INSURANCE OVERSIGHT AND LEGISLATIVE PROPOSALS

HEARING

BEFORE THE

SUBCOMMITTEE ON
INSURANCE, HOUSING AND
COMMUNITY OPPORTUNITY

OF THE

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U.S. HOUSE OF REPRESENTATIVES

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INSURANCE OVERSIGHT AND LEGISLATIVE PROPOSALS

Wednesday, November 16, 2011

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON INSURANCE, HOUSING
AND COMMUNITY OPPORTUNITY,
COMMITTEE ON FINANCIAL SERVICES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:04 a.m., in room 2128, Rayburn House Office Building, Hon. Judy Biggert [chairwoman of the subcommittee] presiding.

Members present: Representatives Biggert, Hurt, McHenry, Westmoreland, Duffy, Stivers; Velazquez, Sherman, and Capuano.

Also present: Representatives Green and Moore.

Chairwoman BIGGERT. The Subcommittee on Insurance, Housing and Community Opportunity will come to order. I hope that we will have some more Members. Maybe it is a rainy day, and it is taking some time to get here. Without objection, all Members' opening statements will be made a part of the record, and I will begin.

Good morning, everyone, and welcome to this hearing. This is the third in a series. I welcome today's witnesses. Today, the subcommittee will examine insurance regulation and three discussion draft legislative proposals. These draft proposals amend provisions in the Dodd-Frank Act in Titles I, II, and V, and specifically address: one, the authority of Federal entities to collect data from insurers; two, the FDIC's Orderly Liquidation Authority (OLA) as it relates to insurance companies; and three, the Federal Reserve's authority to potentially subject some insurers to heightened prudential standards.

Regulatory uncertainty created by the Dodd-Frank Act has unnecessarily extended into the U.S. insurance market in ways that will raise costs for consumers, harm businesses, and weaken job growth. I say "unnecessarily" because as I have said many times before, for over 150 years the State-based system of insurance regulation has worked and endured, even during turbulent economic times. It has allowed the U.S. insurance industry to become a growing and vibrant source of financial security for millions of Americans. It has allowed one sector of our economy to provide 2.3 million wage and salary jobs. The McCarran-Ferguson Act of 1945 maintained the States' regulatory authority over insurance unless a Federal law expressly provides otherwise, such as flood and terrorism insurance.

Unfortunately, certain provisions of the Dodd-Frank Act have intentionally or unintentionally upset this well-functioning, proven

system of regulation. This subcommittee has heard from many witnesses and stakeholders to that end. Insurers have said that they are not expanding their companies and creating jobs, consumer costs may rise, and they may become less competitive abroad.

And finally, I would like to express my sincere disappointment that representatives from the Federal Reserve and the FDIC decided not to testify at today's hearing, which is addressing significant provisions of the Dodd-Frank Act that their agencies are primarily responsible for implementing.

With that, I welcome input from all members of the committee on these discussion drafts, and I would yield to someone on the other side, but they are not here.

Mr. Westmoreland, would you like to give your opening statement now? You are recognized for 2 minutes.

Mr. WESTMORELAND. Thank you, Chairwoman Biggert, for holding this hearing.

Since Dodd-Frank passed, all we have seen is the uncertainty and the harm this law has brought to working Americans and small businesses. The proposals before the committee today are much needed to help insurance companies get out from under Uncle Sam and allow States to continue their long-standing insurance regulation.

Like the chairwoman, I, too, have serious concerns that the FDIC and the Federal Reserve refused to testify at today's hearing. When Congress asks an agency to testify, I think they should come, period. So my question to the FDIC and the Federal Reserve is, what are you hiding or what are you ashamed to testify to?

I urge the chairwoman to hold another hearing and mandate the FDIC and the Federal Reserve to attend so that we can find out what they have to say about this issue, and with that, Madam Chairwoman, I yield back.

Chairwoman BIGGERT. The gentleman yields back, and we will take that under advisement. Thank you. The gentleman from Virginia, the vice chair, is recognized for 1 minute.

Mr. HURT. Thank you. Thank you, Madam Chairwoman. I want to thank you for your leadership on issues relating to the business of insurance.

Today marks the third in a series of hearings that this subcommittee has held to assess the impact of the Dodd-Frank Act on insurers. As we have seen, Dodd-Frank contains a number of provisions that impose unnecessary duplicative regulatory burdens on insurers that have the potential to harm both the industry and consumers. We must be mindful of the cumulative effect of adding new Federal regulatory requirements to existing State insurance regulatory schemes. Witnesses at our previous hearings have demonstrated that excessive and unnecessary regulation of insurance will only restrict consumer choice, inhibit the growth of free and open insurance markets, and drive up costs on consumers in my district, Virginia's Fifth District, and across the country.

The discussion drafts we are examining today take steps to alleviate these regulatory burdens by proposing commonsense reforms that reduce duplication without sacrificing consumer protection or increasing systemic risk.

Again, I want to thank the Chair for holding this hearing. I look forward to our witnesses' perspectives on the draft legislation, and I yield back my time.

Chairwoman BIGGERT. Thank you. The gentleman from Texas, Mr. Green, do you have an opening statement?

Mr. GREEN. Madam Chairwoman, thank you so very much. I will pass at this time, and I look forward to hearing the testimony. Thank you.

Chairwoman BIGGERT. With that, we have two panels today. For our first panel, we are happy to have Mr. Joseph Torti, deputy director and superintendent of insurance and banking, Division of Insurance, Department of Business Regulation, State of Rhode Island, on behalf of the NAIC, the National Association of Insurance Commissioners. Thank you so much for being here.

Without objection, your written statement will be made a part of the record, and you are now recognized for a 5-minute summary of your testimony.

STATEMENT OF JOSEPH TORTI III, DEPUTY DIRECTOR AND SUPERINTENDENT OF INSURANCE AND BANKING, RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION, ON BEHALF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC)

Mr. TORTI. Thank you for the opportunity to testify today. My name is Joseph Torti, and I am superintendent of insurance for Rhode Island. I present this testimony on behalf of the NAIC. To be clear, the NAIC has no position on the Dodd-Frank Act or any current legislative proposals to modify it.

Today, I will cover the unique characteristics of insurance, an overview of the key aspects of insurance regulation, and the NAIC's efforts in working with Federal agencies as they implement Dodd-Frank.

Insurance products are fundamentally different from other financial products. The very nature of insurance significantly reduces the potential of a run-on-the-bank scenario. Importantly, insurance products do not transform short-term liabilities into longer term assets. A key reason many other financial firms suffered during the financial crisis was that the duration of their assets and liabilities were not matched.

The insurance regulatory framework's fundamental tenet is to protect an insurer's ability to pay policyholder claims. Regulators have broad authority to identify and address issues before they become a threat to solvency. The foundation of this system is the detailed and transparent reporting requirements. Insurers are required to prepare comprehensive financial statements using the NAIC's statutory accounting principles, or SAP. SAP utilizes the framework established by GAAP, but unlike GAAP, which is primarily designed to provide key information to investors of public companies, SAP is designed to assist regulators in monitoring the solvency of an insurer.

Financial statements are filed with the NAIC on a quarterly and an annual basis. The NAIC serves as the regulators' centralized repository for this data, and this capability has been cited by the IMF as world leading. We utilize this information as part of our inten-

sive financial analysis. The NAIC also compiles the information to advise us of trends in the insurance sector and the impact of external events. The information is also used in our risk-based capital framework. This framework requires an insurer to hold at least a minimum amount of capital based on the risks on its balance sheet. The framework also includes authority for successive levels of regulatory intervention.

