difficult. It has been noted that “effective political risk management requires distinguishing developments that pose true risks—a well-defined threat to corporate performance—from po-
litical events that are merely dramatic.” In other instances, the perception that an area is risky creates a problem whether or not that perception is based on accurate infor-
mation.

These peculiarities led to some cost issues in the PRI mar-
et. The Federal Reserve Bank of New York conducted inter-
views with PRI providers in 2005 and found that issues sur-
rounding the quantification of risk results in gaps in cover-
age and high prices that discourage participation in the market by some businesses. The Federal Reserve reported that only 10% of those requesting PRI accept the quote they are given for a policy, with 50% not receiving quotes for a project at all and 40% not accepting the quote they are given. The high expense of underwriting political risk for the insurer is also a defining characteristic of these policies.

Despite some of the drawbacks that plague PRI, there is certainly a need for a risk-mitigation tool for corporations or investors seeking to enter developing markets. Many of the world’s most lucrative business opportunities, be they tak-
ing advantage of new and growing labor pools or bountiful natural resources, are located in regions that are likely to be subject to the types of events PRI can help address. Terror-
ism is a threat to ventures across a number of continents. Wagner points out that terrorism has historically had conse-
quences for businesses and will continue to do so, as busi-
nesses represent excellent “soft targets.” Businesses may be the target of terrorism, or simply collateral damage. The terrorists who orchestrated the Sept. 11, 2001, attacks on the United States invested less than half-a-billion dollars in their attacks, but were able to cause more than $50 billion in property damage.

Where political circumstances allow for, or necessitate, strict measures of state control, various forms of expropria-
tion are possible. The effects of the global financial crisis have exacerbated the likelihood that governments may take

Continued on page 13)

3 Ibid.
5 Ibid.
action to restrict the free flow of cash or the foreign ownership of domestic resources. Not only can PRI provide a structured bulwark against financial losses, but many (especially public) PRI providers have developed working relationships with foreign governments to help ensure their clients are exempted from potentially damaging laws.\(^{15}\)

PRI can also help to serve a public need. Investors and insurers are fundamentally businesses and often find it difficult to balance the need to make an investment successful and profitable with local concerns, such as socioeconomic factors, rights of indigenous peoples and ecological concerns, but the project finance industry (of which PRI is one component) creates an environment where those pursuing ventures have good reason to look at their project margins and social factors.\(^{16}\)

PRI is provided by three major types of entities: public insurers, private insurers and multilateral entities. Following describes more about their individual character:

Public insurers have a mandate from their government to dispense PRI. They are more likely to write coverage with a policy goal in mind, set by their parent government.\(^{17}\) As they are funded out of the public treasury, these insurers are also more likely to have restrictions on who they can insure and whether or not they are required to be an “insurer of last resort” for companies that cannot acquire policies on the private market.\(^{18}\)

Private insurers serve a niche market. They supply insurance in a similar manner to other product lines, but are more often than not associated with big multi-national or multi-line insurers.\(^{19}\)

Multi-lateral insurers are non-governmental entities (NGOs) that often seek to foster development in troubled or impoverished regions of the world that private insurers may not have an interest in covering.

It is worthwhile to address the fundamental question of what types of firms or investors most need PRI. Wagner said companies generally fall into three categories: those that insure everything; those that insure nothing; and those that insure against the things that keep them up at night, which is a function of their own perceived risk. He said that the most important factors are an individual investor or firm’s beliefs, experiences and risk-management philosophy, and whether those factors lead them to believe that their cost-benefit analysis values PRI. Ventures in a new place, with a new partner or in a new area of the world that traders of investors might not be comfortable with could be triggers for a company to seek PRI.

It is also important that some local companies acquire PRI when investing in projects in their home country. At the time of the Argentine economic crisis a decade ago, local companies could not obtain PRI due to prohibitive costs and a lack of interest in covering those companies on the part of insurers.\(^{20}\) Information provided by the Multilateral Investment Guarantee Agency (MIGA)—which is a member of the World Bank Group that both provides and studies PRI with the aim of fostering investment in developing economies avoided by the private sector—shows that, while it is not strictly impossible for domestic investors to acquire PRI, it is still difficult.

MIGA can provide coverage to local investors who are repatriating capital to their home country, and many other multilaterals can provide policies under similarly restricted circumstances. They stated that private PRI has a wider variety of coverage circumstances and said that most Lloyd’s syndicates would be willing to offer it, but questions would be raised about the level of risk in the country if its own nationals were seeking protection, and that these questions might affect that investor’s ability to get a policy.

**History of Political Risk Insurance**

PRI first came into being following World War II, when a degree of uncertainty regarding global and regional stability discouraged investors from putting funds into areas that could be threatened by the spread of communism. The 1960s saw the U.S. Agency for International Development (USAID) begin providing investment guarantee programs,\(^{21}\)

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\(^{18}\) Ibid.

\(^{19}\) Ibid.

with those functions being handed off to the Overseas Private Investment Corporation (OPIC) in 1969. It was not until the next decade that private players began to get involved in the PRI market, beginning with underwriting syndicates at Lloyd’s of London and American International Group (AIG). Demand for PRI was expected to wane without the looming threat of expropriation by communist regimes after the fall of the Soviet Union, but the attacks on Sept. 11, 2001, highlighted the vulnerability of many enterprises to risks still posed by terrorist organizations.  

**TYPES OF POLITICAL RISK INSURANCE**

As with other types of insurance, specific PRI policies must be tailored to protect against specific types of political risk and is determined by a variety of interdependent factors. Not all nations will be subject to the same types of risk. Below are brief explanations for the common types of PRI.

1. **Currency Inconvertibility and Transfer Restriction**
   - Protects against losses incurred from being incapable of converting local currency and/or the inability to transfer local currency or foreign exchange outside the country. This is specific to situations arising as a result of government action.

2. **Expropriation**
   - Protects against government action that would result in the loss of the rights to or control over insured property as a result of government action. This could take the form of outright expropriation (e.g., a mine is seized by a foreign government’s troops overnight) or might include what is termed “creeping expropriation.” Indirect or creeping expropriation would involve actions that, when taken cumulatively over a number of years, have the aggregate effect of a loss of control or rights to an investment or, alternatively, when a host government’s actions interfere so much as to render the rights to property useless. This can take a number of forms, from the replacement by company-appointed management with state-appointed management, government takeover of a key supplier, restrictions on occupation of acquired land (or activities on that land) and confiscatory taxation.

3. **Political Violence, War, Terrorism and Civil Disturbance**
   - Protects against the loss, damage to or disappearance of tangible benefits as a result of the outbreak of hostilities or unrest in a host country. These policies can be written to include hostilities as a result of host country actions or the actions of a third party. Those policies can also cover losses resulting from the interruption of business due to hostilities. For example, an oil rig crew might have to be evacuated because a local conflict increases the likelihood that rig will become a target. Despite the fact that the oil rig is not physically destroyed, it cannot be operated without a crew and, therefore, the revenue for the period of the evacuation would be lost.

4. **Breach of Contract**
   - Protects against a failure of a government to pay or perform under a contract. This coverage is often used for infrastructure and mining projects.

As more and more nations become home to large investment ventures, some of these types of insurance have had to evolve to accommodate new leadership styles in developing and developed economies. One article observes that “… governments that may have once upon a time been in the habit of throwing out the rules at the whim of the latest autocrat are these days more likely to simply change the rules.”

