Inside this Issue

Director’s Corner

Expected Changes to Insurance Regulation for Captives and Special Purpose Vehicles

In 2013, regulators conducted an NAIC study on insurer-owned captives, analyzing potential ways to enhance the regulatory framework and provide insurance departments standardized tools and processes for reviewing certain types of captive transactions. This article will discuss two of the important bodies of work that resulted from the study: 1) regulators sought to clarify when they should utilize the national state-based financial regulatory system for the regulation of captives and 2) regulators sought to identify adjustments to the regulatory system to no longer incent insurers to use captives for XXX/AXXX reserves.

Ride-sharing: New Technology Creates Insurance Challenges

Hey buddy, can you spare a ride? This age-old question has taken a new twist as technological advances have changed the way in which business is done. A transportation network company (TNC) is an organization offering prearranged transportation services for compensation using an online application or platform to connect passengers with drivers willing to transport them. The TNC might also be known as a “ride-sharing company.” While the operation of a TNC is not primarily about insurance, this article will discuss some insurance issues surfacing.

Navigating the Regulatory Alphabet Soup

The insurance industry currently faces a fast-growing array of new regulations and reforms that were promulgated in response to the 2008 global financial crisis. These responses have given rise to a plethora of new insurance regulatory acronyms: there is now IAIG, G-SII, HLA, FIO, and ORSA, just to name a few. This article attempts to clarify some of these insurance regulatory buzz words and their significance within insurance regulation.

Examination of the Property/Casualty Insurance Underwriting Cycles

Like all industries, the property/casualty insurance industry experiences cycles of expansion and contraction over time. In the normal economy of growth or recession, these are often called business cycles. This article provides an overview of the property/casualty cycle, explains why the cycle is important to the industry, regulators and policyholders, and focuses on a few of the theories of why the underwriting cycle exists.

CIPR Event Examines Cyber Liability Risk and Issues Facing the Insurance Industry

Growth in technology has brought with it a rising number of data breaches and a greater awareness of cyber risk and the need to manage it. While demand for cyber liability insurance coverage has increased recently, cyber risk remains difficult for insurance underwriters to quantify due in large part to a lack of actuarial data. This article provides an overview of CIPR’s recent event, titled “Insuring Cyber Liability Risk,” where high-level experts discussed cyber liability risk facing the insurance industry.

Overview of U.S. Insurance Industry Holdings of Modeled Non-Agency MBS

The U.S. insurance industry historically has been an important institutional investor in both residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS). This article focuses on insurers’ holdings of modeled non-agency CMBS and non-agency MBS over the past four years and leverages the work by the NAIC Structured Securities Group on financial modeling of RMBS and CMBS to estimate the impact on insurers’ risk-based capital.

Data at a Glance: Market Share of Risk Retention Groups

The Insurance Regulatory Examiners Society
The staff at the Center for Insurance Policy and Research (CIPR) is pleased to provide the latest issue of the CIPR Newsletter. I hope you will find it enlightening and enjoyable. Inside this issue are some timely articles on a variety of insurance topics.

We start with an article on a controversial regulatory matter for life insurers. The shift from a rule-based to a principle-based regulatory framework has been a topic of discussion. Some life insurers have decided to employ captives to provide relief for what they perceive as redundancy in reserve requirements for certain life products while awaiting for principle-based reserving to be implemented. This has led to complaints from insurers not using captives to cover reserve risk transfers and concern from regulators about the financial reporting of these transactions. Kris DeFrain, director of the NAIC Research and Actuarial Department, writes about expected changes to the insurance regulatory framework for captives and special purpose vehicles owned by insurers.

Technology has changed our lives in many ways. There are often winners and losers when a technological innovation changes the way we do things. In an article I drafted, the technology innovation matching passengers with willing drivers is discussed. Innovators, known as transportation network companies (TNCs), have upset the world of taxi and limo drivers with an online application used to allow the public to find a willing driver with a person needing a ride. The article discusses insurance implications for the TNCs, their drivers, passengers and the public.

CIPR Manager Nikki Hall provides an update to an article written a few years ago. As things change, humans tend to develop names and then acronyms for the new products or entities. Ms. Hall brings us up-to-date on some of the new insurance regulatory acronyms and briefly discusses what each involves and their significance in insurance regulation in her article, “Navigating the Regulatory Alphabet Soup.”

What goes up must go down, says Sir Isaac Newton. It seems this is also true for property/casualty insurers. NAIC Statistical Information Manager Aaron Brandenburg and NAIC Research Analyst II Jennifer Gardner provide insight into the property and casualty insurance underwriting cycle. They try to answer the age-old question—Why do underwriting cycles occur? The answer is they do occur and we seem powerless to eliminate them. Enjoy the ride, as things will always change from soft market to hard market and back again.

Next up is an article by CIPR Senior Researcher Anne Obersteadt, who provides an overview of a CIPR event held at the 2014 Spring National Meeting titled “Insuring Cyber Liability Risk.” She provides some interesting insights into managing cyber risk and the nascent insurance market providing cyber liability coverage.

NAIC Structured Securities Group Analyst II Azar Abramov provides a look into the investments held by insurers of modeled non-agency mortgage-backed securities (MBS). Lack of transparency for MBS continues to hamper the private or non-agency MBS markets. Mr. Abramov gives us insight into the insurers’ appetite for these investment vehicles.

Our “Data at a Glance” article provides information about risk retention groups (RRGs). In the article, NAIC Research Analyst II Jennifer Gardner discusses the lines of business being written by RRGs and the states RRGs have chosen to be their regulator.

We finish with an article by Holly Blanchard, current president of the Insurance Regulatory Examiners Society (IRES). Initially an organization focused on market regulation, IRES has grown into other areas and offers a number of educational opportunities to its members. It also maintains a number of professional designations for those involved in regulatory compliance.

Eric Nordman
CIPR Director
EXPECTED CHANGES TO INSURANCE REGULATION FOR CAPTIVES AND SPECIAL PURPOSE VEHICLES

By Kris DeFRAIN, Director, Research & Actuarial Department

INTRODUCTION

State insurance regulators are given powers by state and federal law to regulate insurance companies and insurance captives and special purpose vehicles (hereafter referred to as “captives”) domiciled in their state. While insurers and captives are subject to solvency regulation, the financial regulatory systems for insurers and captives can still be significantly different, largely because captives are unique. As regulators have said, “If you’ve seen one captive, you’ve seen one captive.”

Regulators use a national state-based financial regulatory system for insurers (as developed by regulators through NAIC committees and the NAIC Financial Regulation Standards and Accreditation Program) and use their own state financial regulatory system for captives. Insurers are required to file a uniform financial statement that is shared with all regulators; captives must share specified information with their state regulator. For insurers, there is online shared information between regulators, including financial data and state action information; for captives, there is an option to share information upon regulatory request. For insurers, the domiciliary state takes responsibility with support of cross-checks and balances in the system; for captives, the individual state takes full responsibility.

In 2013, regulators conducted an NAIC study of these insurer-owned captives, analyzing potential ways to enhance the regulatory framework and provide insurance departments standardized tools and processes for reviewing certain types of captive transactions. Two of the important bodies of work that resulted from the study were 1) regulators sought to clarify when they should use the national state-based financial regulatory system for the regulation of captives; and 2) regulators sought to identify adjustments to the regulatory system (e.g., elimination of the perceived redundancy in specific required reserves) to no longer incent insurers to use captives for XXX/AXXX reserves.

NATIONAL SYSTEM FOR MULTI-STATE REINSURERS

States and U.S. territories have collectively established certain standards for regulating the solvency of U.S. insurers. Adherence to those standards by the states is monitored through the NAIC accreditation process. If a state demonstrates its system achieves the objectives of these standards and the state regulators continue to operate their system reliably, the state becomes accredited. Accreditation can be a signal to other states (and even to international regulators) that the state’s system has been evaluated, meets the agreed-upon standards and has been implemented to ensure adequate solvency regulation.

The standards apply to a state’s multi-state domestic insurers and reinsurers, generally defined as insurers and reinsurers: 1) domiciled in the state; and 2) either licensed, accredited, or operating in at least one other state or operating or accepting business as an excess and surplus lines insurer or non-captive risk retention group (RRG) from another state. Confusion arises from an exclusion that the definition “does not include those insurers that are licensed, accredited or operating in only their state of domicile but assuming business from insurers writing that business that is directly written in a different state.” Some find it unclear whether reinsurers—including those organized under captive laws and reinsuring business written in other states—are considered multi-state insurers subject to the accreditation standards.

At the 2014 Spring National Meeting, the Financial Regulation Standards and Accreditation (F) Committee exposed a definition of “multi-state reinsurers” along with an accompanying clarification of when such a reinsurer would need to be regulated under the agreed-upon accreditation standards. The intent of the new definition was to: 1) recognize that a multi-state reinsurer that assumes business written in any state other than its state of domicile would constitute multi-state business, and would therefore be regulated under the accreditation standards; and 2) generally exempt captive insurers owned by non-insurance entities for the management of their own risks.

Of the more than 30 comment letters submitted, most expressed some opposition to the revised definition and opined the scope was too broad. A few letters were sent in support of the change, expressing the issue needing to be addressed is broader than just the XXX/AXXX captives and reinsurers.

(Continued on page 4)

1. “A captive is an insurance company created and wholly owned by one or more non-insurance companies to insure the risks of its owner (or owners). Captives are essentially a form of self-insurance whereby the insurer is owned wholly by the insured.” NAIC website: CIPR: CIPR Key Issues: Captive Insurance Companies.

2. According to the Special Purpose Reinsurance Vehicle Model Act (# 789), special purpose reinsurance vehicles (SPRVs) are designed to facilitate the securitization of one or more ceding insurers’ risk as a means of accessing alternative sources of capital and achieving the benefits of securitization. Investors in fully funded insurance securitization transactions provide funds that are available to the SPRV to secure the aggregate limit under an SPRV contract that provides coverage against the occurrence of a triggering event.

3. The Voluntary of Life Insurance Policies Model Regulation (8830) is commonly referred to as “XXX” and Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38) is commonly referred to as “AXXX”.

July 2014 | CIPR Newsletter 3
that the state-based system of regulation would be strengthened as a result of the change. The Committee is expected to discuss the comments received at the Summer National Meeting.

**Proposed XXX/AXXX Disclosure, Regulatory Financial Analysis, and Reinsurance Framework**

The U.S. financial regulatory framework includes regulatory controls or needed approvals on typical affiliated transactions and reinsurance, largely because of the potential to use these tools to misrepresent economic reality, such as attempting to reduce or bypass high capital requirements.

In a Feb. 11, 2014 letter, the Financial Analysis (E) Working Group explained the regulatory concern with captive reinsurance agreements. The Working Group explained that the “risk for XXX and AXXX captive reinsurance agreements is generally considered to be different, in part because they are structured different than a pure cession. This is because many state insurance regulators consider XXX and AXXX to create overly conservative statutory reserves. As such, the transactions are generally structured in a manner to shift the “redundant” portion of the reserve to the captive insurer in order to more accurately reflect the expected cash outflows that could occur on the underlying policies... FAWG believes the primary risk associated with these XXX and AXXX captive reinsurance agreements is if the experience on the underlying business develops unfavorably to where the statutory reserves on such business may be insufficient to absorb such development.”

In June 2014, Rector & Associates, Inc. issued a report with a proposal for an XXX/AXXX Reinsurance Framework, a new reporting requirement in the 2014 financial statement blank for insurers ceding XXX/AXXX reserves, and the idea of a new section in the Financial Analysis Handbook regarding XXX/AXXX transactions. On June 30, the Principle-Based Reserving Implementation (EX) Task Force put in motion the development of 1) a new financial statement supplement to be required with 2014 annual reporting; 2) the need for regulatory financial analysis procedures for the states’ review of XXX/AXXX reinsurance transactions with captives/SPVs; and 3) details to support the XXX/AXXX Reinsurance Framework that was adopted in concept.

A new financial statement supplement to be required with 2014 annual reporting will be considered by the Blanks (E) Working Group. The Working Group is using Rector’s proposed draft supplement as a starting point. Rector’s proposal includes three tables detailing information about reserves, securities and collateral regarding each assuming insurer. Among other required reporting, the first table would include the name of the assuming insurer, the reserve amounts ceded and the type of reinsurer; the second table would include the name of the assuming insurer, the reserve credit taken by the ceding insurer, and the securities held in the current and prior year; and for each transaction included in the second table, a separate table would include the name of the assuming insurer, categories of assets and the amounts of assets and affiliate or parental guarantees.

The Financial Analysis Handbook (E) Working Group will be developing a new section in the Financial Analysis Handbook to specify procedures or best practices for reviewing XXX/AXXX reinsurance transactions with captives/SPVs. This Working Group is instructed to consider the changes recommended in the Feb. 11, 2014, letter from the Financial Analysis (E) Working Group. These changes include having a life actuary determine the reasonableness of the “economic reserve calculations” such that sufficient margins are included, the company can handle stresses (e.g. significant changes to mortality) and the assets supporting the economic reserves are of sufficiently high quality.