In the unlikely event that an insurer becomes troubled, State receivership laws provide regulators authorities to prevent insolvencies and to provide protection to policyholders. In 2004, we utilized our broad authority in Rhode Island to place a troubled insurer into rehabilitation, preventing its insolvency while ensuring full payment to policyholders.

In an insolvency, State laws give policyholders priority over most creditors. In cases where the assets of an insurer are insufficient to pay claims, the States have guaranty funds to serve as a backstop for most insurance products. Together, receivership laws and the guarantee funds ensure that policyholders are protected and troubled insurance companies are resolved in an orderly manner.

The NAIC has a long history of working closely with the Federal agencies, and this has continued during Dodd-Frank implementation. State insurance regulators are represented on FSOC through John Huff, the Missouri director of insurance. In the recently released FSOC guidance, we were pleased to see a commitment to involve regulators of any insurance companies under consideration early in the process. We are currently reviewing the guidance and will provide our comments through Director Huff. We also continue to encourage the FSOC to enable Director Huff to consult with us regarding other aspects of its work that could impact insurance.

The NAIC has also been engaged in the implementation of the FDIC's new resolution authority. We have met with the FDIC and commented on proposals regarding the circumstances in which the FDIC can take a lien on insurance company assets. We also requested that the FDIC allow for the resolution of any mutual insurance holding companies pursuant to State laws. The NAIC's coordination with the FDIC will be critical to ensuring that policyholders are protected.

Our strong relationship with the Federal Reserve has grown since the passage of Dodd-Frank. Insurance regulators are meeting with Federal Reserve representatives to exchange information and to discuss how we will work together as it implements its new authorities.

The NAIC also continues to engage directly with the FIO as it takes shape. FIO has a critical role to play in international matters. The NAIC will continue to serve as the voice of insurance regulators on these key issues, but the voice of the U.S. Government is essential, so we look forward to partnering with the FIO in demonstrating a united front whenever possible. Dodd-Frank requires the FIO to issue a report on insurance regulation by January 2012. State insurance regulation has been subject to Federal scrutiny many times before, focusing primarily on the perceived costs and redundancy of the system. Rarely have these issues been weighed against the strength of our system's checks and balances that help the insurance sector weather the financial crisis far better than

others. We look forward to meeting directly with the FIO to encourage a balanced view as it finalizes its study.

In conclusion, the NAIC continues to advocate that the unique nature of insurance and its strong system of regulation be recognized. We look forward to continuing to work with you and our fellow financial regulators. Thank you, and I look forward to your questions.

[The prepared statement of Superintendent Torti can be found on page 63 of the appendix.]

Chairwoman BIGGERT. Thank you so much, and with that we are going to move to the questions. Members will have 5 minutes each to ask questions, and I will begin with myself and yield myself 5 minutes.

Mr. Torti, during the subcommittee's October 25th hearing with regard to the Federal Insurance Office (FIO) authority under the Dodd-Frank Act to issue a subpoena to collect data directly from an insurance company, FIO Director McRaith said that the possibility of actually issuing a subpoena to collect information is extremely unlikely.

Can you envision any scenario where the FIO or the Office of Financial Research would need to issue a subpoena to collect data directly from an insurance company aside from the data that can be secured from State regulators, public sources, or any other entity? What kind of data would the FIO or the OFR need to collect?

Mr. TORTI. What I can say about that is that we, as State regulators, collect an extensive amount of data on insurance companies. We have every piece of financial data that is necessary to regulate these companies, and I can't really envision a scenario where the Federal regulators may need something regarding the financial condition of an insurance company that we don't already have, and we are very happy to share any of that information. Anytime we have been requested to provide information to any of the Federal agencies, we have done so without hesitation.

Chairwoman BIGGERT. Thank you. And then on page 8 of your written testimony, you state that regulators have requested that the FDIC allow for the resolution of any mutual insurance holding company pursuant to State insurance receivership laws as the statute is unclear in this regard. The discussion draft number 2 under consideration by the subcommittee today aims to provide this clarity with regard to mutual insurance holding companies.

Do you think that the Dodd-Frank Act lacks clarity about whether they are covered by the insurance company definition for purposes of the FDIC's Orderly Liquidation Authority?

Mr. TORTI. We do think that the intent of the legislation is clear and that it is not intended that mutual insurance holding companies be subject to the resolution authority of the FDIC, and we have been working with the FDIC, we have had several conference calls with the FDIC, and we met with them as recently as early November, just before the recent NAIC meeting in National Harbor, Maryland. So we have worked very closely with them, and we are hopeful that any rule that comes out will clarify that mutual insurance holding companies—

Chairwoman BIGGERT. Can you elaborate on why State regulators have requested that the States resolve a failed mutual insurance holding company?

Mr. TORTI. Right now, under the State laws regarding receivership, mutual insurance holding companies are included in the receivership estate, so the assets of the mutual insurance holding company are available for the policyholders and claimants of that insurance company in that receivership. So it is important that that holding company be resolved in accordance with the State insurance receivership laws in order to protect those policyholders.

Chairwoman BIGGERT. Okay. So you would say that the States are better equipped and experienced to be able to resolve the matter?

Mr. TORTI. I would say that the States are well equipped to resolve insurance company matters.

Chairwoman BIGGERT. Okay. Then, thirdly, why can't a bank model for regulation work for insurance companies? Is there a difference in the way that State insurance regulators establish leverage and risk-based capital requirements for insurance companies as compared to the way that the Federal bank regulators establish leverage and risk?

Mr. TORTI. Banking products and insurance products are very different. Insurance policyholders pay a premium, and insurers make a promise to pay in the future. It is much different, especially in the property and casualty area, than a financial product that might be offered by a banking institution. The chance of a run-on-the-bank type scenario with an insurance entity is much less than with a banking entity. The liabilities and assets are appropriately matched in insurers. If a company is selling long-term type insurance, they match their assets with that long-term insurance. That is one of the key things that insurance companies do and that regulators ensure is done appropriately, especially in the area of life insurance.

So, they are very different products. There is a very different regulatory standard, and we believe that we appropriately regulate insurers.

Chairwoman BIGGERT. Thank you. My time has expired. The gentleman from Texas is recognized for 5 minutes.

Mr. GREEN. Thank you, Madam Chairwoman, and I thank the witness for testifying. As you know, we had great difficulty with some of the "too-big-to-fail" institutions when we were going through the financial crisis. One such institution was AIG. It had financial components, but there were also many other things that were contained within the network that AIG had. In fact, there are some who contend that AIG may have been the glue that was holding everything together simply because they were so vast and so pervasive in the institutions that they covered.

My question to you has to do with Orderly Liquidation Authority. The Orderly Liquidation Authority that we have in Dodd-Frank allows the FDIC to intervene and to do what is necessary under exigent circumstances, I would consider it exigent circumstances. I think what happened with AIG was under exigent circumstances. How would this occur differently today if we had—God forbid, and I would never want it—another AIG to contend with?

Mr. TORTI. I hope I understand your question. Are you saying as a result of the Dodd-Frank changes that have been made, what would be done differently?

Mr. GREEN. How would the States respond to the FDIC handling exigent circumstances comparable to AIG during the financial crisis?

Mr. TORTI. The traditional way that we would handle that type of thing is we try to create a wall around the insurance entity to protect the insurance entity and the insurance entity's policyholders from those circumstances so that the insurance policyholders and claimants aren't made to pay for the problems outside the insurance entity. That is normally the way that we protect an insurance entity in a receivership situation. So if there were a holding company issue or a significant affiliate outside of the insurance entity that had financial difficulties, we would protect the insurer from those financial difficulties through the current receivership laws that we have in all the States.