Regulatory takings are also becoming more common at the expense of outright expropriation, according to a report by MIGA. They note that those regulatory actions can be purely in the name of achieving a measure of expropriation more to the liking of new administrations but can also be a legal and legitimate exercise of regulatory power. To distinguish between legitimate and illegitimate regulatory action resulting in losses for investors, one must consider:

   a) Whether it interfered with an investor’s property rights.
   b) Whether the regulation was enacted for a public purpose, was non-discriminatory to a particular entity and followed due process.
   c) Whether the economic impact was substantial enough to warrant compensation.

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26. Ibid.
It is also worthwhile to recognize that buying PRI is not just useful for financial compensation in the event of a failed investment. Indeed, having PRI measures can serve to prevent harmful measures from ever targeting a company. In “Political Risk Investment Insurance: Renaissance Revisited,” West and Martin point out that disputes have negative effects on existing ties (i.e., informal ties, trade agreements, security agreements, etc.) between an investor’s home nation and host nation. Some countries and multilaterals have “nearly automatic sanctions against countries that have not effectively compensated their national insurers who have assumed...the rights to an insured investor’s assets or shares...or to the local currency....”

Certainly, a number of current events highlight the importance PRI policies can provide in mitigating risk for policyholders. The democratizing wave of protests and rebellions that has come to be known as the Arab Spring is likely to result in the renegotiation, and perhaps even total breach, of some contracts between affected nations and investors. A MIGA study reported that the events making up the Arab Spring have thus far resulted in a small number of claims, although sources also report a number of large trade credit claims in Libya. The report estimates that Libya alone could see between $300 million and $500 million in losses, although, to date, little of what has happened has resulted in losses by insurers. In nations like Egypt, where foreign engagement was permitted, new governments might not look favorably on companies that chose to do business with their oppressors.

**Contemporary Perspectives on Political Risk Insurance**

In 2008, MIGA surveyed major PRI providers on their perceptions and experiences participating in the market. The data shows that, while PRI is increasingly popular, the market for such insurance is still relatively small. Approximately 71% of respondents estimated that the contract written for PRI totaled to less than half of their total business written. That being said, the vast majority of providers believed that their PRI business would increase.

In a 2011 report, only one-in-five firms reported using investment insurance akin to PRI. MIGA reported that most mitigated their risk in foreign investments by implementing their ventures through a domestic partner, moving the project along slowly or undertaking detailed risk analysis as a precursor to putting a project into action. Further, firms viewed informal engagement with local leaders as the best approach, and many respondent firms expressed the belief that no tool could effectively alleviate certain manifestations of political risk.

Even taking all these concerns and alternative methods into account, the 2011 report stated that the market for PRI had increased by approximately one-third over the previous year. In fact, for five years prior to the 2011 report, the PRI market grew more than the levels of foreign direct investment it was meant to protect. The bulk of contracts were written to protect against expropriation with coverage against war, civil disturbances and terrorism, forming the second-highest event insured against. Clients seeking PRI coverage were primarily engaged in the financial market and infrastructure sectors and were seeking to cover ventures located in East Asia/Pacific, Latin America and South Asia regions, respectively.

Investment insurance claims specifically have risen in recent years, totaling nearly $221 million in 2010. MIGA cautioned that single-year figures were prone to the effects of “single data point” events, but the claims statistic still illustrates an important point in the overall market picture. It is becoming evident that stability in the short-term is not a climate that can be taken for granted. In the Middle East/North African region, a number of regimes that have stood for decades are falling victim to unrest as a result of shifting socio-economic factors. Reliance on local leaders alone does a firm no good if that leader falls victim to a coup or popular movement for regime change. If the leader is particularly unpopular, such past ties could serve to hurt a company’s prospects for doing business with that leader’s successor(s).

**Conclusions**

Industry experts anticipate that the demand for PRI will rise in the coming years. With escalating tensions across the world, it is likely that analysts of foreign policy would agree with that assessment. A new, Western-educated leader has come to power in isolated North Korea, prompting discussion.

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30 Ibid.
32 Ibid.
33 Ibid.
sions that he may be more developmentally oriented. Vast deposits of energy resources have been discovered in the vicinity of Vietnam and the Philippines, sparking a standoff with the People’s Republic of China, which disputes the other Pacific nations’ territorial claims. A similar, if much less developed, tension has risen up around energy reserves in the Black Sea. All of these scenarios provide opportunities for potentially profitable and potential risky ventures that might require companies to seek security through political risk insurance policies.

Wagner believes the market is likely to continue to expand. He pointed out that the PRI market has been expanding dramatically for more than a decade: “If underwriters and brokers didn’t think they could make money, then they wouldn’t get in it or stay in it.” He believes that education about the product will help feed that growth, but that ultimately the market will be subject to the risk appetites of those participating in it.

“You can’t invent perceived need and you can’t create believers. Either companies perceive value in PRI or they don’t,” Wagner said. “There are many ways to manage cross-border risk, but over more than 40 years, PRI has proven to be effective, particularly to an educated consumer.”

In an uncertain world, neither traditionally insured risks such as fire and flood nor commercial risks alone represent the entirety of risk facing investors and companies. Actions taken by governments, or as a result of governments, can be covered under PRI. The ill effects of currency inconvertibility, expropriation (either in its outright form or a more gradual “creeping” expropriation) and even civil disturbance, terrorism and war can be mitigated by seeking coverage from one of the many providers of PRI.

Despite the high cost of coverage and difficulty in obtaining PRI, it is one of many tools that can be used by risk managers to help reduce the risk facing their ventures in a foreign market. It is also a tool that can provide an incentive for companies to think about the social consequences of its actions. From a regulatory standpoint, however, Wagner sees no reason that it should be considered differently from any other line of business. “It’s important that the industry be well regulated,” he said, “but, at the same time, the industry also regulates itself.” He pointed out that insurance wordings are frequently modified when claims are filed, as insurers learn from each claim experience, and that clients themselves tend to revise policy wordings according to their own risk perceptions. Compared to more mainstream lines of insurance, PRI is small, but its impact is much larger than its size would suggest, given its ability to prompt lenders to lend and investors to invest.

Small or large, it is undeniable that PRI plays a vital role in allowing companies to trade and invest in developing regions across the globe.

LENDER-PLACED INSURANCE

By Eric Nordman, CPCU, CIE, Director, Regulatory Services Division and the CIPR

The subject of lender-placed property insurance has become a hot topic in recent months. Perhaps it is our economic challenges, particularly the housing bubble, that has made the subject more pertinent.

✦ INTRODUCTION

Lender-placed insurance is also known as creditor-placed insurance or force-placed insurance. It is a property insurance policy placed by a bank or mortgage servicer on a home when the homeowners’ own property insurance may have lapsed or where the bank deems the homeowners’ insurance coverage insufficient. All mortgages require borrowers to maintain adequate insurance on their property. The requirement in mortgages generally specifies maintenance of “hazard insurance.” While hazard insurance is a term used in banking circles, insurers generally refer to homeowners insurance, property insurance or fire insurance.

Borrowers can fail to maintain the required coverage for a variety of reasons—cancellation, a withdrawal by their existing insurer or even just a simple oversight. However, if a property insurance policy lapses or is canceled and the borrower does not secure a replacement policy, most mortgages allow the lender to purchase insurance for the home and “force-place” it. These standard provisions allow the lender to protect its financial interest in the property (its collateral) if a calamity occurs.

✦ HOW DOES LENDER-PLACED INSURANCE WORK?

The typical mortgage contract requires the borrower to maintain property insurance coverage at all times. The preferred method for this to occur is for the borrower to purchase a homeowners policy and include the lender as an additional insured. When the borrower fails to provide the required coverage, the mortgage contract allows the lender to secure coverage for its interest in the underlying collateral (the home).

