INSURANCE SECTOR
2014 YEAR END REVIEW AND FORECAST FOR 2015

DLA PIPER

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Fundamental changes and powerful forces are reshaping the insurance industry. These developments are reestablishing the natural order of the financial services sector and redefining the insurance industry's role in the global economy. Over the last year we have seen:

- Continuing expansion of capital markets players into the insurance sector, creating some significant synergies with and also stiff competition for traditional insurers.
- Heated debates over the capacity and willingness of the insurance industry to insure, with or without government support, natural and man-made cat losses.
- The designation of additional insurers as systemically important – and continuing debate over the validity of these designations and what they should properly mean for the regulation of G-SIIs – and other large multinational insurers.
- Fundamental disagreements over regulatory standards between the regulators of the two largest insurance markets of the word – the US and the EU – particularly with respect to insurance capital standards.
- Emerging or growing new risks, including cyber security, climate change and longevity, which present opportunities and challenges for the industry.
- Increasing globalization of the industry – fueled by significant cross-border M&A activity, which will accelerate this year.
- A continuing low interest rate environment and a commensurate hunt for yield by insurers, particularly those with long tail liabilities.
- A growing interest by governments in insurers as a source of liquidity for infrastructure and other large capital expenditure projects.
- Continued protectionism, which restricts market access for many global players.

This year end review examines some of the most significant legal, regulatory and commercial developments of 2014 and considers how these will play out in 2015 and what new developments and challenges the new year will bring to the insurance sector.

Whatever your role in this dynamic industry, we hope the opportunities are greater than the difficulties and the successes outnumber the setbacks. One thing is clear, however, the insurance industry will continue to evolve in response to a myriad of pressures and market changes.

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REGULATORY – GLOBAL

Recent global regulatory initiatives have raised a myriad of technical and policy related issues. In addition, there is considerable debate and discussion over the ultimate goals of the next generation of global insurance regulation. Is the proper goal the protection of policyholders only or does it include the protection of other stakeholders (e.g., shareholders or bondholders)? Is the goal convergence of regulatory standards? Mutual recognition of different, but equally effective regulatory regimes? Establishing a global baseline of minimum solvency requirements for all insurers? Attempting to level the playing field for global insurers? Enhancing financial stability? All of the above? There are no clear answers to these fundamental questions.

Although there are opportunities for positive gains for regulators and industry if goals are carefully set and reasonably pursued, there is also considerable danger if the reverse is true.

Some of the most significant global trends and developments of 2014 include:

Evolution of Group Supervision and ComFrame

During 2014, insurance regulators in seemingly all parts of the world worked to increase their ability to scrutinize an entire insurance group's financial condition. Although direct regulation of non-insurance entities is still beyond the reach of the legal authority of most regulators, it is clear that regulators are convinced that their supervisory powers over insurance groups are insufficient.

In the US, we saw an increasing number of states adopt the National Association of Insurance Commissioners (NAIC) model holding company act amendments requiring insurance-holding companies to submit Enterprise Risk Management reports. As of the NAIC's Fall National Meeting, 38 states had adopted it.

At the NAIC itself, regulators pushed through another amendment to the model holding company act to formally authorize state insurance commissioners to act as a "group-wide supervisor" for internationally active insurance groups (IAIGs) domiciled in their states. Although the amendments fall short of extending the power of a commissioner acting in the capacity of a group-wide supervisor to directly regulating entities that are not licensed insurers, the amendments provide, among other things, that a group-wide supervisor may request information from any entity within the group about matters such as governance, risk assessment and management and capital adequacy. These changes in US law have been precipitated by both an independent desire by regulators to have more comprehensive authority over an entire group, but they are also in response to international regulators, particularly European regulators, who contend that US group supervision is inadequate.

ComFrame. The most significant global development regarding group supervision is the continued work by the International Association of Insurance Supervisors (IAIS), to develop its *Common Framework for the Supervision of Internationally Active Insurance Groups* (ComFrame). A new version of ComFrame was released in September; however, it reflected mostly minor changes. New drafting related to ComFrame was put on hold, for the most part, during 2014 while supervisors focused on conducting the first phases of field testing the existing ComFrame document and the development of insurance capital standards (ICS), discussed below. Additionally, the IAIS embarked on a new initiative, as its Insurance Groups subcommittee began revising Insurance Core Principle 23, "Group-wide Supervision," to refine the scope of a large business organization that would be considered an "insurance group" for purposes of group supervision.

In 2014, the IAIS conducted field testing exercises based on the "qualitative" and "quantitative" sections of ComFrame on approximately 40 insurance groups that volunteered to undergo this process. As 2014 ended, the IAIS was in the midst of field testing two of the "qualitative" sections, those concerning an IAIG's group-wide management and an IAIG's governance. The "quantitative" ComFrame field testing asked volunteers to provide substantial amounts of financial information to their regulators in early 2014. The IAIS used that information to create a very rudimentary set of capital standards, the "Basic Capital Requirements" (BCR) for global systemically important insurers (G-SIIs). The BCR was used as part of the first phase of the quantitative field testing in late 2014. The second phase of qualitative field testing and another round of quantitative field testing are scheduled to be conducted during 2015."

The response to field testing has been mixed. On the one hand, most field testing volunteers seem to view participation as a valuable exercise for understanding ComFrame and how it may be administered, when and if it is adopted. On the other hand, many volunteers seem to be frustrated that the potential flaws revealed in field testing have not resonated with the IAIS and have not resulted in noticeable improvements in ComFrame, at least so far.

The IAIS continues to target completion of ComFrame for formal adoption in 2018. A new version of ComFrame, including for the first time, the ICS, is scheduled to be released for another consultation period in late 2015. We will continue to closely monitoring what occurs over the course of 2015 related to the ongoing field testing, the ICS consultation, and a series of stakeholder meetings the IAIS has scheduled.

International Capital Standards

In 2013, the IAIS announced its intention, supposedly with the backing of the Financial Stability Board (FSB), to develop a risk based global ICS for IAIGs and to include those standards in ComFrame.

There were two major ICS developments in 2014. First, keeping to the aggressive time table the IAIS announced in 2013, the IAIS issued the BCR for G-SIIs in October 2014. The IAIS touts the BCR as "the first step of the International Association of Insurance Supervisors to develop group-wide global capital standards." Intended to apply only to G-SIIs (and to form the basis for calculating the higher loss absorbency capital levels that such entities must hold), the BCR attempts to reflect major categories of risks impacting the businesses of G-SIIs and accounts for on- and off-balance-sheet exposures. It is a group wide factor-based approach and its application produces a "BCR Ratio" of total qualifying capital over required capital. To its many critics, however, the BCR is a gross measuring tool that will provide little meaningful information about an insurance group and, to its most cynical critics, was cobbled together too quickly by the IAIS simply to meet an arbitrary deadline.

Regardless of the BCR's ultimate significance, it remains but a preliminary bout for the main event, which is the IAIS's goal to develop the ICS. The IAIS gave interested parties a hint of what was in store by releasing an outline of the proposed ICS approach in the spring of 2014, which was met by extremely vocal criticism at a ComFrame Dialogue session the IAIS held in June. The IAIS proceeded to launch a formal consultation of the ICS on December 17, 2014. Notably, the IAIS Consultation Document seems to have been completely unaffected by the proceedings during the June ComFrame Dialogue.

The Consultation Document is 159 pages long and asks commenters to respond to 169 different and, at times, highly technical questions regarding the goals and structure of the proposed ICS. The proposal purports to adhere to and implement ten "ICS Principles." The IAIS stresses throughout the ICS Consultation Document that its primary objective is to achieve "comparability" among IAIGs with respect to their capital adequacy. As currently proposed, the IAIS intends for this comparability to be achieved by the ICS through the imposition of a prescribed capital requirement. The Consultation Document introduces key requirements and standards pertaining to valuation and qualification of capital resources. The proposal seeks to require insurers to use a market adjusted approach to valuation. Although the door is left modestly open for the development of an adjusted GAAP approach, the proposal strongly implies that to be accepted, an adjusted GAAP approach would have to essentially morph into the market adjusted approach.

The formal consultation period for the Consultation Draft ends on February 16, 2015. However, in addition to the formal submission of comments, the IAIS has scheduled a series of stakeholder meetings around the world during 2015 to solicit input from interested parties. The first of these meetings were held in Newport Beach, California on February 5, 2015, with additional meetings in Rome in March and New York City in May. The IAIS intends to have a second version of the ICS completed by the end of 2015 and, as noted above, for that version to be included in a new version of ComFrame that is expected to be exposed for a formal consultation near the end of the year.

Identification and Regulatory Reaction to Systemically Important Insurers – G-SIIs or SIFIs

"Too big to fail" and "systemically important" are phrases that continued to be hotly debated throughout 2014. In 2013, the FSB designated nine insurance groups as G-SIIs and the Financial Stability Oversight Council (FSOC) designated three US companies as non-bank Systemically Important Financial Institutions (SIFIs). Throughout the year, designees and potential designees debated whether the designations make sense. Both the FSB and FSOC continue to claim that they are considering future designations; however, 2014 did not see an addition to the list of G-SIIs. In fact, the FSB announced on November 6 that it had decided not to revise the existing list of G-SIIs to include reinsurers. This decision, which had already been postponed in May, was further postponed for at least a year (to November 2015) so that the IAIS can further develop the methodology used to determine which companies are so designated. The existing methodology will be revised as necessary to ensure it addresses all types of insurance and reinsurance. Supposedly, the revised methodology will be applied starting in 2016.

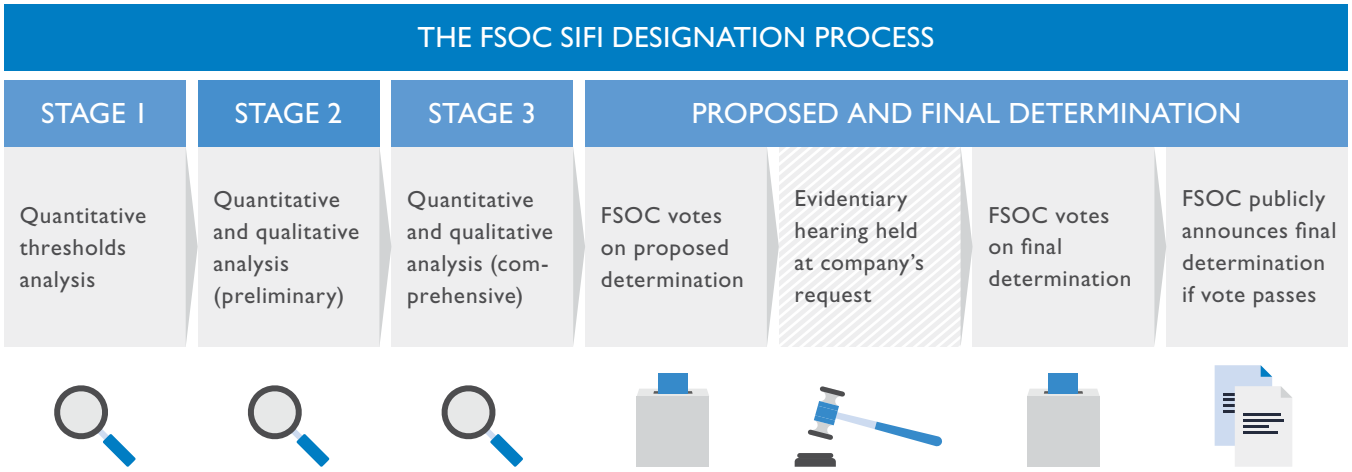
Thus, the initial list of insurance groups as G-SIIs remained unchanged in 2014: Allianz SE, American International Group, Inc. (AIG), Assicurazioni Generali S.p.A., Aviva plc., Axa S.A., MetLife, Inc., Ping An Insurance (Group) Company of China, Ltd., Prudential Financial, Inc. and Prudential plc. However, the year ended in more controversy on the designation issue as the FSOC added MetLife to the list of US SIFIs, over the objection of the FSOC's voting insurance expert, Roy Woodall, and the non-voting NAIC member in December.

In early January 2015, MetLife sued the FSOC in US federal court, seeking to have the designation overturned. MetLife alleges that the FSOC relied on "vague standards and assertions, unsubstantiated speculation, and unreasonable assumptions that are inconsistent with historical experience." The MetLife challenge will likely have far reaching significance. During 2014, neither the FSB nor the FSOC would clarify what additional regulatory rules should apply to this special fraternity of insurers. MetLife's complaint alleges the FSOC's analysis of MetLife (and by

extension the potential systemic significance of MetLife's largely traditional life insurance and annuity business) was arbitrary and capricious. A decision in MetLife's favor, will likely remove any additional speculation that other large US insurers might be designated by the FSOC because, like MetLife, they are simply "too big to fail," whether or not their business activities are truly systemically important. A decision against MetLife might have just the opposite effect and embolden the FSOC to expand the list of US SIFIs to include other insurers.

In addition to the MetLife legal challenge, the FSOC's designation process has been criticized by both parties in Congress and the US Government Accountability Office (GAO). The GAO released a report in November that found problems with the FSOC's data collection and communications during the designation process. The GAO report cited three key areas in which the FSOC could enhance accountability and transparency: (i) tracking and monitoring, including documenting transactions and key evaluation and processing dates to assess the quality of performance over time; (ii) disclosure and transparency, including providing rationales for its determination decisions; and (iii) scope of evaluation procedures, which revealed that the FSOC has used only one of two statutory determination standards to evaluate a company and recommends that the FSOC use both standards to ensure it has identified and designated all companies that pose a threat to US financial stability.

On January 22, 2015, perhaps partly in response to the Congressional oversight, the GAO report and the MetLife challenge, the FSOC announced a number of reforms. The FSOC will change the selection process for identifying SIFIs, create a more standardized process for its annual review of existing SIFI designations and provide an avenue for designees to hear reasons for continued designation. Companies being considered will be notified in the second stage of the designation process instead of the third, thus giving companies a chance to know what public data the FSOC is using to make the decision to designate the company and giving companies an opportunity to respond earlier in the process. The FSOC formally adopted the changes on February 4, 2015.



Source: GAO analyisis of FSOC's final rule and guidance. | GAO 15-51

The Significant Influence of the IAIS Continues

Resolution Planning. In mid-October, the FSB issued a request for public consultation on guidance for the identification of the critical functions and critical shared services for G-SIIs. The guidance would assist national authorities in implementing the recovery and resolution planning requirements set out in the *FSB Key Attributes of Effective Resolution Regimes for Financial Institutions* that would be applied by the IAIS to G-SIIs.

The FSB recognized that the recovery and resolution planning and assessment processes are iterative in nature and will likely require further refinement and adjustment over time as more experience is gained and more issues are identified for deeper examination. Comments were due in December.

Supervisors and industry representatives presented on a panel at the IAIS 21st Annual Conference in October, which discussed several elements of the resolution plans to be required of the nine G-SIIs. Regulators on the panel recognized that insurers are different than banks, but did not want those differences to be overstated, which indicates that the FSB/IAIS will look to the bank framework to develop the requirements for insurer plans. It has been reported that the G-SII plans will be prepared at a group level, although filers also will need to devote significant attention to the resolution of underlying insurance entities. It was also

noted that, except in a few jurisdictions, notably the US, the IAIS initiative to require recovery and resolution plans is not currently have not been adopted into law. Additionally, the participants raised the ever present issue of confidentiality, specifically how to maintain the confidentiality of a plan developed by a multijurisdictional G-SII.

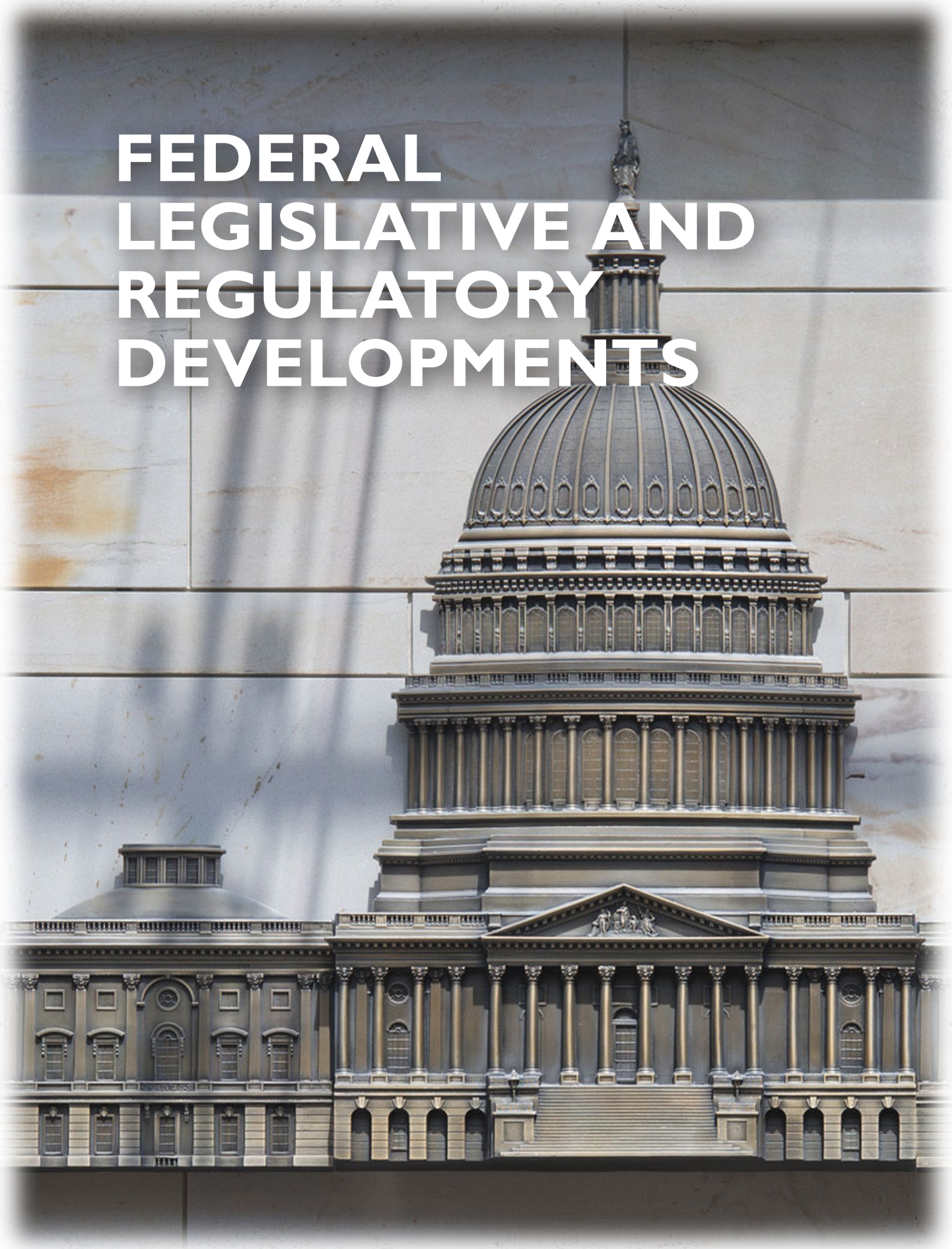
Transparency issues at the IAIS. The IAIS created a firestorm of a public relations problem in the middle of 2014 when it decided to eliminate the observer status from IAIS committee and subcommittee meetings based on the recommendations from the Coordination Group. Secretary General Yoshihiro Kawai insisted that this move was intended to be "part of a larger package of reforms necessitated by the group having to take on new responsibilities, such as developing global insurance capital standards…" Nevertheless, many official and unofficial observers viewed the move as adding an unwanted and unwarranted additional layer of secrecy to the IAIS decision-making process. Secretary General Kawai insists that the IAIS will continue to obtain the appropriate level of industry input because specific insurance companies will be invited to present their views on proposals and initiatives and there will be a new system of "stakeholder" hearings for interested parties to present their thoughts in an open forum.

However, almost without exception, insurers and trade associations around the world, as well as some regulators, most notably the NAIC, decried the IAIS's so-called reform, contending that the stakeholder hearings would not provide interested parties with the opportunity to engage in a dialogue with IAIS decision makers.

IAIS 2014 (AND BEYOND) KEY IMPLEMENTATION DATES

DATES AND TIMEFRAMES	ACTION REQUIRED (OR INTERMEDIATE ACTIVITY)
April to July	IAIS selected expert input in respect of development of BCR.
June to August	IAIS analyzed results from field testing (conducted from March to May 2014) and reflect this and other feedback in BCR proposal and development of factors.
July	Crisis Management Groups (CMGs) established for the initial cohort of designated G-SIIs. Systemic Risk Management Plans (SRMPs) to be completed by the nine G-SIIs.
July	Second BCR consultation period.
October	IAIS approved BCR proposal.
November	FSB and G20 endorsed BCR proposal.
End of 2014	• FSB deferred decision on the G-SII designation of, and appropriate risk mitigating measures for, global reinsurers. • Recover and Resolution Plans, including liquidity risk management plans, for G-SIIs designated in 2013 to be developed and agreed by CMGs.
End of 2015	IAIS to develop implementation details for Higher Loss Absorbency (HLA) that will apply starting from 2019 to those G-SIIs identified in November 2017 using the IAIS methodology.
July 2016	Implementation of SRMPs to be assessed.
January 2019	G-SIIs designated in November 2017 to apply the HLA requirements.

FEDERAL LEGISLATIVE AND REGULATORY DEVELOPMENTS



The evolving insurance regulatory environment coupled with the shake-up in the most recent mid-term elections will make for an eventful 114th Congress. With Republicans now in full control of Congress, further attempts to modify The Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank), as well as more rigorous and coordinated oversight over federal regulatory agencies can be expected. Nevertheless, Congress has shown willingness to support important existing federal programs that were in jeopardy at the end of 2014, such as the Terrorism Risk Insurance Act (TRIA), and the Executive Branch will continue to implement and enforce current insurance and insurance related programs, such as those established under the Patient Protection and Affordable Care Act of 2010 (ACA).

What the 2014 Federal Mid-Term Elections mean for Insurance

The Republican Party swept the 2014 mid-term elections at multiple levels of government. Republicans won control of the US Senate and increased their majority in the US House of Representatives to the highest level since the Great Depression. Republicans also won at the state level, increasing the number of Republican governors to 31 and the number of state houses they control to 69 of 99.

With the balance of power split at the federal level between a Democratic White House and a Republican Congress, conditions are ripe for a tense next two years in Washington, DC. Republicans have promised to demonstrate their ability to govern and President Barack Obama has vowed to take executive action where he deems necessary. Coupled with significant changes in leadership and makeup of the House Financial Services Committees and the Senate Banking Committee, the 114th Congress will be one to watch.

Overview of the outcome of the federal elections.

- There are 54 Republicans in the Senate and 46 in the Democratic caucus (including two Independents). Republicans gained 12 seats in the House and now control the largest GOP majority since 1928.
- Senator Mitch McConnell was elected Senate Majority Leader and Representative John Boehner was re-elected as Speaker of the House.
- Despite Republicans controlling both the House and Senate, they lack a filibuster or veto-proof majority, which will affect what legislation can both pass Congress and be signed into law. President Obama has been up front about his intent to use his position of influence in the legislative process and his ability to take executive action.

