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Noteworthy Now: Sutherland Insurance Regulatory Mid-Year Review

The hot month of July presents an occasion to review major regulatory developments during the first half of the year. In this report, we cover discrete topics we think will be of interest to our friends and clients. Links to an article on each of the topics we selected are below.

No new themes are discernible in the developments we report. Rather, to the extent any themes do emerge, they are a familiar leitmotif. Regulatory reform initiatives focused on oversight of complex groups continue apace at both the federal and state levels – although perhaps with less of a sense of urgency as the 2008 financial crisis recedes in the rear view mirror. U.S. insurance regulation continues to be increasingly influenced by regulation outside the U.S. The use of investigations and enforcement to make public policy endures.

Because of the intertwining of regulatory standards and concepts throughout the globe, we need to understand what is happening in Europe to better understand what is happening here. We have asked our friends Steven Francis and Richard Burger of Reynolds Porter Chamberlain LLP to provide us with an update on the timetable for implementation of Solvency II and progress in the transition to the Bank of England as prudential supervisor for U.K. insurers, as well as the recent announcement of a new European initiative for the protection of consumers of financial products.

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State Insurance Commissioner Appointments from December 2011 through June 2012

State	Name	Date of Appointment
Alaska	Bret Kolb	May 29, 2012
Arizona	Germaine Marks	June 30, 2012[1]
Illinois	Andrew Boron	January 27, 2012
New Jersey	Kenneth Kobylowski	February 11, 2012[2]
Oregon	Louis Savage	May 30, 2012[3]
South Carolina	Gwendolyn Fuller McGriff	December 28, 2011[4]
West Virginia	Michael Riley	January 1, 2012[5]
Wyoming	Tom Hirsig	April 16 2012

[1]Ms. Marks was named Acting Director.
[2]Mr. Kobylowski was named Acting Commissioner, pending Senate confirmation of his appointment as Commissioner.
[3]Mr. Savage served as Acting Insurance Administrator from November 2011 through May 2012.
[4]Ms. McGriff was appointed Acting Director. She will serve until a successor is appointed and confirmed by the South Carolina General Assembly.
[5]Mr. Riley served as Acting Commissioner from July 2011 through January 2012.

Dodd-Frank Implementation

FSOC Issues Guidance on Designation of SIFIs

On April 3, 2012, the Financial Stability Oversight Council (FSOC) approved by unanimous vote a final rule for designating nonbank financial companies as systemically important financial insitutions (SIFI).[6] An FSOC determination of systemic importance will subject a nonbank financial company, including companies involved in insurance operations, to the prudential standards of Dodd-Frank and to the supervision of the Federal Reserve.[7]

The process for making determinations outlined by the final rule and interpretive guidance is substantially identical to that outlined in the Second Notice. Specifically, a three-stage process "of increasingly in-depth evaluation" will be used to consider the 11 factors enumerated in Section 113 of Dodd-Frank, in addition to "any other risk-related factors that the [FSOC] deems appropriate." As in prior FSOC proposals, the interpretive guidance distills the statutory considerations into the following six conceptual categories: (i) interconnectedness; (ii) substitutability; (iii) size; (iv) leverage; (v) liquidity risk and maturity mismatch; and (vi) existing regulatory scrutiny.

The interpretive guidance explains these categories in detail, including how each category relates to the various statutory factors, and discusses the metrics reviewed by FSOC.

Stage 1

Stage 1 will begin with an assessment of which nonbank financial companies with at least $50 billion in total consolidated assets also meet or exceed any one of certain uniform quantitative thresholds. The companies identified in Stage 1 will be further assessed in Stage 2 and possibly Stage 3. The current quantitative thresholds (the Stage 1 Thresholds) are as follows:

- $30 billion in gross notional credit default swaps outstanding that reference the nonbank financial company's debt obligations;
- $3.5 billion of derivative exposure liability to third parties;
- $20 billion of total debt outstanding;

[6]The final rule was published in the Federal Register on April 11, 2012, and became effective on May 11, 2012. 73 Fed. Reg. 21637 (Apr. 11, 2012).
[7]The final rule follows a proposed notice of rulemaking on January 26, 2011 and a second notice of proposed rulemaking on October 11, 2011 (Second Notice).

- 15-to-1 leverage, as measured by total consolidated assets (excluding separate accounts) to total equity; and

- 10% ratio of short-term debt (maturity of less than 12 months) to total consolidated assets.

Additional clarifications to the Stage 1 Thresholds include clarification that, for foreign nonbank financial companies, only U.S. assets, liabilities and operations of the foreign nonbank financial company and its subsidiaries will be evaluated. In contrast, for U.S. nonbank financial companies, FSOC will apply the Stage 1 Thresholds based on the global assets, liabilities and operations of the U.S. company and its subsidiaries. With regard to accounting issues, the interpretive guidance now states that FSOC will use the most recently available data, either on a quarterly or less frequent basis, for companies for which quarterly data is not available, and that FSOC will use Generally Accepted Accounting Principles (GAAP) when such information is available or otherwise rely on Statutory Accounting Principles (SAP).

The final interpretive guidance does, however, retain a controversial provision that "[FSOC] may initially evaluate any nonbank financial company based on other firm-specific qualitative or quantitative factors, irrespective of whether such company meets the thresholds in Stage 1," thus granting a great deal of discretion to FSOC in choosing which companies to evaluate as potentially significant. It is therefore impossible to predict precisely how many nonbank financial companies will be evaluated by FSOC for a possible determination of systemic importance.

Stages 2 and 3

Companies identified by FSOC in Stage 1 will be further assessed in Stage 2 based on publicly available information and information "voluntarily submitted by the company." The interpretive guidance characterizes Stage 2 as a "robust analysis of the potential threat that each of those nonbank financial companies could pose to U.S. financial stability." Based on the Stage 2 analysis, FSOC will contact those nonbank financial companies that FSOC believes merit further evaluation in Stage 3. FSOC noted that Stage 2 is intended to comprise FSOC's initial analysis and that Stage 3 will provide nonbank financial companies with a sufficient opportunity to participate in the determination process.

FSOC revised the final interpretive guidance to clarify that in Stage 2 FSOC will, to the extent deemed appropriate, consult with the primary financial regulator of each significant subsidiary of a nonbank financial company. For insurance companies, Section 1310.2 of the final rule defines "primary financial regulatory agency" as "[t]he State insurance authority of the State in which an insurance company is domiciled," but only "with respect to the insurance activities and activities that are incidental to such insurance activities of an insurance company that is subject to supervision by the State insurance authority under State insurance law." This defi-

nition leaves open the possibility that FSOC may or may not consult with an insurance company group's lead regulator when reviewing the non-insurance activities of the group.