The coverage provided by the lender-placed insurer is typically issued under a master policy where the mortgage lender is listed as the named insured and each borrower is considered an additional insured and a certificate holder. In some regards, the coverage is broader than homeowners insurance coverage. In other ways, coverage is more limited. There is no individual underwriting of the risks. Every uninsured property in the mortgage lender’s portfolio is eligible for coverage. There are generally no exceptions or exclusions related to the insurability of the property or vacancy.

To keep track of all the information to figure out who has met obligations to maintain property insurance, the mortgage lenders often hire third-party tracking firms. The mortgage lenders delegate certain duties to these firms. Included are responsibilities for tracking the status of applicable property insurance and communicating with borrowers when coverage lapses occur. Sometimes an apparent coverage lapse is simply a communication error.

It is the tracking firm’s responsibility to work with the borrower to secure proof that coverage exists, if it does. This process can involve phone calls or letters to advise the borrower that proof-of-coverage is lacking. Many discrepancies are cleared up with a single communication. Others take multiple communications. Some borrowers are found to have a gap in coverage that is filled by the lender-placed property insurance. If the borrower eventually proves that he/she had the applicable coverage, the lender-placed insurer cancels the coverage in its entirety without a charge.

✦ WHAT ARE THE ISSUES?

Recent discussion has focused on the rates charged for lender-placed insurance policies and whether insurers and lenders are making excess profits on this line of business. Typically, the lender-placed insurance premiums are higher than the property insurance the borrower could have purchased on his/her own. There is some debate about the order of magnitude of these higher premiums.

In addition to being more expensive, the lender-placed insurance policy also has more limited coverage. For example, the coverage is typically limited to the dwelling and other structures such as detached garages and outbuildings. Personal property (contents) and liability risks are not covered. Moreover, if a borrower does not pay the lender-placed insurance policy premium, he/she could be at risk of foreclosure. Compensation arrangements are also being reviewed.

A key regulatory concern with the growing use of lender-placed insurance is “reverse competition,” where the lender chooses the coverage provider and amounts, yet the consumer is obligated to pay the cost of coverage. Reverse competition is a market condition that tends to drive up

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prices to the consumers, as the lender is not motivated to select the lowest price for coverage because the cost is borne by the borrower. Normally, competitive forces tend to drive down costs for consumers. However, in this case, the lender is motivated to select coverage from an insurer looking out for the lender’s interest rather than the borrower’s interest.

♦ Regulator Activities
Insurance regulators in California, Florida, New York and Texas recently held public hearings to learn more about these products and practices. There is currently a New York state investigation looking into whether insurers are charging too much and if certain insurance companies are succeeding by what are essentially kickbacks to lenders. A public hearing on lender-placed insurance was held May 17, 2012, at the New York State Department of Financial Services. After the hearing, New York Gov. Andrew M. Cuomo and Superintendent of Financial Services Benjamin M. Lawsky announced that lender-placed insurers operating in New York must lower the premiums they charge. “Our hearings suggest a lack of competition, high prices and low loss ratios, all of which hurt homeowners,” Lawsky said in a news release announcing the decision.

The NAIC has also begun reviewing lender-placed insurance, as the practice has become more common in this weakened economy. On Aug. 9, 2012, the NAIC Property and Casualty Insurance (C) Committee and the Market Regulation and Consumer Affairs (D) Committee held a public hearing to further discuss the use of lender-placed insurance and the effect of the practice on consumers. The hearing took place at the NAIC 2012 Summer National Meeting in Atlanta, GA. Presentations, testimony and audio of the public hearing are available on the NAIC website.¹

There were a variety of presentations and testimony at the NAIC public hearing. Industry proponents described how lender-placed insurance differs from other lines of business. It is not underwritten so that insurers take all risks presented by lenders. Proponents mentioned high concentration of catastrophe risk as an issue, in addition to automatic, continuous and retroactive coverage provisions. Industry proponents stressed that lender-placed insurance provides value to homeowners. It helps lenders satisfy regulatory requirements promulgated by federal regulatory agencies and facilitates the secondary market for mortgage-backed securities. It protects federal taxpayers and protects other policyholders and state taxpayers by keeping substantial numbers of policies out of residual market plans. Industry advocates disputed the notion that lender-placed insurance operates in a market characterized by “reverse competition.”

Consumer representatives maintained that lender-placed insurance exhibits characteristics of “reverse completion,” where the entity selecting the insurer is not the entity paying for the product. They suggested that there were unnecessary placements and inadequate disclosure to consumers regarding such transactions. Consumer representatives maintained that rates are excessive, as were some ancillary charges to borrowers. They maintained that the rates and charges were based on unreasonable expenses and unreasonable actuarial analysis and assumptions. They complained about sales through surplus lines insurers not subject to state solvency and market regulatory standards. They believe the use of captive reinsurance is a tool to allow lenders or producers to garner additional profits at the expense of borrowers. They asked regulators to look into the use of schedule rating, as well as the introduction of some new rating factors and changes to policy forms favoring lenders. They noted that there were both gaps and overlaps in regulation.

♦ Next Steps
The NAIC public hearing was helpful in informing regulators and attendees about the lender-placed insurance products and people’s perspectives about them. The hearing surfaced some differences of opinion regarding the products and their performance in the marketplace. There are some discrepancies contained in the testimony between parties. The Property and Casualty Insurance (C) Committee and the Market Regulation and Consumer Affairs (D) Committee plan to review the testimony, see if the facts line up with what was said and discuss possible next steps.

¹ www.naic.org/committees_c.htm.
THE MARKET CONDUCT ANALYSIS FRAMEWORK

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INTRODUCTION
All regulation of any industry requires regulators to know the marketplace they are regulating and make judgments concerning the activities of the entities they are regulating. To be efficient, the judgment of the regulator needs to be discerning. To be effective, the judgment of the regulator needs to be accurate. Analysis of the facts is critical to making correct judgments. Whether there is a rigorous analysis process in place, we are always analyzing information to make our judgments.

Financial regulation naturally lends itself to rigorous analysis. Financial regulation of insurance companies and other financial institutions relies on the formalized, systematic analysis of the financial statements of companies. For properly credentialed accountants and actuaries, the financial condition of a company is transparent and predictable. Market conduct regulation concerns itself with the behavior of companies and individuals. Human behavior is anything but transparent and predictable. For many years, market conduct regulators had to rely on observations of the marketplace and their professional judgment without the type of robust data found in financial regulation. Like a police officer on the street, they knew their beat, they knew all the players and they knew when something did not appear to meet market conduct standards. Ultimately, however, market conduct regulators were reacting to behavior that had already occurred rather than engaging in proactive analysis based on formalized, systematic analysis.

In recent years, however, the regulation of the market conduct of insurance entities has been maturing toward a more rigorous and systematic analysis process. Pushed along by the 2003 report of the U.S. General Accounting Office titled, “Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation,” regulators have worked together through the NAIC to establish uniform market analysis practices and procedures. Today, the basic process for consistent and uniform market analysis is documented in the NAIC Market Regulation Handbook.1

WHAT IS MARKET ANALYSIS?
Together, market regulators are working to create a structured and formalized system of collecting and organizing market and financial data. Development and improvement of the market analysis framework is coordinated through the NAIC Market Analysis Procedures (D) Working Group (MAP). Each NAIC jurisdiction appoints a market analysis chief (MAC) who oversees market analysis activities in their jurisdiction. The MAC is also responsible for ensuring the implementation of market analysis procedures approved by MAP and the NAIC Market Regulation and Consumer Affairs (D) Committee.