US Senate.

- The 114th Congress has 12 new Senators: Shelley Moore Capito (R-WV), Tom Cotton (R-AR), Steve Daines (R-MT), Joni Ernst (R-IA), Cory Gardner (R-CO), James Lankford (R-OK), David A. Perdue (R-GA), Gary Peters (D-MI), Mike Rounds (R-SD), Ben Sasse (R-NE), Dan Sullivan (R-AK) and Thom Tillis (R-NC).

US SENATE		
	DEMOCRATIC CAUCUS	REPUBLICAN CAUCUS
Pre-Election	53 Democrats **+ 2 Independents**	45 Republicans
Post-Election*	44 Democrats **+ 2 Independents**	**54 Republicans**

US House of Representatives.

- The 2014 mid-term elections resulted in the largest GOP majority in nearly a century. Not since Herbert Hoover was President in 1928 have Republicans controlled more than 246 seats. As of publication, Republicans increased their majority by 12 seats, including six special election wins and at least 38 new members.

US HOUSE OF REPRESENTATIVES		
	DEMOCRATIC CAUCUS	REPUBLICAN CAUCUS
Pre-Election	**201 Democrats**	234 Republicans
Post-Election*	**188 Democrats**	**246 Republicans**

*Note: The seat from the 11th Congressional District of New York is currently vacant.

Financial Services/Insurance Committees outlook for the 114th Congress.

House Financial Services Committee

- The current chairman of the House Committee on Financial Services is Representative Jeb Hensarling (R-TX). Representative Maxine Waters (D-CA) returns as the ranking Democrat on the committee. Representative Blaine Luetkemeyer (R-MO) chairs the Housing and Insurance Subcommittee. Representative Luetkemeyer is a former independent insurance agent who is familiar with insurance issues, so we expect it will be a fairly seamless transition as things get under way in the 114th Congress. Representative Emanuel Cleaver (D-MO) is the subcommittee ranking member.
- Three former members of the Committee were elected to the Senate, including Representatives Shelley Moore Capito (R-WV), Tom Cotton (R-AR) and Gary Peters (D-MI). Senator Cotton sits on the Senate Banking Committee.
- Newly appointed members to the House Committee on Financial Services include Representatives David Schweikert (R-AZ), Robert Dold (R-IL), Frank Guinta (R-NH), Scott Tipton (R-CO), Roger Williams (R-TX), Bruce Poliquin (R-ME), Mia Love (R-UT), French Hill (R-AR) and Juan Vargas (D-CA).

Senate Banking Committee

- The Senate Banking Committee faces a major shakeup in 2015 as a result of the mid-term election, retirement and a change in leadership. Three members of the committee retired at the end of 2014, including former Banking Committee Chairman, Tim Johnson (D-SD), as well as Senators Tom Coburn (R-OK) and Mike Johanns (R-NE). Senator Kay Hagan (D-NC) did not return to the Senate in 2015 after losing her race to Thom Tillis (R-NC). In addition to Senator Tom Cotton (mentioned above), the new members named to the committee include Senators Tim Scott (R-SC), Benjamin Sasse (R-NE), Mike Rounds (R-SD), Jerry Moran (R-KS) and Joe Donnelly (D-IN).
- Senator Richard Shelby (R-AL) now chairs the Senate Banking Committee. He replaces Senator Mike Crapo (R-ID) as the senior Republican leader on the Committee. Senator Shelby is a proponent of easing Dodd-Frank regulations, but some claim that he is no friend of Wall Street. He opposed the Wall Street bailout and has supported measures to shrink the size of the largest banks. Despite no longer being the senior Republican on the Banking Committee, Senator Crapo will still remain very active; he was recently named chairman for the Subcommittee on Securities, Insurance, and Investment.
- Senator Sherrod Brown (D-OH) will be the ranking member of the committee, skipping over three Senators who have other leadership positions: Senator Jack Reed (D-RI), Armed Services; Senator Charles Schumer (D-NY), Senate leadership; and Senator Robert Menendez (D-NJ), Foreign Relations. Senator Brown has been a tough critic of Wall Street and a leading proponent of action to end "too big to fail" policies and break up big banks.

Legislative outlook.

- **Dodd-Frank:** The House and Senate committees will consider proposals to revise a number of Dodd-Frank provisions, including proposals to restrict the Consumer Financial Protection Bureau and the FSOC; ease regulations on community banks; and revise the regulations implementing the Volcker Rule. While any of these proposals could pass the House, many, if not all of them, could be blocked in the Senate if Democrats object. Some of the Dodd-Frank reform legislation could secure bipartisan support, thus increasing its chances of passing.
- **Insurance Capital Standards:** Another key development during 2014 related to SIFIs – and other insurers that are subject to prudential oversight by the Federal Reserve (the Fed) because they own banks – was the increase in the number of staff at the Fed to manage these responsibilities, including a new director, former Connecticut Commissioner Thomas Sullivan. A key substantive development on this issue was legislation enacted by Congress late in the year authorizing the Fed to develop insurance-industry specific standards, thereby enhancing the possibility that Fed-supervised insurers will not be directly subject to the Fed's existing bank-centric standards.

  Given the recent passage of *The Insurance Capital Standards Clarification Act of 2014*, the Fed will now begin crafting tailored insurance capital standards for those insurers that are subject to supervision by the Fed pursuant to Dodd-Frank. We expect the House and Senate to conduct oversight over the Fed's rulemaking process to ensure that the proposed capital standards are not bank-centric and that they are appropriately suited for the business of insurance.
- **International Insurance Regulatory Developments:** The House and Senate committees will continue to monitor insurance regulatory developments overseas at the FSB and IAIS. As the IAIS begins to develop the ICS, Congress will continue to pressure the Fed and Federal Insurance Office (FIO) to resist any global capital standard that favors the consolidated, bank-like approach preferred by European regulators. There will also be bipartisan calls to improve transparency at the IAIS, in particular the opacity of the selection criteria for G-SIIs, the lack of due process to appeal those decisions, and the concern

surrounding the IAIS' recent decision to eliminate the "observer status" at the organization.

- **Designation of Non-Bank SIFIs:** Given the controversy surrounding the FSOC's designation of Prudential and MetLife as non-bank SIFIs, oversight over and legislation addressing the non-bank SIFI designation process will be a main focus in the 114th Congress. Some members, including Financial Services Committee Chairman Hensarling, have already called for a one-year moratorium on all SIFI designations so Congress can conduct more oversight over the process. It remains to be seen how the 114th Congress will react to the FSOC's recent announcement of reforms (discussed above) and whether Congress will pursue additional reforms.

- **Cybersecurity:** Cybersecurity will continue to be a major focus of the House and Senate committees heading into the 114th Congress. We also expect the committees to conduct thorough oversight hearings quickly in the new Congress to determine how financial institutions, retailers, technology companies and insurers can work together to protect consumer data. We expect to see various legislative proposals that broadly deal with the cybersecurity threat. In the 113th Congress, members of both parties in Congress introduced approximately 50 cyber-related bills. We expect this to continue; however, recent engagement by the Administration may provide momentum to find consensus in some key areas.

- **National Flood Insurance Program (NFIP):** The committees will conduct oversight of the NFIP and will study proposals to increase the participation of the private sector in the flood insurance market.

- **Terrorism Risk Insurance Program (TRIP):** The committees will also monitor the TRIP (the extension of TRIA), and oversee the implementation of the reforms passed in the recent reauthorization of the Program.

- **Housing Finance Reform:** We expect both the House Committee on Financial Services and Senate Banking Committee to attempt to renew the housing finance reform debate in the new Congress. Nearly all Members agree that the current system of mortgage finance cannot be sustained, but there is considerably less agreement about how the system should be reformed. Chairmen Hensarling and Shelby will more than likely attempt to address this issue in the new Congress, but engagement from the White House will be key to any movement.

These changes will have repercussions in a number of critical areas in 2015, such as TRIA, Dodd-Frank and the efforts to develop international ICS. These political changes will affect regulators, too, as the growing federal insurance bureaucracy at agencies such the Fed, FSOC and FIO are expected to face increased Congressional oversight and may have their original mandates significantly altered. All of this will continue to play out in a stabilizing yet still uncertain and fragile economic climate.

The FIO

The FIO Reinsurance Report. On December 31, the FIO issued a report to Congress regarding the "Breadth and Scope of the Global Reinsurance Market and the Critical Role Such Market Plays in Supporting insurance in the United States," as FIO was obligated to do pursuant to Dodd-Frank. The report was mostly uneventful. It included a lot of basic information defining reinsurance and describing its history, including a number of market statistics, none of which is news to industry insiders. The FIO report, however, made a few interesting points:

- a short but compelling set of statements demonstrating that reinsurers are a very small component of the insurance industry. These statements seemingly indicate that the FIO is going out of its way to note that reinsurers are not systemically important. The report does stress, however, that reinsurers play an important role in the world and US insurance markets.

- a discussion of alternative forms of capital and a discussion of the convergence of capital markets and reinsurance markets.

- a discussion of US collateral reform and the EU-US Insurance Project. The report says that the FIO and US Trade Representative are "considering" a covered agreement to provide for uniform collateral reform. Nice to be noted, but "considering" is not quite the same as pursuing.

Other FIO Activity. FIO continues to be the driving force within the EU-US regulatory dialogue and, more importantly, FIO is also deeply involved at the IAIS. Director McRaith is an active member of the IAIS Executive Committee. He is also the chairman of the important IAIS Technical Committee, which oversees the development of ComFrame, ICS, and many other IAIS policy initiatives. He was also recently appointed Acting Chair of the G-SII Methodology Task Force until such time as a permanent chairperson is chosen. Currently, Director McRaith appears to be sympathetic to those within the IAIS who believe that a new global ICS is needed. The US industry and the state insurance regulators are working with him to develop an alternative to the ICS that might be more acceptable to US interests.

The Federal Reserve

The Fed has emerged as an important voice in insurance regulation. As a result of Dodd-Frank, the Fed has direct supervisory authority as the consolidated supervisor of certain insurance holding companies – those which include insurers which been designated SIFIs by the FSOC, as well as those that own federally chartered thrifts or banks. As of the end of 2014, the Fed supervised approximately one-third of industry assets.

In addition, the Fed applied for and became a member of the IAIS, and is now significant player in that group and the development of the international standards, discussed above.

The Fed's new role as an insurance regulator includes writing the first national capital standards for the insurance industry – a job that has taken Europe a decade – and setting up a system of how to work with the 50+ state regulators who directly regulate the licensed operating insurance entities within the insurance holding companies that the Fed oversees. This raises important questions about the role state regulators will have in this evolving approach to insurance regulation and how the Fed will manage its relationship with the state insurance regulators. The Fed took one step in this direction by appointing Tom Sullivan, a former Connecticut Insurance Commissioner, as senior adviser for insurance to lead the Fed's effort.

As the Fed's regulatory role evolves, many have questioned whether, with its long history as a prudential banking regulator, it will bring a bank centric approach to the business of insurance. Insurers argue that insurance is fundamentally different from the business of banking and that capital rules and regulatory policies appropriate for insurers could be inappropriate, ineffective and unreasonably costly for insurers.

All eyes will be on the Fed in 2015.

The Alphabet Soup of Federal Legislative and Regulatory Developments – TRIA, ACA, FHA and NARAB II

TRIA Expiration, Extension and the Impact on the P&C Market. One of the shocking year-end developments was the failure of Congress to pass legislation renewing TRIA. The 113th Congress adjourned on December 16, 2014, without renewing TRIA, creating much uncertainty in the commercial property insurance market at year end. TRIA's formal expiration followed on December 31, 2014, thus ending the federal backstop for terrorism risk insurance after more than a dozen years of existence. The 114th Congress, however, acted quickly to retroactively extend the Act for six more years until December 31, 2020. On January 7, 2015, the House passed the Terrorism Risk Reauthorization Act of 2015 (H.R. 26) by a vote of 416 to 5, with the Senate quickly acting to pass the House bill by a bipartisan 93-4 vote on January 8. President Obama signed H.R. 26 on January 12, 2015, thus ending the insurance industry's uncertainty and the high political drama about the existence of a federal backstop for the terrorism risk.

Under the six-year reauthorization bill, a phase in of increases in the program's trigger of annual aggregate insured losses will begin in 2016, rising from US$100 million in 2015 to US$200 million by 2020. Over this same time period, the co-insurance share of an insured loss by individual insurers will increase from 15 percent in 2015 to 20 percent in 2020. The amount of losses the federal government may recoup will increase from the current US$27.5 billion to US$37.5 billion in 2020, with the maximum annual rate of recoupment from policyholders increasing over this period from 133 percent to 140 percent.

The bill's provisions also include:

- An advisory committee to encourage insurers to develop private market risk-sharing mechanisms for terrorism insurance. The committee will be composed of nine members from the insurance industry.
- The Treasury Secretary must now consult with the Secretary of Homeland Security rather than the Secretary of State when certifying an act of terrorism.
- Beginning in 2016, insurers will be required to submit insurance coverage information to the Treasury Department so that it could analyze the effectiveness of the program. Treasury is directed to contract with an insurance statistical aggregator to collect the information and keep it confidential.
- Treasury is also directed to complete a study within nine months on the process by which the Secretary determines whether to certify an act as terrorism and thus make losses eligible for coverage under the program.
- The GAO is required to complete a study within two years on the feasibility of assessing and collecting upfront premiums on insurers and on creating a capital reserve fund requiring insurers to dedicate capital specifically for terrorism losses before they are incurred.

The difficulties in reauthorizing TRIA reflect some strongly held views and skepticism regarding the role of the federal government in commercial activities, like insurance. In fact, it has been reported by certain brokers and insurers that the temporary lapse of the TRIA reinsurance backstop has spurred growth in the stand-alone market, with more insurers offering private coverage of the risk and a greater interest in buyers purchasing private insurance. We have seen these sentiments in other federal insurance programs, such as the NFIP, as well as the UK, where Flood-Re coverage will exclude commercial risks and certain residential risks (see discussion below).

On February 4, 2015, the FIO issued interim guidance on TRIA. The interim guidance did not address this issue of whether TRIA would be retroactive to January 1, 2015. Instead, the interim guidance focused on offers of coverage and notices. The FIO intends to replace the interim guidance with formal regulations; however, the FIO did not provide a timetable for doing so. In addition, FIO released a notice seeking public comment regarding potential improvements to the process for certifying an event as an "act of terrorism." Comments must be submitted by March 6, 2015.

The Affordable Care Act (ACA). Compared to the disastrous technical roll out of the ACA, problems with the federal and state health insurance exchanges, and other late term policy changes that cost Democrats political capital and caused collective head-scratching and handwringing by both proponents and opponents in 2013, the 2014 ACA stories have been relatively tame. With the second enrollment period coming to an end and fewer significant legal challenges to the heart of the ACA, the key current ACA issues remain whether the Republican Congress and Supreme Court will chip away at the ACA.

Despite the comparatively quiet year, there were still some surprises in 2014.

- As of publication, there were 9.5 million confirmed enrollments or renewals in qualified health plans on federal or state exchanges in the second enrollment period.
- Vermont decided not to pursue a single payer system.
- More insurers had access to the markets available on the exchange; however, some major insurers have had difficulties. For example, United HealthGroup, the nation's largest insurer, was recently rejected from participating in the California state exchange because of an obscure rule prohibiting insurers that operated at the time of the exchange roll out from

participating in the state exchange until 2017. This rule was subsequently amended to allow such insurers to provide coverage in areas of the state with fewer than three health plan options.

- Marilyn Tavenner, head of the US Centers for Medicare & Medicaid Services (CMS), quietly announced that she would resign at the end of February. Andy Slavitt, who has been the principal deputy administrator at CMS, will move into Tavenner's job on a temporary basis.

While Republicans have mounted a steady stream of legal challenges to ACA, so far the US Supreme Court has upheld the law. The ACA survived one legal challenge in January 2015, when the Court declined to hear a challenge targeting the requirement that adult Americans enroll for coverage or pay a fine. Another case pending before the Court, *King v. Burwell*, may impact the ACA dramatically in 2015. The case centers around whether the ACA authorizes the federal government to offer health insurance subsidies, a key aspect of the law, through the federally run insurance exchanges in the majority of states that have left administration of their exchanges up to the federal government. Oral argument is scheduled for March.

While we wait for the outcome of another US Supreme Court case in 2015, the GOP continues hacking away at ACA in Congress. The House passed a bill that would redefine the workweek for purposes of the act as 40 hours (which is currently 30 hours for purposes of certain coverage requirements). The Senate has yet to act on a companion bill, and the White House said it would probably veto any bill that came its way.

FHA Rule – Housing Discrimination. The Department of Housing and Urban Development (HUD) has long taken the position that practices that have a disparate impact on protected classes violate the Fair Housing Act (FHA), even if those practices are facially neutral. HUD upheld the 2012 rule implementing its disparate impact standard in February 2013 (Rule), rejecting substantive and technical objections to the Rule. Representatives of the insurance industry opposed the Rule on the ground that disparate impact liability is at odds with the risk-based underwriting and rating requirements of state insurance laws. Meanwhile, HUD has continued to rely on the Rule, initiating investigations and supporting complaints against homeowners insurers since 2012.

Immediately after the Rule was issued, the American Insurance Association (AIA) and the National Association of Insurance Companies (NAMIC) filed suit in the US District Court for the District of Columbia, seeking a declaration that the Rule was invalid. In November 2014, the AIA court vacated the Rule in its entirety, finding that the FHA only prohibits disparate treatment and that HUD had no authority to issue the Rule and adopt a disparate impact standard. In addition, the AIA court found that the application of the disparate impact standard to insurers would run afoul of McCarran-Ferguson, which ensures the primacy of state law with respect to insurance regulation. Furthermore, consideration of disparate impact would require insurers to "mak[e] corrective underwriting, rating and pricing adjustments to recalibrate away from risk and towards parity of 'impact.'" Thus, differences in underwriting and rating would no longer be premised on neutral characteristics determined statistically to be predictive of loss, but, rather, would force carriers to base decisions on those very characteristics which they are prohibited by state law from considering.

The US Supreme Court is poised to address HUD's authority in *Texas Dep't of Housing and Community Affairs v. Inclusive Communities Project, Inc.*, which is being argued as of the time of this publication.

NARAB II. In late January 2015, President Obama signed into law a bill re-establishing the National Association of Registered Agents and Brokers (NARAB II), which aims to ease the ability of agents and brokers to sell insurance on a multi-state basis. NARAB II amended the current requirement that an agent and client must live in the same state to do business together. NARAB II was attached to the legislation reauthorizing TRIA.

NARAB II establishes an insurance licensing clearinghouse. To gain membership in the clearinghouse, an agent would need to be licensed in one state, pass a criminal background check and meet other requirements as set by the clearinghouse. Agents and brokers would still be required to pay each state's licensing fee and comply with its regulations.

Industry observers welcomed the passage of NARAB II and anticipate multi-state licensing will be in place sooner than the two-year deadline imposed by the new law. Proponents of NARAB II are optimistic because the work they have done since the Dodd-Frank Act has set the groundwork for implementation of this new law. There is an NAIC model act and states have adopted similar if not more stringent laws. The timing of multistate registration availability depends on how quickly the Senate confirms the 13 NARAB board members, who are appointed by the President.

NAIC AND STATE REGULATORY DEVELOPMENTS

The November elections, yielded 11 new commissioners and some significant changes in the ranks of insurance regulators. These changes come at a time when state insurance commissioners are responding to a number of significant challenges, including the continuing evolution of the FIO and the emergence of the Fed as an insurance regulator and a strong voice on US insurance regulatory policy. At the same time, US regulators are faced with a number of issues on the international front – including international capital standards and group supervisions issues within the IAIS and equivalence issues with our largest insurance trading partner, the European Union.

Impact of 2014 State Elections on Insurance – Commissioners and the NAIC

Gubernatorial Races. As observers of US insurance regulation know, most commissioners are appointed by governors, so elections can change the make-up of US insurance policy-making bodies, including the NAIC.

- **Arkansas:** Republican Asa Hutchinson defeated the Democratic candidate. As a result, former Commissioner Jay Bradford, who was appointed by the outgoing Democratic Governor, was replaced by former Arkansas Representative Allen Kerr on January 13, 2015.

- **Illinois:** Republican Bruce Rauner defeated the incumbent Democrat. As a result, former Director Andrew Boron, who was appointed by the outgoing Governor, stepped down in January. Deputy Director James Stephens temporarily replaced Director Boron and will serve as Acting Director until a new Director is appointed. As of publication, Governor Rauner has not named a new Insurance Director.

- **Maryland:** Republican Larry Hogan defeated the Democratic candidate. As a result, Commissioner Therese M. Goldsmith, who was appointed by the outgoing Democratic Governor, stepped down on January 21, 2015. Commissioner Goldsmith served as the chair of the Market Regulation Accreditation (D) Working Group.

  The newly appointed Maryland Insurance Commissioner is Alfred Redmer. Commissioner Redmer served as the Maryland Insurance Commissioner from June 2003 until late 2005. He assumed office on January 22, 2015 for a four-year term.

- **Massachusetts:** Republican Charlie Baker defeated the Democratic candidate. As a result, Commissioner Joseph Murphy, who was appointed by the outgoing Democratic governor, resigned in late November. First Deputy Commissioner Gary Anderson, a former aide to Massachusetts Senate President Therese Murray and Senator Anthony Petruccelli, will serve as Acting Commissioner until a new Commissioner is appointed. As of publication, Governor Baker has not named a new Insurance Commissioner.

- **Pennsylvania:** Democrat Tom Wolf defeated the incumbent Republican. As a result, Commissioner Michael Consedine stepped down. Commissioner Consedine was the Vice President of the NAIC (hence he was in line to be NAIC president), and was the chair of the NAIC International Insurance Relations (G) Committee. He also served on the Federal Advisory Committee on Insurance, which advises the FIO, and was extremely active on the international insurance regulatory stage. Commissioner Consedine acted as the NAIC's representative to US – EU Insurance Dialogue Steering Committee and was an active participant in the IAIS. His departure, most believe, is a significant loss to the strength of the US regulatory team dealing with international issues and to the NAIC leadership generally.

  The newly appointed Pennsylvania Insurance Commissioner is Teresa Miller. Commissioner Miller served as acting director of the State Exchanges Group, the Oversight Group and the Insurance Programs Group for the Center for Consumer Information and Insurance Oversight, a part of the Department of Health and Human Services. In that role, she helped the federal agency roll out regulations and guidance implementing the private market reforms of the ACA. Commissioner Miller was also administrator of the Oregon Department of Consumer and Business Services' Insurance Division from November 2008 to November 2011. Her appointment signals a possible shift in the state's commitment to the ACA and Pennsylvania potentially moving from a federal exchange state-based health insurance exchange.

- **Texas:** Republican Greg Abbot defeated the Democratic candidate. As a result, Commissioner Julia Rathgeber resigned on January 20, 2015, to become deputy chief of staff in now Governor Gregg Abbott's administration. Governor Rick Perry appointed David Mattax on January 12, 2015. Commissioner Mattax was a top staff member in the Texas Attorney General's Office.