The third part of the project is to develop the details around the proposed XXX/AXXX Reinsurance Framework. Similar to how the Principle-Based Reserving Implementation (EX) Task Force adopted the framework in concept, the Executive (EX) Committee will consider adopting the proposed XXX/AXXX Reinsurance Framework in concept at the Summer National Meeting. If adopted, numerous groups will develop the details to create the framework for subsequent consideration by the entire NAIC membership.

The proposed framework, as currently adopted by the Task Force, would apply only to the XXX term life insurance business and AXXX universal life with secondary guarantees (ULSG) business. The Framework seeks to address regulatory concerns regarding reserve financing transactions and to do so without encouraging them to move off-shore. The primary goal of the Framework is to ensure enough assets are available to the ceding company to pay policyholder claims. In general, reinsurance transactions with large professional reinsurers, and other transactions that are not of

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the types that regulators have been concerned about, are not affected by the proposed Framework.

It is important to note the proposed framework does not change the statutory reserve requirements applicable to a ceding insurer. Rather, the framework addresses the types of security that can back those reserves in connection with reserve financing transactions. By way of either new requirements or what are effectively safe harbors (depending on the specifics of the transaction), the direct ceding company for reinsurance financing transactions, in most instances, would:

1. Collateralize a portion of the total statutory reserve approximately equal to the principle-based reserving (PBR)-level with hard assets such as cash and securities listed by the Securities Valuation Office (SVO).
2. Collateralize the remainder of the statutory reserve with other assets and forms of security identified as acceptable by regulators.
3. Disclose the assets and securities used to support the reserves.
4. Hold a risk-based capital (RBC) cushion as required for other business.

The proposed framework would be codified through the Credit for Reinsurance Model Law (#785) with the creation of a new model regulation to establish requirements regarding the reinsurance of XXX/AXXX policies. A modification to the Actuarial Opinion and Memorandum Regulation (#822) or other regulation will require the opining actuary for the ceding insurer to issue a qualified opinion if the framework is not followed. Prior to the regulation being modified and adopted by the states, an actuarial guideline would be adopted. As another enforcement tool, a note to the annual audited financial statement would require the ceding insurer, and its independent auditor, to indicate whether the framework is being followed.

It is expected once PBR is implemented, the perceived reserving redundancies precipitating the use of captives for reserving purposes will be addressed and, therefore, the incentive to create these types of captives will be almost, if not fully, eliminated. Industry representatives have agreed if regulators can remove the excessively conservative reserves to get to the “right” reserve level, then financing transactions would no longer exist.

**Conclusion**

Regulators are now in the final stages of implementing some regulatory changes for 2014, including revised financial analysis procedures for evaluating XXX/AXXX transactions for approval and new disclosures through a supplement to the financial annual statement. Based on what gets approved at the Summer National Meeting, changes to RBC could be implemented in 2015 with other changes to follow.

**About the Author**

Kris DeFrain is the NAIC Director of the Research and Actuarial Department. She is currently charged as primary NAIC staff for the Principle-Based Reserving and the Casualty Actuarial and Statistical Task Forces. She manages a staff of actuaries, statistical analysts, insurance contract experts, economists, and research analysts working on regulatory solvency- and market-related issues, providing regulatory services, and conducting research for the Center for Insurance Policy and Research. She received her bachelor’s degree in finance/actuarial science from the University of Nebraska in 1989. Ms. DeFrain received her FCAS designation from the Casualty Actuarial Society (CAS), where she previously served as Vice President—International. She is a member of the American Academy of Actuaries and a Chartered Property & Casualty Underwriter.
RIDE-SHARING: NEW TECHNOLOGY CREATES INSURANCE CHALLENGES

By Eric Nordman, Director of Regulatory Services and CIPR

Hey buddy, can you spare a ride? This age-old question has taken a new twist as technological advances have changed the way in which business is done. Allow us to introduce the transportation network company (TNC). A TNC is an organization offering prearranged transportation services for compensation using an online application or platform to connect passengers with drivers willing to transport them. The TNC might also be known as a “ride-sharing company.”

There are several companies fitting the general description of a TNC. Included on the list are Lyft (available in more than 60 locations), Sidecar (available in Boston, Chicago, Long Beach, Los Angeles, San Diego, San Francisco, Seattle and Washington, D.C.), Summon (available in the San Francisco Bay area), Uber X (available in 36 countries and more than 60 U.S. cities) and Wingz (offers transportation to the Burbank, Los Angeles, Oakland, San Francisco and San Jose airports).

The basic business model starts with an advertisement for drivers. Ads often are along the lines of “Make up to $20/hour; drive your car when you want to pick up passengers we identify for you.” There are no upfront costs to the driver, but the TNC does check the driver’s background and driving record. The TNC will inspect the vehicle and there is some limited training.

The TNC advertises for riders and will generally use an iPhone or Android app as the point of contact. The prospective traveler downloads the app, follows the on-screen instructions to enter information about the pick-up and drop-off points, identifies the date and time for the pick-up and posts a request. The driver responds if he/she wishes to accept the offer and agrees to pick up the rider. The rider is notified by email or text message when the driver has accepted the offer. Another text message is sent when the driver is on the way. The TNC makes its money by taking a percentage of sales. Prices to the public for the service are generally less than for a taxicab. The cost of the ride is charged to a credit card with no tipping involved.

It all sounds wonderful. It’s a good deal for the public and a good deal for the drivers. It’s a win-win situation for all, right? But wait! It seems there may be an issue or two...

◆ TAXICABS AND LIMOUSINES

In most places, taxicabs and limousines are regulated to protect the public. Because taxis and limos are offering to transport passengers from place to place for a fee, shouldn’t the TNC driver simply get licensed as a taxi driver? The taxi and limo drivers certainly think they should. If you type “taxicabs and ride-sharing” into any search engine, a number of articles will pop up where taxi drivers are protesting the TNCs. A June 12, 2014, article in the Pittsburgh Post-Gazette is titled, “Growing Opposition to Ride Share Companies Goes Global.”

There is similar opposition in the U.S. as taxi and limo drivers—and their trade associations—have united to oppose the TNC concept in a variety of ways. The basic argument is the TNC is an unlicensed taxicab company and it is illegally taking away business that rightfully belongs to the properly licensed taxi and limo drivers. In light of the opposition, various governmental bodies have taken action. Some jurisdictions have issued cease-and-desist orders. Others have levied fines against the drivers or the TNCs.

◆ INSURANCE ISSUES

While the operation of a TNC is not primarily about insurance, there are some insurance issues surfacing. The leader among the insurance regulatory community has been California Insurance Commissioner Dave Jones. In September 2013, the California Public Utilities Commission, Transportation Licensing Section issued a press release and guidance to owners of TNCs and their drivers. A consumer-friendly version of the formal guidance was issued in October 2013. The guidance defines the TNC, requiring a TNC to only use smartphone technology applications to facilitate passenger transportation in a driver’s personal vehicle. It distinguishes the TNC driver from a taxicab driver by prohibiting the TNC driver from accepting street hails and requiring all rides to be prearranged using the smartphone digital platform. It requires driver training, a drug and alcohol testing program, a criminal background check and a vehicle inspection by the TNC. The guidance also has insurance requirements: the

(Continued on page 7)

1 www.post-gazette.com/business/2014/06/13/Growing-opposition-to-ride-share-companies-goes-global/stories/201406120314
2 Ibid.
3 http://docs.cpuc.ca.gov/PublishedDocs/Published/G000/A0777/K122/77132276.PDF
4 http://docs.cpuc.ca.gov/PublishedDocs/Published/G000/A0777/K122/77112285.PDF
5 www.cpuc.ca.gov/NR/rdonlyres/1788F1F1-EA38-4B68-B221-4116994F2252/0/TNC_App_instrctns.pdf
RIDE-SHARING: NEW TECHNOLOGY CREATES INSURANCE CHALLENGES (CONTINUED)

TNC must be licensed by the California Public Utilities Commission and must ensure the driver has passed a background check.

Commissioner Jones reviewed the guidance issued by the California Public Utilities Commission and noticed there were some remaining insurance issues left unaddressed by the California Public Utilities Commission guidance. He convened a public hearing March 21, 2014, to investigate the matter. Following the public hearing, Commissioner Jones issued a letter to the California Public Service Commission dated April 7, 2014. In the letter, the Commissioner made eight recommendations to the California Public Utilities Commission and two recommendations to the California Legislature. His findings outline several significant insurance issues.

The major insurance issue surrounds the driver’s personal auto insurance policy. The most commonly used auto policy is the personal auto policy developed by the insurance advisory organization, Insurance Services Offices, Inc. It contains an exclusion that says, “We do not provide Liability Coverage for any insured for that insured’s liability arising out of the ownership or operation of a vehicle while it is being used to carry persons or property for compensation or a fee. This Exclusion does not apply to a share-the-expense car pool.” Other auto insurers have similar exclusionary language in their policy forms.

As a result, a TNC driver’s personal auto insurance policy will not provide coverage when the driver is using his car to transport people in a ride-sharing arrangement for a fee. Following the hearing, Commissioner Jones found, “Drivers’ existing personal auto insurance does not cover TNC-related driving and auto insurers are not planning to offer coverage of this risk in the near future if ever.” Commissioner Jones also found the TNCs were under the mistaken belief that personal auto insurers would provide coverage, which is not the case in all of the states. The issue is compounded when the states have other mandatory insurance requirements, such as personal injury protection (no-fault), uninsured motorists coverage or underinsured motorists coverage.

In addition to the liability coverage gap, a TNC driver might also find personal auto coverage for comprehensive or collision coverage does not apply while the vehicle is being driven for hire.

One of the biggest concerns is determining at what point in time a driver is operating the vehicle for hire. Is it when the driver picks up a passenger? Is it when the driver turns on the TNC app and makes himself or herself available for hire? Lack of clarity surrounding this issue will inevitably lead to coverage disputes as claims arise.

Several of the large TNCs provide $1 million of liability coverage for damages that exceed a driver’s personal insurance limits. However, the coverage applies only when a passenger is in the car or once a driver has accepted a request for a ride from a smartphone application. The coverage gap was identified in the April 7, 2014, letter from Commissioner Jones to the California Public Service Commission. In it, Commissioner Jones recommended the California Public Service Commission redefine its definition of “when providing TNC services.” His correspondence suggested three distinct time periods associated with the delivery of TNC services.

The first period occurs when the driver opens the TNC app and is available to pick up riders, but has not received a matching offer from a potential fare. The second period occurs when a pick-up request is received, the driver has been matched with the rider and the driver picks up the passenger. The third period occurs when the passenger is in the car until the passenger has safely exited the vehicle. Commissioner Jones also recommended the TNC companies be required to maintain primary commercial auto liability insurance in the amount of $1 million for each of the three coverage periods. Further, he recommended the TNCs be required to carry $1 million limits of uninsured motorists coverage and underinsured motorists coverage.

Other recommendations from Commissioner Jones include: requiring notice to personal auto insurers that a person has decided to become a TNC driver; requiring the TNC to share data with the personal auto insurance regarding a claim; requiring the TNC to provide evidence of coverage to its drivers so the driver could share the information with passenger in case of an accident; requiring disclosure regarding the impact on insurance coverage of a TNC driver picking up a “private client” and charging a fee; and suggesting a 60-day delay in imposing the suggested requirements on TNCs and TNC drivers to allow them time to secure the additional coverages. Commissioner Jones also made suggestions to the California Legislature regarding legislation to isolate TNC use from personal auto use and to revisit California’s ridesharing and casual carpooling laws.

(Continued on page 8)
RIDE-SHARING: NEW TECHNOLOGY CREATES INSURANCE CHALLENGES (CONTINUED)

As TNCs have moved into other states and cities, insurance commissioners have reacted in similar ways to advise the public of the shortcomings and insurance issues regarding ridesharing. Most have come in the form of bulletins warning consumers of insurance coverage gaps. Some of the large TNCs say they have filled the insurance gap with extended excess policies, although such policies are new and have not been tested. Also, coverage for when a driver is available to pick up a passenger and has the app on typically has much lower limits, such as $100,000 per occurrence.

Insurance regulators oversee insurance companies and insurance agents, not TNCs. The insurance laws and regulations apply to the insurance company and the insurance producer issuing the insurance policy to the TNC or the individual driver. Municipalities typically regulate the licensing of taxicabs, limousines and other livery services. Municipalities or states can change the requirements on whether ridesharing services must be licensed as taxis.

One of the primary missions of state insurance regulators is consumer protection and many state insurance regulators have recently issued consumer alerts concerning ridesharing. These consumer alerts typically focus on the fact that most personal auto policies contain exclusions for driving for hire or livery services. Regulators have warned consumers that their personal auto policy likely will not provide coverage for liability incurred while driving passengers in exchange for payment (other than in an expense-sharing arrangement, such as carpooling). In addition, even if the state requires the TNC to have a liability policy, that policy may not provide coverage for bodily injury to the TNC driver, damage to the TNC driver’s car or bodily injury or physical damage caused by an uninsured or underinsured motorist. In that case, such drivers may wish to purchase a commercial policy with liability, uninsured/underinsured motorists, personal injury protection, or comprehensive and collision coverage.