By collecting the right data and centralizing it for use by regulators from all jurisdictions, market analysis enables regulators to identify general market disruptions and specific market conduct problems as soon as possible within an efficient and effective regulatory framework. Determining what data to collect and how to interpret it is a continual effort, but the basic analysis framework and the types of data to be analyzed have already been established.

Market conduct issues may be contained in a local geographic area, spread over an entire region or be national in scope. They can range from a solitary underwriter or producer refusing to service a class of customers, to a company making a strategic decision to quickly non-renew policies and stop writing new business in a catastrophe-prone region or delay claims payments nationwide. Analysis, therefore, has to occur at these three levels.

At the local or state level, the state insurance departments have traditionally policed the companies on their own, occasionally asking for assistance from a company’s state of domicile if the company is a foreign insurer. On the local level, the analysis of a company’s market behavior has been driven chiefly by analysis of complaint data and information gleaned from earlier examinations.

The insurance industry, however, operates on a national and global scale. The larger a company becomes, the more likely it will conduct its business in a similar fashion across multiple jurisdictions. As market conduct issues cross state boundaries it becomes increasingly inefficient for each impacted insurance department to address each regional or national issue on its own. It is also costly for companies to work separately with multiple jurisdictions on the same issue. While the separate states still rely on their own market conduct departments to address wider-scale market conduct issues, they are increasingly coordinating and col-

1 The NAIC Market Regulation Handbook is available to regulators, industry and the public. It can be purchased through the NAIC Store at http://store.naic.org.

(Continued on page 20)
The Market Conduct Analysis Framework (Continued)

Collaborating with insurance departments of other states that have the same or similar issues. To assist in collaborative efforts, market regulators work through the NAIC to standardize the market analysis process.

The goals of market analysis are three-fold. First, market analysis aims to find which of the thousands of companies writing insurance in the marketplace warrant further scrutiny by the insurance department. Second, market analysis will identify which market conduct concerns are causing (or may cause) consumer harm and should be addressed by the insurance department. There is a third, arguably more critical, goal: to predict non-compliant behavior before it happens. The third goal has yet to be achieved, and might not be achievable, but predictive market analytics, and the types of data needed to accomplish it, is often discussed whenever methods for improving market analysis are considered.

When good market analysis achieves these goals, the insurance department is more effective and efficient. It targets its resources at the companies with market conduct issues and uses the appropriate amount of resources necessary to bring the issues to fair and equitable conclusions.

To meet the first two goals, market analysts rely on a three-stage process that begins with the entire marketplace of companies in their state and narrows down the number of companies to a manageable number to review more intensively. As the analyst moves from one stage to the next, the data becomes increasingly more detailed.

Market conduct data can be described as either “summary” or “transactional.” Summary data provides a high-level overview of the company. It is a broad look at the operations of the company, such as the number of claims, the amount of premium or how many complaints have been made against the company. On the opposite end of the spectrum, transactional data is specific to each transaction conducted by the company, such as the details of each application for insurance, policy issued, claim handled or lawsuit defended by the company. Almost all of the data used by market analysts today is summary data. Complete transactional data is not currently available to market analysts, other than what might occasionally be requested from a company during an examination or through a specific data call.

**Baseline Market Analysis**

The first stage of market analysis is to prioritize which of the entire set of companies in the marketplace warrant the most concern. Of course, it makes little sense to compare property/casualty companies to health or life companies. So, the first step is to segregate the companies by the type of business they are writing in the state. Fortunately, for

(Continued on page 21)
The Market Conduct Analysis Framework (continued)

purposes of reporting their financial annual statements, the data for companies is already split by line of business. All the market analysis tools available through the NAIC are organized by line of business.

The first stage of market analysis is often referred to as the baseline stage. In this stage, the analyst relies heavily on data at the most summary, aggregated level. The purpose is to compare as many companies as possible at the same time. Most of the states have developed scoring systems that put more weight on some data than others. For example, most insurance departments put greater emphasis on complaint information than on premium or loss trends. However, depending on the issues that are most important to the state at a given time, the weighting of the data will change.

To assist market analysts and to make baseline analysis more uniform among the states, market regulators worked with NAIC staff to create the Market Analysis Prioritization Tool (MAPT). Any state market analyst with the proper security role can access this tool. For any of the 11 lines of business in any state or U.S. territory, a market analyst can create a single spreadsheet, organized by company that provides more than 100 separate data elements per company. These data elements can be directly compared and ranked among the companies.

Because MAPT is a prioritization tool, it does more than just aggregate data for market analysts. Built into the tool is a scoring system. For example, for the homeowners line of business, each company will be scored in 13 distinct categories, including complaints and regulatory actions. The higher a company scores in any category, the more concerns an analyst would have about the company in that area.

For example, MAPT’s complaint score for each company is the combination of scores given to the company based on its most recent complaint index and the complaint index over the past three years. A percentile ranking of the companies is performed based on the size of the index for each company. The percentile ranking of a company determines its score. The higher a company’s complaint indices, the higher it sits in the percentile ranking. The higher the percentile ranking, the higher the complaint score will be. Because the score is based on recent activity and three-year activity, analysts will not focus on just the current companies with high complaint counts.

A similar process for scoring is used in all the categories. To support the scores, MAPT provides the analyst with the underlying data. For example, to support the complaint score, MAPT also provides the analyst with the count of the total number of complaints against a company, the count of confirmed complaints against a company (a confirmed complaint is a complaint that was coded with a disposition considered adverse to the company) and the market share of the company.

The scores in each category are added together to derive overall scores. There are three overall scores. An overall national score is calculated based on national data and an overall state score is calculated based on state data. Finally, a comprehensive overall score is calculated. This score is 75% of the state score plus 25% of the national score.

The features in MAPT serve the variety of market analysis needs discussed earlier. First, it is uniform—it uses the same scoring metric in every state. Each analyst is relying on the same types of data and the companies are prioritized consistently. Yet, recognizing the unique nature of each state’s market, an analyst can temporarily adjust the scoring to provide greater weight to data that is more important to the issues of concern.

Second, it is developed primarily as a state tool organized by line of business. The market analyst can only view companies one state at a time, and those companies must be related by line of business. However, recognizing that market concerns can cross state lines, MAPT provides both state-specific and national data for each company conducting business in the state. This allows the market analyst to broaden the scope and consider both regional and national issues.

Third, because it is a high-level overview of the entire marketplace, it relies entirely on summary data. Many analysts refer to MAPT as a “wall of data” because there is so much data provided for so many companies at one time. Nevertheless, MAPT is incapable of identifying, with certainty,

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1 A company’s complaint index is simply the company’s share of the total number of complaints filed against all companies divided by the company’s market share of premium. A complaint index of “1” means that a company’s share of all complaints is the same as its share of the market. An index higher than “1” means a company has a greater share of complaints than would be expected based on its market share. The complaint index can also be calculated based on the company’s market share of policies or market share insureds.

2 A market analyst should always be aware of the actual number of complaints against a company and whether they are confirmed. A company with a large number of complaints will, of course, warrant the attention of the market analyst. However, a large number of complaints, considered out of context, will not be used to draw conclusions. A company with a greater market share will usually have more complaints. The complaint index puts the quantity of complaints in the context of the company’s position in the marketplace.
companies that are misbehaving in the market. Its primary purpose is to prioritize the companies for more in-depth analysis. As the market analyst moves more deeply into analyzing particular companies, the data becomes less general and more specific.