Insurance Commissioner Resignations

In addition, influential commissioners resigned for personal reasons unrelated to election results:

- **Kansas:** Commissioner Sandy Praeger chose not to run for reelection and Ken Selzer was elected as the new Kansas Commissioner. Commissioner Praeger has been the long-time chair of the NAIC Accident and Health Insurance and Managed

Care (B) Committee and led the NAIC's efforts to implement the Affordable Care Act. The loss of her expertise on health insurance regulatory matters will be difficult for the NAIC to replace.

- **Connecticut:** Despite tremendous support from the reelected incumbent, Governor Dan Malloy, Commissioner Tom Leonardi resigned. Commissioner Leonardi served as one of only two US insurance commissioners on the Executive Committee of the IAIS, sat on the IAIS' Financial Stability Committee and also served on the Technical Committee, having the distinction of being the only US regulator to sit on all three IAIS committees at the same time. He was active on more than 15 supervisory colleges for large internationally active insurance and reinsurance groups in the US and Europe. He leaves behind big shoes to fill.
- **South Dakota:** Director Merle Scheiber resigned on December 4. Director Larry Deiter, who had been serving as interim director, was appointed on January 8, 2015.
- **Wyoming:** Commissioner Tom Hersig resigned to enter the private sector. Governor Matt Mead appointed Commissioner Paul Thomas Glause on January 3, 2015.

NAIC: Shakeup in the Leadership. The most significant change to the NAIC has been to the President-elect position. The office was vacated on January 20, 2015, when the Pennsylvania Insurance Commissioner stepped down (see above). A special election was held on February 8, 2015. NAIC members elected Missouri Insurance Director John M. Huff to fill the vacant position. Director Huff serves as the NAIC representative on the FSOC and chairs the Reinsurance (E) Task Force, the Financial Regulation Standards and Accreditation (F) Committee and the new Governance Review (EX) Task Force (which was created in 2014 to review the NAIC's governing documents, practices and procedures).

There was also a significant change to the leadership of the NAIC International Insurance Relations (G) Committee (G Committee). Florida Commissioner Kevin McCarty (who previously served as vice chair) will be chair and Vermont Commissioner Susan Donegan will be vice chair. It is noteworthy that there have been reports that internal Florida politics may impact Commissioner McCarty, so this significant appointment may be in flux.

Newly named insurance commissioners in South Dakota and Maryland have also impacted NAIC committee leadership. Additional changes to the NAIC committee leadership include: the Health Insurance and Managed Care (B) Committee has two new leaders – New Hampshire Insurance Commissioner Roger Sevigny (chair) and Washington State Commissioner Mike Kreidler (vice chair); the Market Regulation And Consumer Affairs (D) Committee has a new vice chair, North Carolina Commissioner Wayne Goodwin; and the Financial Regulation Standards and Accreditation (F) Committee new vice chair will be newly appointed Texas Commissioner David Mattax.

NAIC 2015 OFFICERS

President	Monica J. Lindeen, Montana State Auditor and Commissioner of Securities and Insurance
President-Elect	John M. Huff, Missouri Insurance Director
Vice President	Sharon P. Clark, Kentucky Insurance Commissioner
Secretary – Treasurer	Ted Nickel, Wisconsin Insurance Commissioner

EU – US Insurance Project

The EU-US Insurance Project (Project) began in January 2012 (and was originally called the EU-US Insurance Dialogue). It was an ambitious attempt by key EU and US regulators to review certain key components of regulation in these two important insurance markets.

The Project is led by a Steering Committee that includes three top supervisory officials from the US and three from the EU. The Steering Committee agreed that they should focus their attention on seven key topics considered fundamentally important to a sound regulatory regime and to the protection of policyholders and financial stability:

1. Professional secrecy and confidentiality
2. Group supervision
3. Solvency and capital requirements
4. Reinsurance and collateral requirements
5. Supervisory reporting, data collection and analysis and disclosure
6. Supervisory peer reviews
7. Independent third party reviews and supervisory on-site inspections.

After moving with remarkable speed through early work streams, which resulted in a technical report on the seven subjects, the Project moved into a second phase, which was to try and seek improvements or greater harmonization/cooperation in the seven areas. Two of the most important were group supervision and reinsurance regulation – both are friction points between the US and the EU. With regards to these two areas, the Project leaders identified the following goals:

"Group supervision. The objective is to establish a robust regime for group supervision, under which there is:

1. a clear designation of tasks, responsibilities and authority among supervisors, including a single group/lead supervisor
2. a holistic approach to determining the solvency and financial condition of a group that is consistent with the way companies manage their business, avoids double counting of regulatory capital, monitors risk concentrations, considers all entities belonging to the group and is complementary to solo/legal entity supervision
3. greater cooperation and coordination among supervisory authorities within colleges and
4. efficient enforcement measures at the group and/or solo level that allow for effective supervision of groups.

Reinsurance and collateral requirements. The objective is to work to achieve a consistent approach within each jurisdiction and examine the further reduction and possible removal of collateral requirements in both jurisdictions in order to ensure a risk-based determination for all reinsurers in relation to credit for reinsurance."

As is often the case, when moving from reporting on the status quo to negotiating new rules or agreements, work slows down and political and practical realties set in. Accordingly, although the Project members met this year, there was little substantive progress on their ambitious agenda. It will be interesting to see whether there is a renewed sense of urgency surrounding the Project in 2015 – particularly as the deadline for equivalence assessments under Solvency II draws near.

This interaction by senior EU and US regulators is viewed by many as an extremely important initiative. There are some significant regulatory policy issues on which the US and the EU do not see eye to eye, and the Project provides a forum for these to be discussed in private among regulators with the requisite seniority and technical expertise.

Reinsurance Developments

Status of Adoption of the NAIC Credit for Reinsurance Model Laws. The NAIC revised the Credit for Reinsurance Model Law and Regulation in 2013 to allow the reduction of collateral required to be posted by unauthorized assuming reinsurers that meet certain certification requirements. As of October 21, 2014, 23 states had adopted revisions to their credit for reinsurance statutes and/or regulations.

Qualified Jurisdiction (E) Working Group. Reduced reinsurance collateral requirements apply only to certified reinsurers that are licensed and domiciled in a "qualified jurisdiction." While the designation of qualified jurisdictions is left to the individual states, the Model Law and Regulation provide for the NAIC to create and maintain a list of Qualified Jurisdictions. Individual states must take this NAIC list into account when designating a qualified jurisdiction. In 2014, the NAIC added three jurisdictions to the list. Each state will be designated for five years (absent a material change in circumstances), after which each insurance regulator will be re-evaluated under the provisions of the Qualified Jurisdiction Process.

Reinsurance Financial Analysis (E) Working Group. The Reinsurance Financial Analysis Working Group (RE-FAWG) was formed to establish a peer review process to allow "passporting," a process by which a reinsurer's certification by one state would allow other states to certify that reinsurer without undergoing a separate review and approval process.

NAIC LIST OF QUALIFIED JURISDICTIONS
(as of January 1, 2015)

JURISDICTION	REINSURANCE SUPERVISORY AUTHORITY	LEAD STATE For Regulatory Cooperation and Information Sharing
Bermuda	Bermuda Monetary Authority	Florida
France	Autorité de Contrôle Prudentiel et de Résolution	California will act as the Lead State, on an interim basis, until a bilateral memorandum of understanding with New York has been updated, at which time New York will begin acting as the Lead State
Germany	Federal Financial Supervisory Authority	California
Ireland	Central Bank of Ireland	Delaware
Japan	Financial Services Agency	California
Switzerland	Financial Market Supervisory Authority	Connecticut
United Kingdom	Prudential Regulation Authority of the Bank of England	New York

Captives and Special Purpose Vehicles (SPVs)

NAIC Adopts AG 48. On June 30, the NAIC Principle-Based Reserving Implementation (EX) Task Force (PBR Task Force) held a conference call to discuss comments to the modified recommendations to the report issued by Rector & Associates, Inc., regarding reserve financing transactions (the Rector Report). By the end of December, Actuarial Guideline 48 (AG48) was adopted by the NAIC Executive Committee and Plenary, effective January 1, 2015. AG 48 is intended to be interim guidance for XXX/AXXX reserve financing transactions through captive arrangements until PBR becomes effective.

The following summarizes the NAIC's activity on this topic during 2014:

The PBR Task Force abandoned the hazardous financial condition concept

The original Rector Report suggested that, under the new proposals, if a ceding insurer reinsured business subject to Regulation XXX or AG38 in a manner that did not comply with the new Rector Report requirements, it would be presumed to be in a financially hazardous condition within the meaning of NAIC's Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to Be in Hazardous Financial Condition (Model 385). This designation would provide insurance regulators with the authority to take corrective actions, such as reduce the total amount of present/potential liability for policy benefits by reinsurance; reduce, suspend or limit the volume of business being accepted or renewed; or increase the insurer's capital and surplus. This approach was subsequently debated as some regulators argued that imposing this label on insurers would be too extreme and would have drastic consequences. Additionally, this approach was identified, most notably by the American Council of Life Insurers (ACLI), as potentially being preempted under Dodd-Frank.

Implementation through the AOMR

AG 48 adopted the ACLI's alternative proposal to use the NAIC's Actuarial Opinion and Memorandum Regulation (AOMR) as the "carrying rule." This approach requires that on or after a specified date, a ceding company's appointed actuary must have determined whether the company's primary assets meet the reserve requirements of the NAIC's Valuation Manual Requirements for Principle-Based Reserves for Life Products (VM-20), the actuarial method for determining so-called "economic reserves." If they do not, the appointed actuary is required to provide a qualified actuarial opinion regarding the insurance company.

RBC asset charge

The Capital Adequacy (E) Task Force was charged with amending the RBC instructions to ensure at least one party to the reserve financing transaction holds an appropriate RBC "cushion" when the assuming reinsuer does not file an RBC report using the NAIC formula and instructions; and determine an appropriate RBC asset charge relative to "Other Security." In late 2014, the Life Risk-Based Capital (E) Working Group began to address these charges, including submitting a request to the Valuation of Securities (E) Task Force for RBC charges on assets that do not meet the definition of primary security, and exploring a potential alternative to measure a more precise penalty in the RBC calculation for non-compliance with the required level of primary security. These charges are anticipated to be completed in 2015 to correspond with the timing of adoption of the proposed XXX/AXXX Reinsurance Framework.

Public disclosure

The Blanks (E) Working group was charged with developing reporting requirements for insurers pertaining to reserve financial transactions. This supplemental filing was adopted, effective for filings as of December 31, 2014.

AG 48 CONTAINS THE FOLLOWING KEY COMPONENTS:

- **Economic reserves for policies subject to it must be determined using the methodology that is being developed for PBR and will result in economic reserve amounts that will be higher than the amount of economic reserves calculated in current Triple X and A Triple X transactions**
- **Insurers must hold "Primary Security" equal to the amount of the economic reserves determined using PBR methodology**
- **An insurer's appointed actuary must issue a qualified actuarial opinion when an insurer's Primary Security is less than the required amount and the insurer must establish a liability for the amount of that deficiency**
- **A fourth component of the Rector Report—an RBC charge to the amount of "Other Security" supporting the amount of reserves between an insurer's economic reserves and total statutory reserves—will be addressed by the Life RBC Working Group in 2015**

Captive Litigation. Readers will recall that in July 2012 the New York Department of Financial Services (NYDFS) began an investigation into the use of captives in reinsurance transactions by 80 New York life insurance companies and their affiliated entities. In July 2013, the NYDFS issued its controversial report, "Shining a Light on Shadow Insurance: A Little-Known Loophole That Puts Insurance Policyholders and Taxpayers at Greater Risk" (the Report). The Report took the position that an insurer that reinsures through a captive that is not required to comply with the same reserving requirements applicable to the ceding insurer is an end run around solvency protections, reduces the adequacy of reserves, and fundamentally misstates the ceding insurer's true financial condition. The Report was widely criticized by industry and by other regulators.

Nonetheless, and to no one's great surprise, the Report has now inspired putative class action lawsuits against two of the insurers named in the Report: MetLife and AXA. The first suit, filed against AXA in April, 2014 on behalf of a putative nationwide class of life insurance purchasers, claims that AXA misrepresented its financial condition and failed to disclose its captive arrangements – all in violation of a New York statute that prohibits insurers from making "any misleading representation, or any misrepresentation of the financial condition of any such insurer or the legal reserve system upon which it operates." NYIL s. 4226(a)(4). Relying on the penalty provision set forth in s. 4226, the suit seeks the return of all premium for all members of the putative class.

AXA moved to dismiss the complaint on the following grounds: (i) that class action claims under statutes that impose a penalty may not be maintained as a class action unless specifically authority is granted by the statute imposing the penalty; and (ii) that the court lacked subject matter jurisdiction as s. 4226 applies only to New York residents purchasing New York policies from a New York carrier, thereby destroying diversity. The motion was denied in October 2014 and the case is currently in discovery, with the class certification motion due in February 2015.

Perhaps emboldened by this ruling, counsel for the representative plaintiff in AXA, class action law firm Perkins Coie filed a second action on January 12, 2015 – this time against MetLife. The claims asserted against MetLife are identical to those asserted against AXA and arise out of the contention, borrowed from the Report, that reinsuring through captives subject to less rigorous reserving requirements, is fundamentally deceptive.

Model Holding Company Act and Own Risk Solvency Assessment Update

Over the last few years, the Group Solvency Issues (E) Working Group has been developing the Risk Management and Own Risk Solvency Assessment Model Act (#505) (ORSA); the Insurance Holding Company System Regulatory Act (#440) (HCA Model Act); and the Insurance Holding Company System Model Regulation (#450) (HCA Model Regulation). There are all also tentative accreditation standards, effective January 1, 2016 (provided they are adopted in the requisite number of states). The ORSA was released for a year-long comment period starting January 1, 2014. As of year-end, 20 states have adopted the ORSA Model Act and 38 states have adopted the HCA Model Act (14 states have adopted the correlated HCA Model Regulation).

Corporate Governance (E) Working Group Update

Corporate Governance Model Act. As the culmination of its five-year study of corporate governance practices, the NAIC's Corporate Governance (E) Working Group (CGWG) finalized the Corporate Governance Annual Disclosure Model Act and Model Regulation, which were adopted by the NAIC Executive Committee and Plenary at the Fall Meeting. The models require all insurers to submit a confidential Corporate Governance Annual Disclosure (CGAD) to its lead state and/or domestic regulator by July 1 each year. The models are intended to be effective January 1, 2016.

The models do not mandate the form of the CGAD, but do require insurers to submit information in four key areas:

- Corporate governance framework and structure, including the rationale for the size and structure of the board of directors (board) and the roles of the chief executive officer and chairman of the board

- The policies and practices of the board and key committees, including appointment practices, maintaining independence, the frequency of meetings held, evaluation and performance review of board members and how the qualifications, expertise and experience of board members meet the needs of the insurer/insurer group
- The policies and practices for directing senior management, including a description of suitability standards, the insurer's code of business conduct and ethics, processes for performance evaluation, compensation and corrective action and plans for succession and
- The processes by which the board, its committees and senior management ensure an application of an appropriate level of oversight to the critical risk areas impacting the insurer's business activities.

In completing the annual disclosure, the insurer may reference other existing documents, such as the ORSA Summary Report, holding company Form B or Form F filings, US Securities and Exchange Commission (SEC) proxy statements or foreign regulatory reporting requirements.

The CGWG has recommended that the models become part of the NAIC's accreditation standards. The recommendation was opposed by Florida, which also opposed the adoption of the models, in light of the breadth of the confidentiality provisions of the CGAD. As adopted, the models provide that a CGAD is confidential and is not subject to discovery or admissible in evidence in any private civil action. The accreditation standard recommended by CGWG would require confidentiality protection "similar" to this clause. Florida has taken the position that its legislature declined to adopt a similar provision in the past. The adopted memorandum was referred to the Financial Regulation Standards and Accreditation (F) Committee for consideration.

Model Audit Rule. The CGWG adopted final revisions to the Annual Financial Reporting Model Regulation (Model #205) (known as the "Model Audit Rule"), requiring large insurers to have an internal audit function. The revisions require individual insurers writing more than US$500 million or insurance groups writing more than US$1 billion in annual premium to maintain an internal audit function providing independent, objective and reasonable assurance to the audit committee and management regarding the insurer's governance, risk management and internal controls. The function is required to be organizationally independent from management and required to report at least annually to the audit committee on the results of internal audit activities. The revisions were adopted by the Financial Condition (E) Committee and became effective at the Summer National Meeting upon adoption by the NAIC Executive/Plenary.

The CGWG also adopted a memorandum recommending the Part A Accreditation Standards and Guidelines include the revisions to the Model Audit Rule, stating that the preceding Model Audit Rule has been adopted in some form in every jurisdiction and that making it a Part A accreditation standard will ensure uniformity and consistency for US insurers. The adopted memorandum was referred to the Financial Regulation Standards and Accreditation (F) Committee for consideration.

CGWG Disbands. At the Fall National Meeting, the CGWG voted (and the Financial Condition (E) Committee granted its request) to disband since it had completed its primary charges. The work of the CGWG had been a key component of the NAIC's solvency modernization initiative.

Property and Casualty Price Optimization

The Auto Insurance (C/D) Study Group, led by the former Maryland Insurance Commissioner, was created to review issues relating to the affordability of auto insurance for low-income households. In 2014, the primary activities of the Study Group were focused on (i) creating a compendium of NAIC resources on the availability and affordability of auto insurance; (ii) offering the compendium information to FIO in response to FIO's April 2014 request for comments on how to define affordability in the context of auto insurance; (iii) creating a data-call template directed at obtaining data that presumably would allow states to measure the impact of certain rating factors/characteristics on low-income households; and (iv) the evaluation of certain pricing practices, primarily premium optimization.

The data-call template was particularly controversial. Members of the Study Group questioned its purpose, the use of evidence of disparate impact on low income households as a means of identifying discrimination and whether the template is even within the scope of the Study Group's charge. Equally controversial has been the Study Group's focus on the use of premium optimization in auto insurance pricing. Premium optimization refers to the supplementation of traditional actuarial loss models to include quantitative customer demands in determining price, resulting in adjustments to models by customer segment for certain risk classes. The process takes into account the company's profit and growth goals, resource (capital or operational) limitations, external environment (regulatory/market/competition), brand and reputation and how best to serve target customers.

As the Study Group was entertaining presentations in 2014, the Maryland Insurance Administration (MIA) issued a bulletin informing all property and casualty insurers that premium optimization was a violation of Maryland's unfair discrimination laws because it distinguished between policyholders "on factors other than actuarial risk." The MIA also required all insurers using premium optimization to rate insurance policies in Maryland to file comprehensive corrective action plans by January 1, 2015. At the Fall Meeting of the NAIC, California's representative to the Study Group lauded Maryland's action and advised that California was contemplating issuing a similar advisory.

EUROPEAN REGULATORY AND LEGISLATIVE DEVELOPMENTS

Solvency II Update

Since coming into force in early 2010, the implementation of Solvency II has been hindered by significant and multiple delays. Omnibus II was finally adopted in April 2014, which, among other things, set the deadline for national transposition to March 31, 2015 and the Solvency II application date to January 1, 2016. As of April 1, 2015, national regulators will be empowered to give Solvency II related approvals.

The adoption of Omnibus II made way for the Level 2 measures, which seek to establish detailed implementation rules on those areas specified in Level 1 as being the subject of delegated or implementing acts. In October 2014, the European Commission published the Delegated Regulation, which sets out more detailed requirements to supplement Solvency II.

As expected, 2014 was an extremely busy year for the establishment of additional detail around Solvency II. In addition to the Delegated Regulation, in January 2014, the European Insurance and Occupational Pensions Authority (EIOPA) published its timeline for the delivery of the Solvency II Implementing Technical Standards (ITS) and Guidelines, its objective being to establish the regulatory and supervisory framework for the technical implementation of Solvency II.

Implementing Technical Standards (ITS). The first set of ITS and guidelines covering approval processes were issued for consultation in April and June 2014. These ITS set out the supervisory approval process under Solvency II for Ancillary Own Funds; Internal Models; Group Internal Models; Matching Adjustment; Special Purpose Vehicles and Undertaking Specific Parameters. Generally, the market appeared to support the consultations. Concerns were raised with respect to discretions afforded to national regulators which could lead to uncertainty, and around internal model applications having to incorporate an estimation of solvency capital requirement (SCR) calculated under the standard formula at the most granular level. Concerns were also raised with respect to the number of guidelines published given the January 2016 deadline given that that the guidelines to be issued "should be essential to ensure the appropriate levels of harmonisation across Europe", "complete the meaning of the elements of the directive and delegations acts" or "avoid material inconsistency in the interpretation of those texts." The first set of ITS were submitted to the European Commission for endorsement in 2014. The guidelines were finalized in November 2014 and are due to be published in all official EU languages in February 2015.

On December 2, 2014, EIOPA issued a further 16 consultations on the second set of ITS, which cover Pillar 1 (quantitative basis), Pillar 2 (qualitative requirements), Pillar 3 (enhanced reporting and disclosure) and supervisory transparency. Responses are required by March 2, 2015, other than for responses on the technical advice, which are required by February 18, 2015. The second set of guidelines will also be consulted on in early 2015, submitted to the European Commission by June 30, 2015 and published in all official EU languages by July 2015.

The countdown. With the application date being less than 12 months away, the level to which member states are prepared for Solvency II varies significantly from state to state. Despite the certainty that Omnibus II provided around matching criteria and internal model approvals, timing and appropriate regulator resource still remain a cause for concern, which has resulted in a reduction in number of those looking for internal model approval.

The results of EIOPA's stress test disclosed that generally the insurance sector was sufficiently capitalised under Solvency II. However, the results also confirmed that around 14 percent of firms have an SCR ratio below 100 percent and in a prolonged low yield scenario, 24 percent of firms would not meet their SCR. Solvency II has already driven some merger and acquisition (M&A) activity, reorganizations and exits from markets, and with under 12 months to go until full application coupled with low interest rates, many expect 2015 to be a year of increased market consolidation, run-off and insurance M&A activity.

United Kingdom – The PRA and Legislative Developments

PRA's Supervisory Statements on Schemes and Capital Extractions. September 2013 saw the publication by the Prudential Regulation Authority (PRA) of two consultation papers (CP). CP6/13 set out the PRA's draft statement on the use of schemes of arrangement by general insurers and CP7/13 set out the PRA's draft statement on capital extractions. These consultations caused considerable debate and controversy within the insurance industry.

The PRA's view with respect to schemes set out in CP 6/13 was that:

- an insolvent scheme may be consistent with statutory objectives where it achieves a better outcome for policyholders than other alternatives and
- a solvent scheme will only be compatible with the PRA's statutory objectives where there are compelling reasons to take a different approach to secure an appropriate degree of policyholder protection or where alternative safeguards are put in place to ensure an acceptable level of continuity of cover for dissenting policyholders.

Respondents to the consultation paper queried the PRA's power to approach schemes in the manner it proposed; raised concerns with respect to what appeared to be a hard and inflexible approach by the PRA; argued that it was inappropriate to emphasize continuity of cover; queried whether the proposed

approach related to both general and life business; and raised concerns around the negative impact that such an approach would have on innovation and investment in the UK insurance market, making it less competitive globally.