Mr. GREEN. In essence, are you saying that you would be able to work within the confines of Dodd-Frank and with the FDIC so as to perfect an orderly liquidation?

Mr. TORTI. We really hope we don't end up in that situation again.

Mr. GREEN. Obviously, yes, I concur.

Mr. TORTI. But, yes, we believe we should be able to work with the FDIC. We are hopeful that we will be able to work with the FDIC. We have a very good relationship with the FDIC. The FDIC has acknowledged that protection of the policyholders and claimants of the insurance entity is of utmost importance to us, and we believe that we should be able to work with them on that type of circumstance.

Mr. GREEN. Are there any technical changes to the draft we have that you would recommend to help to facilitate this?

Mr. TORTI. I can't think of any technical changes that I would offer to the current draft that you have, no.

Mr. GREEN. Thank you, Madam Chairwoman. I will yield back.

Chairwoman BIGGERT. The gentleman from Virginia, Mr. Hurt, is recognized for 5 minutes.

Mr. HURT. Thank you for your testimony today. We have heard from the FIO Director, as you know, and certainly some of the concerns that come to my mind as we look at the defining role that office will play, clearly having more information is a good thing, it seems to me, to help the regulators have a "big picture" view of systemic risk and how that ultimately affects the taxpayer. I do have some concerns, though, about the proverbial "camel's nose under the tent," and I was wondering if you could speak to that. Obviously, I think of it from two standpoints. One is what is the worst case scenario if we have this authority and suddenly it grows and grows and grows, and the next thing you know you have Federal regulations competing, Federal regulatory structure competing with the State regulatory structure. It seems by all accounts to be very successful. I think you have spoken to that. But it is hard for me to look at the examples we have here in Washington where Washington has restrained itself. It is very hard to see any examples of that, and so I guess that is a concern for me. I was won-

dering if you could speak to that, and then also maybe speak to the issue of the data collection because clearly the State regulators will cooperate fully, and I don't have any concern about that, but I can see how if there is an additional burden for data collection put on the insurers that suddenly, the cumulative effect makes it more and more expensive to do business, and those costs get passed on to the consumer.

So I was wondering if you could just speak generally to those two things, and I again thank you for your testimony.

Mr. TORTI. Sure, and I thank you all for your support of the State system and your kind remarks on how well the State system does work. We are very proud of the system, and we think it does work well to protect policyholders and claimants.

With respect to the FIO and the "nose under the tent" issue, I think Dodd-Frank is very clear that the FIO is not an insurance regulator, and I think Director McRaith has acknowledged that the FIO is not an insurance regulator, so I can't say that I am not worried that eventually someone might try to, I guess, compete with the State system of regulation, but I don't—we have not had any indication from the FIO or any of the other Federal agencies that they would do anything inconsistent with the State system of regulation or anything that would in any way interfere with the current regulatory system the way it is now.

With respect to data collection, we do have very robust data collection, and we do extensive analysis of that data. It allows our examiners to do constant financial analysis of every insurance company out there. The statements are hundreds of pages. You can get details of any securities that are on the statements of any insurance company that files an NAIC statutory blank. There are details on reinsurance that are extensive. There are details on loss reserves that are extremely extensive. I cannot think of any information regarding the individual insurance entities or financial information that we don't have in our world class database, so I would hope that it would not be necessary to request any information at all directly from insurers that we don't have. It is very clear that we have anything that—over the 150 or so years that we have regulated insurance, I think we have developed a system that captures everything you could possibly need to regulate these entities.

Mr. HURT. Thank you, and thank you, Madam Chairwoman, I yield back my time.

Chairwoman BIGGERT. The Chair recognizes the gentlelady from New York, Ms. Velazquez, for 5 minutes.

Ms. VELAZQUEZ. Thank you, Madam Chairwoman. Mr. Torti, regulation of the insurance industry takes place primarily at the State level, but as we learned from the collapse of AIG, large firms can become systematically important and accelerate the collapse of the financial system.

In your opinion, does any one State have the resources to monitor and protect the whole country from systematically important insurance companies?

Mr. TORTI. Let me just answer that by saying it is hard to imagine the insurance enterprise, the insurance company itself posing a systemic risk. Just the way that insurance—

Ms. VELAZQUEZ. It is hard to imagine?

Mr. TORTI. The insurance business itself. There could be entities, as we saw in AIG, outside the insurance enterprise that may pose a systemic risk, but the business of insurance is a little different than that. It is very hard to imagine that a single insurance company could pose a systemic risk. What happens at one insurance company usually does not carry over to the next insurance company. There is a promise to pay in the future that an insurer makes, and it is very difficult to imagine something that could occur.

Ms. VELAZQUEZ. So you are telling me that the collapse of AIG didn't send shock waves throughout the—

Mr. TORTI. It absolutely did send shock waves, but that was the financial services division of AIG that did collapse.

Ms. VELAZQUEZ. So you don't see any role for the Federal Government at all in terms of having to deal again with a collapse like AIG to prevent a direct effect across-the-board throughout the insurance system?

Mr. TORTI. I did not mean to imply that there was no role for the Federal Government.

Ms. VELAZQUEZ. Okay.

Mr. TORTI. What I did mean to say is that insurance regulators, State insurance regulators are fully capable of regulating insurance enterprises. There may be—I am sorry.

Ms. VELAZQUEZ. Okay, thank you. Mr. Torti, discussion draft number 2 will prohibit the FDIC from obtaining a lien on a failed insurance company's assets without the written consent of the company's State regulator. How are taxpayers and the public better protected by forcing the FDIC to seek permission from State regulators during the orderly dissolution of a failed firm?

Mr. TORTI. First of all, I want to make clear the NAIC does not take a position on any of the pieces of legislation. However, the job of the State regulator is to ensure that the policyholders and claimants of that insurance enterprise are protected, and if we are not able to have any type of say in what happens to those policyholders and claimants of the insurance enterprise, and the State scheme of regulation includes receivership laws that are intended to protect policyholders of that insurance enterprise, we just need to preserve that role as the regulator of insurers in order to protect those policyholders.

Ms. VELAZQUEZ. Okay. Thank you, Madam Chairwoman.

Chairwoman BIGGERT. Thank you. Just for the record, Mr. Torti, wasn't AIG's holding company a thrift?

Mr. TORTI. It was, and it was actually regulated by the Office of Thrift Supervision, yes. It was not an insurance entity.

Chairwoman BIGGERT. Thank you. I see no further questions, and so we would thank you for your testimony, and thank you for being here. The Chair notes that some Members may have additional questions for you which they may wish to submit in writing. Without objection, the hearing record will remain open for 30 days for Members to submit written questions to you and to place your responses in the record. Thank you so much.

Mr. TORTI. Thank you very much.

Chairwoman BIGGERT. And with that, I will call up the next panel. Thank you all for being here.

I would like to welcome the second panel. We have today: Mr. Michael Lanza, EVP and general counsel, Selective Insurance Group, on behalf of the Property Casualty Insurers Association of America; Mr. Daniel Schwarcz, associate professor, University of Minnesota Law School; and Mr. Steven Monroe, chief compliance officer, U.S. and Canada, for Marsh, Incorporated, on behalf of the Council of Insurance Agents and Brokers.

I seem to have mixed up the names, but we will proceed with Mr. Michael Lanza. You are recognized for 5 minutes for your testimony.