Some insurance regulators have recommended that all TNCs provide high-limit, primary commercial liability insurance that begins the moment a driver switches on the app, as well as uninsured motorist coverage and underinsured motorist coverage to protect the driver and passenger. The Illinois Legislature recently passed a law that would require commercial liability insurance to be primary and in effect the entire time a driver’s app is on. The law would also require conspicuous disclosure to TNC drivers about insurance coverages provided by the TNC.

The personal auto insurers have made it clear drivers should obtain a commercial policy if they are participating in ridesharing arrangements for a fee. There is concern among personal auto insurers that the bifurcated coverage will lead to confusion and conflict. Claims investigations may increase as insurers have to determine which policy (commercial or personal) is responsible for coverage at the time of the accident. These disputes could lead to litigation, driving up costs for all policyholders.

• CIPR EVENT

It is obvious that there are some challenges as we move to new types of business models in the modern technology-driven world. Ridesharing is an example of how a new business idea using a new technology can change the world as we know it. Often the change shifts the balance of power. Some people gain and some people lose. Just as Thomas Edison’s invention of the electric light caused great concern among candlemakers, so, too, has the introduction of the TNC-caused great concern for taxis and limo drivers. Their world has changed and they are trying to sort out what the change means for them.

If you would like to learn more about insurance issues related to ride-sharing and car-sharing, plan to attend the next CIPR event, “Commercial Ride-Sharing and Car-Sharing Issues,” to take place at the NAIC Summer National Meeting in Louisville, Kentucky. The event will be held at 11 a.m. Saturday, Aug. 16, 2014, in Marriott Ballroom V of the Louisville Marriott Downtown. Commissioner Jones will serve as the moderator of the event. A panel of experts, including insurance industry representatives, taxi drivers, TNCs, consumer advocates and others will be represented in what is expected to be a timely and provocative event. We hope to see you there.

ABOUT THE DIRECTOR

Eric Nordman, CPCU, CIE, is the director of the NAIC Regulatory Services Division and the CIPR. He directs the Regulatory Services Division staff in a wide range of insurance research, financial and market regulatory activities, supporting NAIC committees, task forces and working groups. He has been with the NAIC for 23 years. Prior to his appointment as director of the Regulatory Services Division, Nordman was director of the Research Division and, before that, the NAIC’s senior regulatory specialist. Before joining the NAIC, he was with the Michigan Insurance Bureau for 13 years. Nordman earned a bachelor’s degree in mathematics from Michigan State University. He is a member of the CPCU Society and the Insurance Regulatory Examiners Society.
CIPR SUMMER EVENT
COMMERCIAL RIDE-SHARING AND CAR-SHARING ISSUES

NAIC SUMMER NATIONAL MEETING
August 16, 2014 - Louisville, KY
11:00 a.m. - 1:00 p.m.
(Sign-in and lunch from 10:30 - 11:00 a.m.)
Navigating the Regulatory Alphabet Soup

By Shanique (Nikki) Hall, CIPR Manager

The insurance industry currently faces a fast-growing array of new regulations and reforms promulgated in response to the 2008 global financial crisis. Although the U.S. insurance regulatory system proved successful through the financial crisis, the crisis was the largest shock to the financial system since the Great Depression and spawned numerous regulatory responses at the state, federal and international levels. These responses have given rise to a plethora of new insurance regulatory acronyms: there is now IAIG, G-SII, HLA, FIO, and ORSA, just to name a few, and not to mention related abbreviations such as ComFrame. Moreover, there are many insurance acronyms that continue to make news headlines, such as TRIA and NARAB, due to their implications or needed regulatory changes.

To the casual observer, these acronyms and abbreviations can be intimidating and start to look more like a bowl of alphabet soup. This article attempts to clarify some of these insurance regulatory buzz words and their significance within insurance regulation and is an update to a previous article that appeared in the October 2011 CIPR Newsletter titled, “Know Your ABCs … It’s Still Relevant.”

ICPs

Formed in 1994, the International Association of Insurance Supervisors (IAIS) is the international standard-setting body for the insurance industry. Its members constitute nearly all of the world’s insurance supervisors. Since its inception, the IAIS has worked to promote effective and globally consistent supervision of the insurance industry and to contribute to global financial stability. The IAIS has no regulatory power or legal authority, but it influences national and regional regulators by publishing supervisory principles, offering training and support, and advancing the latest developments in international regulation.

Insurance Core Principles (ICPs) were developed by the IAIS to provide a globally accepted framework for the regulation and supervision of the insurance sector. The ICPs prescribe the essential elements that must be present in the supervisory regime in order to promote a financially sound insurance sector and provide an adequate level of policyholder protection. They are applicable to the supervision of all insurers and insurance groups, regardless of their size, international orientation or systemic importance.

The ICPs were first issued in 1997 and have been revised several times, most recently in October 2011. There are currently 26 ICPs that cover a range of subjects, including licensing, suitability of persons, corporate governance, risk management, reinsurance, group-wide supervision and cross-border cooperation. While the ICPs are not binding on IAIS-member jurisdictions, they are used in the evaluation of supervisory regimes under the Financial Sector Assessment Program (FSAP) conducted jointly by the World Bank and the International Monetary Fund, where the financial sector regulatory frameworks of a jurisdiction are assessed against the appropriate international standards. For insurance, the ICPs form the basis for the assessment of insurance regulators’ observance of international standards.

COMFRAME

The regulation of insurance groups has garnered considerable attention following the financial crisis, with various regulatory agencies developing new guidelines and requirements for the supervision of financial holding companies. In the U.S., the Solvency Modernization Initiative (SMI), which began in June 2008, has led to substantive changes regarding how insurance groups will be monitored and regulated in the coming years, including amendments to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation (#450). Globally, however, the most significant development regarding group supervision is a major project initiated at the IAIS known colloquially as ComFrame (Common Framework for the Supervision of Internationally Active Insurance Groups).

(Continued on page 11)

1 Available at: www.naic.org/cipr_newsletter_archive/vol1_abc.htm.
2 The IAIS currently represents insurance regulators and supervisors of more than 200 jurisdictions in over 140 countries, constituting 97% of the world’s insurance premiums.
3 The NAIC’s Solvency Modernization Initiative is a critical self-examination of the United States’ insurance solvency regulation framework and includes a review of international developments regarding insurance supervision, banking supervision, and international accounting standards and their potential use in U.S. insurance regulation.
ComFrame is a set of international supervisory requirements focusing on the effective group-wide supervision of internationally active insurance groups (or IAIGs, discussed in more detail below). It is built on the premise that IAIGs—the largest and most complex insurance groups—should be supervised in a collaborative fashion by home and host supervisors, thereby resulting in more effective and efficient supervision. ComFrame will provide a framework to assist supervisors in addressing the risks arising in IAIGs. The IAIS notes IAIGs need tailored and more coordinated supervision across jurisdictions due to their complexity and international activity, which necessitates a specific framework to assist supervisors in collectively addressing group-wide activities and risks, identifying and avoiding regulatory gaps and coordinating supervisory activities under the aegis of a group-wide supervisor.

ComFrame is built and expands upon the high level requirements and guidance currently set out in the ICPs. It is currently structured in three modules, with each module made up of a number of standards (referred to as “elements”). Module 1, Scope of ComFrame, includes the criteria and process for the identification of IAIGs by supervisors, the breadth of supervision of IAIGs (i.e., which legal entities are included) and the identification of the group-wide supervisor. Module 2, The IAIG, contains the requirements that an IAIG will need to meet. Module 3, The Supervisors, covers the process of supervision, highlighting the role of the group-wide supervisor and other relevant supervisors’ responsibilities within the process. This module covers the supervisory process, enforcement, cooperation and interaction requirements.

The development phase of ComFrame began in 2010 and concluded at the end of 2013, with several ComFrame drafts released for public consultation during this period. Comments received have been referred to various IAIS subcommittees and working groups to improve and refine the document. ComFrame is currently being field tested to assess the value and practicality of the various requirements, so it can be modified as necessary prior to formal adoption. The IAIS currently plans to formally adopt ComFrame by the end of 2018, with implementation by its members thereafter.

♦ IAIG
An internationally active insurance group (IAIG) is a term under ComFrame for insurance groups or financial conglomerates that exceed thresholds on international activity and size. The IAIS has set out proposed criteria relevant supervisors will use for identifying an IAIG, but allowing a degree of supervisory discretion to local regulators as to whether a particular group should or should not be categorized as an IAIG. Under the proposed criteria, to be an IAIG, an insurance group must write at least 10% of its total gross written premiums outside its home jurisdiction and must write premiums in three or more jurisdictions. In addition, the insurance group must have assets of at least $50 billion or premiums of at least $10 billion of a three-year rolling average.

Supervisory colleges are intended to facilitate oversight of IAIGs at the group level and will be the mechanism by which an IAIG is identified. U.S. state insurance regulators both participate in and convene supervisory colleges. The IAIS expects there may be approximately 50 groups that could be considered IAIGs under the proposed criteria.

♦ G-SII
The severity of the financial crisis underscored the interconnected nature of financial institutions, as well as the risks they pose to the financial system when they are in distress. Phrases like “too big to fail” and “systemically important” continuously made news headlines in the midst of the crisis. The Financial Stability Board (FSB) was established in 2009 and tasked by the Group of Twenty (G-20) to develop a framework to address the systemic and moral hazard risk posed by global systemically important financial institutions (G-SIFIs). G-SIFIs are defined by the FSB as “institutions of such size, market importance, and global interconnectedness that their distress or failure would cause significant dislocation in the global financial system and adverse economic consequences across a range of countries.”

As part of this effort, the IAIS is working with the FSB to identify global systemically important insurers (G-SIIs). A G-SII is one class of G-SIFIs. While the insurance industry was not the root cause of the financial crisis, insurance markets have become increasingly global and interconnected, and activities they engage in have become increasingly tied to the financial markets. As such, the FSB asked the IAIS to set up a process to assess insurers’ systemic riskiness and to recommend policy measures designed to prevent catastrophic failure in the sector.

On July 18, 2013, the IAIS released its final guidance on 1) the assessment methodology the FSB uses to assist in identifying G-SIIs; and 2) the policy measure framework to be applied to such insurers. The assessment methodology

(Continued on page 12)
identified five categories to measure relative systemic importance: 1) non-traditional insurance and non-insurance (NTNI) activities; 2) interconnectedness; 3) substitutability; 4) size; and 5) global activity.

According to the IAIS, NTNI activities, the most heavily weighted category, are at the core of systemic risk in the insurance sector, along with the interconnectedness of the insurance business with the wider financial sector. Examples of NTNI activities include credit default swaps transactions for non-hedging purposes or leveraging assets to enhance investment returns. While traditional insurance is not viewed as systemically risky, insurance groups and conglomerates operating in traditional lines of business may suffer considerable distress and become globally systemically important when they expand significantly in non-traditional and non-insurance activities.

The policy measures that apply to G-SIIs consist of the following factors: 1) enhanced supervision; 2) effective resolution; and 3) higher loss absorption (HLA) capacity. Concurrent with the release, the FSB announced a list of nine multinational insurance groups it considers to be G-SIIs—three in the U.S., five in Europe, and one in China (Figure 1)—and therefore rendered them subject to these additional policy measures. The G-SII list will be determined by the FSB on an annual basis, based on information provided by the IAIS.

In the U.S., the Financial Stability Oversight Committee (FSOC), established under the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) is authorized to address systemic risk and has its own separate process for evaluating and designating systemically important insurers. To date, the FSOC has designated two of the three U.S.-based G-SIIs as “systemically significant” and a third insurer is under review.

It is important to note the methodology and related policy measures for G-SIIs are separate from ComFrame. Unlike the IAIS work for G-SIIs, ComFrame does not directly address systemic risks. As such, the criteria—and purposes—for identifying G-SIIs and IAIGs are distinct. The architecture envisioned by the IAIS is illustrated in Figure 2.

(Continued on page 13)
Navigating the Regulatory Alphabet Soup (Continued)

**BCR, HLA and ICS**
There is significant activity currently underway at the IAIS in the area of capital developments for the application to G-SIIs and in conjunction with its work on ComFrame. In July 2013, the FSB directed the IAIS to develop for the purposes of the higher loss absorption (HLA) capacity G-SII policy measure, “straightforward, backstop capital requirements to apply to all group activities, including non-insurance subsidiaries, to be finalized by the end of 2014.” A backstop capital requirement (BCR) will be the first step in the development of HLA requirements to apply to G-SIIs in 2015. According to the IAIS, the HLA will build on the BCR and address additional capital requirements for G-SIIs reflecting their systemic importance in the international financial system.

The IAIS is also currently developing a risk-based global insurance capital standard (ICS), due to be completed by the end of 2016, with full implementation expected in 2019 after two years of testing and refinement with supervisors and global insurance groups. The ICS will be developed within ComFrame and apply to all IAIGs. The IAIS hopes the ICS will provide a more comparable measure of capital across jurisdictions and allow host supervisors to have greater confidence in the group-wide supervisor’s decisions and analysis.

While neither the BCR nor the ICS are expected to replace jurisdictional entity-based insurance capital requirements, there will be continuing discussion at the IAIS about how the ICS might interact with such existing requirements, such as U.S. risk-based capital (RBC) legal entity requirements and RBC ratios. Both are being designed to pick up financial risk and material non-financial risk from all sources within the group, including risk emanating from entities that were heretofore not subject to entity-based regulation.