In Stage 3, FSOC will conduct an in-depth review focused on whether the nonbank financial company could pose a threat to U.S. financial stability because of the company's material financial distress or the nature, scope, size, scale, concentration, interconnectedness, or mix of the activities of the company. This review will be conducted using information collected directly from the company, as well as the information used in the first two stages of review. In Stage 3, FSOC will also work with the Office of Financial Research (OFR) to collect information from the company under review. The Stage 3 examination will be much deeper and specifically targeted and may include an examination of confidential business information. While Section 1310.20(e) of the final rule provides that FSOC shall maintain the confidentiality of any data, information and reports submitted by a company, either voluntarily or in response to a request from FSOC or OFR under the rule, some companies have expressed concern that confidential information may inadvertently become public despite this administrative protection.

Proposed and Final Determinations

Following the Stage 3 analysis, the company will receive written notice that FSOC is considering the company for a determination as a SIFI. The company will then have at least 30 days to submit written materials to contest FSOC's consideration for the proposed determination. Upon issuing the proposed determination, FSOC will also provide the company with a written explanation of the basis of its determination. A nonbank financial company that is subject to a proposed determination may request a hearing before FSOC in accordance with Section 113(e) of Dodd-Frank, and may ultimately seek judicial review in U.S. district court in an action to have the determination rescinded. Under Dodd-Frank, FSOC is required to reevaluate the designation at least annually.

The Federal Reserve Works on Rules for Deciding Whether a Company Is "Predominantly Engaged in Financial Activities"

In addition, the Federal Reserve moved closer to finalizing rules that would govern whether a company is "predominantly engaged in financial activities," and thus subject to FSOC's review as an institution potentially subject to enhanced oversight as a SIFI.

Under Dodd-Frank, an institution generally may be designated as a SIFI only if it is "predominantly engaged in financial activities."[8] In April, the Federal Reserve issued a supplemental notice of rulemaking to further refine its proposed interpretations of those activities that are deemed to be "financial activities."[9] For clarification, the Federal Reserve proposed to include an "appendix" to its rulemaking of

[8]Section 102(a)(4)(B)(ii) of Dodd-Frank.

[9]77 Fed. Reg. 21494 (Apr. 10, 2012). Comments on the proposed rules were due on May 25, 2012.

the types of activities that will be deemed to be "financial activities" for purposes of Dodd-Frank. The appendix, not surprisingly, includes "insuring, guaranteeing, or indemnifying against loss, harm, damage, illness, disability, or death, or providing and issuing annuities, and acting as principal, agent, or broker for purposes of the foregoing in any state."

Industry Awaits FIO Report on Modernizing Insurance Regulation; FIO Solicits Comments for Reinsurance Reports

The U.S. Treasury Department's Federal Insurance Office (FIO), which was created by Dodd-Frank in July 2011, is tasked with monitoring the insurance industry and gathering information, including "identifying issues or gaps in the regulation of insurers that could contribute to a systemic crisis in the insurance industry or the United States financial system." Dodd-Frank requires that the FIO issue several reports to Congress on the insurance industry, including, most notably, (i) a report on "how to modernize and improve the system of insurance regulation in the United States" (due January 2012), and (ii) a report on "the breadth and scope of the global reinsurance market and the critical role such market plays in supporting insurance in the United States" (due September 30, 2012).

The FIO's highly anticipated report on insurance regulatory modernization has not yet been issued. In late 2011, the FIO requested public comments to assist its completion of the report. Commenters were invited to submit their views on a number of topics, including: (i) the systemic risk regulation of insurance, (ii) the degree of national uniformity of state insurance regulation, (iii) the regulation of insurance companies and affiliates on a consolidated basis, (iv) international coordination of insurance regulation, and (v) the costs and benefits of potential federal regulation of insurance. The FIO received nearly 150 comments from the industry and interested parties.

On June 27, 2012, the FIO issued a notice requesting public comments on the global reinsurance market and the regulation of reinsurance to assist the FIO in completing its reinsurance report. Commenters are invited to submit their views on topics such as the purpose of reinsurance, the role that the global reinsurance market plays in supporting insurance in the U.S. and the effect of domestic and international regulation on reinsurance in the U.S. Comments are due by August 27, 2012.

Implementation of Dodd-Frank's Nonadmitted and Reinsurance Reform Act – States Struggle with Preemption; the IID Beefs Up Financial Requirements for Alien Surplus Lines Insurers

The Nonadmitted and Reinsurance Reform Act (the NRRA), which became effective on July 21, 2011 as part of Dodd-Frank, has resulted in changes to state regulation of nonadmitted insurance. In response to these changes, there has been substantial activity on the state level and at the National Association of Insurance Commissioners (NAIC).

Most notably, the NRRA provides that the "home state" of the insured has exclusive authority to regulate the placement of nonadmitted insurance and to collect premium taxes on nonadmitted insurance. Once taxes are collected, however, the NRRA provides that the states may establish a system for allocation of premium tax obligations through an interstate compact or other procedures. In addition, the NRRA preempts state surplus lines eligibility requirements that do not comport with the requirements set out in the NRRA. The NRRA confers nationwide surplus eligibility on U.S.-domiciled insurers that satisfy the minimum capital and surplus requirements set out in the NAIC's Non-Admitted Insurance Model Act, and bars states from prohibiting surplus lines brokers from doing business with nonadmitted insurers listed on the Quarterly Listing of Alien Insurers maintained by the NAIC's International Insurance Department (the IID).

States continue to struggle with how to properly allocate surplus lines premium taxes for multi-state risks following implementation of the NRRA. The Non-Admitted Insurance Multi-State Agreement (NIMA), which was developed by the NAIC and began operating on July 1, 2012, provides a mechanism for the sharing of surplus lines premium taxes on multi-state risks between participating states. However, Alaska, Connecticut, Hawaii, Mississippi, Nebraska and Nevada each withdrew from NIMA during the first half of 2012, leaving only five states (Florida, Louisiana, South Dakota, Utah and Wyoming) and Puerto Rico as NIMA members. Similarly, the Surplus Lines Insurance Multi-State Compliance Compact (SLIMPACT-Lite), which is a competing proposal endorsed by the National Conference of Insurance Legislators (NCOIL) and the National Association of Professional Surplus Lines Offices, Ltd. (NAPSLO), does not currently have enough members to become operational. Alabama, Indiana, Kansas, Kentucky, New Mexico, North Dakota, Rhode Island, Tennessee and Vermont have joined SLIMPACT-Lite, but at least one additional state is required before it can begin operating. It remains to be seen whether NIMA and SLIMPACT-Lite will remain viable options for multi-state allocation of surplus lines premium taxes, or whether another state mechanism will be developed for this purpose.

States also continue to struggle with the scope of the NRRA's preemptive effect on surplus lines eligibility requirements. A number of states continue to assert various requirements that could be seen as violating the spirit, if not the letter, of the

NRRA's preemption in favor of the domestic regulator (in the case of U.S. domestic surplus lines insurers) and NAIC oversight (in the case of non-U.S. insurers). Other states concede they have no enforcement authority over surplus lines insurers that meet Dodd-Frank requirements, but nonetheless continue to maintain a voluntary list of approved surplus lines insurers that they publish for the benefit of brokers and consumers.