Regulators and NAIC staff developed MAPT with a heavy emphasis on the data available at the NAIC. At that time, much of the data at the NAIC was financial data. Data that could be considered strictly market conduct-related data was limited to complaints, market regulatory actions taken by the states and demographic information. Beginning in 2008, however, the NAIC became the central repository of data gathered through the Market Conduct Annual Statement (MCAS.) This has greatly increased the scope of data available to market analysts.

The current form of the MCAS was first collected in 2002 by eight states. It was designed to give the market analysts in those states the market conduct data that they were unable to obtain without a specific data call or examination of a company. It was a quick, uniform method of collecting market conduct data from all companies writing specific lines of business in a state. Like MAPT, the data collected could be compared, scored and used for prioritizing companies of the greatest concern to the market analyst.

For now, MCAS is limited to market conduct data for the auto, homeowners, life and annuity lines of business. The NAIC Market Analysis Procedures (D) Working Group is developing a long-term care insurance blank for MCAS and expects to add lines of business over the next few years.

For the auto and homeowners lines of business, MCAS collects underwriting data regarding non-renewals and cancellation activities. For claims, the data is collected by coverage type (collision, bodily injury, uninsured motorist, etc). Claims data includes how quickly claims are paid, the number of claims closed without payment and the number of lawsuits. Most of the data elements are collected with the intent of measuring prompt and fair policyholder service. As a prioritization tool, MCAS ranks companies according to the level of concern to a market analyst. Ratios have been developed for each MCAS line of business utilizing the data elements obtained from the MCAS filing. There are seven private passenger auto and homeowners insurance ratios and eight life insurance and annuity ratios. The assumption behind each of the ratios is that the higher the ratio, the more attention is required from the market analyst. The rankings for each ratio, therefore, reflect how high the company ratio is when compared to the other companies in the state that filed an MCAS. The company’s ranks for each ratio can be added together to arrive at an overall rank. A high overall rank means that a company has higher ratios than a company with a lower rank.

Besides being an effective prioritization tool, MCAS is also useful in analyzing an individual company. Every year, a company provides data regarding such areas as the speed of claim settlements and the numbers of surrendered policies. Over time, the data submitted by a company can be trended to allow an analyst to view multi-year changes in one direction or another. An analyst can also compare the data to the types of complaints filed against a company. The analyst may find correlations between the complaints and the reported data that substantiates consumer concerns. In addition, because most companies are required to submit MCAS data, the market analyst has a good idea what to expect from a company. For example, using four years of data, market analysts now know that the average time to settle a collision claim is around 15 days and that less than 2% of a company’s life claims should take longer than 60 days.

For the life and annuity lines of business, MCAS collects information on new and replacement activity with a focus on the age of the insured/annuitant and surrender activity, particularly of policies that may incur a surrender charge. There are also claims questions for the life products that address the speed of claim settlement and the percent of claims compromised or denied. Suitability and policyholder service are the focus of the life and annuity MCAS.

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2 For 2011, insurance companies that write at least $50,000 in premium in private passenger auto or homeowners insurance in a jurisdiction were required to file a MCAS with that jurisdiction. A sample blanks for the private passenger auto and homeowners MCAS is available at: www.naic.org/cipr_newsletter_archive/vol5_market_conduct_framework.pdf
3 For 2011, insurance companies that write at least $50,000 in life premium or annuity considerations in a jurisdiction were required to file a MCAS with that jurisdiction. A sample blanks for the life and annuity MCAS is available at: www.naic.org/cipr_newsletter_archive/vol5_market_conduct_framework.pdf
4 The seven private passenger auto and homeowners insurance ratios are: (1) percentage of claims closed without payment; (2) percentage of claims unprocessed at the end of the period; (3) percentage of claims paid greater than 60 days from receipt; (4) percentage of company-initiated non-renewals to in-force policies; (5) percentage of company-initiated cancellations less than 60 days from original issuance date; (6) percentage of company-initiated cancellations greater than 60 days from original issuance date; (7) percentage of lawsuits to claims closed without payment. The eight life insurance and annuity ratios are: (1) percentage of replacements to policies issued; (2) percentage of replacements where the insured is older than 65 or the annuitant is older than 80; (3) percentage of surrender compared to policies issued; (4) percentage of surrenders where the policy was in-force less than 10 years; (5) percentage of deferred annuities issued to annuitants older than 80; (6) percentage of claims paid greater than 60 days from the proof of loss; (7) percentage of claims denied, compromised or resisted; and (8) number of complaints per 1,000 policies.

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22 October 2012 | CIPR Newsletter
days to settle once the proof-of-loss is complete and properly documented.

Baseline analysis as it currently exists has limitations. Scoring algorithms have been created to allow for a quick comparison and prioritization of companies but in almost all cases, and certainly within the MAPT, the algorithms have not been tested in a controlled way to judge their effectiveness. In addition, because the data being used is at a highly aggregated level, the reasons for an anomalous data point can be multifaceted and have no bearing on market conduct.

Baseline analysis tries to isolate companies that are outside the expected norms in the marketplace in a number of key indicators. Most baseline analysis is static and uses a snapshot of a company’s data as of a certain date. A company may be slowly trending in a negative direction but by amounts never enough to trigger a high score during the prioritization process. For example, a company may begin with a low complaint index that gradually creeps upward from less than .5 (less than half the complaints that would be expected for its market share) to 1 (complaint share equals market share) over the course of four years. It would not be flagged in any one year. Nevertheless, the gradual increase in the index could indicate a nascent market conduct issue that could be nipped in the bud before blossoming into a larger problem for consumers.

A good scoring algorithm should take into account the size of the company and the quantity of data available. Using complaints again as an example, a company with a small market share will generate a large complaint index if it receives even one complaint. Most good scoring algorithms will incorporate a threshold to eliminate companies that do not have a statistically valid data set. In the example above, the analyst may eliminate all companies with a premium less than $5 million or less than five complaints. This, however, eliminates the small companies which, of course, can also have market conduct problems that need to be addressed. The reverse of this is also a concern. A large company that dominates a line of business can impact what is considered the norm for a state or a region. It is often useful to segregate out small and large companies for separate analysis.

Baseline analysis cannot, and should not, be used to definitively identify companies with market conduct concerns. The data used in baseline is at too summary of a level to draw any conclusions with certainty. To attempt to bypass the second and third stages of the market analysis process would result in going down too many rabbit holes with a wasteful use of resources. A good baseline methodology, however, will winnow a marketplace of hundreds of companies to a manageable number for the department of insurance. This manageable number of companies can be analyzed to determine why they stand out in relation to the other companies in the marketplace.

**LEVEL 1**

The second stage of the market analysis process that was designed by regulators through the NAIC is commonly referred to as a Level 1 review. This stage moves the focus of market analysis from the marketplace as a whole to a company specifically. As with the baseline process, this stage of review has long been a staple of the market analysis process. Prior to any examination or audit of a company, an insurance department has to know what they need to focus on during the examination or audit. This requires reviewing a company’s financial statements, the company’s communications with the insurance department and consumers’ communications with the insurance department.

Regulators converted this pre-examination analysis into two parts: a preliminary first part (Level 1) and an in-depth second part (Level 2). By developing the Level 1 and Level 2 analysis process, regulators succeeded in standardizing this analysis and incorporating it into a framework for collaborative actions by the insurance departments. They also made its use more prevalent by requiring jurisdictions to conduct a minimum number of Level 1 reviews.