**FIO**
The Dodd-Frank Act, signed into law by President Barack Obama in July 2010, brought about significant changes to financial regulation in the U.S. The stated aim of the legislation is to promote financial stability by improving accountability and transparency in the financial system, to end “too big to fail” and to protect consumers from abusive financial services practices. The Dodd-Frank Act created new laws in all major segments of the financial services industry, including banks, thrifts, mortgage businesses and insurance.

The Dodd-Frank Act established a new Federal Insurance Office (FIO) within the U.S. Department of the Treasury, led by a director who is appointed by the secretary of the Treasury. The FIO is charged with monitoring all aspects of the insurance sector, including identifying activities within the sector that could potentially contribute to a systemic crisis to the broader financial system, the extent to which under-served communities have access to affordable insurance products, and the sector’s regulation.

The FIO does not have supervisory or regulatory authority over the business of insurance. While the FIO serves an important role by providing necessary expertise and advice regarding insurance matters to the Treasury Department and other federal agencies, it is not a regulatory agency and its authorities do not displace the time-tested robust state-based insurance regulatory regime.

The FIO is responsible for issuing several one-time reports as well as annual reports to the U.S. Congress. In December 2013, the FIO released a mandated study titled “How to Modernize and Improve the System of Insurance Regulation in the United States.” The report acknowledges many of the strengths as well as the successes of state-based insurance regulation.

**ORSA**
In November 2011, as part the SMI, the NAIC voted to adopt a significant new addition to U.S. insurance regulation: the U.S. Own Risk and Solvency Assessment (ORSA). One of the key lessons arising from American International Group’s (AIG) difficulties and its resulting bailout during the financial crisis was the need enhance the area of group supervision. The contagion effects experienced by U.S. insurers in the AIG holding company system’s near collapse caused U.S. insurance regulators to reevaluate their group supervisory framework and pay closer attention to the risks that are created by activities going on outside of those entities as well as the reputational and contagion issues that could exist. Following the crisis, 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.

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. Each insurer required to complete an ORSA must issue its own assessment of its current and future risks (i.e., underwriting, credit, market, operational, liquidity risks, etc.) that could have an impact on its ability to meet its policyholder obligations, thereby allowing regulators to form an enhanced view of the insurer’s ability to withstand financial stress.

(Continued on page 14)
Pursuant to the NAIC Own Risk and Solvency (ORSA) Guidance Manual and the recently adopted Risk Management and Own Risk and Solvency Assessment Model Act (#505), starting in 2015, an insurer and/or the insurance group of which the insurer is a member will be required to: 1) complete an ORSA at least annually to assess the adequacy of its risk management and current, and likely future, solvency position; 2) internally document the process and results of the ORSA assessment; and 3) provide a high-level summary report annually to the lead state commissioner if the insurer is a member of an insurance group and, upon request, to the domiciliary regulator if the insurer is not a member of a group. Currently, the ORSA requirements apply only to large insurers and large holding companies.

In 2010, the ORSA concept was added to the IAIS list of ICPs. ICP 16: Enterprise Risk Management (ERM) indicates 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.

**TRIA**

The federal Terrorism Risk Insurance Act (TRIA) was passed in response to the 9/11 terrorist attacks, to ensure the continued availability and affordability of commercial terrorism insurance. U.S. insurance markets were caught off guard by the 9/11 terrorist attacks. Loss of life and property led to an estimated $32.5 billion in insured losses—$43 billion in 2001 dollars—the largest wake of the attacks since TRIA became law in 2002, it has helped create a federal insurance against terrorism risks. The program requires terrorist insurance. U.S. insurance markets were caught off guard by the 9/11 terrorist attacks. In response to the 9/11 terrorist attacks, the Obama administration, state officials and the industry to develop a long-term plan to help make terrorism insurance available and affordable.

The TRIA reauthorization effort has gained momentum in the past few months. On July 17, 2014, the Senate voted in favor of a bill (S. 2244, the Terrorism Risk Insurance Program Reauthorization Act of 2014) that would continue the program for another seven years and the House Financial Services Committee passed a version of the legislation out of committee on June 24. NAIC members are encouraged by momentum in both the Senate and House and urge prompt congressional action to move a TRIA reauthorization bill forward expeditiously.

**NARAB**

Licensing of insurance agents and brokers (collectively, “producers”) has long been an integral part of the U.S. state-based insurance regulatory system. Historically, each state has had its own producer-licensing requirements. Producers licensed in one state generally had to meet the separate licensing requirements for each state in which they wanted to sell insurance. In 1999, the federal Gramm-Leach-Bliley Act (GLBA) sought to modernize and streamline the variation in state laws dealing with the licensing of insurance producers. The GLBA contained a provision requiring the states to enact certain reforms to the insurance producer-licensing process. The provision would create a private, non-profit licensing body, referred to as the National Association of Registered Agents and Brokers (NARAB), if greater state producer-licensing uniformity or reciprocity was not achieved. NARAB would be backed by federal authority and serve as a central clearinghouse for producers who wish to do business in multiple states.

In February 2000, the NAIC adopted the Producer Licensing Model Act (#218) to help the states comply with the GLBA’s reciprocity provisions. Subsequently, the NAIC membership determined a majority of jurisdictions had met the non-resident producer licensing reciprocity requirements under the GLBA and, as a result, NARAB was never created. However, continued concern over the lack of reciprocity among all states has prompted the U.S. Congress to seek a further solution.

A modified version of the national licensing proposal, the National Association of Registered Agents and Brokers Reform Act (or NARAB II, as it is being commonly called), is again pending before Congress. NARAB II would streamline the non-resident producer licensing process but preserve the states’ ability to protect consumers—it does not create a federal regulator for insurance and the states would retain
their regulatory authority over consumer protection, market conduct and unfair trade practices. The states also would retain their rights over resident licensing, as well as supervision, discipline and the establishment of licensing fees for insurance producers.

**FBIIC**

The important role of the U.S. Treasury Department’s Financial and Banking Information Infrastructure Committee (FBIIC) is little known to the public. It does, however, serve a crucial role in assisting with disaster response and recovery. FBIIC is an interagency organization charted in 2001 under the President’s Working Group on Financial Markets. The FBIIC is charged with coordinating efforts across the financial services sector to improve the security and reliability of the critical infrastructure necessary for financial markets to function. Members of the FBIIC include representatives of the Federal Reserve Board, the Treasury Department, the U.S. Securities and Exchange Commission and the NAIC.

On a day-to-day basis, the FBIIC is involved in activities such as identifying critical infrastructure assets, documenting their locations and figuring out their potential vulnerabilities, and then prioritizing each item’s importance to the U.S. financial system. The FBIIC also establishes secure communications capability among the various financial regulators and develops protocols for communicating during an emergency.

The NAIC is engaged directly with the FBIIC on cybersecurity and natural disaster planning issues. In March 2014, Brian Peretti, acting director at the U.S. Treasury Department’s Office of Critical Infrastructure, presented at the CIPR “Insuring Cyber Liability Risk” event, which took place at the Spring National Meeting. Mr. Peretti, who leads the efforts of the FBIIC, provided an in-depth overview of the cyber liability landscape. Please see page 22 for an overview of his presentation.

**DoS / DDoS**

A denial-of-service (DoS) attack is an attempt by attackers to prevent legitimate users of a service from using that service. The most common type of DoS attack occurs when an attacker “floods” a computer network with traffic. This sudden increase in traffic overwhelms the target system, preventing legitimate users from accessing information and services, and essentially leading to system paralysis and a DoS for authorized users.

A distributed denial-of-service (DDoS) is a type of attack where a network of computers are used to target a single system or website. An attacker may also use your computer to attack another computer. The attack is “distributed” because the attacker is using multiple computers, including yours, to launch the DoS attack.

Perpetrators of these attacks typically target websites or services hosted on high-profile Web servers such as banks and credit card payment gateways. Several major financial services firms have recently announced they have been victims of a DDoS attack, including JP Morgan chase, Wells Fargo, Bank of America and Citigroup.

These attacks are growing more common and can result in significant loss of time and money for many organizations. A recent article published in the Wall Street Journal, “A Call to Arms for Banks,” described the growing push by regulators for financial services firms to better arm themselves and the financial system against cyber attacks.

**SUMMARY**

As you can see, there are many new and existing insurance regulatory acronyms to be learned. The CIPR will continue to keep you updated on the latest regulatory acronyms, as well as their developments and implications.

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**About the Author**

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EXAMINATION OF THE PROPERTY/CASUALTY INSURANCE UNDERWRITING CYCLES

By Aaron Brandenburg, NAIC Statistical Information Manager, and Jennifer Gardner, NAIC Research Analyst II

“Interpretations of the underwriting cycle abound. The majority presume that someone is erring: rate making methods are naive, underwriters are simplistic, regulation is rigid, or investment managers are deceived. Such explanations search for a cause where it is not to be found. Insurers are no less rational than other firms are. They exist in a highly competitive market, where the foolish firm does not long survive.”1

INTRODUCTION

Like all industries, the property/casualty insurance industry experiences cycles of expansion and contraction over time. In the normal economy of growth or recession, these are often called business cycles. Unlike other industries, the insurance industry has historically experienced cycles that are typically independent of the business cycle in a somewhat repetitive nature with each lasting from two to 10 years. This phenomenon in the property/casualty insurance world is known as the underwriting cycle and consists of rising and falling premiums and profits, or “hard” and “soft” markets.

The insurance underwriting cycle has been studied extensively over the years and while there have been many theories put forward about its causes and mechanics, there is no generally accepted view as to why it exists. This article will explain why the cycle is important to the industry, regulators and policyholders. It will provide an overview of the property/casualty cycle and focus on a few of the theories of why the underwriting cycle exists. It will also show a history of the property/casualty cycle and attempt to explain at what point of the underwriting cycle the industry currently resides and where it might be headed.

THE IMPORTANCE OF THE UNDERWRITING CYCLE

According to Sir Isaac Newton, what goes up must come down. The same observation holds true for the property/casualty insurance underwriting cycle, which has a pattern of rising and falling prices and profits. Historically, property/casualty insurance markets have alternated between periods of hard and soft markets (Figure 1). In a soft market, insurance is plentiful and available at a reasonable price. Competition thrives in a soft market, leading to stable or falling insurance rates. Underwriting standards may be relaxed and profits fall. Prices are low and the quantity of insurance increases. Insurers compete over business by lowering rates and offering additional coverage. In this part of the cycle, companies may be practicing cash flow underwriting, where insurers lower rates in order to increase premiums and investment income or retain market share. Insurers use investment earnings to make up for underwriting losses. As the industry moves through the underwriting cycle, insurer profits decline and there is a decrease in capital. Eventually, the cycle bottoms out.

As the market hardens, rates increase. Insurers reduce risks and may decrease policy limits. Some insurers withdraw from certain markets. In hard markets, underwriting standards tighten and prices and profits increase. Policy terms become more restrictive as the quantity of insurance decreases. Supply is limited in a hard market and, therefore, insurance comes at a high cost. There is often a decrease in competition and buyers have difficulty finding coverage. Premiums increase and coverage is restricted. At the height of the hard market, there is an increase in insurer profits leading to additional capital coming into the market. This leads to increased competition and pushes premiums down, turning the market yet again as premiums and profits fall.

The underwriting cycle is important, as it has implications on profitability, competition, availability, affordability and solvency. To remain profitable, insurers must pay attention to underwriting cycles and market competition. Occasionally, the cycle reaches a crisis level, as it did with the commercial liability crisis of the 1980s. During this crisis, many businesses saw significant increases in their liability insurance premiums, coverage narrowed, underwriting standards tightened, insurers withdrew from markets and businesses found it more difficult to obtain coverage. Consequently, many businesses increased prices, self-insured or went out of business.

(Continued on page 17)

ness. This led to increased regulation, tort reform and changes to federal legislation allowing for the creation of risk retention groups.

The commercial liability crisis was an extreme example of what can happen to certain lines of business in a severe hard market stage of the cycle. At the other end of the spectrum, regulators look closely at soft markets because they often lead to insolvencies. Insolvencies have historically occurred during a soft market, when prices are low and competition is intense.

The NAIC’s 1991 publication “Cycles and Crises in Property/Casualty Insurance: Causes and Implications for Public Policy” (NAIC’s 1991 publication) found nine distinct underwriting cycles in its study period: 1926–1932; 1932–1940; 1940–1946; 1946–1951; 1951–1957; 1957–1964; 1964–1969; 1969–1975; and 1975–1984. These cycles were measured from peak to peak, so they include both the hard and soft markets. Throughout this time period, cycles were regular, where hardening markets were followed closely by softening markets.

This pattern prevailed until the liability crisis in the mid-1980s. Many have noted that the underwriting cycles thereafter may be lengthening. In the 1970s and 1980s, these cycles lasted three to four years, whereas the softening cycles have now stretched much longer (five and seven years). Other underwriting cycles since the mid-1980s include: 1985–1992; 1992–2001; and 2001–2011. Hard markets occurred in 1975–1978, 1984–1987, and 2000–2003 as premium growth peaked.