The IID has been developing more robust eligibility requirements for IID listing for non-U.S. insurers, which is not surprising given the deference granted IID-listed insurers under the NRRA. During the NAIC's 2012 Spring National Meeting, amendments to the IID Plan of Operation were proposed that would (i) increase the minimum capital and surplus requirement for IID-listed insurers from $15 million to $45 million, incrementally, by the end of 2013, and (ii) increase the maximum IID-listed insurers are required to maintain in trust for the benefit of their U.S. policyholders from $100 million to $150 million by 2013. The amendments are expected to be adopted during the NAIC's National Meeting in August 2012.

Finally, with respect to captive insurers, we expect that the second half of 2012 and 2013 will see a number of U.S. captives seeking to redomesticate to states where their primary insureds are domiciled to take full advantage of certain tax benefits available to them under the NRRA. For many U.S. captives, the "home state" of the captive's primary insured is not the captive's state of incorporation – resulting in a direct placement tax at a higher rate than applies under the home state's captive law. We have seen some related activity on this issue during the first half of 2012 already.

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NAIC's Solvency Modernization Initiative

More and More States Implement Reinsurance Collateral Reform

In November 2011, the NAIC adopted amendments to its Credit for Reinsurance Model Law and Regulation (the Credit for Reinsurance Amendments), which govern when a ceding insurer may take credit for ceded reinsurance. Most notably, the Credit for Reinsurance Amendments permit U.S. ceding insurers to take full credit for reinsurance ceded to qualified non-U.S. reinsurers based upon less than 100% collateralization. Historically, unauthorized non-U.S. reinsurers have been required to post 100% collateral for credit to be granted. The Credit for Reinsurance Amendments provide that collateral requirements may be reduced for non-U.S. reinsurers that meet certain specified requirements (including minimum capitalization and financial strength rating) domiciled in "qualified jurisdictions," as determined by the commissioner. Such reinsurers would be eligible for "certified reinsurer" status, and approved reinsurers would be permitted to post reduced collateral on a sliding scale.

The Credit for Reinsurance Amendments are particularly noteworthy in light of the significant reinsurance reforms implemented under the reinsurance part of the Nonadmitted and Reinsurance Reform Act (NRRA). Most notably, the NRRA provides that, so long as a ceding insurer's state of domicile is NAIC-accredited, that state will have exclusive authority to regulate (i) the ceding insurer's credit for reinsurance, and (ii) the ceding insurer's reinsurance agreements (except with respect to taxes and assessments). Consequently, states that do not adopt reduced reinsurance collateral requirements risk placing their domestic insurers at a disadvantage in the reinsurance market. It is important to note, however, that any new collateral requirements apply prospectively only, and an insurer's existing liabilities must continue to be 100% collateralized.

Prior to the NAIC's adoption of the Credit for Reinsurance Amendments, four states (Florida, Indiana, New York and New Jersey) enacted similar changes to their respective credit for reinsurance laws. In addition, during the first half of 2012, four states (Connecticut, Georgia, Louisiana and Virginia) adopted the Credit for Reinsurance Amendments in some form. To date, in total, eight states have adopted reduced reinsurance collateral requirements.

During the second half of 2012, we expect continued legislative activity on this issue, as well as continued activity at the NAIC. At its 2012 Spring National Meeting, the NAIC's Reinsurance (E) Task Force took various steps intended to assist states in implementing the Credit for Reinsurance Amendments, including (i) es-

tablishing a drafting group to develop a process for reviewing non-U.S. jurisdictions to determine what jurisdictions are "qualified," (ii) developing related accreditation standards, and (iii) establishing a drafting group to develop the process applicable to the advisory group that will be formed to support states in reviewing reduced reinsurance collateral applications.

NAIC Continues Work on "Principles-Based Reserving" for Life Insurers

For decades, a formulaic approach worked well to establish reserves and capital requirements for life insurers as their asset and liability portfolios were relatively simple and products between companies were relatively homogenous with somewhat basic features, resulting in similar risk profiles between companies. With consumers demanding more complicated and varied product benefits and guarantees, insurance companies have engaged in more complex investment and hedging strategies to offer a wide variety of complex products. These changes to product offerings and company practices resulted in different risk exposures for insurers on both the asset and the liability side of their balance sheets. As a result, regulators and the NAIC have attempted to modernize the reserving methodology.

In 2009, the NAIC adopted a revised Standard Valuation Model Law (the Valuation Model) with a proposed Valuation Manual (VM) developed by the Life Actuarial Task Force (LATF) that sets forth the minimum reserve and related requirements for life insurance contracts, accident and health insurance contracts and deposit-type contracts. For life insurance, the details of a principles-based approach to reserve determination are found in VM-20, which establishes the minimum reserve valuation standard for individual life insurance policies. It is expected that VM-20 will apply only to new business written on or after the effective date of the new standard; business written prior to such effective date will continue to be subject to existing reserve standards.

Before it introduces the Valuation Model to state legislatures, the NAIC must finalize the VM. In an effort to understand the impact of the proposed valuation methodology on the U.S. life insurance industry, the NAIC engaged Towers Watson in 2011 to conduct an impact study of the proposed VM-20. The impact study investigated the effect of proposed principles-based reserving (PBR) methodologies on life insurance products and compared the results to current reserving methodologies. Some key findings from the impact study summary report are:

- On average, for term products, the reported VM-20 reserves for the hypothetical one year of new business and five years of new business were lower than the reserves calculated under existing reserving methodology. However, with respect to the universal life products with secondary guarantees, the impact study did not generate an official finding because the results were not consistent due to the different ways in which participating

insurers interpreted Actuarial Guideline 38 (AG 38). For the other products tested (traditional whole life, simplified issue whole life, universal life without secondary guarantees and variable universal life), the reported VM-20 reserves were at similar levels compared to current rule based reserves.

- The impact study showed significant volatility in net premium reserve as a percentage of the Commissioners Reserve Valuation Method, which suggests that the net premium reserve is ineffective as a floor for the minimum reserve.

- The exclusion tests performed within expectations and appear to support the effectiveness of the exclusion tests.

- In determining the adequacy of the overall level of reserves produced by VM-20, LATF should keep in mind that, under PBR, the level of reserves would respond to changes in experience and the economic environment. While as a general matter setting best estimate assumptions may not be an issue, setting overall margins and, in particular, the mortality assumption and blending with the industry table was reportedly very difficult for the participating insurers.