The PRA's view with respect to capital extractions set out in CP 7/13 was that:

- capital extractions through the life of a run-off weaken the level of protection available for the remaining policyholders.
- capital extractions by run-off firms were of particular concern as such firms have limited access to further capital and fewer available options to restore capital levels in the event that the capital requirement increases. For example, run-off firms are susceptible to unexpected reserve deterioration through changes in the expected frequency or severity of known risks, and historic policy data can make it difficult to estimate future claims.
- A run-off firm's capital is low if it is less than 200 percent of the Individual Capital Assessment/Individual Capital Guidance (ICA/ICG).

Respondents to this consultation paper were concerned that the 200 percent cover of ICA/ICG was deemed to be low; that the approach would deter future investment in the run-off sector; and that options to transfer legacy books would be reduced; and queried the length of time the PRA would take to complete its review following a request for a capital extraction.

The PRA provided its response to the various concerns and queries in the relevant supervisory statements summarized below.

The PRA's Approach to Schemes of Arrangement Proposed by Insurers

This statement provides responses to the feedback on the schemes consultation paper, clarifies the PRA's view of schemes, explains the PRA's role in assessing schemes and gives additional information on the interaction with the FCA.

The PRA reiterates its statement set out in the consultation paper that the use of schemes by insolvent insurers may be compatible with its statutory objectives. However, the PRA has softened its approach to solvent schemes by stating that solvent schemes "may not be" compatible with its statutory objectives, as opposed to "unlikely to be" as stated in the consultation paper.

The PRA acknowledges that it does not approve schemes, as schemes are governed by the process set out in the Companies Act 2006. Nevertheless, the PRA states that it has an interest in the use of schemes because of its statutory objective, and so it will review all schemes proposed by insurers to assess the risks to its statutory objectives and will inform the court of its views on the scheme.

In the event that the PRA objects to a proposed scheme, the insurer may proceed, but the PRA's objection would be a matter to which the court would give considerable weight in deciding whether a scheme is fair and reasonable and should be approved. Going forward, the PRA expects firms that are considering a scheme to inform the PRA in advance, in a way which allows the PRA sufficient time to assess the proposal on its merits.

Although the language in the statement has been softened from that in the consultation paper, it is yet to be seen whether the PRA's approach will in practice reflect the scientism it demonstrated in its consultation paper. The prevailing market concern is that the PRA's approach could effectively end solvent schemes of arrangement for insurers, which will negatively impact the run-off market and result in an increased level of internal run-off legacy books.

Capital Extractions by Run-off Firms within the General Insurance Sector

This supervisory statement clarifies the factors that the PRA expects senior management to take into account when considering making a request to the PRA to extract capital during the course of a run-off, and sets out the PRA's general approach when considering such requests.

The statement also provides feedback on responses received during the consultation period. In particular, the PRA accepted that whether the 200 percent ratio represents a relatively low level of cover can only be assessed on a case by case basis, and that capital extractions may be appropriate in certain circumstances; for example, where claims estimates have developed favorably over a long period and where significant levels of surplus regulatory capital have been generated.

Senior management and boards of run-off firms wishing to extract capital must consider such proposals carefully and be satisfied that solvency levels after the proposed extraction will remain adequate. The PRA expects a run-off firm to:

- undertake a thorough review of its capital position to assess the solvency position after the proposed extraction
- assess its current ICA and consider expected progress of the run-off over (as a minimum) the next 3-5 years based on realistic assumptions, in turn founded on factors such as claims, reserve development and investment income
- seek board approval for the extraction and
- address any concerns the PRA has before implementing of its proposal.

Once the PRA has reviewed the information provided by the firm to support the extraction, it may issue to the firm individual capital guidance specifying the amount and quality of capital it considers appropriate for the firm to maintain adequate financial resources.

As with the statement on schemes, although the language in the statement is softer, it does not represent a significant shift from the approach outlined in the consultation paper. The PRA's approach to capital extractions is much more restrictive than the approach of its predecessor, the Financial Services Authority (FSA), and is based on its view that the run-off market presents additional risks to those posed by the live sector.

Concerns remain that restricting investors' ability to extract capital and increased capital requirements could lead to reduced investor interest in the run-off sector and to legacy books being retained by live insurers, which may not have the resources or skills to proactively manage such books.

The impact of the PRA's approach remains to be seen, but the run-off sector continues to express significant concerns with respect to the PRA's view of the sector and that capital extractions weaken policyholder protection, despite only surplus capital being extracted after stringent solvency requirements have been satisfied.

Legislative Developments. 2014 has seen significant development in UK legislation relevant to the insurance industry.

Insurance Contracts Bill

The UK government is currently sponsoring the progress through Parliament of a bill which will reform and update statute law relating to non-consumer insurance contracts for the first time in a hundred years (it also applies to reinsurance and will have a major impact on the law relating to policies taken out by consumers). If enacted the bill would have far reaching effect in certain areas:

(a). **Disclosure:** it would replace the duty on non-consumer insureds to disclose, before the contract is entered into, all matters that would be considered material by a prudent underwriter with a duty to "make a fair presentation." Under this new duty, a failure to disclose all material circumstances would not necessarily matter if what is provided would put the prudent underwriter on notice that it needs to make further enquiries that would reveal all material circumstances. To qualify as a fair presentation the information would have to be provided in a reasonably clear and accessible manner (no more data dumping). It would also introduce proportionate remedies for failure to make such a fair presentation (currently insurers and reinsurers can avoid a contract completely where there has been material non-disclosure regardless of what they would have done had proper disclosure been given). The duty of disclosure in consumer contracts was abolished in the Consumer Insurance (Disclosure and Representations) Act 2012 (2012 Act).

(b). **Warranties:** under current English insurance law, if a policy term is characterised as a warranty, the insurer can treat itself as discharged from liability following a breach, even if the breach was irrelevant to any loss that has occurred and even if the loss occurs after a breach is rectified. The new legislation would deprive insurers of their right to be discharged from liability in these circumstances. It will also outlaw "basis of contract" clauses which convert pre contract statements (*e.g.* in a proposal) into warranties. Such clauses have been described as "despicable" by the judiciary and have already been outlawed in consumer insurance by the 2012 Act. The warranty proposals would apply to both consumer and non-consumer insurance.

(c). **Fraudulent claims:** the new legislation would provide clarity on the consequences of a fraudulent claim both for the claim itself and for the policy under which it is made; the whole claim would be forfeit and the insurer would have the option to serve notice terminating the cover from the date of the fraudulent claim. Again, the fraudulent claim proposals would apply to both consumer and non-consumer insurance.

While the elements of the legislation relating to consumer insurance are compulsory, it merely sets the default position for non-consumer insurance (save in relation to basis of contract

clauses which would be outlawed completely). This means that its terms can be contracted out of the non-consumer context. Whether contracting out by insurers is commercially viable remains to be seen.

The bill has been the subject of considerable debate in Parliament. There has been significant pressure to introduce a further right for an insured to recover damages from insurers for unreasonable late payment of insurance claims (a measure which was recommended by the UK Law Commission, but which has been resisted by the UK government).

The legislation also fixes technical shortcomings in the Third Parties (Rights against Insurers) Act 2010 (Third Parties Act). The Third Parties Act was intended to make it easier for third parties with liability claims against an insolvent person or entity to seek to recover damages direct under any relevant liability insurance taken out by that insolvent person or entity. The Third Parties Act (which itself was a reform of a 1930 Act of the same name) should, therefore, become law after a hiatus of more than four years.

The legislative process is continuing and the form of the legislation (assuming it makes its way onto the statute book at all) may yet be subject to significant amendment. If enacted before May 2015, the Insurance Contracts Act would likely come into force in late 2016. In the meantime, insurers and reinsurers undertaking business in the London/UK markets and subject to English Law will need to prepare for a new statutory framework where the default position under contract law in terms of disclosure obligations and remedies will have been significantly re-balanced in favour of insureds. That will have significant consequences for (a) underwriting departments in relation to the training of underwriting staff and the drafting of underwriting guidelines, policy wordings and proposal forms, and for (b) claim teams in relation to understanding a whole new environment of rights and remedies.

Flood-Re and the Water Act 2014

In May 2014, the UK Parliament enacted the Water Act, which included provisions for the establishment of a compulsory reinsurance scheme. Under this scheme, cover for the flood risk element of home insurance policies can be ceded to Flood Re, a reinsurer set up under the Act. Flood Re will be funded by a combination of a 2.2 percent levy on all UK home insurance premiums and premiums at capped rates for high flood risk properties which are reinsured under the scheme. In December 2014, following agreement between Flood Re and the UK government, it was confirmed that Flood Re cover would be available for all but a small number of high value residential properties in the UK. Commercial property, including for small and medium size enterprises, and residential properties constructed after 2009, would be excluded.

Work is currently continuing on the detail of the scheme and it is expected that Flood Re will be fully up and running and offering reinsurance cover for properties within the scheme in the second half of 2015. When in place, it is hoped that Flood Re will provide a long term solution to the problem of providing home owners with flood cover. The UK insurance industry and government have been wrestling with this issue since 2007.

Italy

On June 24, 2014, Decree 91/2014 (the so-called Competitiveness Decree) was published in the Official Gazette. The decree aims to foster the growth of Italian companies through facilitating access to new sources of financing. It introduces a new category of asset to cover the technical reserves of life and non-life insurers, which can now also include facilities disbursed to entities other than individuals and micro-companies. The measure will become effective only once the Italian insurance supervisory authority, Istituto per la Vigilanza sulle Assicuazioni (IVASS), has issued specific rules outlining the conditions and limits for recourse to this type of investment.

On September 3, 2014, public consultation regarding the draft measure containing the rules on the type of investment concerned closed. This measure will amend IVASS Regulation 36/2011 in the matter of technical reserves.

Financing activity by insurers – main conditions. The following conditions will apply:

- Borrowers must be identified by a bank or financial intermediary duly entered in the register provided for in Article 106 of Decree-Law 385/1993. If borrowers are identified directly by the insurer without a bank's involvement, prior IVASS authorization of the investment will be required.
- The bank or financial intermediary must have a significant economic interest in the transaction up to the moment that it is completed.
- The company's system of internal controls and risk management must be adequate to enable a full understanding of the risks – especially credit risks – connected to this category of asset, although this requirement of understanding does not entail a true assumption of the credit risk.
- The company must have an adequate level of capitalization.
- The facilities should be disbursed to companies through the signing of debt securities (*e.g.*, corporate bonds, either maxi or mini) or credit instruments (*e.g.*, listed shares), as has been demonstrated by the minister of economic development.

As the Italian Association of Insurance Companies has pointed out, the condition that identification of the borrower rest with the bank or financial intermediary might discourage insurers

which intend to use their own internal structures to identify borrowers. Most importantly, this condition is not contemplated by any of the jurisdictions which allow insurers to disburse loans directly.

Other proposed amendments to IVASS Regulation 36. The proposed amendments to IVASS Regulation 36 are primarily designed to expand the opportunity for insurers to invest and diversify their investments, with a view to facilitating access to financing.

In addition to the new rules governing financing activity by insurers, the most noteworthy new provisions are as follows:

- Investments in equity securities not traded on regulated markets now include securities issued by limited liability companies whose financial statements are subject to certification. The requirement that certification be held for the past three years has been removed. The same provision on the certification of financial statements has been extended to corporate debt securities not traded on regulated markets.
- With reference to alternative investments, the limit of 5 percent of the technical provisions relating to the overall assets belonging to Classes A5.2(a) and A5.2(b) has been removed, while it has been confirmed that the general limit of 10 percent applies to the entire general class.
- IVASS may allow companies to invest in assets other than those provided for in Regulation 36 and in excess of the quantitative limits established in this regulation. Following a company request (to be supported on reasonable grounds), authorization will be granted for one or more investments, provided that:
  - the company demonstrates its ability to assess and manage risk
  - there is consistency between assets and liabilities and
  - the company complies with the solvency requirements, even in the medium to long term (also taking into account the absorption of regulatory capital that these investments will require under the new EU Solvency II regime).

Lending by Insurance Companies. Law Decree no. 91 of 2014 added the following provision to paragraph 2 of article 114 of Legislative Decree no. 385 of September 1, 1993 (Consolidated Law on Banking or TUB): "2-bis. Italian insurance companies and [business credit insurers] (Sace) shall not carry out any kind of financing activity with the public, other than the granting of guarantees and only to subjects that are not physical persons or microenterprises, as defined in art. 2, paragraph 1 of the Annex to Recommendation 2003/361/EC of the European Commission of May 6, 2003, within the limits set by Legislative Decree no. 209 of September 7, 2005, as amended by this Law, and related implementation provisions issued by IVASS."

On October 21, 2014, IVASS approved the amendments to Regulation no. 36/2011 dealing with investments to cover technical reserves, providing in fact that insurance companies can provide loans to enterprises within the limits and under the principal terms (some of which were anticipated in one of our previous "focus" issues) summarized below:

- the amount of each loan must not exceed, as regards the share of the insurance company:
  - 20 percent of the amount of net equity shown in the last financial statements of the borrowing company or
  - 1 percent of the technical reserves of the insurance company
- 4 different categories of loans are envisaged:

  A2. 2a) direct loans selected by a bank or a financial intermediary that possess all the characteristics on the quality of the borrowers and the relationship with the intermediary (admissible within the maximum limit of 5 percent of technical reserves to be covered):

  (a) the bank withholds a percentage of at least 50 percent of the loan and is entitled to the same rights as those of the insurance company (as regards interest and repayment of principal)

  (b) the borrowers have a high degree of creditworthiness and

  (c) the financial statements of the borrower are audited.

  A2. 2b) direct loans selected by a bank or a financial intermediary but that do not possess all the characteristics on the quality of the borrowers (admissible within the max. limit of 2.5 percent of technical reserves to be covered).

These are loans where the bank withholds a percentage of at least 50 percent of the loan and is entitled to the same rights as those of the insurance company (as regards interest and repayment of principal) but where one or both of the conditions provided in letter (b) and (c) above do not apply

A2. 2c) direct loans selected by a bank or a financial intermediary that does not possess the characteristics relating to borrowers and the relationship with the intermediary (allowed within the max. limit of 1 percent of technical reserves to be covered).

These are loans where none of the conditions provided in letters (a) through (c) above apply.

A2. 2d) direct loans not selected by a bank or a financial intermediary (allowed based on a specific authorization by IVASS).

IVASS can authorize the autonomous carrying out of the activity entailing the identification of potential borrowers of direct loans following the evaluation of the activity plan, taking account (inter alia) of:

- a Solvency Capital Requirement in excess of the Minimum Capital Requirement and
- measurements of capital absorption for direct loans that are the subject of evaluation to be made with a view to the future supervisory regime defined by Directive 2009/138/EU (Solvency II).

Poland

The Polish insurance market in 2014 saw the introduction of many pro-consumer reforms, which seems to be the beginning of a general trend that is expected to continue into 2015.

Unit-linked products. In 2014, Poland's Office of Competition and Consumer Protection (UOKiK) imposed fines totaling PLN-50,414,411 on four financial institutions (one insurance company and three intermediaries) for violating the collective interests of consumers in the sale of complicated unit-linked products. UOKiK concluded that the companies misled consumers by withholding information on the products (referred to in Polish as polisolokaty), as well as information on the rights and obligations of both parties under the contracts concluded with the customers. The decisions are not final yet and are subject to appeal. The Polish regulator's actions are in line with the general plans of the European Commission and EIOPA to regulate the offering of insurance (and in particular unit-linked products) in a way that strengthens the rights of customers in their relations with insurers.

KNF guidelines for insurance companies. *In 2014, the Polish Financial Supervision Authority (KNF) decided to regulate the process of offering insurance products (in particular bancassurance) and it issued special guidelines for banks (Recommendation U on best practice in bancassurance) and for insurance companies (Guidelines). According to these regulations, insurers should only pay remuneration to entities offering insurance products, if they are professional insurance intermediaries. Both regulations will come into force in 2015.*

Further, in December 2014, the KNF issued 21 guidelines for insurance companies on claim adjusting in the motor insurance sector (due to come into force in 2015). These guidelines concern the organization, management, supervision, control of the claims adjustment process and the methods for calculating damages. According to the guidelines, the insurer will be required to meet deadlines for compensation payments and the customer will receive full information about the claims settlement process.

The KNF wants all insurance companies to apply the same standards in settling claims and it believes that the guidelines will enhance prudent and sustainable management in the insurance sector. However, the insurance sector is afraid that the implementation of these motor insurance guidelines could result in an increase of insurance costs by up to 40 percent.

In 2015, the insurance market expects more guidelines to be announced, as both EIOPA and the KNF are very active in this field.

It should also be noted that in 2014 the KNF announced the Principles of Corporate Governance for Supervised Institutions, which came into force on January 1, 2015. These set out guidelines for the internal and external relations of supervised institutions, including their relations with shareholders and clients, their internal organization, internal supervision and key internal systems and functions, as well as principles relating to cooperation with statutory bodies.

Claims Handling. In 2015, for the first time, Polish drivers will have the opportunity to make use of direct claims adjustment offered by several insurers (referred to as BLS). Instead of the injured party having to seek compensation from the insurer of the driver who caused the accident, the injured party's insurer will take care of the damaged car directly. This process is much simpler for motor insurance customers. As a consequence, the Polish Insurance Association (*Polska Izba Ubezpieczeń*) is currently working on a set of agreements for direct claims adjustment for the whole market with the aim that they become common practice in 2015. It is said that the introduction of direct claims adjustment should put an end to the price war in the Polish motor insurance market as the quality of assistance should become more important to the client than the total price of the motor insurance.

On the one hand, these changes in the Polish insurance market will make it more customer friendly, but, on the other hand, it means that 2015 will be a difficult year for Polish insurers who will have to adapt to the new regulations and bear the related costs.

ASIAN REGULATORY DEVELOPMENTS

China

State Council Issues New Guideline To Accelerate Insurance Development. On August 14, State Council promulgated Several Guiding Opinions Regarding Accelerating the Development of Modern Insurance Services (the New Guideline). The New Guideline is deemed as the essential impetus to the Peoples Republic of China (PRC) insurance industry. Compared with the original Guideline, the New Guideline has two significant traits. On one hand, it specifically defines the orientation of insurance industry from the perspectives of national governance system and modernization of governance capacity. On the other hand, it expressly emphasizes the significance of innovation and reform in the development of insurance industry. Overall, it releases good signals for the development of insurance industry in China.

Revised Insurance Law. Along with the reform of PRC Company Law, the Insurance Law was amended by Standing Committee of the National People's Congress on August 31. The amended Insurance Law (2014) raises the criteria for investors aiming to be majority shareholders of an insurance company, expands the business scope of insurers, broadens the areas in which insurance funds can invest, and covers changes involving operating and funding rules, supervision and management, and legal responsibility. Several of them represent ratification of regulations passed by the China Insurance Regulatory Commission (CIRC), the insurance industry regulator in China, in recent years that are not yet included in the legislation.

New M&A Rules for Insurance Companies. China's insurance sector has been heavily regulated by the government, with restrictions that have made it difficult for foreign insurers to expand and achieve scale. Since 2013, the CIRC has launched a series of initiatives to liberalize the insurance market. The most recent development of significance is the release of the Circular on the Administrative Measures for Mergers and Acquisitions of Insurance Companies (the M&A Measures), which took effect on June 1.

The M&A Measures aim to accelerate restructure within the insurance market in China and create a more flexible regulatory environment for both foreign and domestic insurers looking to acquire their competitors.

Highlights of the M&A Measures are:

- **Companies to which the M&A Measures apply.** As clarified in an official statement published on CIRC's website, the M&A Measures mainly apply to the merger and acquisition of insurance companies that are established in China, including pure domestic insurers and foreign-invested insurers (the Target Company). The M&A Measures do not regulate equity investment in overseas insurance entities.
- **Types of Mergers and Acquisitions that are covered.** The M&A Measures regulate the following types of Target Company acquisitions:
  - The buyer acquiring more than 1/3 of the equity in a Target Company (either cumulatively or via an one-off acquisition) and becoming the largest shareholder of the Target Company; or
  - The buyer acquiring 1/3 or less of the equity in a Target Company (either cumulatively or via an one-off acquisition) and becoming the largest shareholder and *de facto* controller of the Target Company (collectively, the Acquisition).

  The Acquisition covers acquisition by the buyer, its associated persons and persons acting in concert. The M&A Measures fail to define 'associated persons' and 'persons acting in concert', but specifically provide that (i) persons who have had an association relationship with the buyer within the 12 months preceding the execution of the acquisition agreement will be deemed to be 'associated persons'; and (ii) two or more investors investing in the same Target Company within the span of three months will be deemed to be 'persons acting in concert' unless there is evidence to the contrary.

  The M&A Measures also regulate the merger of two or more Target Companies (the Merger).
- **Relaxation of Certain Restrictions.** When compared to the old regime, the M&A Measures relax certain restrictions previously imposed on the acquisition of insurance companies, including:
  - **Acquisition competitors.** According to the Administrative Measures on Equity of Insurance Companies, an insurer could only have a stake in one peer competing in the same market segment. The M&A Measures relax such a restriction and allow an insurer to acquire two competitors (subject to CIRC approval).
  - **Source of funding.** The M&A Measures also relax previous restrictions on using bank loans to finance Acquisitions. With CIRC's approval, an acquirer may now finance up to 50 percent of the monetary acquisition price with credit facilities.
  - **Qualification of the acquirer.** One of the shareholder qualifications set out in CIRC Circular [2013] No.29 is that any shareholder intending to hold more than 20 percent equity in an insurance company must have already invested in such company for a minimum of three years. This restriction has now removed by the M&A Measures for any Merger or Acquisition (subject to CIRC's approval).

- **Three-year Lock-up Period.** The M&A Measures echo the restriction set out in CIRC Circular No. 29 that the acquirer is not allowed to transfer its equity in the Target Company for three years following the Acquisition. However, the M&A Measures provide examples of exceptions to this rule, such as equity transfers for the purpose of risk management or transfers among entities that are controlled by the same enterprise.

- **CIRC's Review of Mergers and Acquisitions.** The M&A Measures require the Target Company to apply to CIRC for a review of any Merger or Acquisition. For an Acquisition, the application documents include, among other things, an acquisition plan (containing a feasibility study, details of the transaction structure, acquisition fund resources , the payment method, etc.), information on the acquisition price and pricing mechanism, merger control clearance (if needed) and opinions from professional intermediary agencies.