STATEMENT OF MICHAEL H. LANZA, EXECUTIVE VICE PRESIDENT AND GENERAL COUNSEL, SELECTIVE INSURANCE GROUP, INC., ON BEHALF OF THE PROPERTY CASUALTY INSURERS ASSOCIATION OF AMERICA (PCI)

Mr. LANZA. Thank you. Chairwoman Biggert, and subcommittee members, thank you for the invitation to testify. I am Michael Lanza, executive vice president and general counsel of Selective Insurance Group. Selective is an insurance holding company with seven property and casualty insurance subsidiaries. I am also testifying on behalf of the Property Casualty Insurers Association of America, which has over a thousand members and the broadest membership of any national insurance trade association.

Selective and PCI strongly support the discussion drafts you are considering to clarify the treatment of insurers under various provisions of the Dodd-Frank Act. Home, auto, and business insurers did not cause the financial crisis and are not systemically important to the financial markets.

There are five key reasons why P/C insurers are not systemically risky: one, they have low financial leverage; two, they are not highly connected with other financial firms; three, they are in a highly competitive market with low individual company market penetration; four, they have low failure rates and, through State guaranty funds, have their own effective resolution authority; and five, and most importantly, P/C insurers do not sell products that can result in a run on the bank.

In Dodd-Frank, Congress generally recognized the distinctions between non-risky P/C insurers and other types of financial firms that can pose systemic risk. Some fine tuning needs to be done to make those distinctions even clearer. That is why Selective and PCI support the proposed amendments. We do not believe that the proposals in any way scale back any powers that Dodd-Frank granted Federal agencies to regulate the types of risky activities that gave rise to the financial crisis.

The discussion drafts propose technical amendments that clarify Dodd-Frank's application to insurers. These changes will reduce the potential for unintended intrusions on State regulatory authority and other unintended consequences.

I want to comment in particular on four areas that the discussion drafts address. First, we are concerned that Dodd-Frank's provisions ensure the confidentiality of nonpublic information provided to the Federal Insurance Office, but they may not protect that information when the FIO shares it with other agencies such as the Office of Financial Research or the Financial Stability Oversight

Council. The discussion drafts tightens those provisions so information will not lose its confidentiality when it is shared with various agencies and regulators.

Second, Dodd-Frank gave the FIO subpoena powers that are much broader than those of other Treasury agencies. Typically, Federal agencies have subpoena power to further their primary regulatory role in conducting formal administrative proceedings or civil, criminal or Inspector General investigations. FIO, however, does not have a primary regulatory role. That remains with the States. FIO does not need subpoena power when State regulators already have that power.

Moreover, Dodd-Frank requires the FIO to get information from State regulators. We believe State regulators and the FIO can and will work together cooperatively and successfully to obtain needed information. By giving FIO, a non-regulator, subpoena powers duplicating the principal State regulators, there is a significant likelihood of redundant, costly, and burdensome data calls, and those costs will ultimately be borne by consumers.

Third, Dodd-Frank gives Federal regulators the power to resolve failing financial companies. P/C insurers, however, are already subject to State insolvency mechanisms, including guaranty funds that protect the consumers. Dodd-Frank permits the FDIC to take a lien on the assets of financial companies, but it does not exempt insurance companies. The discussion drafts requires the written consent of the insurer's domiciliary regulator before the FDIC can place a lien on insurer assets. This ensures that insurer assets cannot be used to shore up non-insurance affiliates, only policyholders. Dodd-Frank also gives the FDIC the ability to assess insurers for the resolution costs of non-insurance financial firms. This provision creates inequity between insurers and non-insurers and leads to the possibility that insurers could be doubly assessed. The discussion draft addresses this inequity.

Finally, Dodd-Frank gives the Federal Reserve the power to impose heightened prudential standards on firms that are found to be systemically important. The discussion draft requires the Federal Reserve to take into account State insurance regulatory and accounting procedures, including risk-based capital, and prevents regulatory conflicts between the Fed and the States.

For these reasons, we strongly urge that these discussion drafts be introduced and adopted. Thank you.

[The prepared statement of Mr. Lanza can be found on page 30 of the appendix.]

Chairwoman BIGGERT. Thank you, Mr. Lanza. Mr. Monroe, you are recognized for 5 minutes.

STATEMENT OF STEVEN M. MONROE, CHIEF COMPLIANCE OFFICER, U.S. & CANADA, FOR MARSH, INC., ON BEHALF OF THE COUNCIL OF INSURANCE AGENTS & BROKERS

Mr. MONROE. Good morning. I am Steve Monroe, chief compliance officer for Marsh in the U.S. and Canada, on behalf of the Council of Insurance Agents and Brokers, which represents the Nation's leading insurance agencies and brokers, including Marsh. I would like to thank you for the opportunity to address the implementation of the insurance provisions of Dodd-Frank.

Council members employ more than 120,000 people and annually place more than 80 percent, over $200 billion, of all U.S. products and services. Marsh, a unit of Marsh & McLennan Companies, is the world's leading insurance broker and risk adviser, with over 25,000 employees in over 100 countries. My written statement has addressed why the Council supports the legislation that will clarify the intent of Congress in enacting Dodd-Frank, but excluding the insurance sector from the FDIC resolution authority and from the so-called Volcker Rule.

I will focus the remainder of my statement on the States' implementation of the Dodd-Frank reforms known as the Nonadmitted and Reinsurance Reform Act, or NRRA, and address three issues that are most problematic right now.

The first major concern is the vastly different approaches States have taken to tax surplus lines transactions. The NRRA's taxation provisions are based on the concept of home State rule. Only the home State of the insured has the ability to tax surplus lines premiums. The Federal law permits but does not require States to allocate taxes amongst themselves in accordance with a multi-State agreement or compact.

The States are currently taking five different approaches. A number of States are taxing and keeping 100 percent of the taxes based on their own tax rate. This is the preferred approach of Council members. Some States are taxing a surplus lines transaction based on proportion of the insured exposure in each State, based on each State's tax rates, but they keep 100 percent of the tax. Other States have taken no action at all, which means they are only taxing that portion of the risk in their State. Other States have chosen to allocate, using one of the two methods, either NIMA or SLIMPACT. However, neither agreement is operational yet, leaving it to the brokers to figure out how to calculate, collect, and pay the taxes applicable in those States.

The second major concern is that on January 1, 2012, at least 11 States will require brokers to use the unworkable NIMA allocation formula. It requires allocation of all casualty lines, including lines for which brokers have no information regarding the location of the risk. However, there is an alternative that was adopted by the SLIMPACT States which takes a more rational approach for casualty and property lines.

The third cause of concern is the potential for double taxation of international risks under the surplus lines policy. Since the enactment of the NRRA, a number of States are considering taxing non-U.S. risks. And at least two jurisdictions have already enacted practices to do just that. This goes against the letter and the spirit of the NRRA and could subject policyholders to double taxation, which may violate the Due Process Clause of the U.S. Constitution. Moreover, the collection of taxes on non-U.S. risks has the potential to unfairly expose insurance producers and professionals to liability claims from insureds who, after being told by the producer to pay premium taxes to their home State based on 100 percent of the exposure anywhere in the world, are informed by a foreign jurisdiction that such payments are insufficient to satisfy their tax liabilities.

In conclusion, despite congressional intent, the States have not devised a single uniform approach to the collection and allocation of premium taxes for non-admitted insurance. Instead, the States have gone beyond and devised multiple approaches that are confusing and cause compliance headaches. We hope the situation will improve, but once again the States have demonstrated they will not modernize insurance regulation without Federal pressure, and even then they will not do it easily.