The momentum behind PBR for life insurance products has increased recently given the increased scrutiny of AG 38 for specific universal life with secondary guarantees product features. At its 2012 Spring National Meeting, the NAIC pushed hard to have the VM finalized for adoption by the NAIC at its 2012 Summer National Meeting in August. As it currently stands, there are still some issues that need to be resolved before such adoption could happen, and during the conference calls organized by LATF on June 19 and 21, the issues of mortality assumptions and net premium methodology as the floor were discussed. If the VM is completed by the end of 2012, the revised Valuation Model, including the VM, will be provided to state legislatures for adoption in 2013. During the second half of 2012 and most of 2013, LATF is expected to continue to work on resolving a number of implementation details referenced by the VM. Among the implementation details outstanding are the clarification of data sources and an update process for prescribed asset default costs and benchmark spreads.

For the PBR methodology to become effective, at least 42 states must adopt it. If the support from the industry and regulators is sufficient, with the NAIC's resolution of implementation, PBR may be implemented in various states as early as 2015. If PBR is implemented, all insurance companies subject to the new law must spend significant time developing models and systems to calculate reserves under PBR. Life insurers that write term products and universal life products with secondary guarantees will most likely see changes to those products' reserve valuations. Captive and reinsurance strategies developed during the past five to 10 years to address the 38 and 38A issues might still remain under a PBR framework due to the floor and potential mortality assumption issues, although it might be

harder for an insurance company to argue that a portion of the statutory reserves calculated under PBR is indeed redundant.

States Begin to Adopt Holding Company Act Amendments Requiring an Annual ERM Report

In 2010, the NAIC adopted amendments to the Model Insurance Holding Company System Regulatory Act (the Holding Company Act Amendments) and related regulation, which regulate transactions involving a domestic insurer and its affiliated entities (i.e., entities in the same insurance holding company system). During the first half of 2012, five states (Connecticut, Indiana, Kentucky, Louisiana and Nebraska) adopted the Holding Company Act Amendments in some form. The Holding Company Act Amendments were adopted in some form by Rhode Island, Texas and West Virginia in 2011.

The NAIC adopted the Holding Company Act Amendments to address certain weaknesses in the regulation of insurance holding company systems (particularly with respect to enterprise risk) that were highlighted during the recent economic downturn. Most notably, the Holding Company Act Amendments include the following key changes: (i) the ultimate controlling person of every insurer subject to registration must file an "enterprise risk report" (Form F) annually, which must identify, to the best of the ultimate controlling person's knowledge and belief, the material risks within the insurance holding company system that could pose enterprise risk to the insurer; and (ii) annual registration (Form B) filings must include a representation by a domestic insurer's board of directors with respect to corporate governance and internal controls.

With bills addressing the Holding Company Act Amendments pending in a number of states, including California, Illinois and Pennsylvania, continued activity on this issue can be expected throughout the remainder of the 2012 legislative session. The NAIC is also currently accepting comments on a proposal that state adoption of the Holding Company Act Amendments (or its key elements) be made a requirement for NAIC state accreditation. The proposal notes that the Model Holding Company Act and Regulation are currently an accreditation standard and that the Holding Company Act Amendments should be as well. The NAIC is expected to address this proposal during its 2013 Spring National Meeting.

NAIC Develops ERM Framework Requirements

In 2011 and the first half of 2012, a key issue for state insurance regulators has been establishing a requirement that insurers maintain an enterprise risk management (ERM) framework. The rapid pace of work on this issue is partially driven by international expectations regarding ERM, as expressed in the International Association of Insurance Supervisors Insurance Core Principles No. 16 (ICP-16). ICP-16 provides that insurance regulators should require an insurer's ERM framework to "provide for the identification

and quantification of risk under a sufficiently wide range of outcomes using techniques which are appropriate to the nature, scale and complexity of the risks the insurer bears and adequate for risk and capital management and for solvency purposes."
As noted above, the Holding Company Act Amendments require that the ultimate controlling person of every insurer subject to registration file an "enterprise risk report" annually that identifies the material risks within the insurance holding company system that could pose enterprise risk to the insurer. In addition, the NAIC continues its work on a requirement that insurers meeting certain size thresholds conduct an own risk and solvency assessment (ORSA) annually and report the results of that ORSA to their domiciliary regulator. Essentially, an ORSA is an insurer's internal assessment of the risks associated with its business plan and the sufficiency of capital to support those risks. In 2011, the NAIC adopted the ORSA Guidance Manual, which provides insurers and state regulators with guidance as to what an ORSA should entail and what an ORSA Summary Report should address.

The ORSA Guidance Manual recommends that an insurer's ERM framework consider, at a minimum, the following key principles:

- A governance structure that clearly defines and articulates roles, responsibilities and accountabilities; and a risk culture that supports accountability in risk-based decision-making.
- A risk identification and prioritization process that is key to the organization; clear ownership of this activity; and a risk management function that is responsible for ensuring that the process is appropriate and functioning properly at all organizational levels.
- A formal risk appetite statement, and associated risk tolerances and limits that are foundational elements of the insurer's risk management; and Board understanding of the risk appetite statement, which ensures alignment with risk strategy.
- Risk management and controls that are an ongoing enterprise risk manage ment activity, operating at many levels within the organization.
- Risk reporting that provides key constituents with transparency into the risk management processes and facilitates active, informal decisions on risk taking and management.

The ORSA Guidance Manual requires that an insurer's ORSA Summary Report provide a high-level summary of these ERM principles and include three distinct sections addressing the following issues: (i) a description of its risk management framework; (ii) quantitative and/or qualitative measurements of its risk exposure in normal and stressed environments for each material risk; and (iii) a group economic capital and prospective solvency assessment that documents how the insurer combines qualitative elements of its risk management policy and the quantitative

measures of risk exposure in determining the level of the financial resources needed to manage its business over the long-term business cycle (e.g., two to five years).

During the first half of 2012, the NAIC has been working to develop the ORSA Model Act, which would make conducting an ORSA a legal requirement (as opposed to merely an examination standard), due to pressure from the international community to have express authority granting Commissioners the ability to require an ORSA. As currently proposed, the ORSA Model Act would require all insurers meeting certain size thresholds to (i) maintain a risk management framework, (ii) conduct an ORSA, and (iii) report the results of the ORSA to their domiciliary regulator annually.

As currently proposed, the ORSA Model Act's requirements would apply to all insurers, except insurers with less than $500 million in annual direct and unaffiliated assumed premiums that are part of a group with total direct and unaffiliated assumed premiums of less than $1 billion; however, the state insurance commissioner may, at his or her discretion, require an insurer to provide an ORSA based on unique circumstances. The ORSA Model Act would require insurers to conduct an ORSA in accordance with the ORSA Guidance Manual at least annually, but also "at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member."

The NAIC released the latest draft of the ORSA Model Act for public comment on June, 29, 2012, with comments due by July 13, 2012. Currently, the proposed effective date of the ORSA Model Act is January 1, 2014, but it is unclear whether the Model Act will be ready for implementation in time. Industry representatives have expressed serious concerns with respect to the confidential treatment of information provided in the ORSA Summary Report, particularly in light of the sensitive, forward-looking nature of the information. In addition, questions have been raised regarding whether additional guidance is required on what an acceptable ERM framework should include before such a requirement is adopted. Given these outstanding questions, significant developments are expected on this issue throughout the remainder of 2012.