Measuring the Underwriting Cycle

The underwriting cycle is often measured by looking at premium growth and the combined ratio. As premium grows, the market becomes harder and more profitable. The combined ratio has the opposite effect; i.e., a high combined ratio is unprofitable for the industry, a sign of a soft market. The NAIC’s 1991 publication provides an excellent analysis on the implications with using premium growth and combined ratios to measure underwriting cycles.

The combined ratio is a measure of underwriting performance. It is calculated by adding the loss ratio to the expense ratio. The loss ratio is a fundamental measure of the cost of underwriting operations, signifying the quality of business written and the adequacy of premium rates. Expense ratios represent the cost to obtain and retain customers and the efficiency of underwriting operations. The combined ratio decreases when losses or expenses decrease compared to premiums.

A combined ratio of less than 100% signifies an underwriting profit. The combined ratio is an imperfect measure of the actual price of insurance as it is based on calendar year data, which may exclude loss experience on policies written. Premium growth may be a result of either an increase in the price of insurance or an expansion in policies written or the quantity of insurance sold. Premium growth can signify an increase in supply in the marketplace. Total premiums may increase as new companies enter the market or existing companies write more policies in an attempt to increase market share.

Another way to measure the underwriting cycle is by examining profitability. The return on net worth, or return on equity as it is called in non-insurance institutions, is profit after taxes divided by allocated capital and surplus. Return on surplus shows after-tax profitability from underwriting and investment activity. Several metrics measuring the underwriting cycle will be shown later in this article.

Theories of the Underwriting Cycle

Perhaps surprisingly, there is no universally accepted explanation as to the causes of the underwriting cycle or why it exists. Through the years, explanations for the cycle include lack of restraint, overreliance on the previous period’s experience and regulatory regulations. This article focuses on the effect of exogenous shocks on the underwriting cycle. These shocks could come in the form of economic effects, a disequilibrium between supply and demand, or other external shocks.

Economic effects such as changes in real gross domestic product (GDP), interest rates, unemployment or inflation can produce a shock to the insurance industry, causing a shift in the underwriting cycle. Shocks to supply, such as changes in interest rates and inflation, have a larger impact on the combined ratio, because the industry cannot respond to shocks to supply as well it might to shocks in demand.

Some have argued that the uncertainty of loss costs contribute to underwriting cycles. With economic downturns may come moderate inflation or reductions in the values of insured exposures, ensuring moderate rate revisions for several years. As the economy recovers, loss costs rise rapidly. The result is a time lag between data compilation and

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1 Available at www.naic.org/store_pub_special.html#cycles_crisis_pc.
4 Ibid.
rate implementation so necessary premiums are not earned immediately. However, this theory has recently been criticized because it assumes a lack of rational behavior by actuaries; i.e., that they are not capable of forecasting loss cost trends from experience.

Interest rate volatility has an effect on underwriting cycles as insurers pay losses sometimes years after they collect premiums, particularly in long-tail lines. The price of insurance reflects a discounted present value of anticipated losses, expenses and taxes. Longer tail lines such as medical professional liability and workers’ compensation may be more heavily impacted by interest rate changes due to the increased discount for the time value of money. Premiums are invested and income earned until losses are paid.

Interest rates rise during periods of inflation. As interest rates rise, insurers are able to rely more heavily on investment income and less so on underwriting income. Therefore, insurers may loosen underwriting standards, accept more risk or lower prices below loss costs in order to increase market share. This is called cash flow underwriting and is characteristic of a soft market in which supply is abundant and prices are low. Rising interest rates also cause an increase in expected loss payouts as nominal settlement values rise. The result of the increase in inflation is unclear, because rising interest rates increase investment income as well as anticipated losses.

As investment income increases, underwriting income decreases and insurers may write policies at expected underwriting losses. As interest rates fall, if insurers continue to write policies with underwriting losses, they may see loss of profits. In more recent years, there have been stable interest rates and yet the underwriting cycle persists. This theory also assumes that insurance companies are unable to adjust rates due to changes in investment income.

When interest rates are high, insurance markets usually are soft, meaning lower prices because insurers seek investment returns. With lower interest rates, investment income is low and insurance companies rely on income through underwriting profits. They, therefore, are more cautious about taking risks.

Claim trends affect pricing and underwriting cycles as trends in claim payouts impact loss costs. High liability losses cause prices to rise as loss costs are built into the rate. Claim trends can follow social and economic trends. During recessions, jury awards tend to be less liberal but in times of economic expansion, payouts can be extraordinary. Liability lines, such as medical professional liability and auto insurance with liability components, are more heavily impacted by claim trends.

Another theory of the underwriting cycle is based on capacity-constraint theory and focuses on the supply of insurance, as well as insurers’ access to capital or reinsurance. An increasing number of researchers now accept this capacity-constraint theory, which asserts that negative net worth shocks caused by such things as large natural catastrophes lead to rapid price increases (a hard market), which then erode slowly as net worth adjusts (a soft market).

The insurance pricing cycle can be viewed in terms of supply-and-demand economics. Surplus is a measurement of underwriting capacity. When the supply of insurance capacity increases faster than the demand for capacity, prices fall. Conversely, when supply constricts relative to demand, prices increase. In the soft phase of the cycle, prices are falling due to an abundance of insurance capacity relative to waning demand. Insurers are overcapitalized during soft markets, and they compete to put the excess capacity to work.

We can use GDP as a proxy for demand. The change in GDP represents the change in demand for insurance capacity. Because most companies already are fully insured, the need to buy more insurance is directly tied to growth, represented by the change in GDP.

Growth in policyholders’ surplus measures a company’s overall financial condition. Major changes in policyholders’ surplus mark instability and are concerning, whether it is an increase or decrease in surplus.

Surplus tends to move up and down more than demand for insurance. As surplus falls, insurance companies are more selective of risk and the industry becomes less competitive, as the market hardens. As surplus rises, the industry becomes more competitive and rates fall. Insurers use the extra capital to write risks they might not ordinarily consider, leading to a soft market.

Increasing values in the surplus-to-GDP ratio mean growth in supply (policyholders’ surplus) exceeds the growth in demand (GDP), ultimately leading to falling premiums. Conversely, when values are decreasing, it means supply is shrinking relative to demand (or demand is increasing faster than supply), and premiums eventually will rise.

The role of reinsurance in underwriting cycles pertains to the supply of capital. When availability of reinsurance is abundant, insurers may be willing to write additional risk.

(Continued on page 19)
and use reinsurance to hedge against losses. In addition to reinsurance, other mechanisms that allow insurers to write policies and assign risk have a similar impact on the supply of insurance. For example, the price of catastrophe bonds may influence underwriting cycles, as they are used to insulate against natural disaster. A lack of supply in capital markets, such as during recessionary times or market crashes, leads to restricted access to reinsurance and insurers are less willing to insure risk. Restricted access to reinsurance and, further, a reduced supply of insurance, leads to a hard market.

One way surplus can fall is through another exogenous shock of which insurers are well aware: catastrophes. This theory of the underwriting cycle focuses on external shocks such as natural catastrophic events. Such shocks can be planned for to an extent, but no one knows for certain if or when they will occur. The property/casualty insurance industry anticipates large losses through its surplus, but enormous losses are often large enough to turn a market. As large catastrophes occur, surplus can fall, causing companies to be more selective of risks and the industry to be less competitive, turning the market hard. Recent catastrophes, such as the terrorism events of 9/11 and Hurricane Katrina in 2005, have resulted in large losses but have failed to significantly impact the overall surplus of the industry.

**A LOOK AT THE OVERALL ECONOMY**

Before examining where the property/casualty underwriting cycle might currently stand, we will first look at the overall economy. As noted earlier, economic conditions can have a large impact on the underwriting cycle. Despite some signs of an improving economy, real GDP surprisingly declined 2.9% in the first quarter of 2014. The slowdown reflected a downturn in exports, business investment, inventory investment and consumer spending. Growth in GDP can be seen as a prerequisite for demand for insurance. As market growth occurs, so does the need to increase insurance. This can be seen as inventories and labor markets grow.

Unemployment was unchanged in May at 6.3% after falling by 0.4% in April. Over the past 10 years, unemployment peaked in 2009 at 9.9%. This was a marked increase from the 4.4% unemployment rate in 2006. Since 2009, unemployment has steadily come down to the 6.3% seen today.

Inflation rose by 1.4% in the first quarter of 2014 after rising 1.5% in the fourth quarter of 2013. The price of goods and services, excluding food and energy, rose 1.4% in the first quarter versus 1.8% in the fourth quarter of 2014. As inflation rises so, too, may anticipated losses due to increased nominal settlement values.

The Federal Reserve Bank purchased more than $3 trillion in government bonds since the 2008 global financial crisis. This was done in an effort to lower long-term interest rates and stimulate the economy. Meanwhile, the central bank has kept its short-term interest rate near zero since the crisis began. While there are mixed reviews regarding the actual effects of the Fed’s attempted stimulation of the economy, one thing is for sure: rates will have to rise at some point. As stated above, an increase in interest rates may increase insurer’s investment income, leading to a soft market.

**THE CURRENT STATE OF THE UNDERWRITING CYCLE**

The industry experienced a soft market post-2003 as premium growth declined, and actually became negative in 2008 and 2009. Since then, the market has shown signs of hardening, with price increases in many lines, particularly commercial ones. Rates rose in 2013 due to above average losses and low investment returns.

The combined ratio for 2013 fell to 95.8% from 103.7% in 2012. This marks the first year of underwriting profit since 2007 (Figure 2). Written premiums in 2013 increased to $486 billion from $465 billion in 2012. Property/casualty insurance premium has been rising in recent years due to higher prices and increased exposures in the slowly expanding economy (Figure 3 on the following page).
Policyholders’ surplus in the U.S. property/casualty industry is at a record high of $665 billion at year-end 2013 (Figure 4).

The capacity-constraint theory showed the insurance pricing cycle is driven by the law of supply and demand. For the past several years, the supply of insurance capacity has exceeded the demand for capacity, forcing prices down. For the market to fully harden, demand will need to increase with an improved economy and increased exposures or the supply will need to fall via a decrease in surplus (Figure 5).

The property/casualty insurance industry was profitable from 2003 through 2007; however, rates declined after that. Profitability remains weak, although it increased in 2013 due to low catastrophe losses and favorable combined ratios. Underwriting results were much improved although investment results remain tepid (Figure 6 on the following page).

Overall, it is difficult to say where the industry currently sits in the underwriting cycle. Certainly, the soft market seems to have turned, but we appear to be in a weak hard market. In addition, recent history shows that cycles do not seem as severe.

**What’s Ahead for the Cycle**

Several factors are typically needed to turn a market. One is a sustained period of large losses. The insurance industry experienced near-record insured catastrophe losses in 2011 and 2012. The average insured catastrophic losses in the U.S. are around $20 billion; losses were $33 billion and $35 billion in 2011 and 2012, respectively. However, 2013 saw much better results with insured catastrophe losses at only $13 billion.

Another factor that can turn a market is a decline in surplus or capacity. Policyholders’ surplus in the U.S. property/casualty industry is at a record high of $665 billion at year-end.

(Continued on page 21)
end 2013. Figure 4 on the previous page shows surplus has continued to rise in recent years. A weak growth in demand has been insufficient to absorb the excess capacity.

Commercial and personal lines rates have started to move upward. As noted earlier, the combined ratio was low last year, with the industry exhibiting underwriting discipline. Recently, insiders have predicted the market to harden due to low interest rates, but this has only partially occurred. A recent Towers Watson survey found that 75% of responding chief financial officers believe the property market is hardening or already at the top of the cycle. As we’ve seen, surplus has not declined, but instead is at a record high. This has put pressure on the hardening of the market.

Record levels of surplus and aggressive competition are moderating the growth in price increases. Low interest rates have tempered investment earnings. Most think prices will rise but capacity is high and competition remains strong, so it is doubtful if rate increases will be extreme. Catastrophe losses are the great unknown. Significant rate increases seem unlikely unless there is an exogenous shock to the industry, such as a major catastrophic event.

**SUMMARY**

Even with the tremendous amount of research devoted to underwriting cycles, they remain unpredictable and, at times, difficult to even define, at least in present terms. Their importance, however, remains paramount for the industry and for regulators.

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CIPR EVENT EXAMINES CYBER LIABILITY RISK AND ISSUES FACING THE INSURANCE INDUSTRY

By Anne Obersteadt, CIPR Senior Researcher

Cyber risk is increasingly cited as a significant emerging threat to businesses. Growth in technology has brought with it a rising number of data breaches and a greater awareness of cyber risk and the need to manage it. In 2013, several well-known retailers, such as Target and Neiman Marcus, were subjected to cyber-attacks. In the wake of these high-profile data breaches, organizations are becoming more aware of their exposure to potential cyber threats. According to Marsh, demand for cyber liability insurance coverage increased 21% from 2012 to 2013.¹ However, cyber risk remains difficult for insurance underwriters to quantify due in large part to a lack of actuarial data. Insurers compensate by relying on qualitative assessments of an applicant’s risk management procedures and risk culture. As a result, policies for cyber risk are more customized than other risk insurers take on, and, therefore, more costly. However, despite the challenges to insuring cyber risk, insurers and other stakeholders appear to be moving the market forward through the development of industry risk management standards and other collaborative efforts.