Thank you for taking my testimony and thank you for your continued interest in our industry.

[The prepared statement of Mr. Monroe can be found on page 37 of the appendix.]

Chairwoman BIGGERT. Thank you, Mr. Monroe.

Mr. Schwarcz, you are recognized for 5 minutes.

STATEMENT OF DANIEL SCHWARCZ, ASSOCIATE PROFESSOR, UNIVERSITY OF MINNESOTA LAW SCHOOL

Mr. SCHWARCZ. Thank you very much for the opportunity to testify to this subcommittee. I want to make four points in my oral testimony today that are based on my written comments.

The first point I want to make is that one of the core lessons I think we learned from the global financial crisis is that we don't always know what we don't know. We have heard lots of stories today about why it is that insurance is not systemically risky, and I will be the first to admit that it is certainly true that insurance is less systemically risky than banking and that there are fewer concerns. That being said, we should all be skeptical of people who claim to have a complete understanding of insurance, who say things like, it is hard to imagine that. It was hard to imagine 2008 before it was 2008.

So one of the lessons I think we take from the global financial crisis, then, is that we need an adaptive regulatory regime that focuses on systemic risk. We need a regime that has all of the information at its fingertips and that can assess risk across holding company structures, across legal entities quickly and efficiently. That is not what this legislation does. What this legislation does is it ensconces a particular view of systemic risk based on what we now think and even based upon the fact and even ignoring the fact that there are real systemic risks within insurance companies.

We have heard that insurers do not threaten the risk of a run-on-the-bank scenario, but that is not true. In fact, a run-on-the-bank scenario in life insurance is perfectly possible because many life insurance products allow policyholders to withdraw funds, to borrow against their policies. So, you certainly could have a run-on-the-bank scenario in life insurance.

We heard that with the AIG crisis, it was only the non-insurance entities that were problematic. Not true. There was a lot of instability within the insurance companies of AIG, particularly with respect to their securities lending program, and there was, in particular, a substantial amount of risk created by the interaction of the insurance companies and the non-insurance companies. The reason the insurance companies of AIG got into so much trouble with their securities lending program is because of the fact that their financial products unit jeopardized their liquidity. We have

heard that guaranty funds provide a fail-safe. Not necessarily true. Guaranty funds at the State level are not prefunded. There is not a single dollar in a guaranty fund. They rely on the assumption that large insurers will be able to cover the risk if other insurers fail. That is fine and good until you have some sort of systemic event.

So the assumptions upon which this legislation rests, I think, are problematic.

The second point I would like to make is actually a point that Mr. Monroe made himself, that the States will not modernize until and unless there is Federal pressure. That is exactly true. If you look at the history of State insurance regulation, virtually every single thing that they do well, they do well because there was a threat at the Federal level to take over. This legislation ignores that lesson. It creates a domain in which State regulators are exempt from scrutiny, where they can give as much information as they want, where they don't have anyone looking over the threat of systemic risk that they create.

The third point I want to make is we have heard State regulators have all the information that is necessary for the FIO and the OFR to do their job. I would submit: one, that is not true; and two, even if I didn't know one way or another that it wasn't true, you couldn't either. We don't know what the future will demand in terms of the necessity to gather information. What I can tell you, for instance, is that State regulators did not have information about the contracts and pooling relationships between AIG's insurance subsidiaries and its non-insurance subsidiaries. That was obviously crucial information at the time. If we were to think that State regulators had all of the information that could ever be wanted by a systemic risk regulator, that should not have occurred. In fact, recently I learned that State regulators don't even have copies of the products of the contracts that insurers sell to their policyholders, so to say that they have all of the information is simply not right.

Finally, I am sympathetic to the view that regulatory uncertainty is problematic and we need to balance the risk and harms of regulatory uncertainty against the necessity of regulation. That is clearly true. But I would submit to you that this legislation targets areas that really don't create very much uncertainty. The subpoena power is very limited. Why is it then valuable? It is valuable as a threat. It is valuable because it will allow States and the FIO and the OFR to leverage that threat to collect data that they need.

So with that I will conclude, and I will be happy to answer any questions.

[The prepared statement of Professor Schwarcz can be found on page 53 of the appendix.]

Chairwoman BIGGERT. Thank you, Mr. Schwarcz, and for all of you, your entire written statements will be made a part of the record. With that, I will turn to Member questions, and I will recognize myself first.

I almost hate to ask this question, but I would like the three of you just to briefly tell me what are the primary differences between banks and insurance companies? We will start with you, Mr. Lanza.

Mr. LANZA. Madam Chairwoman, I am not an expert on banks. I know insurance companies and how they are regulated, and I couldn't really explain the banking industry to you.

With regard to the financial products, P and C companies sell property, casualty, and policies, and we do not sell products that are tied to other financial events or models.

Chairwoman BIGGERT. Okay, thank you. Mr. Monroe?

Mr. MONROE. I will keep this simple. I think there are several key differences between banks and insurance companies. In the insurance industry, I don't think there is really a risk of a contagion. If there is a problem in one insurance company, it really doesn't spread to another insurance company, there isn't going to be a run on the bank, and despite what Mr. Schwarcz said, with the hundreds of years we have had life insurance, there has never been a run on life insurance, and I don't see one happening, and it didn't happen during the financial crisis. Traditional P and C companies are very heavily regulated at the State level. The quality of their investments are very high, and the call on an insurance policy is based on an occurrence that happens. If there is an auto accident in California, it does not impact my ability to call on my auto policy in New York, so there are a lot of differences between insurance and banking, and there are liquidity issues, and the ability for the States to actually do an orderly runoff of insurance companies has been proven to be very successful.

Take Reliance, for example, that failed in the 1990s. They didn't have an impact upon other companies. In fact, it is so competitive in the insurance industry that other companies are very ready, willing, and able to step in and absorb those customers.

Chairwoman BIGGERT. Thank you. And then briefly, Mr. Schwarcz, since you did speak of this before?

Mr. SCHWARCZ. Thank you. There are obviously a lot of differences. I will highlight just a few. The first is that there is group supervision of banks. There is not group supervision of insurance companies under State law right now, so that is a major difference. Another difference is that it is true that banks are certainly more susceptible to runs than insurers, but particularly with life insurers, it is also very true that the obligations can be called. Most life insurance products do allow for borrowing against the policy, do allow for surrenders of policies, and we have seen runs of individual insurers. Now, we have not seen a run on the life insurance industry generally, but I think it is hard to say whether or not that would or would not have happened if we didn't have the Federal intervention we had in the global financial crisis.

The third point I would make is that they are not backed by the Federal Government in terms of guarantees. It is a State guaranty system. That State guaranty system is much, much less reliable than a Federal guaranty system.

Chairwoman BIGGERT. Has that guarantee ever failed?

Mr. SCHWARCZ. That guaranty system has not failed, but we have not had multiple concurrent insolvencies of large companies, so I think it is true that it has worked, and it is true that historically the system has worked, but I think that it is not true that we can be assured that it will always work in the future.

Chairwoman BIGGERT. Okay, thank you. Mr. Lanza, under the draft legislation number one which is under consideration today, and that is to protect confidential insurance data as it is shared among Federal and State regulators, why do they need exclusive language in the law to protect confidential insurance data?

Mr. LANZA. Under the Model Holding Company Act, where we provide State regulators a lot of detailed information about our business plans and other things, we are sure that the information is confidential. The concern here is that, if we are providing that same kind of information to the Federal Insurance Office, the way the language is written, we are not sure that confidentiality is retained, so this is just to clarify that anything we submit retains its confidentiality.