III

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Recovery of Unclaimed Life Insurance Benefits

State Investigations and Settlements of Unclaimed Life Insurance Benefits Continue

During the first half of 2012, the life insurance industry continued to see an escalation in the number and intensity of multi-state market conduct examinations focused on insurers' practices with regard to unclaimed death benefits. More than 40 state insurance regulators have hired Verus Financial LLP to conduct market conduct examinations of certain life insurers' claims practices. At the same time, Verus is performing aggressive unclaimed property audits of the same insurers for a contingency fee on behalf of at least 35 State Treasurers. ACS Unclaimed Property Clearinghouse, another contingent fee audit firm, is also performing unclaimed property audits of certain life insurers. And Attorneys General in Massachusetts, Minnesota and New York State have continued their probes of insurers' death claim and escheatment practices, applying different standards and legal constructs to their data requests than Verus. These exams and inquiries are requiring insurers to invest significant resources to gather large amounts of data in response to extensive information requests and interrogatories, in some cases requiring data on policies out-of-force for 20 years, without coordination among regulators.

The driving theory behind the Verus unclaimed property audits is that, just as unused gift cards must be escheated to the states as unclaimed property if dormant for a certain period of time, death benefits on life insurance and annuity policies that are unclaimed by beneficiaries must be escheated to the states within a dormancy period that is triggered by death – not by notice of death or the filing of a perfected claim. However, the industry believes unclaimed property laws do not support this theory, and it is long established that the state insurance laws and insurance contracts approved by insurance departments require the filing of a claim in good order by a beneficiary before a claim is due and payable.

The regulatory initiatives are attempting to shift the burden to the insurer to determine whether an insured is deceased and benefits are payable by requiring periodic sweeps of an insurer's entire book of business against the U.S. Social Security Administration's Death Master File (DMF). In the process, regulators have created significant compliance uncertainty among all life insurers.

Regulatory settlements by two prominent life insurers have raised numerous questions within the industry about the sudden change in regulators' expectations. On

February 2, 2012, seven lead states (California, Florida, Illinois, New Hampshire, North Dakota, Pennsylvania and New Jersey) announced a $17 million multi-state regulatory settlement agreement (RSA) with The Prudential Insurance Company and its life insurance subsidiaries (Prudential) that requires Prudential to conduct monthly sweeps of the DMF against its life insurance, annuity and retained asset account blocks of business, with some exceptions, using an algorithm that includes "fuzzy match" criteria. If Prudential finds that a policyholder has died, the agreement requires Prudential to use "best efforts" to conduct a "thorough search" for beneficiaries, using all contact information in its records and online search and locator tools. If beneficiaries cannot be located, Prudential must turn the proceeds owed to beneficiaries over to the states as required by state unclaimed property laws. Prudential is required to submit quarterly reports to the lead states for a 36-month period and to undergo a second multi-state market conduct exam by Verus within 39 months, with costs borne by Prudential. The RSA terminates 10 years after signing. As of this writing, all states, except New York and Minnesota, have signed the Prudential RSA.

The Prudential RSA is in addition to the unclaimed property audit settlement that Prudential signed with Verus in January 2012 on behalf of 36 State Treasurers. That Global Resolution Agreement (GRA) is essentially a workplan for reporting and remitting unclaimed death benefits to the states, and requires the aggressive reporting and processing of remittances on 10-15,000 unclaimed death benefits, matured policies and dormant retained asset accounts per month. Prudential agreed to pay beneficiaries, and if unfound, the states, 3% compounded interest on the value of amounts held from the date of the owner's death or January 1, 1995, if later, and to accelerate turning over unclaimed property to the states.

In April 2012, six insurance commissioners in lead states (Florida, California, Illinois, North Dakota, Pennsylvania and New Hampshire) announced a $40 million RSA with MetLife, Inc. and its life insurance subsidiaries (MetLife) that is materially consistent with the Prudential RSA. The MetLife RSA requires MetLife to change its business practices to conduct monthly DMF searches across all lines of business using "fuzzy match" criteria, use "best efforts" to conduct "thorough searches" for beneficiaries, provide quarterly reports to the lead states and undergo a second market conduct exam within 39 months.

Also in April 2012, it was announced that Verus has entered into a national unclaimed property GRA with MetLife that is materially consistent with the Prudential GRA. Estimates are that MetLife will pay at least $500 million in unpaid life and annuity benefits to beneficiaries and/or escheat the benefits to the states. MetLife agreed to an additional review and remittance of up to 12,000 industrial policies per month (32,000 policies per month in total) beginning within 30 days of the effective date of the GRA.

Meanwhile, NCOIL has introduced the Model Unclaimed Life Insurance Benefits Act, sponsored by Representative Robert Damron of Kentucky, that will be con-

sidered at the 2012 NCOIL Summer Meeting. That bill would require quarterly searches against the DMF of in-force life insurance policies and retained asset accounts, use of "good faith" efforts to locate beneficiaries and the escheatment of unclaimed benefits to the states. However, the Director of Communications of the Florida Office of Insurance Regulation is reported to have pushed back against the NCOIL model act, citing regulators' concern that insurers will try to use the NCOIL model as a reason why states should not complete their market conduct exams and unclaimed property audits. He reiterated that state insurance regulators intend to reach agreements similar to the Prudential and MetLife RSAs with other insurers that are, or in the future will be, under examination.

As a result of this increased regulatory activity, insurers are looking to understand the full implications of these developments for their business and to develop a comprehensive strategy that will reduce the uncertainty and their exposure from these developments.

New York Implements Unclaimed Death Benefit Requirements

On May 14, 2012, the New York Department of Financial Services (the NYDFS) announced the emergency promulgation of Insurance Regulation 200. The emergency regulation requires all life insurers doing business in New York to immediately begin to implement significant new procedures to identify unclaimed death benefits and locate beneficiaries so as to make prompt payments of benefits. Regulation 200 became effective June 14, 2012, and remains in effect for 90 days thereafter.

Last July, the NYDFS issued a letter to insurers pursuant to New York Insurance Law § 308 (the 308 Letter). The 308 Letter required life insurance companies and fraternal benefit societies doing business in New York to conduct a cross check against the DMF, or another comparable database, of their entire block of business, using "exact" match criteria. Every life insurance policy and annuity contract and retained asset account issued by a New York domestic insurer or delivered or issued for delivery in New York by an authorized foreign insurer since 1986 was subject to the requirement, with certain exceptions. Insurers were required to pay any unpaid death benefit payments that may have been due under the policies and accounts and to submit monthly reports to the NYDFS on their progress in bucketing, paying and/or escheating amounts due and payable with regard to valid matches against the DMF.