The Level 1 analysis of a company was designed with the intent to be quick, yet thorough enough to isolate and focus an insurance department’s attention to specific operations of a company. The expected amount of time to be consumed by a Level 1 is no more than three to four hours. Like the baseline analysis, the data provided to analysts for use in the Level 1 review is summary data, but it is presented in greater detail.

For example, a company may stand out in the baseline analysis because of high complaint indices for the past three years. For purposes of baseline analysis, this is enough to flag the company for additional review. In the subsequent Level 1 analysis of the company, the market analyst will still only look at the total number of complaints, but the compan-

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4 Detailed information of each area of a Level 1 review is available in Appendix B of the NAIC Market Regulation Handbook. A copy of Appendix B is available on the CIPR website at: www.naic.org/cipr_newsletter_archive/vol5_market_conduct_framework.pdf
The Market Conduct Analysis Framework (Continued)

plaints will be organized by the coverage type, reason and final disposition. The analyst now has a much better idea whether the index is the result of claim handling, marketing, producer issues or something else.

The Level 1 review is a template with a series of questions that guides an analyst though a comprehensive review of data available in the NAIC’s market and financial information systems. There are 12 sections to the review, each section dealing with a specific area of concern for a company: operations and management; financial ratios; special activities; regulatory actions; examinations; market initiatives; premiums; market share; loss and expense ratios; resisted and unpaid claims; complaints; and MCAS results.

The analyst accesses this template through the NAIC Market Analysis Review System (MARS). MARS is located alongside the other financial and market system tools. Each section of the Level 1 review is populated with the data necessary to answer the questions about the company and links to the relevant NAIC financial and market databases. This ensures a uniform, standardized process of in-depth analysis that is repeatable, as necessary, on a company. Additionally, because the reviews are located in MARS, they can be reviewed by analysts in other jurisdictions. To ensure the quality of the reviews, every review is approved by the MAC of the jurisdiction prior to being made accessible to other state analysts. Only analysts with the proper security roles can view and enter reviews in MARS.

Prior to conducting the Level 1 review of a company, an analyst should review the reasons the company was chosen as a Level 1 candidate. If the company was identified in a baseline review because of increasing losses and defense cost expenses, the analyst will want to concentrate on these areas during the Level 1 review to determine the cause of the increases or the types of claims or issues that may be driving the costs upward. If a company’s MCAS filing created concerns that prompted the Level 1 review, the analyst will want to concentrate efforts on the MCAS issues that drew the company to the state’s attention. However, although analysts should have a focus during the review, they need to be thorough in the review of all areas of the company in order to not overlook other, possibly more critical, indicators of market conduct issues.

A well-performed Level 1 review should give a clear picture of the company’s overall financial condition and possible market conduct issues. In fact, the Level 1 review forces the analyst to draw a conclusion based on the results of their analysis. The analyst is provided with a menu of conclusion possibilities from which to choose. They range from “no further analysis is necessary” to recommendations for contacting the company, collaborating with other states regarding the company and even scheduling an examination. All conclusions need to be justified in final concluding comments.

A successful Level 1 review is not necessarily a review that uncovers a market conduct issue and recommends immediate action. In fact, more than half the time, Level 1 reviews conclude that no further analysis is necessary. This, too, is a benefit to the insurance department and to the company. Without tying up days, weeks and months of insurance department and company resources, the analyst develops an overview of the entire company and concludes that the jurisdiction’s resources are better served focusing on other, more critical, concerns.

However, more than one-third of the conclusions of Level 1 reviews in 2011 were either to take some regulatory action with the company (17% of the time) or to conduct a Level 2 review of the company (18% of the time). Because the Level 1 review uses summary data with a limited level of detail, it can sometimes be difficult to say with the necessary certainty that regulatory action is needed. Even if it is certain that there is an issue and what the issue is, additional supporting information is often required to be sure nothing is overlooked when the company is contacted.

* LEVEL 2*

The third stage of the market analysis process is the Level 2 review. As with the Level 1 review, an analyst will complete this review within MARS. This promotes uniformity and collaboration on market conduct actions. All Level 2 reviews approved by the MAC of the domiciliary jurisdiction are available for viewing by market analysts that have the appropriate security roles in the other states.

A Level 2 review relies on data that is more specific than in the previous two stages. It should be at the transactional level wherever available. The data utilized in the Level 2 review is often unobtainable through the NAIC market information systems and is often accessible only to regulators in the state that is conducting the Level 2 review. After the review concludes, the analyst is given a series of conclusion possibilities from which to choose. They range from “no further analysis is necessary” to recommendations for contacting the company, collaborating with other states regarding the company and even scheduling an examination. All conclusions need to be justified in final concluding comments.

* Detailed information of each area of a Level 2 review is available in Appendix C of the NAIC Market Regulation Handbook. A copy of Appendix C is available on the CIPR website at: www.naic.org/cipr_newsletter_archive/vol5_market_conduct_framework.pdf*
Level 2 review, when viewed in conjunction with the data from the previous stages of the market analysis, the analyst has as complete a picture of the company and its operations as possible, short of an actual examination.

The Level 2 review requires thoughtful responses from the analyst. Unlike the Level 1 review, there are no “yes” and “no” questions. The analysts are required to report their analysis findings in six core areas: consumer complaints; continuum activity; examinations; interdepartmental communications; market analysis; and regulatory actions. The MARS Level 2 template also provides space for the analyst to comment on the results of analysis in 15 additional, non-required, areas.8

Using data available to them from within their insurance department, an analyst can analyze specific complaints, the work product and transactional data available from current and recent examinations, as well as the results of current and previous market analysis. State analysts are encouraged to contact other regulators within their own department or other state insurance departments to build a complete profile of the company’s market conduct activities and issues.

The Level 2 review also includes an analysis of regulatory actions and continuum activity. To promote collaboration among the states, the design of each stage (Baseline, Level 1 and Level 2) includes both state and national details. By reviewing regulatory actions, the analyst becomes aware of issues already addressed by their state and other states. If other states are handling similar issues, it may be beneficial for the states (and for the company) that they be addressed uniformly at one time, rather than in a piecemeal fashion.

**Continuum**

Continuum activity is any regulatory response to a market conduct issue. The range of possible responses is referred to as a continuum because of the multitude of possible ways to work with companies in understanding and resolving market conduct concerns. The possible responses can range from a telephone call or letter to audits and examinations and everything in between, such as an interview or survey. As noted above, successful market analysis results in an efficient use of insurance department resources. Good market analysis will provide enough information to allow the insurance department to determine what type of regulatory response is needed to resolve a market conduct concern.

**Conclusion**

The States regulate insurance entities to help ensure financial solvency and to promote a fair and competitive marketplace. Regulators rely on data gathered from a variety of sources to monitor the marketplace. The goal is to spot disruptions as early as possible and resolve them effectively and efficiently. To do so, the data must be organized, analyzed and evaluated. This is the responsibility of financial and market analysts.

Because the insurance market operates across state lines, regulators in each state must have confidence in the analytical abilities of the other states. Working through the NAIC, market conduct regulators have developed a three-stage process that all members of the NAIC are encouraged to use. The three-stage market analysis cycle promotes uniformity, completeness and collaboration between the states.

The three stages organize the market analysis cycle into a funnel shaped process moving from a large overview of the entire marketplace to single concerns about individual entities. At each stage of the process, the level of detail that the analyst uses moves from summary information to transaction-level detail. By the time the analyst completes the analysis, the insurance department should have enough detail to choose the appropriate next step(s) from among the continuum of regulatory responses.