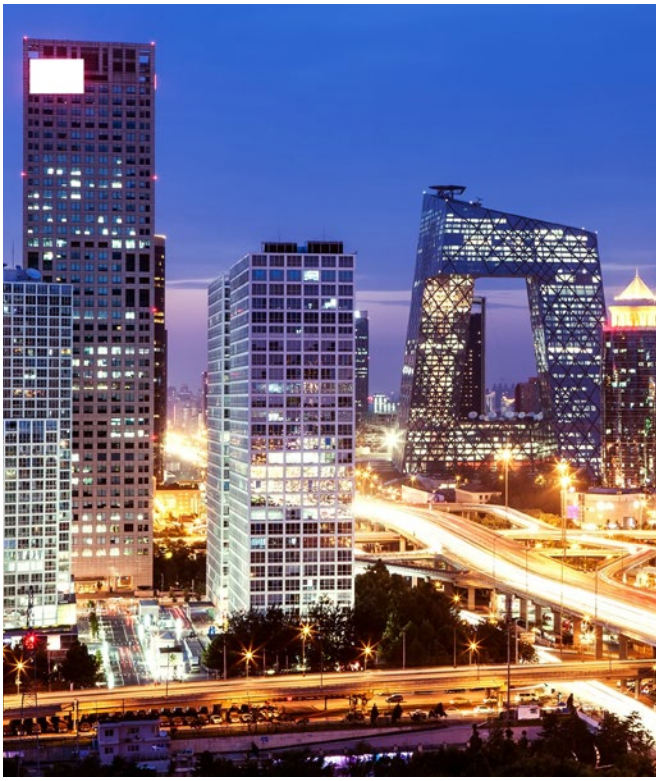
  The M&A Measures do not provide further information on CIRC's review procedure. According to the official statement published on CIRC's website, CIRC will follow the existing approval procedures applicable to equity transfer and change of registered capital for insurance companies when reviewing Acquisition applications. The website also indicates that the current approval procedures on the merger of insurance companies will be applied to CIRC's review of any Merger.

Unification of Investment Ratios. As part of its effort to streamline and improve the regulatory supervision on proportional use of insurance funds and to further liberalize insurance fund investment, the CIRC promulgated the Circular on Tightening and Improving Supervision on the Proportional Use of Insurance Funds on January 23 (the Circular).

Previously, there were around 50 ratio requirements on insurance fund investments into different fields/categories, which were scattered across a variety of CIRC regulations. The CIRC has now developed a multi-level, user-friendly ratio supervision framework for insurance fund investment, by consolidating and streamlining all investment ratio requirements into one single regulation. A much welcomed result, the number of investment ratios are now significantly cut down to about 14, and the investment strategies of market players are further liberated.

In a nutshell, under the Circular, the CIRC:

- defines five asset classifications (*i.e.* liquid assets, fixed-income assets, equity assets, real property assets and other financial assets) for investments with insurance funds
- provides three categories of ratios, namely general asset supervision ratios, concentration risk supervision ratios and risk monitoring ratios



- requires insurance companies to establish a robust internal control system on investment diversification, risk control and liquidity risk management so as to implement requirements under the Circular
- specifies the supervisory measures to take when incompliance or serious operational risk exists that may trigger instability and
- makes it clear that the investment ratios will be reviewed at regular intervals and adjusted when needs arise.

Under the Circular, the assets for investment by insurance companies (excluding assets in independent accounts) are classified into five types: liquid assets, fixed-proceeds assets, equity assets, real property assets and other financial assets.

To mitigate systematic risks, the Circular has set certain upper limits on insurance fund investments to major asset categories. To avoid risk arising from concentration, the Circular has also set the upper limits on insurance fund investments in a single asset or with single transaction counterparty.

The new classification of five general asset categories and uniform ratio requirements under the Circular is a more systematic approach for the regulator to supervise, and for the insurance companies to observe, the investment rules. In contrast, prior to issuance of the Circular, there was no uniform defined general categories for investments, and different investment limitations applied for different specific categories.

The CIRC will require rectification within a specified timeframe if an insurance company breaches any of the above ratios. If the investments exceed the required limits due to certain

emergencies, an insurance company should not further increase such investments and should report to the CIRC within five working days after the occurrence of such events, and should adjust its investment ratios within a timeframe required by the CIRC.

In principle, an insurance company may determine the investment portfolio on its own so long as the investments are within the permitted scope and meet the various ratio requirements under the general categories control and concentration control.

However, for the purposes of monitor and mitigate liquidity and fluctuation risks, the CIRC has set monitoring ratios in accordance with insurance companies' liquidity status, scale of financing and asset type.

The CIRC may regularly review and adjust from time to time on an as needed basis the classification of investment assets, their respective definitions, and their types and related ratios, so as to factor in ever changing market practice and to supervise effectively and efficiently in the real world. It would be a reasonable expectation that the supervision of insurance fund investment regimes will be more proactive and evolving constantly (sometimes on a trial and error basis), and market participants are advised to stay alert to prepare themselves for changes to come.

Indirect Supervision on Non-insurance Subsidiaries of Insurance Companies. In recent years, the insurance companies control, through direct or indirect investments with complicated legal structures, a large number of non-insurance related subsidiaries in wide spread industry sectors that are not subject to the supervision of the CIRC. To better regulate the investment activities of insurance companies with an aim to mitigate financial and reputational risks that may be involved in these investments, the CIRC released the Interim Measures for the Administration of Non-insurance Subsidiaries Affiliated with Insurance Companies (the Subsidiary Measures) on September 28.

Under the Subsidiary Measures, non-insurance subsidiaries affiliated with insurance companies refer to those domestic and overseas non-insurance companies that are directly or indirectly controlled by insurance companies, and mainly include four types: banks, securities, trusts and other financial institutions; service-sharing companies that undertake part of the function of insurance companies; related industry companies that are formed by investing in upstream and downstream industry chains of the insurance industry; and other companies with no business relevance.

The Subsidiary Measures particularly regulate five types of behavior of insurance companies in relation to their investment and management of non-insurance subsidiaries, including investment and management; supervision; internal transactions; outsourcing; and construction of firewalls.

Hong Kong

Consultation Paper on a Risk-based Capital Framework for the Insurance Industry in Hong Kong. On September 16, 2014, the Office of the Commissioner of Insurance (OCI) announced the publication by the Insurance Authority (IA) of a "Consultation Paper on a Risk-based Capital Framework for the Insurance Industry in Hong Kong" (the Consultation Paper). The Consultation Paper sets out detailed proposals of changes to the existing regime towards establishing a risk based capital (RBC) regime.

In 2011, the IAIS, of which the IA is a member, issued new Insurance Core Principles (ICPs) in relation to RBC requirements with which IA must comply as soon as practicable to move towards an RBC regime.

It is proposed that the establishment of a RBC regime will take place in four phases:

I. Development of framework and key approaches – the Consultation Paper published on September 16, 2014 is the first step in this phase.

II. Development of detailed rules – beginning in 2015/2016, this will be followed by another round of consultation. A quantitative impact study will be conducted for different types of insurers to ensure that the new regime is viable and practicable for the insurance industry.

III. Amendment of legislation – it is envisaged that this will require at least two to three years to complete, including public consultations.

IV. Implementation – the new RBC regime will be rolled out with sufficiently long run-in period, to allow industry practitioners enough time to properly understand the new requirements and achieve full compliance with the new regime.

The current regime. The current regime for Hong Kong's insurance industry is essentially a rules-based capital adequacy framework, with capital and solvency requirements stipulated in the ICO and guidance notes issued by the IA.

Under the existing regime, capital adequacy of an insurer is based on the excess of assets over liabilities against the required margin of solvency. Generally, the solvency margin requirements are proportional to the business volume and size of reserves. All insurers are required to maintain assets in excess of liabilities by at least the solvency margin stipulated under the ICO, being 100 percent. However, for monitoring purposes, the IA requires general insurers to maintain at least 200 percent solvency margin and long-term insurers to maintain at least 150 percent solvency margin. If an insurer's solvency level falls below these thresholds, the IA can take regulatory measures on solvency grounds.

In addition to capital adequacy, the existing rules, regulations and guidance notes provide a governing framework for insurers in relation to their corporate governance practices, valuation methodologies, investment activities and public disclosure obligations. There is currently no explicit enterprise risk management (ERM) requirement, although the IA has issued a guidance note (Guidance Note on Asset Management by Authorized Insurers, GN 13) to provide some guidance on issues of risk management on business operations and investments.

The proposed RBC regime. The focal point of a RBC framework is to make capital requirements risk-sensitive, so that insurers that present greater risk to policyholders must carry more capital.

While the details of the proposed regime are yet to be decided and require further discussion and consultation, the IA has proposed various changes under Three Pillars:

Pillar 1: Quantitative Aspect. Proposed changes include:

- A total balance sheet approach in the assessment of capital adequacy requirements
- Expansion of the current regime to include two explicit solvency control levels: (i) the prescribed capital requirement (PCR) and (ii) the minimum capital requirement (MCR). A breach of either of these levels would trigger intervention by the IA. Details of how the PCR and MCR should be calculated requires further consultation
- A standardized approach (*i.e.*, set down by the IA and to be adopted by all insurers) to determine regulatory capital requirements, while retaining the flexibility to allow internal models (*i.e.*, models created and adopted by individual insurers) subject to approval by the IA
- The standardized and/or internal approach for determining capital requirement is to be based on specified broad categories of risk, being (i) underwriting risk (ii) credit risk (iii) market risk and (iv) operational risk. Other risks not captured by these broad categories (such as liquidity risk, legal risk and reputational risk) are to be assessed through strong risk assessment processes
- Stress-test based approach (specifying a set of stresses and modeling the impact on assets and liabilities) to be adopted for (i) the underwriting risk of long term business and (ii) market risk of all insurers;
- Risk-factor based approach (specifying a set of capital charges and applying that to key risk drivers) to be adopted for all other risks
- A "tiering" approach to assessing the ability of capital resources to absorb losses, categorizing capital resources into different classes of quality (tiers) and applying certain limits/restrictions with respect to these tiers
- The measurement and valuation bases for determining capital adequacy should be the same as those used in general purpose financial statements prescribed by the HKFRS or IFRS (with adjustments as needed)
- Adopt an economic valuation (which reflects the risk adjusted present value of the underlying cash flows being valued) for all classes of business except Class G of long-term business (such as retirement scheme contracts or Occupational Retirement Schemes). Class G long-term business will retain the valuation basis set out in the Guidance Note on the Reserve Provision for Class G of Long Term Business (GN 7).

Pillar 2: Qualitative Aspect. Proposed changes include:

- Enhanced corporate governance with more detailed requirements on internal controls and risk management than those under the current regime
- Enhanced ERM by requiring all insurers to put in place effective ERM frameworks that provide for the identification and quantification of risks with Asset-Liabilities Management policies incorporated
- Own Risk and Solvency Assessment (ORSA), a strategic analysis process that links the outputs of risk, capital and strategic planning to determine the current and future capital requirements of an insurer, should be amended to include continuity analysis, stress and scenario testing and reverse stress testing
- The rationale, calculations and action plans connected with the performance of ORSA should be formally documented into a report which should be submitted to the IA annually for review.

Pillar 3: Disclosure and Transparency. Proposed changes include:

- Enhanced disclosure requirements by requiring insurers to make public periodically reports on their capital resources and capital requirements
- To obviate any issues relating to publicizing sensitive, firm-specific information regarding risk and capital, these disclosure requirements will be phased in
- Further consideration in Phase II of whether and what information should come under the scope of external audit.

Group-wide supervision. The Consultation Paper also sets out proposals relating to group-wide supervision of insurers that have onshore and offshore operations, as well as group and sub-group operations. The IA proposes to adopt a three-tier group-wide supervision approach. Determining which one of the three tiers that will apply to a solo entity and its group will depend on the structure of the group in question.

The proposed move towards a RBC regime would see Hong Kong moving in line with the EU, whose Solvency II regime is scheduled to be implemented in all 27 Member States from January 1, 2016. As demonstrated above, the proposed RBC regime is very similar to Solvency II, which is also a risk-based system based on the same three Pillars of Quantitative (capital requirements), Qualitative (corporate governance and supervision) and Disclosure and Market transparency. It will also see Hong Kong becoming more aligned with international insurance standards, such as Singapore and Australia, which already have adopted a similar risk-factor approach.

Health Protection Scheme in Hong Kong. In 2008, the Hong Kong government conducted the first-stage public consultation on healthcare service reforms and six possible supplementary healthcare financing options. On October 6, 2010, the Hong Kong government launched a second stage consultation to seek views from the community on the proposals to set up a voluntary and government-regulated Health Protection Scheme (HPS). A Working Group and a Consultative Group were set up under the Health and Medical Development Advisory Committee to formulate detailed proposals for the HPS. On December 15, 2014, with reference to the proposals made by the Working Group and the Consultative Group, the Hong Kong government initiated a three-month public consultation to consult the public on implementing a government-regulated, market-operated Voluntary Health Insurance Scheme (VHIS).

Aims of the VHIS. The VHIS aims to facilitate the greater use of private health services as an alternative to public healthcare and to provide wider choices to those who are able and willing to pay for private healthcare and to relieve pressure on the public healthcare system. In terms of addressing the inadequacies of existing private health insurance sector, VHIS aims to improve the transparency and price levels in the healthcare insurance market through the offering of packaged charging for common medical procedures. It also aims to enhance consumer protection and confidence as well as to assure quality of healthcare services in the market.

Individual hospital insurance under the VHIS. The individual indemnity hospital insurance products (the Standard Plan) to be offered under the VHIS must meet 12 mandatory minimum requirements (the Minimum Requirements). They are designed to provide the insured individuals with benefit coverage and reimbursement levels that would enable them to access a general ward class of private healthcare services when needed, as well as enhancing the quality and transparency of hospital insurance. The Minimum Requirements would only be confined to indemnity hospital insurance products, which are designed to cover the actual hospital charges and related medical expenses incurred by a patient. It is proposed that insurers offering indemnity hospital insurance products must make a Standard Plan available as one of the options to consumers.

VHIS also ensures the insurer retains freedom to structure their own health insurance plans by offering top-up benefits known as Flexi Plan and Top-up Plan. Flexi Plan is a single product that combines the Minimum Requirements with the enhanced benefits (*e.g.*, higher benefit limits, higher ward class). On the other hand, a Top-up Plan provides benefits other than in the nature of indemnity hospital insurance plan and may be attached as a rider or form part of a Standard Plan or a Flexi Plan.

The government also proposes to set up a High Risk Pool (HRP) to ensure that high-risk individuals (*i.e.*, those whose applications are rejected by insurers, or accepted with additional clauses imposed, or charged a premium loading at a rate deemed appropriate by insurers) can purchase hospital insurance that meets the Minimum Requirements. The HRP will be supported by public funding and the government has estimated that the total cost for funding the operation of the HRP for a 25-year period (2016 to 2040) would be approximately HK$4.3 billion.

Since VHIS is a voluntary scheme, it is targeted to individuals who can afford and are willing to pay for value-for-money private healthcare services. Individuals with existing health insurance can choose whether to migrate to health plans under VHIS accompanied with costs. Participating insurers will be required to offer their existing individual health insurance policy holders an option to transfer to VHIS without being subject to re-underwriting within one year after the introduction of VHIS.

Group hospital insurance under the VHIS. Group hospital insurance is not required to comply with the Minimum Requirements under the VHIS as the cost of purchasing the group policies is borne by employers who might be subject to budget constraints. Therefore, in order to better protect employees' interests, it has been proposed to require insurers to include a conversion option in the group hospital insurance products. If the employer decides to purchase the group policy together with the conversion option, an employee covered by such group policy can exercise the conversion option upon leaving employment and switch to an individual Standard Plan at the same underwriting class without re-underwriting, provided that he/she has been employed for a full year immediately before transferring to the individual Standard Plan. In addition, insurers may also offer a voluntary supplement to individual members covered by the group policy to procure at their own costs additional protection on top of their group policy. The group policy, enhanced by the voluntary supplement, should provide insurance protection at a level comparable to a Standard Plan.

Implementation of the VHIS. After consolidating and analysing the views received from the public consultation, the government would proceed to implement the VHIS through enacting new legislation. The bill and subsidiary legislation required for the VHIS is expected to be introduced in 2015/16.

India

A Milestone towards liberalization. The Insurance Laws (Amendment) Bill (Amendment Bill), which proposes, among others, to lift the cap on foreign direct investment (FDI) in an Indian insurance company by an non-Indian entity from the current limit of 26 percent to 49 percent, has been a subject of discussion increasingly since 2008.

On December 10, 2014, the Rajya Sabha (the Indian Parliament's upper house) Select Committee submitted its report on the Amendment Bill to the Rajya Sabha. On December 24, 2014, the Union Cabinet had approved the promulgation of the Insurance Laws (Amendment) Ordinance 2014 (Amendment Ordinance). The Amendment Ordinance has been signed by the President of India. It is expected that the Amendment Ordinance will be introduced in the Indian Parliament for consideration and passage in the next session, beginning February 2015.

The Amendment Ordinance will amend the Insurance Act 1938, the General Insurance Business (Nationalization) Act 1972 and the Insurance Regulatory and Development Authority Act 1999, in accordance with the Amendment Bill as reported by the Rajya Sabha Select Committee. The key changes will be:

- the FDI cap in an Indian insurance company will be increased from 26 percent to 49 percent but ownership and "control" of the Indian insurance company will remain with Indian residents
- foreign re-insurers will be permitted to conduct reinsurance business through setting up branch offices in India
- the requirement for Indian promoters of insurance companies to divest shareholding in excess of 26 percent or such other prescribed percentage will be removed
- insurance companies will be permitted to raise new capital through instruments other than equity shares
- "health insurance business" will be recognized as an exclusive field of insurance business (and carved out from general insurance) and insurers who carry on exclusively health insurance business will be required to maintain a minimum paid-up equity capital of Rs. 50 crore (approximately US$7.9 million)
- "insurance agent" will be included in the definition of "insurance intermediaries," and will be regulated by the Insurance Regulatory and Development Authority (IRDA)
- the IRDA will be empowered to regulate key aspects of insurance company operations in areas like solvency, investments, expenses and commissions and
- penalties for breaches of insurance laws will be enhanced, for example, a fine of up to Rs. 25 crore (approximately US$3.85 million) and 10 years' imprisonment will be imposed for carrying on insurance business without registration with the IRDA.

The Indian Ministry of Finance said in a release that "insurance penetration in India is very low compared to the global average. The sector is in need of capital to expand and ensure better access to insurance services, especially in rural areas and for economically weaker sections. Enhancement of the foreign equity cap from 26% to 49% with the safeguard of Indian Ownership and Control is a critical aspect of the Ordinance, which will potentially enhance capital availability."

Although raising the ceiling from 26 percent to 49 percent may not satisfy those foreign investors wanting more control, it will still be significant in two ways. First, it will increase the focus of the existing private insurers operating within the Indian market. The private companies are increasingly diverging on strategy as they are influenced by their foreign partners and, in this regard, increasingly look to such foreign partners for product innovation, operating processes, systems and insurance know-how. It is likely that increased foreign ownership will lead to differentiated strategy, more niche players and a wider product range. Second, it is expected to increase the supply of capital in the Indian insurance market as new investors will decide to enter the market or existing investors seek to increase their holdings up to 49 percent. It is our understanding that virtually all of the existing foreign investors have "regulatory call options" to increase their current shareholdings to the maximum 49 percent if and when Indian law permits this.

It is estimated that the liberalization of the FDI cap in Indian insurance companies from 26 percent to 49 percent will have the potential to attract up to US$7billion to US$8 billion from overseas investors. The hike in capital availability following the liberalization will facilitate the expansion of the insurance sector in India in view of the relatively low insurance penetration as compared to global average at current time.

As a general practice outside the insurance industry, foreign ownership in India is divided into four phrases of gradual "opening up" to foreign investment: (1) up to 26 percent; (2) between 26 percent and 49 percent; (3) between 49 percent and 74 percent; and (4) up to 100 percent. The passage of the Amendment Ordinance, which is expected to be in February 2015, will be an important step towards further liberalization of the insurance market in India.

We will provide further updates in relation to the Amendment Ordinance to keep you updated with the Indian market as and when available.

The AEC and the ASEAN Insurance Sector

In January 2007, Association of Southeast Asian Nations (ASEAN) leaders committed to accelerating the establishment of the ASEAN Economic Community (AEC), paving the way for the free movement of goods, services, investment, skilled labour and freer flow of capital within the 10 ASEAN member countries. The ASEAN leaders adopted the ASEAN Economic Blueprint (AEC Blueprint) in November 2007, to serve as a coherent master plan to guide the implementation of the AEC. The AEC Blueprint stipulates that by December 31, 2015, foreign equity participation of at least 70 percent be allowed for all service sectors and that there will be no restrictions on cross-border supply of services and consumption of services abroad. Furthermore, member countries are expected to progressively liberalize restrictions in the remaining sub-sectors or modes not identified under "pre-agreed flexibilities" by December 31, 2020.

In recognition of the diversity in economic and social background for each ASEAN member country, liberalization will be conducted in various stages and different timelines and milestones will apply for each member country depending on their individual circumstances and readiness for reform. As we approach the first milestone date of December 31, 2015, we take stock of the progress made in the insurance sector by four key member countries: Indonesia, Thailand, Malaysia and Singapore.

Indonesia. Indonesia has committed to liberalizing its direct life and non-life insurance, reinsurance and retrocession, insurance intermediation and services auxiliary to insurance sub-sectors by the end of 2015.

Foreign equity participation in the insurance sector in Indonesia is already quite liberalized, where up to 80 percent foreign ownership in (re)insurers and insurance intermediaries is permitted. The Financial Services Authority (FSA) may give approval on a case-by-case basis where: (i) there is a mandatory need to increase paid up capital (e.g., to meet the solvency requirement) and (ii) the Indonesian shareholder cannot (or will not) contribute its pro rata share of the additional capital, for foreign equity ownership of more than 80 percent in Indonesian (re)insurance companies, except during the initial establishment stage and provided it is by way of a share subscription to increase the issued capital, whereby the Indonesian shareholders' holdings may be diluted.

Any party (including foreign insurers) wishing to carry on insurance business in Indonesia must have a license from the FSA. Insurance companies providing insurance to Insured Objects in Indonesia also require a local business permit with some limited exceptions where no local conventional or sharia insurance company is capable or willing to provide the relevant coverage. In light of the broad definition of "insurance business," which includes the provision of insurance coverage, marketing and distributing insurance products and the provision of consultancy and broker services, essentially all services which are insurance-related are caught by the licensing regime.

Cross-border supply of insurance services to Insured Objects, including through an overseas branch of a foreign insurance company in another ASEAN member country, is not allowed except in the situation where no local insurance company is capable or willing to provide the coverage in question. The FSA will review such situations on a case-by-case basis. Consumption abroad by Indonesian policyholders purchasing insurance policies in another ASEAN member country is also restricted as Indonesian law provides that if insurance coverage is provided to an Insured Object in Indonesia, the insurer (even if based in another ASEAN member country) must be licensed by the FSA.

Thailand. Thailand's insurance sector has made little tangible progress towards the goals of the AEC, which is unsurprising given it has not specifically committed to liberalizing its insurance sector by the end of 2015. It will, therefore, remain among the most restrictive insurance regulatory regimes within ASEAN for the time being.

Nonetheless, the Office of the Insurance Commission (OIC) published an AEC roadmap on March 24, 2014, which focused on three main goals:

- Enhancing financial stability of insurers by:
  - increasing the minimum capitalization levels of insurers and
  - relaxing the current foreign ownership limitations (a 24.9 percent cap on foreign shareholdings which can only be relaxed with the permission of the OIC or the Finance Minister).
- Developing a competition strategy to boost growth by:
  - relaxing the controls on premium levels and commissions. The former are currently set by the OIC, while the latter are capped for non-life insurance at a general level of 18 percent and
  - streamlining the process for issuing insurance business licences.