Regulation 200 has expanded, rather severely and without providing an opportunity for notice and comment, the scope of the procedures that insurers must immediately undertake to identify valid death claims and pay beneficiaries. Regulation 200 also significantly changes the scope of retained asset accounts of foreign insurers that are subject to the regulation from that contained in the 308 Letter (i.e., accounts delivered or issued for delivery in New York) to "any account established under or as a result of" a life insurance policy or annuity contract delivered

or issued for delivery in New York. The emergency regulation's key requirements that went into effect on June 14 are as follows:

- Prior to issuing a policy or establishing an account, insurers must request detailed information regarding each owner, annuitant, insured and/or beneficiary of a policy or account. At a minimum, the insurer shall request names, addresses, social security numbers and telephone numbers.

- Insurers must conduct quarterly cross checks against the DMF (or a comparable database) of every policy and account using the criteria set forth in the 308 Letter.

- Insurers must implement "reasonable" matching procedures to account for common variations in data that would otherwise preclude an exact match with a death index. In other words, insurers are required to use an algorithm when cross checking the DMF that will generate fuzzy matches. This provision raises significant interpretative and systems issues.

- Insurers must establish "reasonable" procedures to locate beneficiaries and must make prompt payments or distributions of benefits.

- Upon receipt of notification of death or identification of a death using the DMF, insurers must search every policy or account subject to Regulation 200 to determine whether the insurer has any other policy or account for the insured or account holder.

- Upon receipt of notification of death or identification of a death using the DMF, the insurer must also notify each life insurer in their holding company system of the death notice, regardless of the location of the other insurer. This provision raises significant jurisdictional, notice and compliance issues.

- Insurers must respond to requests from the NYDFS Superintendent to search for policies insuring the life of, or owned by, decedents, and to initiate the claims process for any death benefits that may be identified as a result of the requests received through the new Lost Policy Finder system; and

- Insurers must submit a report to the New York Office of the State Comptroller, by February 1 of each year, specifying the number of policies and accounts identified as having unpaid benefits as of December 31 of the prior year.

There are many other aspects to Regulation 200 that present challenges for insurers, including the 30-day time-frame for implementing most of the procedures required by Regulation 200, such as the requirement to search for multiple policies and accounts. While Regulation 200 gave insurers an additional 150 days from

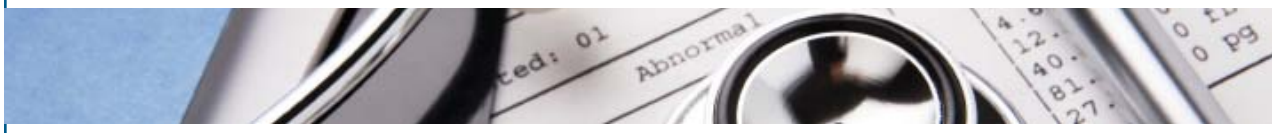
the effective date to implement fuzzy match procedures, the additional time may not be sufficient for insurers that do not have such procedures in place and whose systems currently would not support such searches.

Adding to the regulatory uncertainty is legislation that has passed both houses of the New York State Legislature and, as of this writing, is slated to come before the Governor for signature. That legislation, which is supported by the life insurance industry, would require DMF matches but maintain the life insurers' ability to verify that an insured identified by the cross-match is actually deceased by requiring the beneficiary to produce a death certificate. Until this matter is resolved, insurers face the uncertainty of inconsistent regulatory obligations that require significant systems changes with short implementation deadlines.

IV

SUTHERLAND

NYDFS and NAIC Focus on Force-Placed Insurance



Lender-placed (also known as "force-placed") insurance is now getting attention from state insurance regulators, even though we are in the fifth year after problems with subprime residential mortgages first appeared. The latest development is the NAIC's announcement that it will hold a public hearing on lender-placed insurance on August 9 at the Summer National Meeting in Atlanta. The NAIC's announcement states that it expects the hearing to probe:

- The process for lender-placed insurance and its impact on homeowners, including a review of the relationships between lenders, mortgage servicers and insurers;
- Whether coverage is being imposed on consumers retroactively;
- Disclosures used to inform consumers about lender-placed insurance; and
- Coverage, premiums charged, loss ratios and related pricing information.

This announcement followed on the heels of widely-reported public hearings by the NYDFS in May. The NYDFS began looking at lender-placed insurance last Fall, when it issued wide-ranging subpoenas and data requests to mortgage lenders and agents and insurers who participate in the lender-placed insurance market. In September 2011, the NYDFS entered into an agreement with a subsidiary of Goldman Sachs, Ocwen Financial Corp. and Litton Loan Servicing to adhere to specified mortgage servicing practices. The agreement was reached as a condition to allowing Ocwen's acquisition of Goldman's mortgage servicing subsidiary, Litton. The agreement includes a number of requirements with respect to force-placed insurance, including a requirement that insurance provided through a master hazard insurance policy be "reasonably priced in relation to the claims that may be incurred" and a prohibition from purchasing a master hazard insurance policy from an affiliate.

During the May hearings, New York Superintendent of Financial Services Benjamin Lawsky and several of his deputies heard testimony over the course of three days from homeowners, consumer advocates, banks, mortgage servicers and insurers. Superintendent Lawsky reported that during the period from 2004 to 2010, New York experienced a 265% growth in premiums from lender-placed insurance. Testimony from consumers included a litany of reports of shoddy customer service and errors by mortgage servicers, but of particular concern to the Superintendent

and his staff was whether premiums for force-placed insurance are excessive. He expressed the view that the price disparity between voluntary insurance and lender-placed insurance appears to be unjustified and questioned whether the inflated premiums may be from the lack of competition and relationships between insurers and lenders. He discussed what he labeled an "inverted incentive" structure in which there is little incentive for lenders to place insurance with insurers that provide low rates. Instead, he expressed concern that insurers receive business precisely because of the opportunities they provide lenders to transfer portions of premium back to the lender through commissions paid to captive agencies and reinsurance agreements with captive reinsurance companies. The Superintendent discussed actions he may take to address the perceived problems: banning the relationships between lenders and insurers, enforcing a minimum loss ratio and improving disclosures. The Superintendent's concern with rates was pressed by Joy Feigenbaum, Executive Deputy Superintendent for Financial Frauds and Consumer Protection, who grilled insurer representatives on the adequacy and reliability of historical loss data supporting their current rates. Subsequent to the hearing, New York Governor Andrew Cuomo announced that DFS had ordered insurers offering lender-placed insurance in New York to submit proposals for new rates by July 6.

During the NAIC's Spring National Meeting in New Orleans, NAIC-funded consumer representatives requested that the NAIC take up lender-placed insurance, based on the view that premiums are excessive in light of historical losses, as well as the charge that insurance was being purchased retroactively and improperly placed through group insurance with nonadmitted insurers. It is worth noting that the primary focus of the New York regulators was on pricing and disclosure, perhaps reflecting a higher level of sophistication of the NYDFS staff in understanding the products. It remains to be seen whether these issues get aired again during the August hearing.