The NAIC Center for Insurance Policy and Research (CIPR) recently held a four-hour event, titled “Insuring Cyber Liability Risk,” to bring together various high-level experts to take a closer look into cyber liability risk issues facing the insurance industry. This informative event took place March 28, 2014, at the NAIC Spring National Meeting in Orlando. Close to 200 attendees from a variety of segments—including insurance regulators, industry representatives, consumer advocates, information technology professionals and journalists/reporters from various media outlets—registered for the event. The event was moderated by Mississippi Insurance Commissioner Mike Chaney and included three sessions on the following topics: the cyber risk landscape; cyber liability insurance coverage issues; and federal regulatory initiatives related to managing cyber risk.

• THE CYBER RISK LANDSCAPE

Session one, “The Cyber Risk Landscape,” covered operational cyber risks, cybercrime and legal trends related to cyber liability. Speakers for this session included:

• Brian Peretti, acting director, U.S. Department of the Treasury, Office of Critical Infrastructure Protection and Compliance Policy
• Kenn Kern, chief of staff, Investigation Division, New York County District Attorney’s Office
• Jeremiah Posedel, associate attorney, Drinker Biddle & Reath LLP

Mr. Peretti began the session by providing an overview of the cyber liability threat landscape and how the Treasury Department’s Office of Critical Infrastructure Protection seeks to facilitate threat information-sharing and improve resiliency with the financial sector. He noted that cyber attacks may come from nation states, terrorists, criminals, activists, external opportunists and company insiders (both intentional and unintentional). Cyber criminals attack to gain some type of political, military or economic advantage. They usually steal money or information that can eventually be monetized, such as credit card numbers, health records, personal identification information and tax returns.

Mr. Peretti stated criminals are becoming more sophisticated. For example, cyber criminals are employing several new social engineering tactics. Social engineering is designed to trick victims into offering additional personal information by providing just enough information to appear legitimate. “Spear phishing” emails are one of the recent twists on this technique. In this type of attack, the identity thief targets a specific organization or person using information personal to the victim to appear to be from a trusted source.

Mobile devices were also identified by Mr. Peretti as an emerging risk. Cyber criminals frequently use phishing techniques in social media attacks, such as when a victim unknowingly clicks on a “friend request” which initiates malware. Mr. Peretti said a whole set of malware specific to mobile devices is now being deployed. Additionally, he noted most companies’ security systems are not designed for mobile devices, increasing the risk for insider threats in workplaces that permit the use of personal mobile devices. He also emphasized cyber criminals seek to exploit the “weak link” in an organization’s supply chain, rather than take it head on. For this reason, financial institutions need to ensure their entire supply chain is secure.

Mr. Kern spoke about the impact of cybercrime on businesses, individuals, and the economy at large from a law enforcement perspective. He said more than 30% of all of the New York County District Attorney Office’s felony complaints involve some sort of cybercrime or identity theft. From a prosecutorial law enforcement perspective, the cyber risk landscape encompasses four key threats: 1) distributed denial of service (DDoS) attacks (which are designed to make a machine or network resource unavailable to its intended users); 2) hacking; 3) theft of personal identifying information; and 4) intellectual property theft.

Mr. Kern told the audience that between 2011 and 2013, there was a significant volume of DDoS attacks on the financial sector. These attacks continue to the present day. Political dissent and ideological “hacktivism” continue to be one driver behind these cyber-attacks.

Intellectual property theft is another salient problem facing the private and public sectors, as well as the academic community. Intellectual property theft often involves the theft of data or source code, often by insiders or employees. Law enforcement has seen insiders leave their firm and then sell stolen data or use it to start their own firm. Mr. Kern said, “These trends indicate employees, while in and outside of the firm’s employment, must be considered as both assets and potential threats.”

Separately, the theft of personal identifying information (PII) is frequently monetized by selling it online, often on the “deep Web.” Mr. Kern explained that the deep Web uses a series of encryptions to preserve seller and buyer anonymity.

Mr. Posedel provided an overview of how security and privacy are regulated in the U.S., and the potential liability an organization faces when cyber attacks and other breaches occur. He explained that many countries take an “omnibus” regulatory approach, meaning privacy and security rules relating to the processing of information in any manner are regulated under one law. However, the U.S. takes a “sectoral” regulatory approach, whereby numerous federal and state privacy laws address specific processing activities, industries, individuals and data types. “For instance,” Mr. Posedel explained, “the Health Insurance Portability and Accountability Act (HIPAA) has privacy rules, security rules and breach notification obligations, but it only applies to specific entities covered by HIPAA (namely healthcare professionals, insurance companies, and healthcare exchanges).” Likewise, the federal Gramm-Leach-Bliley Act imposes privacy and security requirements, including recommending implementation of a risk-based breach response program, but applies only to financial institutions, including agents and brokers.

At the state level, a number of state privacy and security statutes add to the regulatory landscape. According to Mr. Posedel, most states require prompt notification be given following a breach, with 47 states requiring entities to send breach notification letters. “In addition,” he added, “states can—and do—regulate privacy and security practices through their state unfair and deceptive trade practices acts.”

While there has been a push for more overarching legislation in the wake of significant breaches, it is difficult for affected individuals to hold companies liable when breaches occur. Mr. Posedel told the audience that the courts routinely dismiss cases based on lack of actual damages and/or failure to establish causation, both necessary for a plaintiff to state a claim for relief. As Mr. Posedel explained, “This element of injury—a real tangible harm—is relevant and necessary for both specific causes of action and Article III standing. In a lot of cases, plaintiffs are unable to demonstrate any actual injury and, as a result, their claims are dismissed.” He added this is because the expectation of future harm, such as the possibility stolen credit card information could be used to inflict financial damages, does not typically constitute an existing and real harm. Similarly, even where fraudulent credit card charges occur, affected individuals are normally reimbursed by the card-issuing financial institution, thereby eliminating any damages to the individual.

**Federal Initiatives Related to Managing Cyber Risk**

Session two, “Federal Initiatives Related to Managing Cyber Risk,” focused on the National Institute of Standards and Technology (NIST) Framework for Improving Critical Infrastructure (Framework). Discussions centered on implementation considerations and the Framework’s potential influence on the cyber security insurance market and cyber risk management. Speakers for this session included:

- Adam Sedgewick, senior information technology policy advisor, NIST
- Tom Finan, senior cybersecurity strategist and counsel, U.S. Department of Homeland Security, National Protection and Programs Directorate (NPPD)

The Framework provides a structure of standards, guidelines and practices to aid organizations, regulators and customers with critical infrastructures in effectively managing their cyber risks. On Feb. 13, 2014, NIST, a non-regulatory agency of the U.S. Department of Commerce, released the final draft of the Framework. Mr. Sedgewick said the Framework was the outcome of Executive Order 13636: Improving Critical Infrastructure Cybersecurity, issued by President Barack Obama in February 2013. The executive order asked NIST to work with the industry to identify core cyber security practices applicable to sectors exposed to evolving threats. Mr. Sedgewick said the diversity of critical infrastructures ranged from large multi-national corporations to small regional banks and water utilities. The goal, according
to Mr. Sedgewick, was to build off standards in use today, thereby allowing the Framework to become a tool for business-to-business relationships.

In developing the Framework, NIST held a number of workshops to gather information from organizations on the challenges they experienced in securing their cyber infrastructure. Through these workshops, NIST found communicating cyber security risk throughout an organization was a major issue. Mr. Sedgewick noted, “It was often difficult [for organizations] to get executive buy-in and to transition the needed changes all the way to the person who needs to implement the solution.” Organizations also expressed the need for tools to fuse threat information with business information and for a deeper talent pool. Additionally, they indicated there was a gap in industry-driven conformity programs and a need for models to assist organizations in evaluating and improving their capabilities.

The Framework is composed of three parts: the core; profiles; and implementation tiers. The core simplifies and groups the existing standards, requirements and best practices into five ascending structure levels of identify, detect, protect, respond and recover. “Identify is the most important of the broad categories,” Mr. Sedgewick said. “To get started, you need to know what you have to be able to protect it.” The profiles are used by organizations to define their existing and targeted set of cyber security standards. Mr. Sedgewick explained organizations can overcome difficulties in communicating threats, both inside and outside the organization, by using the profile tools. He added the implementation tiers provide a set of guidelines to assist organizations in determining how they should manage their cyber security risks in relation to their risk management practices and business needs.

Mr. Sedgewick stressed the Framework was designed to be a flexible tool for diverse industries and stakeholders to be able to use in improving their cyber security and privacy practices. Its structure is intended to complement, rather than replace, the various regulatory and business requirements employed today. “Now that we are done,” he stated, “it is important the industry picks up [the Framework] and uses it. This will be the true measure of our success.” Mr. Finan told the audience NPPD, which is responsible for helping federal civilian agencies protect themselves against cyber attacks, hopes engaging the insurance industry will lead to the implementation of cyber security underwriting practices designed to promote greater adoption of the Framework. In 2012, NPPD began identifying a series of challenges to first- and third-party cyber security markets.

As Mr. Finan, who leads NPDD’s efforts in this area, stated, “What piqued our interest was [the insurance industry’s] potential to promote better cyber security. What we discovered was the market may in fact get us there, but we are not there quite yet.”

According to Mr. Finan, a sizable and growing amount of actuarial data on data breaches has led to a functional third-party cyber security insurance market. This coverage covers various costs associated with a data breach, such as credit monitoring for impacted parties, cyber forensics and notification costs. However, Mr. Finan indicated the first party market, which covers an organization’s own damages from such as loss of profits, reputation and intellectual damages, is nascent due to a lack of actuarial data. “Perhaps, and unsurprisingly, companies are not publicly disclosing their own damages from cyber events they themselves are experiencing,” he stated. “Consequently, there is just not enough actuarial data to lay the foundations for a robust first party market.”

To compensate for this lack of actuarial data, insurers told NPPD they examine a potential insured’s risk culture alone, or in addition to, their technical compliance with available standards when accessing qualifications for coverage. In so doing, they pay particular attention to the cyber security practices and procedures the organization has adopted, implemented and enforced. Oftentimes, this approach results in insurers drafting custom policies for their clients rather than broader template policies. Mr. Finan believes the increasing focus on engaged cyber risk cultures appears to be an emerging underwriting trend. This trend appears to be linked to the growing convergence of cyber risks with more traditional risks, resulting from the adoption of enterprise risk management (ERM) strategies.

Mr. Finan said NPPD held a workshop with the insurance industry in September 2013. The workshop aimed to gain insight from insurers on how the Framework could facilitate insurers’ ability to incentivize better cyber security management within organizations. In these discussions, Mr. Finan said insurers identified three ways the Framework might help the market. First, the Framework could serve as a risk-management tool insurers could use immediately to access the current state of a potential insured’s cyber security. Secondly, the Framework could increase capacity by incentivizing carriers to direct and simplify their discussions about developing new kinds of business interruption policies. “If cyber-related business interruption becomes more commonplace,” Mr. Finan explained, “the current distinction

(Continued on page 25)
between physically caused physical loss and cyber-caused physical loss will likely become untenable.” Third, the Framework might have a positive impact on policy pricing by improving an insured’s ability to demonstrate a good consequence analytics and incorporating cyber risk into traditional ERM programs.

### CYBER LIABILITY INSURANCE COVERAGE, BARRIERS AND PRICING

Session three, “Cyber Liability Insurance Coverage, Barriers and Pricing,” featured discussions on cyber coverage provided by traditional insurance and cyber-specific policies, underwriting and risk-management considerations for cyber risk policies, cyber insurance barriers and pricing considerations. Speakers for this session included:

- Robert Parisi, Jr., managing director and national technology, network risk and telecommunications practice leader, Financial and Professional Liability Practice (FINPRO) unit, Marsh USA
- John Coletti, vice president and underwriting manager, XL Group

Mr. Parisi explained insurers view cyber and privacy risks as a broad risk encompassing most organizations. Insurers, he added, view cyber events as a financial risk, coming from two basic places. The first is risk stemming from the collection or handling of information. The second is an organization’s reliance on the use of technology in its business operations. “Generally,” noted Mr. Parisi, “you’d be hard-pressed to find a company that doesn’t qualify under at least one of these categories.”

Mr. Coletti stated cyber policies have evolved from primarily covering online activity to including first- and third-party components. “The community,” he added, “is innovative and constantly coming up with new ways to attack the exposure.” In recent years, first-party business interruption coverage has expanded to cover not just damages triggered by a cyber attack, but those resulting from a network downfall (whether a breach or an internally caused network error). Mr. Parisi noted that coverage from a technology outage is an issue rarely highlighted publicly. “What we’ve seen over the last several years,” he explained, “is that disruptions to a company’s supply chain—the logistics behind a company’s operation—is more likely to be due to a technology outage than adverse weather.” Technology outages are not only more frequent than adverse weather, they are more severe, he added.

Mr. Coletti said dependent business interruption coverage is another recent addition. Organizations purchase this coverage for their critical activities performed, stored or accessed from the cloud. He added organizations commonly purchase coverage for data breach response and crisis management to pay for breach-related costs, internet technology forensics, credit monitoring, attorney fees and call center operating costs. “The reason for this,” Mr. Coletti explained, “is it’s the one cost everyone can rationalize and say, OK, that happened to my business.” Insurers provide coverage on either a dollar-limit basis, a per-person basis or they cover costs on a certain number of records breached. Other typical coverages, he added, include costs incurred in restoring data damaged or lost from a computer virus and data extortion threats.