- Developing fundamental infrastructure necessary for business expansion, namely:
  - investing into other countries in the AEC and
  - promoting cross-border sales of insurance products.

Other than sporadic instances (e.g., the launch of regulations for Thai insurers to open ASEAN branch offices), specific details and precise commitments underlying the broad concepts above are yet to be announced.

Currently, despite Thai policyholders being able to purchase non-Thai insurance products, insurers and brokers are not allowed to market such products in Thailand (reinsurance excepted). Consequently, although Thai policyholders may purchase insurance policies from an insurer based in another ASEAN member country, the marketing restriction referred to above will apply.

The insurance sector in Thailand has traditionally been very restrictive in terms of foreign ownership. Currently:

- there is a general 24.9 percent limit on foreign ownership of Thai insurers
- this can be relaxed to 49 percent with the permission of the insurance regulator and
- to move to majority foreign ownership, permission of the Finance Minister, together with a recommendation from the insurance regulator, is required.

Consolidation within the sector, particularly non-life, has been a long-standing goal of the regulator. To that end, no new licenses to conduct insurance business in Thailand are being issued but an interesting opening to the Thai market does now exist through mergers and acquisitions. In an effort to achieve the consolidation aim and given that certain Thai insurers are struggling with the recently introduced risk-based capital requirements, the head of the insurance regulator has remarked that majority or 100 percent foreign ownership will likely be permitted to investors acquiring two or more smaller Thai insurers, with the implication that the acquired entities will then be merged. The Finance Minister appears supportive of this approach and a strong statement of governmental backing was provided recently when the Thai Deputy Prime Minister publicly announced that the insurance sector needs to be liberalized.

This alignment of support from government and regulator for foreign participation has not been seen for decades. With Thailand becoming an increasingly affluent society yet still with low insurance penetration rates, an appealing and impressive opportunity is available to foreign insurers looking to enter, or even expand their existing ownership in, a market with significant growth prospects.

Malaysia. Malaysia has committed to liberalizing its direct non-life insurance, reinsurance and retrocession, insurance intermediation and services auxiliary to insurance sub-sectors by the end of 2015.

The insurance industry in Malaysia is relatively open to foreign investors, with a limit of 70 percent on foreign equity ownership of Malaysian (re)insurers and no limits on foreign ownership of Malaysian insurance intermediaries. Nonetheless, there are still restrictions regarding the liberalization in cross-border supply and consumption abroad of insurance services. Currently, soliciting and advertising in Malaysia of insurance policies by foreign insurers based in another ASEAN member country are not allowed. Furthermore, approval is required from Bank Negara Malaysia for direct placement outside Malaysia of insurance of property located in Malaysia, and approval will only be granted if such insurance is not available from direct insurance companies in Malaysia.

Singapore. Singapore has committed to liberalizing its direct non-life insurance, reinsurance and retrocession, insurance intermediation and services auxiliary to insurance sub-sectors by the end of 2015. In many ways, its insurance sector is already fully liberalized (e.g., there are no limits on foreign ownership of Singaporean insurers and intermediaries). There are, however, substantial restrictions on marketing matters, such as non-admitted insurers soliciting for insurance business in Singapore and intermediaries promoting non-admitted insurance in Singapore.

Currently, no tangible measures have been identified to achieve the remaining steps towards liberalizing the insurance industry in Singapore. It appears that Singapore wants to see regional consistency in approach and commitment by the various ASEAN insurance regulators before making its own concessions. There are indications that the various regulators will commence relevant discussions within 2015; the precise regulatory steps taken by Singapore will, in all likelihood, be driven by the outcome of these discussions.

Looking Beyond 2015. Progress in implementing the AEC is quite varied and the ASEAN insurance sector still tends to be heavily regulated, especially in the areas of the cross border supply and consumption of insurance services. Accordingly, a great degree of liberalization is still required to realise the goals of the AEC, for which December 31, 2015 is only an early milestone and where continued liberalisation is anticipated beyond December 31, 2020. The challenge (and opportunity) for participants in the ASEAN insurance sector will be to regularly take stock of both the ASEAN wide framework as well as the domestic insurance regulatory regime within each ASEAN member country.

AUSTRALIAN REGULATORY DEVELOPMENTS

2014 was a year of developing regulatory activity for the industry. The government announced new initiatives as well as witnessed the roll-back of some of its 2013 regulatory changes.

In November 2014, the Senate rejected the Future of Financial Advice (FOFA) changes which came into effect on July 1, 2014. As a result, and due to the impact on the industry, Australian Securities and Investment Commission (ASIC) announced a facilitative approach to the implementation of the changes through until July 1, 2015.

The federal government also announced the establishment of an aggregator website for North Queensland strata, home building and home contents insurance coupled with a proposal to allow unauthorized foreign insurers (UFI) into the North Queensland market signaling a shift in government policy. In Senate Estimates hearings, the acting Treasurer, Senator Mathias Cormann, explained in response to questions from Senator McLucas (Cairns based) that the aggregator is designed to "increase transparency and increase competition in the marketplace." Senator Cormann went on to note that most of the criticism he had heard of the government plans had come "from people who might not be all that keen to be exposed to more competitive tensions in the market."

The aggregator, to be operated by ASIC, is due to be operational by March 2015.

The Financial System Inquiry (Inquiry) delivered its final report on December 7, 2014. The independent committee, chaired by former Commonwealth Bank chief executive David Murray, was charged with examining how to best position the financial system to meet Australia's evolving needs and support sustainable economic growth.

In recommending policy options, the Inquiry was asked to consider how the financial system had changed since the Wallis Inquiry (completed in March 1997), as well as considering emerging opportunities and challenges.

In preparing its interim and final reports, the Inquiry consulted extensively, both domestically and internationally, with regulators, industry participants and consumer groups.

The Interim Report, released on July 15, 2014, made an initial assessment, based on submissions that "many areas of the financial system are operating effectively and do not require substantial change." Accordingly, the Interim report identified areas of potential change and improvement for consideration by stakeholders rather than making recommendations.

In relation to insurance, the Interim Report's preliminary assessment was that the insurance sector has levels of concentration and profitability similar to the banking sector.

However, by and large, the Interim Report submissions did not raise concerns regarding competition in the insurance industry.

The Interim Report addressed the following issues for the insurance sector:

- **Aggregators** – their use, the industry's concern about the complexity of aggregating insurance products, access to sensitive pricing models and the continuing risk of over emphasis of pricing leading to underinsurance.
- **Statutory insurance schemes** – the possibility of opening statutory schemes to private sector competition.
- **Underinsurance** – the submissions raised a range of issues including affordability, availability and the impact of State taxes.
- **Life Insurance** – observations that underinsurance for life and disability insurance is significant.

In his address to the Committee for Economic Development of Australia releasing the Final Report, Mr. Murray AO, emphasized the importance in undertaking the Inquiry for sustaining confidence in the Australian financial system and funding the sustainable economic growth of Australia.

The report makes 44 recommendations "to improve the efficiency, resilience and fairness of Australia's financial system." The recommendations are based around two general themes: funding Australia's economy and boosting competition.

In a nod to the strength of the insurance industry, the submission observed the reforms that took place following the collapse of HIH Insurance Limited in 2001 and concluded that there was not a "compelling case" for further changes to the "stability settings" in insurance at this time.

The insurance recommendations were as follows:

- Introduce a targeted and principles-based product design and distribution obligation (recommendation 21)
- Production intervention power (recommendation 22)
- Align the interests of financial firms and consumers (recommendation 24)
- Improve guidance (including tools and calculators) and disclosure in general insurance, especially in relation to home insurance (recommendation 26).

The Final Report also includes general commentary on insurance and natural disasters. The committee believes this issue should be primarily handled by risk mitigation efforts rather than direct government intervention. Interestingly, the Australian Government Actuary has confirmed in its investigation that the pricing adopted by insurers in North Queensland is reasonable because of the risk in that area. The Final Report cautioned that if the use of UFI became widespread, the impact on the stability of the market should be revisited. It was reasoned that allowing UFIs into the domestic market may result in Australians being exposed should their insurers fail.

What Next?

There is likely to be more activity in the regulatory environment for the industry in 2015. In addition to the industry waiting to see what recommendations the government adopts from the Financial System Inquiry, ASIC has also foreshadowed working with the industry to improve electronic financial services disclosure.

ASIC's consultation paper 224, Facilitating electronic financial services and disclosures, invites financial product providers and advisors to provide feedback on improving electronic financial services disclosure. The paper is seeking both quantitative and qualitative information.

This development is a positive step by ASIC to address a growing preference from financial product advisors to provide disclosure documents electronically. It also opens the door for the possibility of more interactive disclosure documents.


COMPLIANCE

An important subset of regulatory issues is compliance. Insurers have seen new and evolving rules and the emergence of hot enforcement areas – at times stimulated by political developments and other developments. The result is that compliance functions have become more important and more complex, and the cost of failure is high and multi-faceted.

EU Data Protection Directive Update

We reported last year on proposed changes to the EU Data Protection Directive which will affect all organizations that handle personal data and are subject to European data protection laws. The European Commission's proposals will reform the existing data protection regime and harmonize its enforcement across the EU and will be directly applicable into national law. As a result, national governments will not be able to offer the flexibility which is currently afforded in certain jurisdictions such as the UK. Proposed changes, and harsh sanctions for non-compliance, will have a significant impact for those operating in the insurance sector.

Key proposals include:

- imposing legal compliance obligations on data processors (as well as data controllers) which potentially increases the exposure for insurers processing policy holders' personal data, as they will become directly responsible for compliance
- requirements that only the minimum amount of data is used, processed and otherwise stored
- restrictions on insurers' ability to profile consumers and use automatic risk scoring
- restrictions on the use of gender identifiers which may limit the way insurers currently collect and process consumer personal data making the process much more onerous
- more stringent rules on how consent must be obtained from data subjects
- consumers will be given enhanced rights, which insurers will have to accommodate, to access their personal data in a readily available "portable" format which could then be used by another insurer
- mandatory reporting obligations following a data breach which could increase the number of reported data breaches significantly
- harmonization of the regime across the EU (a positive step for insurers in what has been a complex area to navigate with differing rules in different member states)
- a prohibition on disclosing personal data to a court or administrative authority of a country that is not deemed to be "adequate" by the European Commission – which could cause problems for insurers operating across multiple jurisdictions and
- increased penalties for non-compliance – the current proposal is for fines of up to €100 million or up to 5 percent of annual worldwide turnover, whichever is greater.

Progress and timetable for implementation. In March 2014, following very extensive negotiations, the European Parliament finally voted to back the architecture and the fundamental principles of the Commission's proposals, which marks an important step in the EU legislative procedure. A final consensus on the exact wording of the Regulation has still not been reached, with progress being stalled in the European Council. Once the Council has reached a broad consensus on the wording, the Commission, Council and Parliament will then engage in tri-partite negotiations. Current expectations are that an agreement will be reached at some point in 2015, with enforcement commencing from 2017 to allow time for businesses to prepare for the new legislation.

Tax Updates

The Taxability of Retrocession Contracts: An Important Development for Reinsurers. In 2014, the District Court for the District of Columbia's decision on the taxability of retrocession contracts in *Validus Re., Ltd. v. United States*, 19 F.Supp3d 225 (February 5, 2014) was an important tax development with implications for both domestic and foreign reinsurers. This decision could benefit foreign reinsurers in arguing that the federal excise tax (FET) does not apply to retrocession contracts and can provide a basis for domestic reinsurers arguing that retrocession premiums ceded to foreign retrocessionaires may be gross of the FET.

Under the Internal Revenue Code (the Code) Sections 4371, *et seq.* the FET is imposed on each policy of insurance, indemnity bond, annuity contract or policy of reinsurance issued by any foreign insurer or reinsurer. "Policy of reinsurance" is defined as any policy or other instrument by whatever name called whereby a contract of reinsurance is made, continued or renewed against, or with respect to, any of the hazards, risks, losses or liabilities covered by contracts taxable under paragraph (1) or (2) of section 4371. A policy of reinsurance covering any of the contracts stated-above is taxed at a rate of 1 percent of the premium paid on the policy of reinsurance covering any of the contracts stated-above.

From the plain language of the relevant Code sections, it is unclear whether the FET applies only to the first level of reinsurance contracts that reinsure contracts of insurance or if the FET applies to all reinsurance contracts that reinsure contracts of reinsurance assuming risks situated in the United States (US *situs* risk). It is clear, however, that the government's

position is that the statutory scheme as a whole demonstrates an intent on the part of Congress to impose the FET on successive reinsurance contracts issued by foreign reinsurance companies as long as the primary insurance policy insures against US situs risks.

Validus Re., Ltd. v. United States considered whether the FET applies to retrocession contracts.

Validus is a Bermuda corporation that is principally engaged in the business of reinsurance. Validus buys retrocession contracts for a portion of its potential liabilities under the reinsurance contracts it sells. At issue were nine retrocession contracts that Validus obtained from "foreign reinsurers," as defined in the Code.

Looking exclusively at the plain language of Sections 4371, *et seq.*, the court held that the FET only applies to premiums paid on insurance contracts covered by Sections 4371(1) and (2) and premiums paid on reinsurance contracts that reinsure contracts of insurance covered by 4371(1) or (2). The court determined that Congress intended to limit the application of the FET to "premium[s] paid on the policy of reinsurance covering any of the contracts taxable under paragraph (1) or (2)." The contracts taxable under Section 4371(1) are contracts for "[c] asualty insurance and indemnity bonds," and the contracts taxable under Section 4371(2) are contracts for "[l]ife insurance, sickness, and accident policies, and annuity contracts." Because second-level reinsurance policies do not cover casualty insurance, indemnity bonds, life insurance, sickness or accident insurance, or annuity contracts, the court determined "[a] policy of reinsurance guarding against risk assumed by contracting to provide reinsurance is … outside the scope of Section 4371(3)… [.]" Therefore, the court held that the FET does not apply to a retrocession contract reinsuring a contract covered by Section 4371(3).

On April 3, 2014, the government filed a notice of appeal in *Validus* seeking review from the US Court of Appeals for the District of Columbia. After receiving an extension of time from the circuit court, the government filed its opening brief on August 29, 2014. Validus' response brief was filed on October 3, 2014, and the government's reply brief was filed on November 7, 2014; a corrected reply brief was filed on November 11, 2014. Additionally, on October 10, 2014, the International Underwriting Association of London Ltd. and the London & International Insurance Brokers' Association filed an amicus brief in support of Validus. Oral Argument will be held on February 17, 2015.

The district court's decision is a very favorable development for foreign reinsurers that engage in retrocession transactions, particularly in light of *United States v. Northumberland Ins. Co., Ltd*, 521 F. Supp. 70 (D.NJ. 1981) and the Internal Revenue Service's published guidance (*see e.g.*, Rev. Rul. 2008-15, 2008-1 CB 633) sanctioning a "cascading" FET. If they have not already, foreign reinsurers will want to closely evaluate the impact of the district court's decision in *Validus* on the FET that they have already paid in recent years in order to determine whether they should file a protective refund claim by filing IRS Form 720X and consider its the impact on future transactions. Additionally, domestic reinsurers ceding risks to foreign retrocessionaires should develop strategies for negotiating contracts and ascribing liability for withholding (or not) FET on retrocession contracts. DLA Piper LLP (US) has kept abreast of the developments in the government's appeal and endeavors to keep each of its clients informed as new developments arise.

2014 Marks Two Victories for Captives Against the IRS. In *Rent-A-Center, Inc. v. Comm'r*, 142 T.C. 1 (T.C. 2014), a majority of the US Tax Court held that payments made by a parent to its subsidiary insurance company on behalf of other wholly-owned subsidiaries were deductible insurance premiums. In *Securitas Holdings, Inc. v. Comm'r*, T.C. Memo 2014-225 (T.C. 2014), the US Tax Court held in a memorandum opinion that payments made to a brother-sister insurance company were also deductible as insurance premiums. The court, finding in favor of Securitas Holdings, Inc., found in part that a parental guarantee did not foreclose the relationship from constituting insurance (as once thought to be), and, more importantly that adequate risk distribution can be attained through high volumes of independent risks rather than number of policyholders.

Both cases (*Securitas Holdings, Inc.* and *Rent-A-Center, Inc.*) may be viewed as effectively legitimizing many existing captive insurance arrangements and shedding further doubt on earlier IRS guidance in 2005 and 2002. These cases are encouraging developments for captive owners.

Premiums for insurance against various types of business risks, such as property damage or professional liability, are generally deductible as business expenses. However, where certain insurance arrangements lack the elements of risk-shifting and risk-distribution, payments usually are not deductible. Neither the Code nor the Treasury regulations promulgated thereunder define the terms "insurance" or "insurance contract." The US Supreme Court has said, however, that both risk shifting and risk distribution must be present for an arrangement to be treated as insurance (among certain other requirements).

These two holdings are significant because they provide further indication that the Tax Court evaluates risk distribution based on general insurance principles, looking at the number of independent risks, rather than based on the number of legal entities insured (the approach endorsed by the IRS). Additionally, these holdings confirm that in some instances parental guarantees will not prevent adequate risk shifting.

No Adoption of Legislative Proposals for US Income Taxation of International Insurance Transactions and Insurers but Potential Revisions Loom. The US rules for the taxation of cross-border income have been the subject of much criticism. Critics have had a few broad, sometimes conflicting, policy concerns. Members of

the US Congress have introduced legislation to reform the US international tax rules.

For example, Dave Camp, former chairman of the House Ways & Means Committee, released a draft comprehensive tax reform proposal on February 28, 2014. Several provisions focused on eliminating perceived abuses in the insurance tax area, including eroding a US taxable base and indefinite deferral of income. Ultimately, the Camp proposal was not adopted, but there is a good chance that all or part will serve as a framework for major tax reform, which appears to be on the horizon. Below is a discussion of several key insurance-related provisions in the international context.

Modification of the Passive Foreign Investment Company (PFIC) Insurance Exception

Under current law, a US shareholder of a PFIC generally is subject to US taxes on his share of the PFIC's income under one of three alternate anti-deferral regimes, some of which attach punitive results for unknowing taxpayers. A foreign corporation is a PFIC if 75 percent or more of its gross income is passive income or if 50 percent or more of its assets consist of assets that produce passive income. However, under an insurance company exception, passive income does not include income derived in the active conduct of an insurance business by a corporation predominantly engaged in an insurance business and that would be taxed under the provisions of the Code addressing insurance companies if it were a domestic corporation.

Under Camp's proposal, the insurance exception would be amended to apply only if: (1) more than 50 percent of the company's gross receipts for the tax year consist of premiums; (2) insurance liabilities constitute more than 35 percent of the company's total assets; and (3) the company would be taxed under the provisions of the Code addressing insurance companies if it were a domestic corporation.

This proposal would minimize the availability of tax deferral for investors in foreign insurance programs, seriously impacting the players in this market, as well as the end users. Many reinsurance companies established by, affiliated with or that invest in hedge funds, may lose the benefit of this exception as the PFIC test is applied annually.

Base Erosion through Affiliated Foreign Reinsurance

Under current law, US insurance companies generally are permitted to deduct premiums paid for reinsurance ceded to foreign affiliates that are not subject to US taxation. To match income and deductions, ceding commissions, return premiums and other receipts associated with this reinsurance are included in income.

Under Camp's proposal, US insurance companies would not be permitted to deduct reinsurance premiums paid to a related company that is not subject to US taxation on the premiums, unless the related company elects to treat the premium income as effectively connected to a US trade or business (and, therefore, files a US return with the IRS reporting such income). However, if the taxpayer demonstrates to the IRS that a foreign jurisdiction taxes the reinsurance premiums at a rate at least as high as the US corporate rate, the deduction for the reinsurance premiums would be allowed. Also, to match income and deductions, any amounts recovered from reinsurance by the US insurance company, as well as any ceding commissions received in connection with a premium deduction that has been disallowed, would not be subject to US tax.

This proposal would eliminate the material benefit enjoyed under many foreign insurance programs and would likely eliminate the market for these types of products, seriously impacting the players in this market, as well as the end users. It would deny deductions for many legitimate insurance and reinsurance relationships.

Insurance Subpart F Income

Under current law, a US parent is subject to current US tax under Subpart F on "foreign personal holding company income" (*i.e.*, dividends, interest, royalties, rents and other types of passive income) earned by its foreign subsidiary, whether or not the foreign subsidiary distributes such income to the US parent. However, for certain tax years, there is an exception for such income if it is derived in the active conduct of a banking, financing or similar business, or in the conduct of an insurance business (active financing income).

Under the Camp proposal, the exception would be extended for five years for active financing income that is subject to a foreign effective tax rate of 12.5 percent or higher. Active financing income that is subject to a lower foreign tax rate would not be exempt, but would be subject to a reduced US tax rate of 12.5 percent, before the application of foreign tax credits.

This provision would extend the current active financing exception in a modified form.

Value-Added Tax (VAT) Developments for Insurance Companies in Europe. For VAT purposes, a supply of services from the headquarters of a company to a branch office is generally not subject to VAT. This is a well-established principle, based upon the notion that a branch cannot be regarded as a separate economic person where it does not operate independently, covers no economic risk and does not have capital assets of its own. The decision of the European Court of Justice (ECJ) in Skandia in September 2014 fundamentally changed this position for supplies to VAT-grouped branches.

The Skandia case concerned a US insurance company which made internal supplies of IT services from its US headquarters to a branch office in Sweden (which was not a separate legal entity). The cost of those services plus a percentage mark-up was charged to the branch. The branch was registered as part of a group for Swedish VAT purposes. The branch used the IT services it received from the US to provide services both within the VAT group and to customers outside the VAT group. No Swedish VAT was applied to the amounts charged from the US headquarters to the branch. The Swedish tax authorities took a different view and raised a VAT assessment. Skandia's appeal against that assessment was ultimately referred to the ECJ.

The ECJ decided that the supplies were subject to Swedish VAT because they were made not to the Swedish branch, but to the representative member of the Swedish VAT group (which was effectively deemed to be a separate entity for Swedish VAT purposes). The representative member therefore had to account for Swedish VAT under the reverse charge rule.

This decision is likely to impact insurance businesses (and other financial services businesses) across the European Union particularly hard. Insurance businesses are generally exempt or partially exempt for VAT purposes, meaning that they are unable to recover VAT on their costs in full. Insurance businesses have often used branches to conduct overseas businesses and VAT groups to minimise the VAT leakage on re-charges. Insurance business with EU branches may now need to look again at how they structure and allocate the costs of their cross-border intra-group supplies of services in order to minimise VAT leakage.

US Sanctions

Economic and trade sanctions have become the first and most popular option for policymakers in shaping the US response to world events. From the Ukraine to the Middle East to the Caribbean, the extension and retraction of sanctions has become the primary economic weapon for advance US policy interests abroad. The heightened popularity of sanctions has produced ever more specific and sophisticated forms of economic restrictions, generating frequent and new challenges for the compliance departments of insurers.