Chairwoman BIGGERT. Thank you. And then Mr. Monroe, is a mutual insurance holding company an insurance company?

Mr. MONROE. I am not familiar with each State's regulations of mutual insurance holding companies. If a mutual insurance holding company actually holds risk, it would be an insurance company, and very often they do hold risk, and then to the extent that they do hold risk, I think they should be subjected to the State regulation.

Chairwoman BIGGERT. Okay. Then in your opinion, does the law need clarification to exclude mutual insurance holding companies like other insurance companies from the FDIC's Orderly Liquidation Authority?

Mr. MONROE. Again, to the extent that they hold risk like a normal insurance company would, I think that clarification would be needed.

Chairwoman BIGGERT. Thank you. My time has expired. The gentleman from Massachusetts, Mr. Capuano, is recognized for 5 minutes.

Mr. CAPUANO. Thank you, Madam Chairwoman. Mr. Monroe, I am just curious, has your group taken a position on an optional Federal charter for insurance companies?

Mr. MONROE. I think we would like to have an optional Federal charter for insurance companies.

Mr. CAPUANO. Honestly, as I was listening to your testimony and reading it this morning, it certainly seems to be heading that way.

Mr. MONROE. Yes.

Mr. CAPUANO. Okay. That would obviously address your concerns. Is that a fair statement?

Mr. MONROE. Yes, it is.

Mr. CAPUANO. That is fair enough. Thank you. Mr. Lanza, reading your testimony, and listening, you make several points on why property casualty companies are different, but I am just curious. You have one here that is a highly competitive market with low individual company market penetration, I agree that is a statement of fact. Is there any law that you know of, Federal or State, that would prohibit consolidation within the industry?

Mr. LANZA. Only with regard to the process of acquiring insurance companies. Under State law, there is a process generally known as a Form A, and the States require information regarding market penetration and other items under something known as a Form E, but that is the only—

Mr. CAPUANO. Right. But there is no prohibition on it, they just want to oversee it?

Mr. LANZA. That is correct.

Mr. CAPUANO. So the consolidation could happen like it has happened in a thousand other industries before; there is no prohibition?

Mr. LANZA. Yes, subject to standard antitrust review.

Mr. CAPUANO. They are not highly interconnected with other financial firms. Again, is there any law that prohibits them from being interconnected with other firms, like AIG was?

Mr. LANZA. Not that I am aware of.

Mr. CAPUANO. So it is an industry practice, not a requirement or a limitation?

Mr. LANZA. Correct.

Mr. CAPUANO. The last one is the low financial leverage. Again, all these statements I agree with as of today, I think they are all factually accurate, I am not arguing at all, but again, is there any law that prohibits or limits the amount of leverage an insurance company might have?

Mr. LANZA. Yes, there is, related to—not only from a regulated side but from a ratings standpoint in terms of the amount of debt and other things you have, you are governed by the rating agencies in addition to the regulators who are concerned about various—

Mr. CAPUANO. I wouldn't associate myself too much with the rating agencies after what they did the last couple of years. They have gotten better, but my faith is not restored just yet.

I would like to see anything it limits, because I am not aware of any Federal law that limits the leverage. Again, I agree that it is an industry practice at the moment, that you are not a highly levered industry, but I don't know of anything that prohibits you from being that. If there is one, I would like to see it and I would appreciate your forwarding it to us as you go along.

But I have to say, and I also agree with the statement that you made that says, "there is little likelihood that one failed PCA insurer requires other financial institutions to fail." I agree with that. I think that is a fair statement. My concern is that everything else after this, including that, is all what it is now, not what it could be tomorrow.

And, you made some good points on confidentiality. I totally agree with you if there are holes. I would like to work with you in filling those holes. There is no sense there.

But everything else is—you are concerned with yes, they may not coordinate with States. And if they don't, I agree with you that we should work on that. That was the whole idea, that they would coordinate with States. But, again, something that may happen, my concern is that what may happen is that we end up with one big huge P/C company that is overleveraged and unregulated.

I don't expect that is going to happen tomorrow, but it is my concern that it may happen. And the whole concept of what we did in the insurance industry was simply to gather information so that we could hopefully be ahead of the curve the next time in case this situation starts setting itself up. And, again, I am not arguing one iota that under today's situation, property casualty companies are

anything other than safe and secure. From everything I know, I agree with you.

I am not concerned about today; I am concerned about tomorrow and the idea being that if we don't have information gathered with someone, some neutral people looking and asking questions confidentially, I totally agree with that, that we put ourselves at risk. Again, not for the good players, it is never the good players I am worried about. Regulations are not there for people who want to live by the rules and the standards of the industry.

Regulations are always there for the outliers, for the people who drag an entire industry down or drag an entire economy down. So I will argue very clearly that, again, the details of confidentiality—I am happy to work with you—but exempting, pretending that because we have a situation today, it will never change, I think is really shortsighted, and I think it really opens the door to true problems tomorrow.

And I say that only because I have absolute total faith that the insurance industry is a lot smarter than government. You will come up with ways around anything we do, as you should. That is the nature of private industry.

My concern is not that, and I am not trying to take anybody down, not call anybody a bad player. I agree with you on the comments you make about current and past history on property casualty. But to pretend that a major industry or player, a major financial player, will never, ever put us in a difficult situation I think ignores the facts of 2008 and pretends that nothing will ever change. And, again, for the details of what is going on, especially since even you agreeing to testimony that FSOC basically said you are not a risky player.

That is pretty much what they said. That is what you said in your testimony, and I agree with that. That is pretty much what they said. But to then say that because I have already done it, that they will never be allowed to do it, simply says we want to go back on the same footing as we had before. And I apologize, I guess my time is over. I didn't think I would take the whole 5 minutes, but I apologize. So I will represent details as far as making sure that the rules that we have are right, but I think it is a mistake to pretend that what is will always be.

Chairwoman BIGGERT. The gentleman's time has expired.

Mr. CAPUANO. I apologize.

Chairwoman BIGGERT. That is fine.

The gentleman from Virginia, Mr. Hurt, is recognized for 5 minutes.

Mr. HURT. I thank each of you for your testimony. And, Mr. Schwarcz, I was interested in your testimony and I appreciate the fact that you seem to recognize that there should be a cost-benefit analysis that goes with every regulatory structure. And you spoke of balance, and I appreciate that.

But I guess I have two questions. One deals with the State regulatory structure and what I think everybody agrees, it seems like even you agree that we have evidence of successful regulation by the States of these companies. And I guess my question for you is, if you have that evidence, you can say we don't know what we don't know, but I am not sure how that guides us as policymakers in try-

ing to game out every possibility despite the overwhelming evidence to the contrary.

I think that when the legislature does that, when we try to base policy on what we think could possibly happen in the future, I think that you will always wind up with unintended consequences. The answer to every problem here in Washington seems to be, we will just regulate it, and I think that at least as I travel across the Fifth District of Virginia where I represent people who recognize that is not a good formula for encouraging job growth and prosperity and freedom, and maybe you could speak to that.

Mr. SCHWARCZ. Absolutely, thank you for the question. Let me just first address your point of how do we, as policymakers, respond to the fact that we don't know what we don't know. To me, this is really a fundamental point, and I think it goes to what systemic risk regulators need to do, because we all have to admit that this is complex stuff that none of us fully understand, and we are learning about it as we go.

The answer is, you build regulatory systems that are adaptive, that are flexible, that can learn and that limit uncertainty, but at the same time, you don't hamstring them by precommitting them to visions about what is and is not systemically risky.