Mr. Parisi said privacy has also received a lot of public focus, as this risk impacts any organization handling data, regardless of their use of technology. He explained privacy coverage is different from network coverage provided under a traditional cyber liability policy in how it is triggered. Network coverage is triggered by a technology-related event and provides liability coverage for related damages. Privacy coverage is triggered by unauthorized disclosure, unauthorized access or wrongful collection of confidential information. Mr. Parisi further added, “The privacy coverage strips out the requirement there be any technological aspect to it. It doesn’t have to be electronic data. It could be a three-ring binder with everyone’s Social Security number in it.”

Mr. Coletti said he has seen an increase in demand for cyber and privacy insurance in response to recent high-profile cyber breaches. He added, “We are seeing a huge increase in cyber purchases since the Target and subsequent breaches. Those industries are looking not only to buy limits for the first time, but to increase any current limits they already have.” Regulated industries, such as financial institutions, healthcare providers, retailers and universities, are the traditional buyers of cyber liability policies. But, Mr. Coletti noted, this is changing, as he is seeing increased applications from nontraditional purchasers such as professional service firms, manufacturing firms and hospitality companies. “These companies are now recognizing the need for notification coverage provided only by cyber liability policies,” he explained.
Mr. Coletti stated insurers do not know how to price cyber liability policies. Instead, he said, “It’s a market-driven price historically based on error and omissions rates from the 1990s.” Insurers are trying to build databases for solid actuarial algorithms. However, Mr. Coletti believes these databases are not complete enough to ensure accurate pricing. He also expressed concern, as an underwriter, over aggregation risk. “If you’re in the situation where you are insuring multiple insureds that were breached by the same vendor,” he explained, “you could have an aggregation exposure.”

Dr. Hoffman shared the results of a recent Cyber Security Policy and Research Institute (CSPRI) commissioned report, "Insurance for Cyber Attacks: The Issue of Setting Premiums in Context." The report was authored by Costis Toregas and Nicolas Zahn and released in January 2014. Dr. Hoffman said the report outlines market barriers to cyber liability insurance and presented dialogue highlights with various market actors. It also suggested a collaborative research agenda designed to improve information security metrics and risk management in an expanded internet framework. Dr. Hoffman believes the report underscores the high cost of breaches, “with more than 17 million personal records breached in 2012, resulting in an average financial impact of $10 million.”

As an outcome of its review of prior studies, the report identified several challenges specific to the cyber liability insurance market. In terms of the legal framework, there is uncertainty surrounding liability exposure, coverage gaps and insurance exclusions. Additionally, insurers face conceptual issues, such as knowing how to identify correlated, interrelated and global cyber risks. Additionally, the report indicated insurers struggle with how to quantify cyber-related risks and costs and how to integrate related decision-making beyond the information technology silo. Dr. Hoffman said the report found setting premiums was particularly challenging to insurers, given the lack of normative standards, reinsurance and actuarial data.

Dr. Hoffman discussed CSPRI’s desire to collaborate with stakeholders to improve the viability of the cyber insurance market. He suggested a multi-disciplinary workshop—with participants from the insurance, academia, government and legal communities—could easily be used to identify points of consensus and disagreement. This type of research and cooperation between stakeholders, he said, could advance cyber liability insurance standards for premium rate setting. Dr. Hoffman stressed standards will become particularly important as technology continues to be integrated into everyday devices. He pointed out, “Industry can set standards, but if they don’t, the technological firms are going to build their own devices with little or no privacy and security built in.” For this reason, he continued, it is important for approaches to be developed before a solution is imposed that may be wrong or under-researched.

**SUMMARY**

The CIPR event illustrated privacy and cyber breaches threaten all organizations. It also demonstrated, while organizations have made great progress in mitigating their cyber and privacy exposures, the risk is still not fully understood. Many organizations find it difficult to move cyber risk discussions beyond their IT department, inhibiting their ability to instill an organization-wide cyber risk culture. However, recent concerns about regulatory compliance standards have helped to push these conversations into the boardroom. Moreover, the proliferation of connected devices—such as cameras, cell phones, digitized equipment—will create new channels for cyber threats. As such, stakeholders must become more proactive in establishing cyber and information security practices and standards. Likewise, insurers must continue to evolve if they are to provide effective risk-transfer solutions specific to the emerging threats industries face. Additional information on this CIPR event, including the agenda, presentations and audio, can be found on the CIPR website at [http://cipr.naic.org](http://cipr.naic.org).

**ABOUT THE AUTHOR**

Anne Obersteadt is a researcher with the NAIC’s Center for Insurance Policy and Research (CIPR). She has 14 years of experience with the NAIC performing financial, statistical and research analysis on all insurance sectors. In her current role, she has authored several articles for the CIPR Newsletter, a CIPR Study on the State of the Life Insurance Industry, organized forums on insurance related issues, and provided support for NAIC working groups. Before joining CIPR, she worked in other NAIC Departments where she published statistical reports, provided insurance guidance and statistical data for external parties, analyzed insurer financial filings for solvency issues, and authored commentaries on the financial performance of the life and property/casualty insurance sectors. Prior to the NAIC, she worked as a commercial loan officer at U.S. Bank. Ms. Obersteadt has a bachelor’s degree in business administration and an MBA in finance.
OVERVIEW OF U.S. INSURANCE INDUSTRY HOLDINGS OF MODELED NON-AGENCY MORTGAGE-BACKED SECURITIES

By Azar Abramov, CFA, Analyst II, NAIC Structured Securities Group

♦ INTRODUCTION
The U.S. insurance industry has historically been an important institutional investor in both residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS). This article focuses on insurers’ holdings of modeled non-agency CMBS and non-agency MBS over the past four years. It covers the period since the development by NAIC of the alternative modeling process for evaluating the risk of loss arising from RMBS and CMBS instead of relying on ratings by nationally recognized statistical rating organizations (NRSROs).1 The decision to end regulatory reliance on NRSRO ratings followed the mass downgrades of RMBS and CMBS at the height of the 2008 global financial crisis. These aggressive downgrading actions greatly impacted insurers’ portfolios and their risk-based capital (RBC) charges which are tied to NAIC designations mapped to credit ratings by NAIC-approved NRSROs known as credit rating providers (CRPs).

This article leverages the work by the NAIC Structured Securities Group on financial modeling of RMBS and CMBS to estimate the impact on insurers’ RBC, henceforth referred to in this article as eRBC2, from deriving NAIC designations based on the modeled intrinsic prices (IP)3 instead of CRP credit ratings. It is also important to note that this procedure follows the requirements set forth in the Statement of Statutory Accounting Principles (SSAP) No. 43R—Loan-backed and Structured Securities—Revised.

Each RMBS and CMBS security is modeled to determine its intrinsic price, which drives the breakpoint carrying prices.4 The estimated expected losses, discounted at the security yield, are used to calculate each security’s intrinsic price. The intrinsic price is then applied to translate expected loss ranges into carrying price ranges for each NAIC designation. Insurers use these breakpoint carrying prices by reference to their book/adjusted carrying value (BACV) for that security to determine the appropriate designation and apply the corresponding RBC factor. This SSAP No. 43R procedure has a significant impact on the amount of RBC that insurance companies must maintain, particularly for RMBS holdings.

♦ CHANGES IN INSURER HOLDINGS
The non-agency MBS holdings discussed in this report pertains only to CMBS and RMBS that were financially modeled. For the most part, insurers’ year-end 2013 modeled CMBS and RMBS holdings remained similar to previous years. The most noteworthy change was the decline in eRBC for RMBS holdings based on modeled designations. In addition, this was the first year that average BACV price and IPs of insurers’ RMBS holdings increased in value. On the CMBS side, almost all of the holdings remain as zero loss bonds. These bonds have no expected loss under any of the modeling scenarios and were, therefore, modeled at an IP of 100%, thus automatically equivalent to an NAIC 1 designation regardless of the insurer’s carrying value.

Insurers’ holdings of CMBS and RMBS have gradually declined over the past four years, although this trend seems to be slowing down. Repayments of existing loan balances, realized losses and low new issuance have led to substantial declines in the current outstanding balance of the U.S. non-agency MBS market. However, CMBS new issuance has been rebounding.

At year-end 2013, according to the Securities Industry and Financial Markets Association (SIFMA), total outstanding5 CMBS decreased (6.2%) to $604.9 billion and RMBS decreased (28.3%) to $1,044.7 billion, compared to year-end 2010 CMBS of $644.8 billion and $1,456.5 billion in RMBS. In contrast to the market decrease in outstanding mortgage securities, over the past four years, the insurance industry’s CMBS holdings declined by a larger percentage (13.2%), while RMBS holdings declined less than the market (12.3%).

The modeled year-end 2013 holdings of CMBS were $157.402 billion in par value (or 25.6%) of total CMBS outstanding, and RMBS at $132.674 billion in par value (or 12.7%) of the total RMBS market (Figure 1 on the following page).

♦ RESIDENTIAL MORTGAGE-BACKED SECURITIES
The insurance industry continues to have significantly lower eRBC requirements for RMBS as a result of the SSAP No. 43R-based model-driven designations. The positive differential between using CRP ratings-based designations6 and SSAP No. 43R-based designations is shown in Figure 2 on the following page. The differential eRBC rose to $16.909 billion at year-end 2013, mainly as a result of a large de-

(Continued on page 28)

1 The NAIC has been modeling insurance industry’s CMBS for the past four years and RMBS for the past five years.
2 This is our estimate of the actual RBC and we qualify it with an (e)-estimate. Financial model-based designations and RBC calculations are estimated based on insurers’ reported BACV matched against the breakpoint carrying prices, which results in an NAIC designation and is matched to the RBC factor (C1) and multiplied by the reported BACV. There is also no consideration for covariance. For further reference, see SSAP No. 43R.
3 The modeled intrinsic price is defined as difference between remaining par value and expected principal losses, which are generally discounted at the coupon rate of the security.
4 Breakpoint Carrying Price is the Intrinsic Price divided by 1 minus the expected loss for each NAIC designation.
5 Excluding $11.4 billion of manufactured housing for RMBS and $20.9 billion of resecuritize for CMBS.
6 CRP-based designations are as of April 2014.
crease in SSAP No. 43R-based model-driven eRBC to $1.447 billion, from $2.605 billion at year-end 2012.

Year-end 2013 RMBS holdings consisted of 26.58% zero loss bonds, an improvement from the previous year’s 21.30% zero loss portion. These bonds have no expected loss under any of the modeling scenarios and were, therefore, modeled at an IP of 100%. Conversely, 73.42% of securities were non-zero loss with an average IP of 85.11%, which is also an improvement over year-end 2012 non-zero loss portion, which had an average IP of 81.85%.

The first period that both the average IP and BACV price experienced a year-over-year increase was at year-end 2013. The large decrease in eRBC based on SSAP No. 43R in 2013 can be partially attributed to IP increasing at a faster pace than the BACV price, as shown in Figure 3. Intrinsic price increased to 88.44% at year-end 2013 from 85.05% the previous year, while the BACV price did not increase as much to 80.69% from 79.49% over the same time period. As the gap between IP and BACV price widened, the estimated SSAP No. 43R designations improved, and the eRBC requirement declined to $1.447 billion, which represented 1.4% of total RMBS (or $107.050 billion BACV holdings). This trend is consistent with positive market dynamics and increases in the Case-Shiller Home Price Index.

Subsequent to the financial crisis, insurers recognized impairments and newly acquired securities were trading at discounted prices to par which led to lower BACV, particularly in the RMBS market. Other-than-temporary-impairments (OTTI) have decreased over the past four years from $4.16 billion to $0.5 billion.

Figure 4 on the following page illustrates 84.7% of RMBS holdings experienced an upgrade based on SSAP No. 43R designations compared to CRP-equivalent designations. The upgraded portion has a higher average IP of 87.69% compared to insurers’ more conservative average BACV price of 78.78%. This led to a materially lower eRBC. Securities that had no change in designations represented 14.6%, where the IP and BACV price were about the same, and 0.7% were downgraded, where the IP was lower than the BACV price.

* Based on CRP-equivalent designations and SSAP No.43R-based designations. Source: NAIC, Structured Securities Group.

1 IP and BACV price are dollar-weighted averages based on insurers’ actual holdings.

(Continued on page 29)
Figure 5 depicts the RMBS breakdown by estimated designations (SSAP No. 43R-based in the left-hand column running vertically) vs. designation based on CRP ratings in the top column running across. The SSAP No. 43R-based NAIC 1 category makes up most (84.93%) of the holdings of total BACV vs. CRP-equivalent designations of (13.76%).

The bulk of the eRBC differential stems from the SSAP No. 43R-based upgrades to NAIC 1 designation, resulting in an eRBC difference of $14.272 billion. This SSAP No. 43R-based NAIC 1 balance of $90.919 billion (or 84.9%) of the RMBS portfolio has an average BACV price of 79.24%, which, in comparison, is favorably below the IP of 89.45% and leads to a significantly lower eRBC requirement.