Cuban Sanctions. President Obama's surprise initiative in December 2014 sought to reestablish diplomatic relations and authorize specified travel, trade and financial transactions with Cuba. This has been described as the most significant change in Cuban policy in more than 50 years. The scope of changes to Cuban sanctions will not be clear until the implementing regulations by Treasury's Office of Foreign Assets Control (OFAC) were published in early 2015. Even then, threats of congressional action to thwart any loosening of Cuban sanctions pose legal uncertainties for OFAC's implementing regulations. Nevertheless, 2015 promises to be a watershed year for US trade and commerce with Cuba that will provide significant opportunities for insurers. Expanded writings of travel and cargo insurance can be expected to accompany loosened sanctions related to Cuban travel and trade, while the removal of restrictions on financial services for Cuban nationals residing in a third country will provide greater flexibility to US insurers who do business through affiliates abroad.

Iranian Sanctions. The significant US efforts in 2014 to obtain an agreement to prevent Iran from obtaining a nuclear weapon capability are expected to continue to make headlines in 2015. The extension of limited sanctions relief to Iran by the P5+1 Group (the US, France, Britain, Russia, China and Germany) until July 1 has two deadlines that will be watched closely: a policy-level political agreement by March 1, 2015, and an implementing technical agreement by July 1. While restrictions on the provision of some insurance services by non-US insurers have been eased, the continued application of full Iranian sanctions to US insurers has made the Joint Plan of Action (JPOA) relief provisions of very limited value to the insurance sector as a whole. Whether a permanent agreement is reached by July or not, Iranian sanctions are most certain to continue to require the attention of compliance professionals in 2015, including compliance professionals in the insurance industry.

Russian and Ukrainian Sanctions. The complex and highly specific sectoral sanctions imposed on Russia beginning in March 2014 will continue to be a critical component of US foreign policy involving the Ukraine and the Crimea in 2015. Congress has also become a significant actor on the Ukrainian and Crimean sanctions stage with the surprise passage of HR 5859, the "Ukraine Freedom Support Act of 2014," in the last hours of the 113th Congress. We can expect to see these discretely targeted sanctions provisions adjusted and revised as new events in the Ukraine, the Crimea and Eastern Europe unfold. While the current version of sectoral sanctions have minimal application to insurers per se, they can quickly and easily be expanded. More importantly for insurers, the designation of Russian financial sector entities such as Specially Designated Nationals (SDNs), and in particular Bank Rossiya, has raised difficult questions about the status of non-designated financial entities partially owned by the SDNs. SOGAZ OJSC, for example, is a large multi-line Russian insurer and reinsurer partially owned by Bank Rossiya. This relationship has been the subject of much uncertainty and consternation among US insurers and reinsurers in 2014 and will likely continue to pose uncertainty in 2015.

Insurance Enforcement Actions. OFAC continues to be active in scrutinizing sanctions compliance within the insurance sector. While not large compared to civil penalty actions involving banks, two settlements were announced with insurers in 2014 for a total amount of $407,742. One of these settlements – with Florida affiliates of the UK's British United Protective Association (BUPA) – was quite significant as a precedent for the scope of sanctions applicable to insurance transactions. Of particular note

was the application of sanctions to insurance support services provided by affiliates of an insurer issuing an insurance policy to a sanctions target, or SDN. Multiple violations were found for the issuance of an insurance policy to an SDN – separate penalties were calculated for each affiliate providing insurance support services for each policy period the policy was in force. This broad interpretation of insurance "services" has widespread implications for insurer operations, particularly insurers and insurance support organizations who operate in a holding company structure.

Cyber Issues

Cybersecurity has become an emerging issue for insurance companies as cyberthreats have become increasingly sophisticated. Insurance companies have been responding by strengthening or offering new cyber risk products to help companies manage this growing area of risk. Insurance companies also have also been high profile victims, such as Anthem Inc., the second-largest health insurer in the US. Anthem announced that on January 27, 2015, it discovered that hackers breached its databases containing personal information for about 80 million customers and employees. In response to the breach, members of the NAIC called for a multi-state examination of Anthem and its affiliates' security. The NAIC anticipates all 56 states and territories will sign on to the examinations.

The New York Department of Financial Services (DFS) was the first state to individually respond to the breach by issuing a report on cybersecurity threat in the insurance industry. The Department also announced that it will begin regular, targeted assessments of cybersecurity preparedness for insurance companies based in New York and propose enhanced regulations requiring institutions to meet heightened standards for cybersecurity.

Prior to the breach, the NAIC announced cybersecurity in the insurance sector as a key initiative for 2015. During the Fall National Meeting, a new Cybersecurity (EX) Task Force was created to monitor emerging cyber risks, their impact on the industry and whether regulatory action will be required. North Dakota Insurance Commissioner and immediate NAIC Past President Adam Hamm will serve as chair of the Cybersecurity Task Force while South Carolina Department of Insurance Director Raymond G. Farmer will serve as vice chair. The task force will coordinate NAIC efforts regarding: the protection of information housed in insurance departments and the NAIC; the protection of consumer information collected by insurers; and monitoring cyber-liability market. The group will report and make recommendations directly to the Executive Committee.

New York Fines Insurers: Doing Business without a License

New York has long taken the position that with few exceptions, one must be licensed by New York to conduct the business of insurance (including reinsurance) from New York, wherever the subject of the insurance is located or wherever the policy is issued or delivered. The New York DFS also has historically taken a broad view of the kind of conduct that requires an insurer to be licensed in New York, although the Department does carve out activities that may be conducted from within the state without a license, based on the administrative or ministerial nature of those activities. Internal administrative services and back-office support functions that do not include "core" insurance activities may be performed in New York by an unauthorized insurer without violating the New York licensing laws.

This issue came to a head in April 2014, after the DFS initiated an investigation into the 2010 transaction by which American Life Insurance Company (ALICO) and its affiliate, Delaware American Life Insurance Company (DelAm) were acquired by MetLife from AIG. In 2011, DFS initiated an investigation of ALICO and DelAm to determine whether they were doing an insurance business in New York without a New York license and aiding other insurers in doing an insurance business in New York without a New York license. According to DFS, sales representatives conducted "road shows" in New York to solicit and sell group insurance products of ALICO, DelAm and their subsidiaries and affiliates and other unaffiliated insurers. The sales representatives, for example, conducted a "road show" at the AIG corporate dining room at 70 Pine Street for multinational companies with operations in Brazil. DFS alleged that the Brazil "road show" was designed to generate new sales in the amount of US$25 million. Also, sales representatives resident in New York participated in incentive compensation plans that compensated them (based on a percentage of premium) for placing business with DelAm and the foreign operations of ALICO. DFS concluded that these activities were not back office or ministerial functions and constituted the transaction of insurance under the Insurance Law.

In April 2014, MetLife consented to the payment of a civil fine of US$50 million plus another US$10 million. AIG, however, initially refused to settle. Instead, it filed suit in federal district court seeking a declaration that New York's requirement that an insurer hold a certificate of authority from New York to transact insurance from New York with respect to a risk that is not resident in New York or under a contract not to be performed in New York is unconstitutional. New York moved to dismiss the suit, primarily on abstention grounds. After the motion was fully briefed, but before a ruling was issued, AIG and DFS announced a settlement. AIG agreed to pay US$35 million and to dismiss its federal suit.

ALICO stands as a cautionary tale to insurers. While carriers may conduct administrative, back-office services, including strategic and governance activities by high-level executives from New York offices, with very few exceptions, DFS will not tolerate client-facing sales-related conduct within its borders, wherever the risk is located or the contract is performed.

Unclaimed Life Insurance Benefits and the Death Master File

Large and Small Insurers at Risk. In April 2012, a US$40 million settlement with the ultimately 43 states was announced, after the multi-state examination of MetLife's use of the Social Security Administration's Death Master File (DMF) to investigate the payment of life insurance benefits and reporting of unclaimed property. Since the initial investigation of John Hancock started in 2009, and the formation of the NAIC Life/Annuities Claim Settlement Practices Task Force, state insurance regulators have reached settlements or completed investigations of 18 of the top 40 insurance companies, representing 60 percent of the total market. The NAIC estimates the settlements have added US$1.7 billion to state unclaimed property bureaus over the last several years.

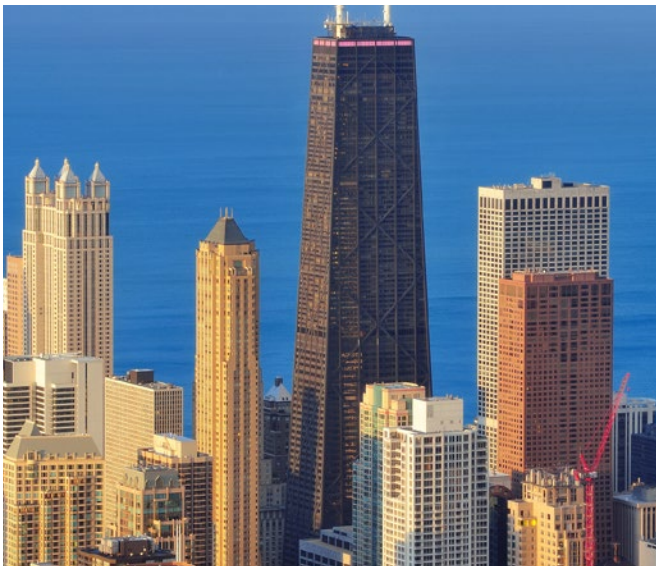
Smaller insurance companies were not spared from the NAIC task force investigations. Companies like Thrivent Financial for Lutheran and American National Insurance Company of Galveston, Texas challenged the investigations in court in 2014. A Florida Appeals Court ruled in favor of Thrivent in August, that challenged the scope of information Florida can request regarding compliance with state unclaimed property laws. The decision held that Florida's unclaimed property law does not make life insurance proceeds due and payable at the time of the insured's death, as the Florida Office of Insurance Regulation originally interpreted the state's unclaimed property law to mandate. The industry has interpreted the decision to limit the power of Florida to require the use of the DMF by insurers to check their records to ensure unclaimed property goes promptly to the states. Some industry observers also interpreted the case as limiting Florida's ability to specify the frequency of those checks. American National Insurance Company of Galveston, Texas has a similar case pending in California.

States movement toward Legislation. Despite the legal challenges, it is not likely that the Florida Appeals Court ruling will impact the states that have adopted a model law crafted by the National Council of Insurance Legislators (NCOIL), including: Alabama, Indiana, Iowa, Kentucky, Massachusetts, Maryland, Mississippi, Montana, New Mexico, Nevada, North Dakota, Oklahoma, Rhode Island, Tennessee, Vermont and Georgia. New York has a similar statute. Furthermore, the NAIC Unclaimed Life Insurance Benefits Working Group (ULIBWG) voted to recommend that a new NAIC model law be developed to address the issue of unclaimed death benefits. As part of its recommendation, the ULIBWG sent a comment letter to the Uniform Law Commission's Drafting Committee to Revise the Uniform Unclaimed Property Act. The purpose of the letter was to inform the Committee of its recommendation to develop a NAIC model on the issue of unclaimed life insurance benefits and to urge the Committee not to revise the Uniform Unclaimed Property Act to permit the dual regulation of life insurers.

By the end of 2014, a panel of former insurance commissioners addressing the subject at the annual conference of the ACLI, stated that the focus of state insurance regulators and corporate treasurers was moving away from enforcement actions, *i.e.*, imposing fines and dictates on use of the Social Security Death Master File (DMF), and is turning to legislation as evidenced by the renewed activities of NCOIL and the NAIC. Nevertheless, it was announced that Allianz reached a settlement in January 2015.

Access to Death Master File Threatened in 2014. One unintended consequence of the federal budget crisis in late 2013 and early 2014 was the impact to the access to the DMF. An obscure provision of the Bipartisan Budget Act of 2013 limited public access to the DMF, effective March 26, and required the Department of Commerce (DOC) to develop a certification program to allow persons meeting certain criteria to have continued access to the DMF. The intention of the provision was to reduce opportunities for identity theft.

Under intense pressure from industry and Congress, the DOC, through the National Technical Information Service (NTIS), published an interim rule in March that ensured continued seamless access to the DMF for legitimate users. The NTIS received several public comments on the interim rule. The NTIS issued a proposed final rule in late December, with the comment period ending on January 29, 2015. Among other things, the proposed "Certification Program for Access to the Death Master File" would establish a Limited Access DMF process for allowing "certified" persons to be eligible for access to DMF information on a deceased person within three years of the death. This rule would replace the temporary certification program for subscribers to the DMF issued last year. By 2015, at least 45 states will have entered into regulatory settlements requiring insurers to use the DMF or a comparable database and at least 16 states will have adopted a model law requiring use of the DMF.



COMMERCIAL AND TRANSACTIONAL ISSUES AND TRENDS

Global Trends in Insurance M&A in 2014 and Beyond

Looking back on 2014: The Year of the billion-dollar transactions. In recent years, insurance companies have largely focused on improving their performance by cutting costs amidst a slow post-global financial crisis environment. However, the past two years have seen the tide change: the industry is now seeking to bolster profits by embarking upon both domestic and the potentially more lucrative emerging market M&A. Economic confidence is growing and those insurance companies that suffered, yet survived, the rock bottom of the economic crisis are beginning to bounce back and consider opportunities to invest in their now well capitalized companies both internally and by external expansion. After a slow 2013, we saw a significant uplift in M&A activity in the sector in 2014. For the first time in a number of years, the industry has seen billion-dollar deals, some of which are identified in this paper.

In this review, we share our top eight observations of the insurance M&A market in 2014: 1) Acquisition volume and value are up; 2) Disposals have increased, impacting on the dynamics of supply and demand as a result of the increasing trend for market consolidation; 3) Private equity firms have continued their interest in the insurance sector, especially within broking, life insurance and annuities; 4) Group reorganizations motivated by regulatory change have been a dominant feature; 5) Increased interest in property investment; 6) Digital and tech strategies are increasingly important drivers; 7) the direction of deal flow has started to shift with Asian companies reversing the 'outward only investment' trend previously associated within Europe and the US; and 8) a run-off market that looks increasingly active again.

Acquisitions are on the up. The big insurance groups are buying again, even those that suffered during the global economic crisis and have been quiet on the M&A radar for some time. The number of publically disclosed insurance deals in 2014 is up around 11 percent on 2013 from 316 to 354 (*mergermarket*). Not only are acquisitions on the up, the value is up, too, with some billion dollar deals including Dai-ichi Life Insurance Company's acquisition of Protective Life in a deal valued at US$5.7 billion, Canada Pension Plan Investment Board's (CPPIB's) US$1.8 billion acquisition of Wilton Re, Manulife's US$4 billion acquisition of the Canadian operations of Standard Life, and Onex Corporation's sale of The Warranty Group to TPG for US$1.5 billion.

We have seen a high proportion of acquisitions in the intermediary and broker markets – markets that traditionally attract and have often been backed by private equity (PE) funding. Large deals include Kohlberg Kravis Roberts & Co.'s (KKR's) acquisition of Sedgewick Claims Management Services, Inc. for US$2.4 billion and Blackstone's purchase of US$610 million of Lombard from Friends Life. Brokers actively acquiring have included JLT, who recently acquired FBD Insurance Brokers, an insurance broker based in Ireland and AON plc's Aon Risk Solutions acquisition of Grana y Asociados, a Peruvian insurance business.

It's not all about acquisitions. We have seen an increasing trend for disposals, generating a renewed supply of buying opportunities, and in response there's been real demand with an increasingly competitive market for buyers. Insurers are continuing to dispose of under-performing and non-core businesses in order to consolidate and transform into more lucrative, streamlined businesses with a clear business strategy. Aviva is a case in point. With a strategic aim to narrow the group's focus to businesses where it has a leading market position and can generate good profitability, Aviva has spent the past two years disposing of assets including its US annuity business, which it sold to Athene Holdings for US$2.3 billion (£1.5 billion) in October 2013, as well as its Turkish general insurance business and joint ventures in both Spain and South Korea. Yet, in December 2014, it embarked upon its major acquisition of Friends Life to create a new insurance, savings and asset management giant.

Notably, 2014 has also seen Stephen Hester's large-scale overhaul of Royal & Sun Alliance (RSA), which has resulted in a series of disposals of non-core assets in order for the business to focus on core strengths in its main markets. These sales fed the global market with some interesting deals. It kicked-off with PZU, Poland's largest insurer, snapping up RSA's Polish and Baltic assets for £300 million, closely followed by its Chinese business being sold to Swiss Re for £14 million. In August 2014, RSA's Asian assets in Hong Kong and Singapore were also sold to Allied World Assurance Co. for £130 million along with a disposal of businesses in Canada, Italy and Thailand. RSA's sales have certainly gained momentum and have attracted a great deal of attention from some of the world's largest insurance players.

The other high-profile example of streamlining driven by financial distress was QBE's de-leveraging plan, which has seen the Australian insurance company divest its US agency businesses and its Central and Eastern European operations in order to improve financial resilience. More recent disposals have included Zurich's strategic sale of its retail business to OLMA group in Russia and Allianz's sale of Fireman's Fund to ACE for US$365 million.

And it's not all about buying and selling. Group reorganizations and mergers are on the rise. As we predicted last year, activity has undoubtedly been spurred on by regulatory changes and the looming implementation of Solvency II in Europe. As a direct result of Solvency II coming into force on January 1, 2016 across the EU, we are seeing some large insurance companies committing to significant group reorganizations in the UK and across continental Europe. Despite the lack of clarity on the details of Solvency II and regulation elsewhere, companies have been taking a common approach: seeking improved

internal economies of scale and crucial compliance with capital requirements. Such capital adequacy uncertainty, however, will impact how companies address retained cash that would otherwise have been invested internally, through M&A or by return to shareholders demanding higher returns on equity. Such uncertainty is a barrier to M&A and boards are likely to vote for caution until required capital levels become clearer.

Private equity firms have become significant players. Meanwhile we have seen the PE players display a greater interest in insurance investments, often primarily on the intermediary and broker front which PE houses favor for their lack of underwriting risk, strong cash flow and low asset holdings. PE interest increased in 2014 despite historic reluctance due to debt burden, low margins and ever-tightening regulation. Yet the low interest rate environment meant that PE firms (and indeed all companies seeking debt-financed led acquisitions) were more attracted to businesses in the insurance sector. This trend was illustrated in the Towers Watson and *mergermarket*'s annual survey of the industry, in which 84 percent of respondents said they expected investment to continue into the insurance market with a particular interest from the private equity firms. Over recent years we've seen large PE firms such as Carlyle Group, Apollo Global Management and Blackstone Group make significant investments in the insurance industry. Earlier in 2014, we saw Carlyle raise US$1 billion for its second fund to invest in financial institutions and insurance companies and the February KKR Sedgwick acquisition mentioned above. 2014 also saw some high-profile PE exits such as Bregal Capital's successful sale in May of Canopius to Sompo Japan Insurance Inc., one of the largest insurance companies in Japan.

Real estate investment has become more popular. Over the past 12 months we have heard from a number of insurance companies with big plans to invest heavily in property. Asian insurance companies in particular are making the most of increasingly relaxed regulations on insurance funds with the likes of Ping An, who are well known to be actively interested in investing in property in international markets following their purchase of the Lloyd's of London building in 2013. In fact CBRE, estimated that an additional US$75 billion would enter the global insurance market by 2018 through property investment – the UK and US being the primary target markets. With banks reluctant to lend and interest being low combined with Solvency II regulations making property investment particularly attractive, insurance companies are increasingly plugging the funding gap as alternative lenders, offering them attractive yields. The investment arm of Prudential, M&G has invested £900 million over the last 18 months through its secured property income fund.

Digital strategies are increasingly important drivers. As the insurance industry begins to wake up to the reality that it's way behind other consumer sectors in the digital world, 2014 has seen potential for M&A driven by demand for new distribution channels and access to technology platforms; a trend likely to continue and grow into 2015 and beyond. Aetna is one example of a business investing in technology when the US based insurance provider acquired bswift for US$400 million late in 2014, giving the provider access to consumer-friendly cloud based technology to aid consumers shopping for insurance.

The direction of deal flow has started to change. Over the past few years the M&A landscape has been dominated by western insurers investing in high growth developing markets, with Western Europe and the US receiving little in the way of inbound investment. While developing markets, particularly in South East Asia, Latin America and Africa, continue to attract investment from the US and Europe – such as Swiss Re's entry into the Kenyan market and its acquisition of a 51 percent stake in Colombian specialty insurer Confianza – we have certainly seen a reverse trend increase momentum throughout 2014. A number of Asian investors in particular have invested capital into Europe and the US despite slow growth rates. Some of the biggest and highest profile deals have involved Asian companies entering these mature markets. A prime example is Fosun, a leading Chinese investment group, with more than one third of its total assets invested in the insurance industry. Over the past 12 months we advised on its acquisition of state-owned Caixa Seguros, Portugal's largest insurance group for €1 billion; Ironshore, the Bermuda reinsurer, for US$460 million and, just last month, the US property-casualty insurer Meadowbrook Insurance Group Inc. for US$433 million. Dai-ichi Life's US$5.7 billion purchase of Protective Life is another example. Further, European and American investments by Asian buyers are also rumored to be in the pipeline in the near future. There has also been a similar pattern in reinsurance with developing economies expanding into mature markets, unsurprisingly dominated by Brazil (the region's largest M&A player) whose Grupo BTG Pactual S.A. acquired property and casualty specialist Ariel Re in July.

However, despite this emerging market counter-trend, it would be remiss not to mention the activity seen in Eastern Europe, with Poland and Turkey being particular hotbeds of insurance M&A transactions over the past 12 months. As we've already mentioned, PZU have been active in Poland, completing multiple acquisitions of RSA's non-core businesses across the Baltic region.

And, after years of discussion of potential consolidation among the Bermuda reinsurers, recently a number of transactions have been attempted, with some likely to succeed. In addition to the US $4.2 billion XL-Catlin transaction, early in 2015 AXIS Capital Holdings Ltd. agreed to merge with PartnerRe Ltd., combining two Bermuda-based reinsurers in a "merger of equals" with a total market value of almost US $11 billion amid accelerating consolidation in the industry. RenaissanceRe Holdings Ltd. struck a deal in November to purchase Platinum Underwriters Holdings Ltd. for about US $1.9 billion. With reinsurers reeling from a perpetually soft market, spurred to a great extent by the expansion of insurance-linked securities and alternative capital, insurers as

buyers of reinsurance have begun tiering reinsurers – with those in tier 2 possibly forced to look at strategic transactions.

The run-off market looks increasingly active. Particularly in Europe, where the value of the run-off market has grown by €7 billion in 2014 on 2013 from €235 billion to €242 billion. Growth is largely been fuelled by a change in mind set and growing acceptance that placing a business in run-off or selling that business is not a negative move but can be beneficial for insurers and policyholders alike. Of course Solvency II and its capital requirement is also playing a role in this trend, encouraging M&A in the run-off space as insurance companies assess all financial risks and focus on investment returns. As Solvency II implementation deadlines move nearer, we expect to see more M&A activity here.