So my concern with this legislation is it is based—and it encapsulates this view about what systemic risk is and is not that we can't be sure is right.

And so I admit we need to make that balancing, but to me the costs of uncertainty that are being addressed here are just so limited. Subpoena power? Why is that valuable? It is valuable because it allows for the threat to get information quickly, and it allows for the FIO to be able to criticize the States without worrying that States are going to say, then, I am not going to give you information.

Mr. HURT. Thank you, because that was my next question, and that deals with the data collection. It seems to me that a prudent policy to come from Congress would be that we will rely on the State regulators who demonstrated that they can regulate successfully and that they have the data necessary for the FIO to be able to make the judgments that it needs to make, so then why don't we allow that system to work. Let's try that, and then if it doesn't work, if the FIO comes back to this committee and comes back to Congress and says, hey, we are not getting your information we need from the States, then let's fix it. It seems to me that is a more prudent approach consistent with what you just said.

Mr. SCHWARCZ. It is very hard—as I am sure you know much better than me—to change the law, right, it is very hard to say, have the FIO come and change the law and it is very hard to get, so I think what you need is you need a system that can adapt more quickly than that.

And the other point I would make is we keep saying, State regulations work reasonably well. I would say that State regulations did not work particularly well in the case of AIG. I think that there was a real failure to appreciate among State regulators the fact that non-insurance companies within holding companies can have real risks for the insurance companies. There was a lack of an appreciation at the interconnectedness among the different entities

and there was the lack of information about the nature of that interconnectiveness.

We keep saying AIG didn't fail and insurance companies are safe. What was bailed out? We don't know what would have happened to the insurance companies if there hadn't been a bailout.

So my claim is not that State regulation isn't working at all; it is that we need to be cognizant to the fact that there are limitations, that there is not a proven track record on group regulation and respond accordingly.

Mr. HURT. Thank you, Mr. Schwarcz. Thank you, Madam Chairwoman, I yield back my time.

Chairwoman BIGGERT. The gentleman from Ohio, Mr. Stivers, is recognized for 5 minutes.

Mr. STIVERS. Thank you, Madam Chairwoman. I appreciate the hearing on this matter.

And the first question I have is for Mr. Lanza. Do you believe we have an effective State-based regulation system in America?

Mr. LANZA. Yes.

Mr. STIVERS. Great answer, quick answer.

The second question I have is for Mr. Schwarcz. I am just curious what you think is wrong with the Federal Office of Insurance being required to work with existing regulators, and I want to quote from the actual discussion draft and help you explain to me what you have a problem with on page 3 where it says, "before data collection from a nonbank financial company that is an insurer or their affiliate of an insurer pursuant to title II, a financial regulator shall coordinate with each relevant Federal agency, State insurance regulator or other relevant State and Federal regulator, agency, in the case of an affiliate or insurer, and any publicly available sources that determine if the information can be collected is available and may be obtained in a timely manner by that State or Federal agency or through publicly available sources."

What is the problem with that?

Mr. SCHWARCZ. I don't have any particular problem with that language. That language actually is already basically in Dodd-Frank. That is one thing that I don't really understand. You are changing Dodd-Frank to do what Dodd-Frank already does.

But the problem I have with respect to that draft bill is the lack of subpoena power, because then, if that information is not available, you have no capacity to go out and get it. And, moreover, it is not that I think subpoenas are going to be issued all the time so, as I said, the threat of a subpoena changes the dynamic. It allows you to get information, and it allows the FIO to do so without having to be completely beholden to State regulators.

Mr. STIVERS. Right. Mr. Schwarcz, you are a law professor, correct?

Mr. SCHWARCZ. That is correct.

Mr. STIVERS. So isn't there essentially a regulatory unwritten rule that those that get subpoena power are also those that regulate? Isn't that historically the way we have regulated?

Mr. SCHWARCZ. I would think that unwritten rules are not a good way to operate.

Mr. STIVERS. But isn't that a good system? Shouldn't people only have subpoena power when they can regulate?

Mr. SCHWARCZ. No. The entire point of the FIO is to—the mission of the FIO is to monitor the insurance market, and to potentially recommend changes. So you are going to task an agency to monitor a market and to potentially suggest changes to a State-based system, but then to have it beholden to the State-based system in getting information?

That means that the only information they have is the information that regulators have, and it might be that the reason you need to modernize regulation is because regulators aren't capturing all the relevant information.

Mr. STIVERS. Did you take a look at the discussion draft on page 4 where it basically covers how the regulators can request information if they feel that information is either not publicly available or not, will not be available in a timely way, Mr. Schwarcz?

Mr. SCHWARCZ. Yes, and I continue to believe that is not sufficient because, again, one of the potential roles of the FIO is to suggest how State regulations are insufficient, the problems that exist there. Now, if I am going to be the person who is going to sit there and be critical of, and you say here are the ways in which you need to change, the best way of making sure that I don't do that very effectively is to say in this—and you can ask the person who you are criticizing for information—and there is an unwritten rule that they might have to give it to you but no actual rule and no subpoena authority.

And then what you are going to say is, sure, I will give you this information, but only so long as you make me look good. And if you don't make me look good, I am not sure if I am going to give it to you or not, so you need that threat.

Mr. STIVERS. Are you familiar with the costs related to data collection in some cases that have been particularly burdensome, and would you favor some type of system to ensure that there is a cost-benefit analysis on the cost of the data collected versus the actual benefit of the data, because I think that is the concern that led to this draft. So can you maybe help us with your thoughts on that?

Mr. SCHWARCZ. Yes. Absolutely, I think the FIO needs to think about the costs of any data call versus the benefits. And so does the Office of Financial Research and, again, I am certainly not completely unsympathetic to the view that regulation is costly and getting data is costly; we just need to balance it. So I agree with that principle, but to me, that is not what is encapsulated here because the legislation sort of is predetermined about how that cost benefit analysis—

Mr. STIVERS. Sure. I do want to quickly, because I have about 30 seconds left, it seems to me that it is hard to construct a circumstance where there would be some mass run on people borrowing on their life insurance accounts. Can you help us, as a committee, understand your thought process there and what you were trying to build, because it really seems like the banking system would have to have collapsed or something out of that, and it just seems difficult to imagine.

Mr. SCHWARCZ. Sure. No, people wouldn't be doing that because they didn't have money from banks. What would happen is that there would be a massive loss of confidence in a particular life insurer say, several life insurers. All of a sudden, big news stories

broke about how they weren't, they didn't have money to pay claims. People would then worry, I am not going to get anything, I better start going and taking out my cash to the extent I can from this life insurer, and then that would be exacerbated by the fact—again, this is a potential calamitous scenario, but we need to think about it—that State guarantee funds wouldn't potentially cover all of the exposure out there. So that is how it could occur.

Mr. STIVERS. My time has expired, Madam Chairwoman. Thank you.

Chairwoman BIGGERT. Thank you, Mr. Stivers. The gentlelady from Wisconsin, Ms. Moore, is recognized for 5 minutes, and thank you for joining our subcommittee today.

Ms. MOORE. Thank you so much, Chairwoman Biggert, for allowing me to come discuss your discussion drafts. I am specifically interested in discussion draft number 2, which is to exclude insurance companies from the FDIC's Orderly Liquidation Authority and, Madam Chairwoman, I guess I would like to yield to you before I address our distinguished panel, because I am just seeking clarification.