Market analysis does not, and maybe cannot, have the same exactness of financial analysis because of the nature of what it is attempting to analyze: human behavior and the arena in which it takes place—56 NAIC jurisdictions with distinct and occasionally different market conduct regulations. Market analysts, however, continue to refine their methodologies in an attempt to be predictive. Regardless of the methodologies, predictive analytics are not possible without adequate data. The only data adequate to the task is transaction-level data. Regulators, particularly market analysts, must continue to push for greater access to transaction-level data from companies.

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8 The additional areas of review for a Level 2 review are: departmental filings; dispute resolution activity; financial analysis; financial rating agencies; geographic analysis; human resource department; Internet/World Wide Web; legal information; NAIC bulletin boards; other governmental and quasi-governmental agencies; producer licensing; Special Activities Database; state-mandated items; trade publications and other media sources; and voluntary accreditation/certification programs.
In this issue, we are pleased to feature an analysis of insurance-related gross domestic product (GDP) and insurance employment trends, as well as revenue and budgetary statistics for state insurance departments. The data was derived from statistical data collected by the NAIC from state insurance departments, and is available on NAIC’s Center for Insurance Policy and Research website. Employment and GDP data were derived from the U.S. Bureau of Labor Statistics (BLS) and the U.S. Bureau of Economic Analysis (BEA), respectively.

The finance and insurance industry plays an integral role in the U.S. economy, making up 7% – 9% of total GDP in the United States (Figure 1). GDP attributed to the finance and insurance industry reached its highest point in 10 years in 2010. Insurance alone accounted for roughly 3% of total GDP. Figure 2 shows that for the years 2002 – 2011, insurance premiums made up 10% – 12% of total U.S. GDP, although this measurement is not a true representation of the industry’s contribution of added value.

As a result of the Great Recession, total non-farm employment fell significantly across all industries for three straight years beginning in 2009. Employment in the insurance industry followed the same trend, declining from 2.12 million in 2009 to 2.06 million in 2010 and 2.05 million in 2011 (Figure 3 on the following page). Trend data shows that the percentage of insurance employment relative to total non-farm employment remained near 1.7% in 2002 and 2006, but fell below 1.6% following the recent financial crisis. Although the economy still faces challenges created by the recent recession, the BLS predicts insurance sector employment to grow from 2010 to 2020, stemming from the needs of an increasing population and new insurance products on the market.

(Continued on page 27)
Because of the economic downturn, state insurance departments, much like the private sector, have been forced to operate more efficiently and on a tightened budget. Figures 4 and 5 show that total revenues and budgets as reported by all state insurance departments have marginally increased over the prior 10 years. Budgets climbed for all states from 2006 to 2009, fell in 2010 and increased slightly in 2011.

The NAIC publishes statistical data collected from insurance departments in each of the 56 jurisdictions. Data relative to employment, revenue, budgets, GDP and historical premiums per line for each state or territory, as well as national statistics can be found at www.naic.org/cipr_statistics.htm.


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3 This report also includes information found in the Insurance Department Resources Report, which is available for purchase at: www.naic.org/store_pub_naic_state.htm#dept_resources. For more information about this data, please contact a member of the Research and Actuarial Department staff. Additional information can be found at: www.naic.org/research_actuarial_dept.htm.
Managing Cyber Risks

By Eric Nordman, CPCU, CIE, Director, Regulatory Services Division and the CIPR

*INTRODUCTION*

As I write this article, I long for the days when life was simpler ... when the post office brought my mail instead of a desktop computer ... when I gave my handwritten notes or dictation to the typing pool and eventually a letter came back for my review ... when people did not stand in line overnight to get the latest, greatest Apple iPhone. OK, so now you know that a curmudgeon is writing this article on cyber risk management. It is still worth reading, as my background tends to push me into evaluating everything from a risk-management perspective.

All of this new technology comes with risk. Once these risks are identified, understood and quantified, they can be avoided, controlled, combined, retained or transferred using insurance or other risk-management techniques. So now you get the picture. This article will discuss cyber risks and have some suggestions about what to do with them. Some creative insurers have already done much thinking about cyber risks and are offering innovative insurance products to meet businesses’ risk management needs.

*CYBER RISK MANAGEMENT*

If you own a computer, you are at risk. If you have the computer connected to the Internet, you are at greater risk. If you use the computer to send and receive email, you are at risk. If you store anything on the computer, you are at risk. If you let employees place sensitive information on a laptop, your risk increases. If you allow employees to use memory sticks or thumb drives, you are at risk. Nearly anything you do with a computer creates risk for you.

The cyber risks for a business are almost endless. As data breaches occur more frequently, there are additional pressures for business to step up efforts to protect the personal information in their possession. In fact, there is legislation requiring the protection of personal financial information and personal health information. Some of the key risks associated with owning a computer are:

- Identity theft as a result of security breaches where sensitive information is stolen by a hacker or inadvertently disclosed, including such data elements as Social Security numbers, credit card numbers, employee identification numbers, drivers’ license numbers, birth dates and PIN numbers.
- Business interruption from a hacker shutting down a network.
- Damage to the firm’s reputation.
- Costs associated with damage to data records caused by a hacker.
- Theft of valuable digital assets, including customer lists, business trade secrets and other similar electronic business assets.
- Introduction of malware, worms and other malicious computer code.
- Human error leading to inadvertent disclosure of sensitive information, such as an email from an employee to unintended recipients containing sensitive business information or personal identifying information.
- The cost of credit monitoring services for people impacted by a security breach.
- Lawsuits alleging trademark or copyright infringement.

Applying avoidance by selling all of your computers is probably tempting on some days, but is not generally the risk-management technique of choice. That leaves various forms of mitigation and risk transfer on the table for consideration. Because managing computer networks is outside my scope of knowledge, the remainder of this article will focus on managing cyber risks through insurance.

*CYBER LIABILITY POLICIES*

Most businesses are familiar with their commercial insurance policies providing general liability coverage to protect the business from injury or property damage. However, most standard commercial lines policies do not cover many of the cyber risks mentioned earlier. To cover these unique cyber risks through insurance requires the purchase of a special cyber liability policy. The markets for these policies are relatively new, with a growing number of insurers offering coverage. Like all new markets, coverage contained in the policy forms is evolving as risks evolve and competitive forces come into play. As a result, if you have seen one cyber liability policy you will have seen one cyber liability policy. It will be different than the cyber liability policy from the next insurer.

There are some risks that are commonly covered by cyber liability policies. Generally, cyber liability policies cover a business’ obligation to protect the personal data of its customers. The data might include personal identifying information, financial or health information, or other critical data that, if compromised, could create a liability exposure

(Continued on page 29)
Managing Cyber Risks (Continued)

for the business. The policy will cover liability for unauthorized access, theft or use of the data or software contained in a business’ network or systems. Many policies also cover unintentional acts, errors, omission or mistakes by employees, unintentional spreading of a virus or malware, computer thefts or extortion attempts by hackers.

Cyber liability policies tend to be customized to meet the risk-management needs of the policyholder. Because businesses are unique in many ways, this customization feature allows the insurer to tailor a policy to meet the unique nature of each business. Thus, the type of business operation will dictate the type and cost of cyber liability coverage. The size and scope of the business will play a role in coverage needs and pricing, as will the number of customers, the presence on the Web, the type of data collected and stored, and other factors.