In the life insurance run-off space, 2014 was a quieter year than 2015, with the notable exception of Wilton Re. Wilton Re acquired Continental Assurance Company from CNA Financial in February 2014 at an announced value of US$615 million, with the block consisting mostly of group annuities and structured settlements. In March, Wilton Re announced both the acquisition of Conseco Life Insurance Company from CNO Financial for US$237 million as well as Wilton Re's acquisition by the CPPIB for US$1.8 billion from a group of investors led by Stone Point Capital, Kelso & Company, Vestar Capital Partners and FFL. In October, Wilton Re announced that it would acquire the majority of the Aegon N.V. operations in Canada for CA$600 million, consisting of Transamerica Life Canada, Canadian Premier Life, Legacy General Insurance Company, Aegon Capital Management, Aegon Fund Management, CRI Canada and Selient, Inc. (Transamerica Canada Business). Not the only acquirer, RGA announced in August it would reinsure approximately 170,000 life insurance policies from insurance company subsidiaries of Voya Financial with a reported face value of US$100 million.

2015 may be a busier year than 2014 for life insurance run-off dispositions and reinsurers, continuing the lasting effects of private equity firms seeking "permanent capital" vehicles through life (re) insurance.

The outlook for 2015. We anticipate global M&A activity volume and value to continue to rise during the course of 2015.

While the Lloyd's of London market has been active over recent year with a high number of transactions, we haven't seen many mega deals. We expect this is likely to change in 2015, spurred on by the Catlin deal with XL's £2.5 billion offer, which will be the largest ever purchase of a Lloyd's insurer (if the deal closes). Clearly, Lloyd's continues to be a very attractive market, not least for its international reach and profile. Entry by acquisition, rather than start-up, remains an appealing route into Lloyd's, particularly the PE players who are becoming increasingly active in the sector.

Cheap lending, strong levels of capital and low growth in the mature markets will continue to impact acquisitions of targets in Latin America, Asia and also the Middle East and Africa – we expect countries including Turkey, Brazil and Chile to carry on attracting investors seeking high levels of growth in 2015.

We also expect to see an increasingly competitive market leading to further market consolidation throughout 2015. As we move ever closer to the Solvency II implementation date, smaller companies will buckle under the burden of increasingly tight regulation and this will undoubtedly lead to further regulatory-driven M&A deals and group reorganizations.

In the US, 2015 may lead to further investment by Asian companies in the insurance market, as well as the continued involvement of private equity and private equity-like investors (*e.g.*, CPPIB) in life insurance M&A and capital markets transactions. In addition, the continued impact of insurance-linked securities and alternative capital on the property/casualty reinsurance market, as well as the impact of tiering of reinsurers by major insurers, will likely lead to increased consolidation, particularly among "Bermuda" reinsurers (including those domiciled in Switzerland).

2015 has the potential to be an exciting year for insurance M&A activity. With economic conditions and confidence improving, deal value and volume increasing and the ever dominant presence of the PE sector, the shape of the industry is likely to start to change at a pace over the next 12 months.

Antitrust Issues

Antitrust developments in 2014 that could affect insurance companies were evolutionary, not revolutionary.

There were few significant lawsuits against the insurance industry (although, see below, there is a major antitrust litigation brought by auto body shops, claiming that more than 80 car insurers conspired to fix prices on car repairs).

What we see as more relevant to insurers is an increased tendency to challenge collaborative activity, including collaborative-competitive activity taking place in joint ventures. We refer specifically to *Dahl et al v. Bain Capital Partners*, a federal antitrust case that settled last fall for about US$590 million. The claim there was that private equity companies, which typically operate in joint ventures, actually conspired to limit the number of bidders on each buyout and thereby lowered the return for shareholders. While this case dealt with a different market from insurance, we believe the reasoning of the case could apply to aspects of the insurance industry that rely on collaboration and information sharing.

On the EU front, we see the same concern with insurer collaborative activity, with the EU reporting that they are seeing some failures to conform to block exemption practices, and also

calling for comments on whether it should renew the insurance block exemption.

Our takeaway is that insurers should re-check their antitrust compliance programs, specifically with regard to actual monitoring of joint venture activity and the sharing of information among joint venture partners. History has shown that what often begins as well-intentioned and perfectly legitimate commercial practices can easily morph into antitrust violations. The widespread, indiscrete and apparently unmonitored use of email is yet another element that could heighten antitrust exposure, as news stories throughout the year have proclaimed (though none so expertly as the Libor emails).

United States

The Bain Capital Case. In 2007, shareholders of companies that had gone through leveraged buyouts filed an antitrust case against 11 private equity companies. The complaint charged that the companies conspired to limit the number of bidders on any deal, using artificial bidding protocols, thereby reducing the level of competition for any buyout, and ultimately reducing the shareholder return. The complaint asked for billions in damages. The case went on for seven years, was heavily litigated, and went through five amended complaints. Last fall, the parties settled for about US$590 million and US$200 million in attorneys' fees.

Among the defendants in the case were Bain Capital, Apollo, KKR, Carlyle, Goldman Sachs and Silver Lake.

Among other things, the complaint charged that the PE companies were staffed by people who worked closely with each other, who were often personally friends, who often switched to work for competing firms during their careers and who allegedly followed "club etiquette" regarding buyout transactions. This essentially meant that PE firms did not "jump" each other's deals – or, if they did, would back down in the face of a direct request to desist.

The judge in the case narrowed the issues. But he kept alive for trial the claim that the defendants had agreed not to jump each other's deals. If true, that could have constituted a horizontal agreement not to deal, a per se violation of the antitrust laws. All the defendants settled before the threatened trial date in November 2014.

As we mentioned before, this is not an insurance case. But the case involved a market where there was often joint venture activity to spread the risk of individual IPOs, not dissimilar to the collaborative relationships among insurers and reinsurers. What supposedly happened in *Bain Capital* was that the scope of the legitimate joint venture risk-sharing activity morphed into an agreement to allocate transactions. It is significant – and hardly unexpected – that much of the alleged evidence in the case came from email traffic.

From these facts, we can draw certain conclusions that may be relevant to the insurance market. Collaborations with competitors are obviously legitimate in many cases, and having close friends in the industry is obviously not an antitrust violation. Nevertheless, the question that often arises is whether parallel industry conduct is unilateral or the result of an agreement. Among the many factors used to analyze the behavior is the opportunity for collaboration. As a result, provided there is a legitimate question of conspiracy, the closer the contacts in any commercial community, the greater the risk of an inference of agreement. This risk is dramatically increased if companies act contrary to their own economic interests, as when they forego business in favor of a competitor.

And finally, there is the question of what email activity exists that could support an allegation of conspiracy. It should be obvious that many companies are totally unaware of what email evidence their servers contain: if there is any doubt about this, consider the Libor emails.

Our conclusion is that even where a company has an antitrust policy in place, and believes that it is operating in compliance with international antitrust standards, it still needs to back that up with regular compliance audits. The defendants in the *Bain Capital* case all initially claimed that the case was completely meritless. Despite that, they settled for US$590 million to avoid a trial.

The Auto Body Case. As further proof – if any were needed – that insurance companies are not necessarily immune from antitrust attack under federal antitrust law, we have only to look at *In re: Auto Body Shop Antitrust Litigation*, which is a 2014 consolidation in the Florida district court of at least five separate antitrust lawsuits. The consolidated case number is MDL No. 2557.

The plaintiffs in these cases are individual auto body shops. The defendants are 80 of the leading auto insurance companies in the US. The claim is that the insurance companies conspired to fix the prices for collision repairs at an artificially low level.

The complaint in AE& Auto Body Inc. v. 21st Century Centennial Insurance Company, *et al.*, runs to 34 pages and essentially claims that:

> Over the course of several years, the defendants have engaged in an ongoing, concerted and intentional course of action and conduct with State Farm acting as the spearhead to improperly and illegally control and depress automobile damage repair costs to the detriment of the plaintiffs and the substantial profit of the defendants.

Among the so-called coercive tactics is, allegedly, the threat to "steer" the consumer business away from auto shops that don't comply with the demands for reduced prices. Specifically, the

complaints allege that the agreements among auto-body repairers and the insurance company provide for "market rates"; that State Farm conducts "surveys" of "market rates"; that State Farm manipulates its survey of rates; and that the manipulated rates are then imposed on body shops under the threat of removing all the insured work unless the body shop complies. Similarly, the complaint claims that if an auto body shop increases its prices, State Farm argues that it no longer complies with the local "market rate" requirement and that the auto body shop has thereby violated the agreement.

Finally, and most important, the complaint claims that the other insurance companies follow State Farm's lead – either by agreement or by conscious parallel behavior – and also that the leading auto body collision estimating database companies further this conspiracy. The complaint concludes that, among other things, this behavior is a price-fixing conspiracy that violates the Sherman Act and charges that the scheme is a "boycott."

It remains to be seen whether this case will be dismissed, settled or litigated. The McCarran-Ferguson Act provides an exemption from *federal* antitrust law for the "business of insurance," but the alleged anticompetitive agreements may not actually be the "business of insurance." In any event, even if McCarran-Ferguson applied, these same claims could be brought as state court claims under local antitrust laws.

A more interesting question is the claim of inter-insurer conspiracy. "Conscious parallelism," or similar companies acting in the same way under the same circumstances, is not illegal. For example, no company would be likely to pay higher than market rates for anything. On the other hand, if discovery begins, it is possible that documents and emails might show communications among insurers that could suggest a commitment to a common plan. As one antitrust court said, to show a conspiracy, "a knowing wink is enough."

European Commission. The major insurance-related developments in the EU concern group compliance with insurance block exemption antitrust immunities, and the possible renewal of the block exemption.

The EC's Ongoing Supervision of the Insurance and Reinsurance Markets. In 2013, Ernst & Young prepared a report for the European Commission, entitled *Study on Co(Re)Insurance Pools and on Ad-Hoc Co(Re)Insurance Agreements on the Subscription Market*. E&Y updated that report in July 2014.

One of the issues in that report was compliance with the terms of the insurance block exemption. The block exemption for pool immunity is conditioned on market shares: the safety zone for reinsurance is 25 percent of the relevant market, and for insurance 20 percent of the relevant market.

The report found a surprising degree of non-compliance with these requirements:

> Response rates to questions relating to self-assessment, relevant market and market shares were disappointing. Some of these pools had not conducted a full self-assessment because they considered themselves exempted from covering new risks or they were confident that their market share was below the 20 percent threshold. Overall, awareness of the Insurance BER appeared mixed, though those pools that had reassessed their position since the issue of the new BER did not report a change in their compliance status.

Essentially, what this means is that the pools and their members were not conducting due diligence to see if they even qualified for antitrust immunity. Although that fact alone does not mean that any antitrust violation took place, it does mean that immunity may not be available in case of a litigation challenge.

The second question found in the report is whether the traditional Lloyd's "best terms and conditions" clause persists, even though the Lloyd's drafting panel abandoned that practice after 2010, when the EU insurance block exemption was narrowed. (The "best terms and conditions" clause guaranteed that all the members of a syndicate or pool undertook the same coverage and received the identical premium.) This practice is now condemned by the European Federation of Insurance Intermediaries, or BIPAR.

The E&Y report did not declare any persistent use of "best terms and conditions." It did note, however, that on co- or re-insurance agreements, "[p]ricing is also typically aligned, though respondents described how some large contracts might be placed on a verticalized or partially verticalized basis to benefit from different terms and prices." The E&Y report also noted that the Business Insurance Sector Inquiry (2007) had "found that, while use of a formal 'best terms and conditions' clause appeared then to be in decline, it was nonetheless a widespread practice in the market to conclude such agreements on identical terms for all participants, including premiums."

Based on the specific facts involved in any agreement, the use of "best terms and conditions" could be a violation of Articles 101(1) and (3) of EU competition law, roughly equivalent to the Sherman Act in the US.

The failure to perform pool due diligence on market shares, or the use of "best terms and conditions," could also expose insurers and reinsurers to antitrust liability. Email traffic has the obvious potential to color the intent behind the practices. The prudent response would be to audit current underwriting practices and ensure that compliance with all insurance-specific antitrust laws has actually been performed.

Consideration to Renew the Insurance Block Exemption. As we just mentioned, the Insurance Block Exemption Regulation (IBER) allows insurers and reinsurers to invoke an antitrust exemption against claims of antitrust conspiracy (specifically, Articles 101 (1) or (3) of the Treaty on the Functioning of the European Union). It is somewhat similar to the McCarran-Ferguson Act.

The block exception covers two types of insurance agreements: (i) agreements on joint compilations, joint tables and studies, or risk pooling studies; and (ii) joint coverage of certain risks in insurance or reinsurance pools. The insurance exemption is one of only three markets in the EU that are still protected by a block immunity (the other two are the maritime liner shipping and the motor vehicle distribution markets). The insurance block exemption is scheduled to expire on March 31, 2017, and in 2014 the EU called for comments on whether it should be renewed.

As expected, industry supporters came out in favor of an extension, arguing that eliminating the immunity could either reduce capacity or make access to capacity more difficult. For example, the submission made by Federation of European Risk Management Associations argued that normal antitrust joint-venture guidelines are not sufficient to protect insurers:

> As a Regulation, the IBER is the best suited legal instrument to ensure a consistent enforcement of exemptions from European Union competition law.
>
> Because it is a binding instrument, it applies without a margin of discretion for national competition authorities. Therefore there is no distortion of competition as a consequence of differences in the interpretation of EU guidelines.
>
> On the other hand, the EU guidelines on horizontal cooperation agreements cannot ensure the same level of legal certainty and create doubts over the compliance of the practices mentioned in the IBER.

The legal certainty of the IBER is beneficial for the small and medium insurers which are therefore encouraged to bring capacities and seek counsel on some specific risks.

Some critics of the industry have argued that large companies have a large enough internal risk data pool so that they don't need to share that data with other companies. Aviva is one of the insurers taking this position, even for them the exemption would be beneficial:

> the ability to review our own experience against that of the market standard tables has assisted us in pricing more accurately and providing greater stability of costing. …
>
> [I]f companies did not have a large enough volume of own data to ensure the statistical credibility of their own mortality experience analysis, they would have to assume greater potential variability of outcomes when setting best estimate assumptions and stress testing to establish capital requirements. This could lead to higher prices.

The comments of the German Actuarial Association, among other submissions, argued that Solvency II heightened the pressure to reduce risks and that "it is essential to have market information on best estimates for insurance risks. This information can only be gathered through joint studies, tables and compilations."

Predictably, other groups took a more resistant attitude. For example, the BIPAR argued that there may be a need for an exemption but that:

> it is generally in the consumers' interest to have well-defined limits imposed on collaboration between insurance undertakings, thus ensuring free competition in the insurance sector.

And Electricité de France (EDF) suggested a partial renewal of the pooling exemption but *not* the joint studies exemption. Its explanation (written in English) is that:

> position differs for damage, where we think that not to renew [the joint studies provision] is advisable to foster competition, whereas for liability [pooling] it seems more difficult as gathering capacities is needed to cope with revised Paris Convention obligations.

The Commission is required to submit a report on the functioning and the future of the IBER to the European Parliament and the Council by March 2016.

The United Kingdom

Mind the GAP: The FCA, competition and add-ons. Throughout 2014, the FCA grew into its new role overseeing competition in the insurance sector by conducting significant research, the results of which are likely to work themselves into regulations over the course of 2015. In December 2014, the FCA published the consultation paper CP14/29, which sets out their proposal to improve competition in the market for Guaranteed Asset Protection Insurance (GAP).

This proposal stems from the FCA's market study conducted into general insurance add-ons, which was finalized in July 2014. This study concluded that the market for general insurance add-ons is anticompetitive for two reasons. First, the add-on mechanism and point-of-sale marketing impacts consumer behavior, negatively affecting incentives to shop around or to become fully informed about the product they are purchasing; and second, there is a lack of transparency and comparability in the market that compounds this effect. According to the FCA, this deficiency of competition in the market is evidenced by the especially low claims ratios and high levels of overpayment on add-on products.

The report suggested four remedies to the identified problem, one of which related solely to GAP and forms the focus of the consultation paper. GAP was highlighted as a particular area of concern within the add-on market as the majority of GAP is sold as an add-on and the claims ratios for GAP are particularly low. The FCA's proposed remedy for the GAP market aims to increase transparency and comparability at the level of the consumer by implementing the following rules:

- A deferred opt-in where GAP is sold as an add-on to the purchase of a vehicle. This means that GAP cannot be introduced and sold on the same day. The 'deferral period' would start when the customer is given certain prescribed pre-sale information and end four days after that information is provided.
- Improved information about shopping around. As part of the prescribed pre-sale information, those offering GAP at the point-of-sale must provide the customer with enough information for them to determine whether they require GAP, and must inform them of the existence of other providers than their suggested provider.

Comments have been requested by March 13, 2015. The FCA has, however, already received and disregarded one set of comments on these proposals, in between the provisional findings published in March and the finalized research published in July 2014. In this period, several market participants voiced concerns about the remedy, including protests that it would lead to increased costs and lower sales for retail distributors and that it amounted to a ban on point-of-sale transactions. Others argued that as these disadvantages would decrease the incentive for intermediaries to provide GAP at the point of sale, this was likely to lead to lower consumer awareness of the availability of the product and leave some consumers who would benefit from GAP uninsured. Despite these points, the proposed remedy remained very similar in the current consultation paper from the March draft. The one addition proposed by the FCA was a variation which allows a confident consumer to purchase within the deferral period if they wish to do so, at their own initiative, though still not on the day on which the information is provided to them.

The FCA will publish a policy statement with finalized rules by June 2015, which will take into account all comments received, and expects the rules to come into force on September 1, 2015.

Consultation proposals for the other three remedies are likely to be released during early 2015. These remedies are:

- a ban on opt-outs, *i.e.*, occasions where the consumer has to proactively decide to not purchase add-ons
- a requirement for firms to publish their claims ratios to highlight 'low value' products and
- making improvements to the way in which price comparison websites provide add-on options and pricing.

It is also worth noting that the FCA mentioned in the GAP consultation paper (CP14/29) that, while it does not directly affect the proposals in that paper, firms interested in the paper should also be aware of the Supreme Court case *Plevin v Paragon Personal Finance Limited*. This was a recent Supreme Court case regarding the sale of payment protection insurance, in which an independent broker did not disclose the unusually high proportion of the PPI premium that was to be his commission. It was decided that this behavior could still be deemed to be unfair behavior under the Consumer Credit Act despite the fact that the broker had not acted outside of the Insurance Conduct of Business Rules. The FCA is currently considering the wider impact of this case, but the inclusion of it in a paper on add-on regulation suggests that they may be willing to expand the lessons learned in the area of PPI to a wider range of insurance. It seems, therefore, that add-on insurance may well be the next area to fall under scrutiny both for its impact on competition and its fairness to consumers.

CONCLUSION AND FORECAST

In 2014 we witnessed many commercial, legal and regulatory developments throughout the insurance sector. These created a fluid, rapidly changing business environment for the insurance industry. These changes provide new opportunities for the nimble and the brave, but they are also raising new challenges to regulators and the industry.

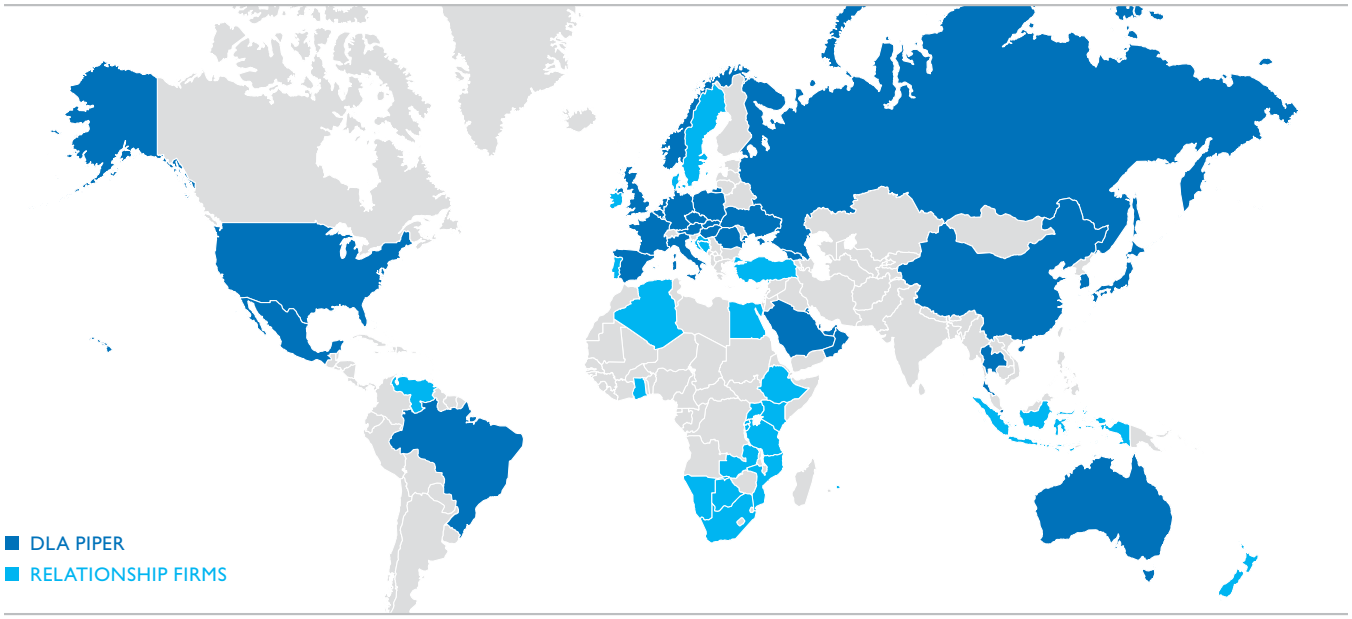
Internationally and domestically, the rules of the game (and even the referees) are in flux – and in some critical areas, unclear. Global regulators particularly are faced with a growing, increasingly international insurance industry. In addition, rapid growth is taking place in many emerging insurance markets, which do not have the mature regulatory systems developed by a number of other countries. This reality raises significant questions for regulators: Should there be one set of rules for IAIGS, wherever they operate and yet a different set of rules for local insurers against whom they may compute? Should the focus of global standards be on raising minimum solvency requirements across all jurisdictions? In addition, given real differences in regulatory approaches, even among well regulated markets, what level of convergence is realistic or desirable. These are some of the issues facing global insurance regulators, they are difficult ones, but important to get right.

In 2015 we will be watching, among many other important developments, the following:

- Whether regulatory fatigue will exact a serious toll on insurers, especially those that have been, for the past fourteen years, heavily engaged with the development of Solvency II in Europe and who are now involved with the development of the ICS.
- Whether regulatory tensions continue to rise, especially if the US is not deemed equivalent under Solvency II.
- The continued development of the ICS and whether the US Congress and other governmental agencies will intervene in the process.
- How many reinsurers are deemed G-SIIs or whether the FSB/IAIS will defer further designations again in 2015?
- A continuing wave of significant cross-border transactions, particularly those going East to West and West to East.
- The continuing consolidation of the Bermuda market.
- The evolving role of the Federal Reserve and the FIO as insurance regulators or standard setters.
- Whether the NAIC adopts principles-based reserving.
- What disruptive technology will emerge in the insurance industry?
- Whether the new Republican controlled Congress will enact significant changes to the Affordable Care Act and Dodd-Frank?

These, and other developments, await the industry in 2015. For our friends in the industry, we hope it is another successful year.

OUR GLOBAL PRESENCE



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