This regulatory activity continues despite the fact that lender-placed insurance practices were a component of the $25 billion National Mortgage Servicing Settlement Agreement among the major banks and the 50 states that was announced in February. The general requirements of the settlement with respect to force-placed insurance are:

- Servicer must have a reasonable basis to believe that the borrower has failed to maintain property insurance prior to force-placing homeowners insurance.

- Servicer must provide written notice to the borrower reminding the borrower of his obligation to maintain homeowners insurance. The notice must contain a warning that, if the borrower does not provide proof of insurance, the servicer will force-place insurance at the borrower's expense. The notice must also warn the borrower that the cost may be significantly higher than the cost of the borrowers' current coverage.

- The servicer must provide a second notice to the borrower, not less than 30 days after the mailing of the original notice.
- Insurance may not be force-placed until 15 days after the second notice is sent.
- Servicer must not force-place insurance in excess of the greater of (a) replacement value; (b) last known amount of coverage; or (c) outstanding loan balance.
- Within 15 days of the borrower providing evidence of coverage, the servicer shall terminate the force-placed coverage and refund the premium for any period of overlap.
- Servicer must make reasonable efforts to work with the borrower to continue or reestablish the existing homeowners policy if there is a lapse in payment and the borrower's payments are escrowed.
- Any force-placed insurance policy must be purchased for a commercially reasonable price.

Significantly, the settlement did not include a prohibition on placing insurance with a subsidiary or affiliated company or from receiving "kickbacks," referral fees or anything of value in relation to the purchase or placement of force-placed insurance, which was included in a prior discussion draft.

V

SUTHERLAND

Insurer Insolvencies

Early 2012 witnessed three important events relating to impaired insurers.

New York Court Approves Liquidation and Restructuring Plan for ELNY

On April 16, 2012, Justice John M. Galasso of the Supreme Court for the State of New York, Nassau County, issued an order declaring Executive Life Insurance Company of New York (ELNY) insolvent and approving a liquidation and restructuring plan proposed by the New York Superintendent of Financial Services in his capacity as rehabilitator of ELNY. Justice Galasso's order is the most recent court decision in the 20-year receivership relating to the distressed insurer. Established in 1935, ELNY sold annuity contracts and other life insurance policies, many of which were used to fund structured settlement agreements relating to physical injury claims. When the financial difficulties of ELNY's parent company, Executive Life Insurance Company, began to impact ELNY's financial condition, the New York Superintendent sought and obtained an order placing the company into rehabilitation in 1991.

While in rehabilitation, ELNY continued to make all benefit payments under its annuity and insurance contracts. By December 31, 2010, however, ELNY registered a deficit of $1,568,372,142. In August 2011, the rehabilitator sought an order of liquidation, which included a restructuring plan under which ELNY's remaining assets would be transferred to a not-for-profit captive insurance company (Newco) responsible for making claims payments.

The restructuring plan was the result of extensive negotiation among and evaluation by the New York Superintendent, the state guaranty funds and the life insurance industry. The final plan as approved uses three sources of funding to pay benefits under ELNY contracts: (i) the remaining assets of the ELNY estate, (ii) allocations from 40 participating state guaranty associations for their state residents and (iii) voluntary contributions by the life insurance industry. In addition to the court-approved restructuring plan, many life insurance companies making voluntary contributions to Newco have also facilitated the formation of a not-for-profit hardship fund. The hardship fund plans to review applications from any ELNY beneficiary not receiving full benefits under the court-approved restructuring plan and make claims payments based on certain hardship criteria.

A Notice of Appeal was filed by objectors to the order of liquidation and restructuring plan approval on May 30, 2012. Briefs have not yet been submitted in connection with the appeal.

Pennsylvania Court Denies Request to Liquidate PTNA and ANIC

It is quite unusual for a court to deny a regulator's liquidation petition. On May 3, 2012, Judge Mary Hannah Leavitt of the Commonwealth Court of Pennsylvania did just that and denied the Pennsylvania Insurance Department's (PID) petition to liquidate Penn Treaty Network America Insurance Company (PTNA) and its subsidiary American Network Insurance Company (ANIC). Judge Leavitt's 164-page Memorandum Opinion and Order was issued after a 30-day trial and ordered that the PID develop a plan of rehabilitation of PTNA and ANIC in consultation with the companies' ultimate parent Penn Treaty American Corporation (PTAC).

Prior to consenting to rehabilitation in 2009, PTNA and ANIC issued long term care insurance (LTCI) policies covering certain health care costs such as paying for custodial or skilled care in a nursing home, an assisted living facility or a person's home. The companies' policies issued prior to 2002 (known as OldCo business) experienced financial difficulties due to the pricing and underwriting standards used for that business; however, the policies issued starting in 2002 (known as NewCo business), apparently, remain profitable, and the companies' assets actually grew in 2010.

In her decision, Judge Leavitt specifically rejected the projections of the PID actuarial expert as "unreliable" and "too pessimistic." Furthermore, the court's opinion severely criticized the current system of LTCI rate regulation, stating that "the Rehabilitator's evidence showed that rate regulation is governed by politics, not actuarial evidence or legal principles."

Judge Leavitt also criticized the Rehabilitator for treating the rehabilitation "as a conservatorship to give him time to prepare for liquidation," citing the same court's 2002 opinion granting the petition to liquidate Legion Insurance Company and Villanova Insurance Company, and criticized the Rehabilitator for failing to draft a formal rehabilitation plan prior to seeking liquidation: "Without a formal plan of rehabilitation, the Rehabilitator cannot make the case that a plan he never proposed or implemented is futile."

PTAC responded to the announcement of the decision with a press release announcing that the company looks forward to "working with Insurance Commissioner Consedine and his team to forge rehabilitation approaches that will put the Companies back on the track to solvency and beyond."

FGIC Becomes First New York Financial Guaranty Insurer to Enter Receivership

On June 28, 2012, Justice Doris Ling-Cohan of the Supreme Court for the State of New York, New York County, issued an Order of Rehabilitation for Financial Guaranty Insurance Company (FGIC) as requested in the June 11, 2012 Verified Petition of New York State Superintendent of Financial Services Benjamin M. Lawsky. FGIC is the first financial guaranty insurance company to be put into receivership in New York.

The Order of Rehabilitation was entered with the consent of the Board of Directors of FGIC and follows the filing of FGIC Corporation, FGIC's parent entity, for Chapter 11 bankruptcy protection on August 3, 2010. The United States Bankruptcy Court for the Southern District of New York confirmed FGIC Corporation's Chapter 11 plan on April 23, 2012, but the plan has not yet become effective.