Cyber liability policies might include one or more of the following types of coverage:

- Liability for security or privacy breaches. This would include loss of confidential information by allowing, or failing to prevent, unauthorized access to computer systems.
- The costs associated with a privacy breach, such as consumer notification, customer support and costs of providing credit monitoring services to affected consumers.
- The costs associated with restoring, updating or replacing business assets stored electronically.
- Business interruption and extra expense related to a security or privacy breach.
- Liability associated with libel, slander, copyright infringement, product disparagement or reputational damage to others when the allegations involve a business website, social media or print media.
- Expenses related to cyber extortion or cyber terrorism.
- Coverage for expenses related to regulatory compliance for billing errors, physician self-referral proceedings and Emergency Medical Treatment and Active Labor Act proceedings.

Securing a cyber-liability policy will not be a simple task. Insurers writing this coverage will be interested in the risk-management techniques applied by the business to protect its network and its assets. The insurer will probably want to see the business’ disaster response plan and evaluate it with respect to the business’ risk management of its networks, its website, its physical assets and its intellectual property. The insurer will be keenly interested in how employees and others are able to access data systems. At a minimum, the insurer will want to know about antivirus and anti-malware software, the frequency of updates and the performance of firewalls.

**Conclusion**

The market for cyber liability insurance policies is relatively new. Like many new markets, it is off to a good start, but expected to grow dramatically over time. New competitors are closely following what early entrants have done. Businesses are gradually becoming more aware that current business policies do not adequately cover cyber risks. With each announcement of a system failure leading to a significant business loss, the awareness grows. Soon, business leaders will recognize what their information technology staff has been telling them. Running a computer operation with exposure to the Internet is risky, but necessary, for a business to succeed in the modern world. Thankfully, there are ways to protect the business from financial ruin through this rapidly growing niche insurance market.
Revised AG 38 Adopted By NAIC

By Dimitris Karapiperis, CIPR Research Analyst III

This article is the third installment in our series on Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38) in the interest of keeping you informed about the latest developments and regulatory efforts on this important policy initiative. The previous two articles appeared in the January 2012 and April 2012 CIPR newsletters.

On Sept. 12, 2012, the NAIC Executive (EX) Committee and Plenary adopted revisions to AG 38, which addressed certain reserving practices for universal life insurance products with shadow account secondary guarantees (ULSGs), including term universal life products with secondary guarantees. The Executive (EX) Committee had earlier formed the Joint (A/E) Working Group of the Life Insurance and Annuities (A) Committee and the Financial Condition (E) Committee to address these issues, because there was a perceived lack of consistency and uniformity among the states and the industry in setting reserves for these products. After much effort, which included a Draft Framework document outlining issues to be addressed and key decisions, the Joint (A/E) Working Group was able to achieve a universal compromise on these issues, which resulted in the revisions to AG 38.

Consistent with the Draft Framework, the AG 38 revisions take a bifurcated approach to in-force and prospective business. The new Section 8D of AG 38 deals with in-force business and applies to policies and certificates (i) issued on and after July 1, 2005; (ii) issued prior to Jan. 1, 2013; and (iii) in force on Dec. 31, 2012, or on any valuation date thereafter. New policies (prospective business), issued on or after Jan. 1, 2013, are covered under new Section 8E of the revised AG 38.

Section 8D describes the reserve requirements for in-force ULSGs and it provides specifics on whether they apply based on certain face amount levels of in-force business, various policy features and possible exemptions. Generally, most in-force ULSG policies fall under Section 8D, unless the minimum gross premiums for policies are determined by applying charges and credits that produce the lowest premiums (regardless of the imposition of constraints, contingencies or conditions that would otherwise limit the application of those credits and charges).

The primary reserve methodology as it is spelled out in Section 8D uses a principle-based reserve (PBR) deterministic gross premium approach, except that it requires a projected net investment return from existing assets based on the lesser of (i) a portfolio of A-rated corporate bonds purchased in the same year the policies are issued with the yields at the year of the bonds’ issuance; or (ii) the company’s actual portfolio of invested assets. For the reinvestment assets, Section 8D uses a net reinvestment return rate assumption equal to the lesser of (i) the 12-month average Standard Valuation Law (Model #820) reference interest rate (the composite yield on seasoned corporate bonds published by Moody’s Investor Services); or (ii) 7% per annum. The cash flows generated from the starting and reinvestment assets determine the future year-by-year net investment returns, which, in turn, are used to compute the reserve for the policies by discounting the applicable cash flows for those policies.

In addition to this annual reserve determination/valuation, for those companies using the primary reserve methodology, Section 8D also provides for a one-time (2012) reporting of the PBR deterministic gross premium reserve approach using a net reinvestment return rate not greater than the Model #820 maximum valuation interest rate for the year of issue of each policy (rather than the 12-month NAIC reference interest rate).

Section 8D also provides for the use of an alternative reserve methodology (in lieu of the primary reserve methodology) provided the reserves held by the company for the in-force business are at least as great as those determined in accordance with the Nov. 1, 2011, Life Actuarial (A) Task Force Statement on Actuarial Guideline XXXVIII (LATF Statement), subject to certain requirements applicable to the mortality and lapse assumptions used.

Section 8E of the guideline provides details for reserving for prospective business. The approach is consistent with the LATF Statement, as it applies to those policies that fall (Continued on page 31)
within the three policy designs described in Method I of Section 8E. It is anticipated that the majority of ULSG policy designs will fit within one of these specified policy designs. For policy designs that fall outside the three policy designs, Section 8E provides for a “greatest deficiency reserve” approach that would result to reserves at least as large as, and likely larger than, reserves determined following the LATF Statement.

The new sections of AG 38 provide for an important role for the NAIC Financial Analysis (E) Working Group (FAWG) in reviewing the reports on the appropriateness of the reserving methodologies submitted by the companies in confidential consultation with the domiciliary state that is ultimately responsible for the regulatory review and evaluation. The involvement of FAWG would also include the issuance of a confidential report sent to non-domiciliary states indicating whether a company’s reserve calculations have been performed according to the requirements as they are spelled out in Section 8D or Section 8E. It was also noted many times during the adoption process that the revisions to AG 38 do not serve to delegate regulatory authority to the FAWG or the NAIC, and that these confidential reports are informational in nature and are not considered to be binding on the individual states.

Work continues on issues related to AG 38, and the Joint (A/E) Working Group hopes to have processes in place for the review of prospective business that will become effective as of Jan. 1, 2013, and the appropriate role of the Financial Analysis (E) Working Group in this process.

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Policy Design #1: For a policy containing a secondary guarantee that uses a shadow account with a single set of charges and credits, the minimum gross premium for any policy year is the premium that, when paid into a policy with a zero shadow account value at the beginning of the policy year, produces a zero shadow account value at the end of the policy year, using the guaranteed shadow account charges and credits specified under the secondary guarantee.

Policy Design #2: For a policy that compares paid accumulated premiums to minimum required accumulated premiums (cumulative premium policy), with both accumulations based on a single set of charges and credits specified under the secondary guarantee, the minimum gross premium for any policy year is the premium that, when paid into a policy for which the accumulated premiums equals the minimum required accumulated premiums at the beginning of the policy year, results in the paid accumulated premiums being equal to the minimum required accumulated premiums at the end of the policy year.

Policy Design #3: If, for any policy year, a shadow account secondary guarantee, a cumulative premium secondary guarantee design, or other secondary guarantee design, provides for multiple sets of charges and/or credits, then the minimum gross premiums shall be determined by applying the set of charges and credits in that policy year that produces the lowest premiums, ignoring the constraint that such minimum premiums satisfy the secondary guarantee requirement and ignoring any contingencies or conditions that would otherwise limit the application of those charges and credits.
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