**COMMERCIAL MORTGAGE-BACKED SECURITIES**

The insurance industry’s CMBS holdings have a narrower eRBC differential between SSAP No. 43R-based designations and CRP-based designations than RMBS. Nevertheless, the industry continued to experience a positive eRBC differential over the past three years (Figure 6).

The greatest difference between CMBS and RMBS is the quality of holdings. At year-end 2013, 95.96% of insurers’ CMBS holdings had no expected loss under the modeling scenarios and were, therefore, at an IP of 100%, thus automatically equivalent to an NAIC 1 designation regardless of the insurer’s carrying value. This was an improvement from year-end 2012, where zero loss portion was a smaller percentage (93.81%) of the CMBS portfolio.

Both IP and BACV price have gradually increased over the past four years for CMBS along with the Commercial Property Price Index (CPPI). Year-end 2013 was the first time that insurers’ average BACV price was shown to be higher than the IP. Nevertheless, the overall estimated eRBC requirement was lower than it would have been under the CRP-equivalent designations. This is mainly due to 10.2% of CMBS being upgraded based on SSAP No. 43R designations,
which is driven by the high percentage of zero loss bonds. In addition, OTTI have decreased over the past four years from $2.489 billion to $0.421 billion.

Figure 7 illustrates while the overall BACV price of 98.38% is higher than the average IP of 97.73%, there were still improvements in the SSAP No. 43R-based designations; 10.2% of holdings were upgraded in relation to CRP-equivalent designations. The average upgraded IP was favorably higher at 90.66% vs. the average BACV of 84.27%. Securities that had no change represented 89.1%, where the IP and BACV were about the same, and 0.7% were downgraded, as the IP was lower than the BACV. This led to a total estimated eRBC difference of $0.727 billion.

Figure 8 depicts the CMBS breakdown by estimated designations. The SSAP No. 43R-based NAIC 1 category makes up most of the holdings at 97.5% of total BACV compared to the CRP-equivalent 1 designation of 88.13%. The main driver for the difference was that zero loss bonds accounted for 95.96% of NAIC 1 designations.

Observing the SSAP No. 43R-based designations, most of the lower eRBC results from the NAIC 1 designation, where the IP of 99.12% is slightly higher than the BACV price of 99.02%. This NAIC 1 category, which accounts for $150.974 billion (or 97.4%) of the CMBS portfolio, contributed to a difference of $0.720 billion in eRBC out of the total difference of $0.727 billion.

**Conclusion**

The implementation of SSAP No. 43R with financial modeling for insurers’ year-end reporting of non-agency MBS has had a large impact on insurers’ RBC requirements, particularly for RMBS. The overall profile of non-agency holdings continues to improve and is consistent with positive market dynamics. The insurance industry’s average BACV price of RMBS holdings is conservative relative to the financial model of intrinsic price. Additionally, the portion of zero loss bonds and prices increased at year-end 2013 from year-end 2012. CMBS holdings are comprised almost entirely of zero loss bonds. The SSAP No. 43R-based profile of insurers’ non-agency MBS has resulted in materially lower eRBC requirements relative to CRP-ratings-equivalent designations.

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**About the Author**

Azar Abramov has nearly a decade of professional experience in insurance regulation and analysis of investments. Abramov’s career began with the New York State Insurance Department as an intern in the Capital Markets Bureau, where he assisted in analyzing Insurers’ investment portfolios. He transitioned to the NAIC in 2006, where he continued to analyze insurance company portfolios, perform research on industry wide investments and monitor capital markets activity. Since the onset of the 2008 global financial crisis, Abramov has been heavily involved in the analysis of structured securities and their impact on the insurance industry. He earned a bachelor’s degree in finance and investments from Baruch College’s Zilkin School of Business and is a charted financial analyst (CFA).
**DATA AT A GLANCE: MARKET SHARE OF RISK RETENTION GROUPS**

*By Jennifer Gardner, NAIC Research Analyst II*

The federal Liability Risk Retention Act (LRRA) was enacted in response to the availability and affordability crisis of product liability insurance in the 1980s. It was amended in 1986 to include all lines of commercial liability coverage except workers’ compensation. The LRRA allows industry-specific groups of businesses with similar risk exposures to pool their risk through a form of group self-insurance. An amendment to the bill has been drafted to expand the types of coverage allowed by risk retention groups (RRGs). The proposed amendment, Risk Retention Modernization Act of 2014, was drafted to expand coverage to other forms of commercial insurance such as property and auto physical damage.

On April 10, 2014, the U.S. Second Circuit Court of Appeals ruled that the LRRA categorically preempts a New York law that allows a direct action lawsuit against an RRG. The ruling supports the provision of the LRRA that allows RRGs to operate nationally with limited regulation in the states in which they do business other than their domiciliary state. The verdict provoked inquisition regarding the relative size of premiums written by RRGs versus the property/casualty industry as a whole. The NAIC collects annual financial statements from property/casualty companies and tracks the company types, such as RRG. This article includes the results of the NAIC’s market analysis on RRGs.

Per the LRRA, an RRG is:

- any corporation or other limited liability association (A) whose primary activity consists of assuming, and spreading all, or any portion, of the liability exposure of its group members; (B) which is organized for the primary purpose of conducting the activity described under subparagraph (A); (C) which—(i) is chartered or licensed as a liability insurance company under the laws of a State and authorized to engage in the business of insurance under the laws of such State...

RRGs are formed to insure groups of businesses operating in the same industry. Types of businesses insured through RRGs include construction companies, homebuilders and subcontractors, healthcare services, nursing homes and assisted living facilities, legal practices, schools and nonprofit organizations, and physicians... just to name a few. Liability coverages include general liability, professional liability, commercial auto liability, errors and omissions, product liability, and professional liability.

Figure 1, derived from the NAIC 2013 financial statement filings, shows the top three lines of business written in 2013 by RRGs, which accounted for approximately 2.6% of the total liability premium written countrywide. Approximately 14% of the total premiums in the medical professional liability line of business were written by RRGs in 2013. Medical professional liability premiums made up 54% of the total premiums written by RRGs in 2013. RRGs wrote less than 2% of the total written premium in the other liability line of business, which represents approximately 38% of the total premiums written by active RRGs in 2013.

As displayed in Figure 2, RRGs were domiciled in 24 states or territories in 2013. Vermont had the highest number of RRGs, with 85 companies. Approximately 30% of the RRGs that filed with the NAIC were domiciled in Vermont. South Carolina had the second most, with 38 companies or almost 14% of all RRGs. The third highest was the District of Columbia, which had 36 companies or approximately 13% of the total number of RRGs that filed with the NAIC. Of the 278 active RRGs, 242 actually wrote business. Seven groups went out of business voluntarily in 2013 and four went into receivership.

(Continued on page 32)
Medical professional liability was the most prevalent line of business for which premiums were written. There were 135 RRGs that wrote premium for medical professional liability in 2013. Other liability total had the second highest line of business written, with 74 RRGs writing premiums in that line. Twenty-three RRGs wrote premiums in commercial auto-no fault. The remainder of the lines of business included less than five writers in each line.

Approximately 65% of the RRGs that filed as active with the NAIC in 2013 did not write premiums in their state of domicile. Seventeen of those groups did not write premiums at all, but were still filed as active. This is an important metric, as the capital requirements for RRGs are based on their state of domicile. In fact, almost 97% of the premiums written by RRGs in 2013 were written outside of their state of domicile.

Vermont has the highest number of RRGs domiciled, with 85 active groups, and yet only 31% (or 26) of them actually wrote premium in Vermont. Only six of the 38 RRGs domiciled in South Carolina actually wrote premium in the state. Hawaii, Iowa and Virginia all had RRGs domiciled in their state in 2013, but none of them wrote business in their state of domicile. RRGs are regulated by their state of domicile and yet many of them write the majority of premiums outside of their domiciliary state.

This is an example of the information available through the NAIC. Financial statement data can be obtained through the NAIC Store at [http://store.naic.org](http://store.naic.org). Market share data by line and by state can be found in the Property/Casualty Market Share Report for Groups and Companies. More information about that report can be found at [www.naic.org/store_pub_statistical.html#market_share](http://www.naic.org/store_pub_statistical.html#market_share).

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

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**Figure 2: Risk Retention Groups by State of Domicile**

Source: NAIC.
THE INSURANCE REGULATORY EXAMINERS SOCIETY

By Holly Blanchard, AIE, Assistant Director, Examination Resources, LLC and President, Insurance Regulatory Examiners Society

The Insurance Regulatory Examiners Society (IRES) was established in 1987 by a group of state insurance regulators dedicated to continuing education and professionalism for those working in market regulation. Initially, only those employed by a state insurance department were able to become members of IRES. Gradually, membership opportunities have expanded, first to state market examination contractors and later to those working in the insurance industry as associate members. Today, IRES is a diverse group of insurance professionals, including regulators and company representatives, working together to help ensure regulatory compliance and consumer protection remain critical components in the insurance industry.

Ethics and education form the foundation for IRES members. IRES has established a robust code of professional standards for members engaged in the regulation of the insurance industry. The organization promotes uniform ethical standards to engender employer and public confidence in the professionalism of IRES members. IRES promotes and enforces minimum requirements of conduct, training and expertise for its members. IRES has developed education and training programs specifically targeted to the specialized field of insurance regulation. Members are required to complete 15 hours of continuing education to maintain the right to use IRES designations.

IRES is also engaged in today’s public policy debates. IRES members are respected representatives on various NAIC committees and throughout the insurance industry, and are continually forging new paths in the insurance marketplace. The leaders within IRES are also state leaders who have their finger closely on the pulse of all things related to insurance regulation.

♦ IRES EDUCATION AND DESIGNATION PROGRAMS

Insurance education is a top priority for IRES. Currently, five well-respected designation programs are offered, which are well-rounded and recognized in the insurance field. These designations are also recognized and accepted in accreditation standards throughout the country.

♦ AIE AND CIE DESIGNATIONS

The accredited insurance examiner (AIE) and certified insurance examiner (CIE) designations are awarded to IRES general members who meet the established minimum education and employment requirements. Currently, more than 400 professionals hold an AIE or CIE designation. These designations provide an extensive, diverse curriculum in understanding various components of the insurance industry. Professionals that hold the AIE and CIE designations are considered experts in their fields, and oftentimes find themselves with career advancement opportunities due to their designations. Recently, for the first time ever, the AIE and CIE designation programs have been extended to insurance industry representatives.

♦ CICSR

The certification in customer service (CICSR) designation has been designed for regulators and the industry. It builds on an educational commitment for insurance consumer/customer service and market regulation.

♦ MCM

The market conduct management (MCM) program is designed to provide hands-on training for regulators and insurance industry professionals on how to efficiently and effectively manage market conduct examinations and to promote the interests of insurance regulators. The MCM program provides education covering:

- Market regulation and examinations
- Exam management
- Communication and report writing
- Standardized data requests and technology
- The role of market analysis

It is a unique and practical program designed both for the experienced professional and those wishing to enhance their regulatory and compliance career.

♦ AMCM

The advanced market conduct management (AMCM) program is designed to pick up where the MCM left off, by providing advanced market conduct case studies and analysis, enhanced training and more in-depth analysis for regulators and insurance industry professionals.

♦ IRES MEMBERSHIP

Becoming a member of IRES provides many benefits. Members have exclusive access to designation assistance programs led by experienced, knowledgeable industry representatives. Members also enjoy educational opportunities through exclusive webinars; access to the IRES newsletter, The Regulator, leadership opportunities through various committees and subcommittees; and extensive interaction and networking with other insurance regulators and insur-

(Continued on page 34)
 ance industry representatives. These opportunities provide IRES members the information and knowledge they need to stay on the cutting edge of all things insurance related.

Joining is easy. Simply visit www.go-ires.org/benefits/join to start the process.

Becoming involved in IRES was a career-changing decision for me. Because of the network I developed through IRES, I was able to talk to and learn from the people that are spearheading and changing insurance regulation forever. In addition to the educational opportunities, the comradery and the professional development, you will meet people who will become life-long friends. I hope that you will take the opportunity to join IRES. If you have any questions about the benefits of becoming an IRES member, please contact me at hollyblanchard@examresources.net.

As the current president of IRES, I would like to take this opportunity to extend an invitation to you to consider adding an IRES membership to your resume.

### ABOUT THE AUTHOR

Previous to joining Examination Resources in 2013, Holly worked for the Nebraska Insurance Department for eight years and held the position of Life and Health Administrator, responsible for overseeing the rates and form filings for all Life and Annuities, Accident and Sickness and Health policies. Prior to that position, Holly was the Examiner in Charge for the Market Conduct Division within the Department. Holly was actively involved with various NAIC Committees over the years, and served on multiple working groups to help establish model laws and appropriate regulatory guidance. As the Assistant Director for ER, Holly is responsible for assisting with the continued development and growth of ER’s healthcare implementation and compliance consulting services and other insurance regulatory consulting services. She is the President for the Insurance Regulatory Examiners Society (IRES) and serves as the Chair of the Executive Committee. Holly received her B.A. in Business Administration from Nebraska Wesleyan University, graduating magna cum laude. ¹

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