In remarks to the New York City Bar Association on June 28, 2012, the day the order was issued, Superintendent Lawsky hailed the entry of the FGIC order as facilitating a new model of rehabilitation under the insurance laws that he hopes will follow the model of prepackaged bankruptcies for non-insurance companies. We understand that Superintendent Lawsky has promised to draft a plan of rehabilitation for FGIC within 60 days.

London Speakers' Corner: Meeting the Regulatory Challenges of Solvency II

Never before have UK insurers and reinsurers faced such significant regulatory risks and uncertainties as they do today. While it is hoped that the changes will benefit the industry long term – better aligning the reality of insurance business with its regulation, freeing up capital, encouraging an environment where director engagement can take place and improving the quality of day-to-day supervision – in the shorter term, firms will face a challenging environment.

Update on Solvency II Implementation

The current prudential rules for insurance businesses are 30 years old and no longer fit for purpose. The previous solvency regime specified the capital that insurance businesses needed to hold by reference to pre-prescribed solvency margins. The system was failing to take into account developments in insurance, risk-modeling, risk management and governance. It was possible for well managed and controlled firms to be allocating too much dead capital on their balance sheets, providing no regulatory-dividend for those that deserved it, whilst firms which posed a genuine risk of failure might be required to set aside too little.

The aims of Solvency II are to prevent insurance failures and to make the market more robust; to increase efficiency in the use of capital; to create a framework for timely and consistent supervision of firms, in particular of insurance groups; and to provide benefits for consumers and other insurance buyers by increasing competition and access to insurance products and services across the EU. The main tool by which this is to be achieved is the use of refined risk measurement – in particular, firm-specific internal models – by which capital is to be more accurately allocated to risk. The new regime is intended to take into account market, credit and operational risk, underpinned (so it is hoped) by proper governance standards in firms, all under the supervision of informed and knowledgeable national, or more likely supra-national, regulatory bodies.

The timetable of implementation

An important requirement to achieving success with any regulatory transformation project, for both insurers and regulators, is to understand clearly what is going to happen and when. Unfortunately, Solvency II has become mired in doubts over its implementation timetable.

The Solvency II Directive requires member states to implement the new regime by October 31, 2012. In May 2012, though, the European Commission published a

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proposed directive that will amend the Solvency II transposition and implementation dates, extending the date by which Solvency II must be transposed into national law to June 30, 2013. It provides that Solvency II will apply to insurance and reinsurance firms from January 1, 2014, on which date the current European regulatory framework for the prudential supervision of insurance and reinsurance businesses will come to an end.

The delay has come about because of the European Commission's Omnibus II Directive proposal. This was published on January 19, 2011, and in part amends the Solvency II regime to reflect the EU's revised supervisory framework to render it consistent with the Lisbon Treaty, itself concerned with updating and modernizing the EU's constitutional framework. The Omnibus II Directive also affects other important changes in Solvency II; for example, EIOPA (the European Insurance and Occupational Pensions Authority), which has replaced CEIOPS (the Committee of European Insurance and Occupational Pensions Supervisors), has been given new powers to lay the ground work for developing a single EU rulebook applicable to all insurance businesses in the EU. Indeed, only a few days ago there was news that the European Parliament, European Commission and European Council had failed to resolve outstanding issues with the proposed Solvency II reforms. This may mean that the European Parliament will not be able to vote on the reforms until October 2012, after politicians return to business following the summer recess. However, whatever the delay, those involved in insurance businesses in the UK should have no doubt that further harmonization is on the way. The future will see common prudential and conduct of business rules, a single regulatory approach and fluid cooperation between state agencies when firms are in difficulty and are subject to enforcement action. The London insurance market will remain, but its regulation will be increasingly dictated by officials residing in other parts of Europe.

Changes in U.K. Regulator

Insurers and reinsurers will also face a new supervisory environment. The current City regulator, the Financial Services Authority (FSA), will be disbanded. Insurers' prudential regulator is to be the Prudential Regulatory Authority (PRA) (operating under the supervision of the Bank of England) and their conduct regulator is to be the Financial Conduct Authority (FCA). No one pretends that this "Twin Peaks" approach to regulation was designed with insurers in mind – it was banks and the quality of their balance sheets that has led to calls for a specialist prudential regulator – but there appears to be a real determination amongst senior staff at the FSA and Bank of England to ensure that insurers will not be squeezed into an unsuitable regulatory framework. It is expected that the PRA and the FCA will be operating from early 2013. In the meantime, though, the FSA has organized its internal affairs along the Twin Peaks model so that prudential and conduct regulation is split between FSA supervisory teams.

The Bank of England has already voiced concerns about insurance regulation and the prudential preparation work undertaken by insurers. In a speech in May 2012, Paul Tucker, the Deputy Governor of the Bank of England, expressed his dismay at the amounts of money both insurers and the FSA were spending on Solvency II.

He made it clear that there were real risks in regulator and regulated getting too embroiled in the details of the risk models being produced without properly considering governance and the macro-prudential environment.

There is no doubt that Lloyd's of London and the FSA have sought to do their part to work with firms around the efficacy of internal models, entering into a pre-application dialogue with insurers. This has allowed the regulator to understand what firms are doing, and to provide informal feedback, prior to the formal phase of application for regulatory approval of the internal modes to be used. It has also enabled the FSA to avoid the bunching of requests for model approval, which is bound to happen if firms have no real inkling of whether their models will be satisfactory when presented to it. But this approach causes problems for firms and the FSA. Because of the timing uncertainty described above, the FSA will not take legal powers as early as had been assumed, and yet it (and obviously insurers) will want to allow firms to use the investment they have made in models for this current round of pre-Solvency II capital adequacy assessments. The FSA is being flexible and working with firms, and this is surely all to the good.

European Commission Announces New Consumer Protection Initiatives

It should not be assumed that insurers face change only in relation to prudential risks. In early July 2012 the EU unveiled new measures to protect consumers, which will include new disclosure requirements for insurance products. The aim is to ensure that consumers are not sold investment and insurance products that are unsuitable given their needs and circumstances, and the EU will want to see the same level of consumer protection applying to a direct purchase from an insurer as applies to a sale achieved via an intermediary.

EU proposals of this nature impose burdens on the regulator and firms. First, the laws must be transposed into English law obligations, then firms must track what additional burdens are placed on them and ensure that their systems of internal control are attenuated accordingly.

The regulatory environment is a fluid one. There are conflicting signals about the regulatory approach to be adopted with unclear timetables. Tracking the number of new initiatives and policy proposals is a massive burden, causing firms and individuals to experience a form of regulatory fatigue. The key to success is for firms to focus on taking a risk-based approach, drilling into the significant risks while being aware of all of them, avoiding the micro-management of every regulatory issue to which a firm must respond. Common features of those who thrive in this environment will be sound instincts, access to appropriate management information, a constructive relationship with their regulator and the support of first-class risk control staff.

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