In the original Dodd-Frank bill, there was an amendment offered by me and Ms. Speier which, in fact, excluded—let me see, I have the amendment here, it amended section 203, and we inserted part E, which an insurance company that is covered, if it is a covered financial company or a subsidiary or affiliate of a covered financial company, the liquidation or rehabilitation of such insurance company and any subsidiary or affiliate of such insurance company that is not accepted under paragraph 2 shall be conducted as provided under applicable State law.

Our intent with this amendment was to distinguish that insurance companies and, indeed, mutual insurance companies, were not subject to FDIC resolution because they didn't provide systemic risk.

So I want to yield to you, Madam Chairwoman, because my question is, do you think that perhaps discussion draft bill 2 may be duplicative? I understand and I agree with what you are trying to do, but I believe we have already done this through Dodd-Frank.

Chairwoman BIGGERT. Actually, this part of the legislation is based on your amendment to the Dodd-Frank bill. So I think it was to make explicit clarification of that amendment.

Ms. MOORE. Okay, because the thing that I think that—the extent to which there was any exposure—maybe I can ask you gentlemen now—to the extent that there was any discussion of bringing the insurance industry into it was because AIG was systemically risky in terms of it being a threat and being an insurance company and having all of these various activities. I guess I want you all to respond of what your understanding of discussion draft 2 is.

This would not—we are not talking about limiting the FDIC's ability to resolve or interfere with a systemically risky firm that has—insurance company that has a financial institution connected with it. Is that your understanding of this draft as well?

Mr. LANZA. Yes. The concern we have is the fact that an insurance company, which is governed by statutory accounting rules, which is the liquidation value, would have assets go to areas other than the policyholders. So the concern is that we would like the in-

surance regulator to approve any assets going for anyone other than the policyholder.

Ms. MOORE. So you think that this discussion draft is necessary because you are concerned that assets may go to someone other than the policyholder. Are these investors? What are the other entities that you anticipate?

Mr. LANZA. The purpose of the State regulatory system is to have the assets of the insurance company available to pay just the policyholders. And if you can put a lien on those assets to resolve another organization other than the insurance company, that is problematic if there were policyholders at risk. So we believe that the discussion draft solves the problem of having any assets go anywhere beyond the policyholder.

Ms. MOORE. Would anyone else like to respond to that?

Mr. Schwarcz?

Mr. SCHWARCZ. Actually, my understanding was the draft bill didn't change very much in Dodd-Frank.

Ms. MOORE. It did?

Mr. SCHWARCZ. It did not change very much. Dodd-Frank already reflected the fact that insurers would be resolved by State entities, and it allowed the FDIC to intervene if the State regulators were not, in fact, operating. And I am not—I would need to study this a little bit further to understand whether that authority is removed or not. I would think that authority is important, again, to create the leverage the State regulators are not acting, but I do think it is a matter of sort of—it makes sense at first to have State regulators resolving insurance companies.

Ms. MOORE. Thank you so much. And thank you, again, Mrs. Biggert for allowing me to attend this meeting.

Chairwoman BIGGERT. Thank you.

Ms. MOORE. I just wanted to seek that clarification. Thank you. I yield back.

Chairwoman BIGGERT. The gentleman from Wisconsin, Mr. Duffy, is recognized for 5 minutes.

Mr. DUFFY. Thank you, Madam Chairwoman. It appears there is somewhat of a disagreement on the panel as to how we should move forward. And I don't know, Mr. Lanza or Mr. Monroe, if you had a chance to read over Mr. Schwarcz's statement before you came here, but you have had a chance to hear it. Now that you have heard his position or his take on the drafts, do you agree with them?

Mr. LANZA. No. In particular, on the subpoena power, my company has seven subsidiaries in addition to all of the quarterly and annual statements we have to file, we average about 840 data calls a year. Now those data calls, some of them are very easy for us to respond to because it is financial information that we track in evaluating the profitability and other performance factors of our business, but some of those data calls are information we may not have. And the cost of finding that information in some cases can get complicated because we don't have the systems in place in order to capture it.

So the issue we have around the whole thing is that if the FIO was to study the industry as a whole, it makes sense for them to

go to the State regulators to study the industry as a whole before they come to the individual companies.

Mr. DUFFY. Mr. Monroe?

Mr. MONROE. I didn't get a chance to read Mr. Schwarcz's testimony before I got here, and the counsel always supports efforts to improve insurance regulations. We supported the NRRA because of the disparate treatment of surplus lines taxes across the United States. So to the extent that there are gaps in State regulation that the Federal regulation can help improve, we would certainly be willing to look at that and support it to the extent that it will improve the insurance industry.

Mr. DUFFY. Okay. And Mr. Schwarcz, quickly, how many of our property and casualty insurers currently pose a systemic risk? If you know?

Mr. SCHWARCZ. I am not sure. I think that we can't be perfectly sure. My understanding is that based on the recently proposed regulations by FSOC, essentially zero. I think it is pretty clear zero property casualty insurers are going to fall under that. I think my point would be that we need to plan for the future and sort of allow for that flexibility.

Mr. DUFFY. What kind of risk do they pose today?

Mr. SCHWARCZ. What type of risk do property—today?

Mr. DUFFY. Yes.

Mr. SCHWARCZ. I think that today, as far as we know, they pose little systemic risk.

Mr. DUFFY. And if we look at the potential of a systemic risk that you are trying to be a visionary here and look into the future, if we give a little more authority for oversight on the Federal side, will that very much lessen the systemic risk for the future?

Mr. SCHWARCZ. So, two things. First, I am not trying to be a visionary; what I am trying to do is actually say that you are not visionaries either. We don't know.

And that is why we need to adjust the system, take into account that none of us are visionaries, none of us predicted 2008, and that is why we need a flexible regime that is not hamstrung by preordained conclusions.

Mr. DUFFY. But I would say that with property and casualty insurance you are saying, listen, there is a potential for systemic risk in the future and, therefore, you want to head that off at the pass today. So in a way, I would say you are acting as a visionary.

Mr. SCHWARCZ. I will leave it to others to decide whether or not I am either a visionary or attempting to be one. But what I would say is that I don't perceive much systemic risk in the property casualty realm right now right now. I perceive it more in the life realm, but I think that we don't want regulatory assistance that ensconces that viewpoint and doesn't consider the possibility that it might be wrong.

Mr. DUFFY. Thank you. And I wanted to take the remainder of my time and yield it to Mr. Stivers.

Mr. STIVERS. Thank you to the gentleman from Wisconsin. I have a quick question for Mr. Monroe and Mr. Lanza.

In the scenario that Mr. Schwarcz gave earlier about a run on life insurance companies, wouldn't the State regulatory scheme

under McCarran-Ferguson have to essentially completely collapse and fail and the State regulators not do their jobs?

Mr. LANZA. I believe so.

Mr. MONROE. I would have to agree with that. I can't imagine a scenario where it would be a contagion from life insurance company to life insurance company. In fact, given the competitiveness of the insurance market, I think if there was a run on one, others would quickly step in.

Mr. STIVERS. And the last question, I guess, for Mr. Schwarcz, given our discussion earlier about subpoena power, is there any requirement now for the FIO to do any cost-benefit analysis before they would issue a subpoena?

Mr. SCHWARCZ. I don't have Dodd-Frank before me right now, but I think the answer is no.

Mr. STIVERS. I yield back—or to the gentleman from Wisconsin.

Mr. DUFFY. No, I yield back.

Chairwoman BIGGERT. I thank the gentleman. The gentleman from California, Mr. Sherman, is recognized for 5 minutes.

Mr. SHERMAN. Thank you. Mr. Lanza, you said the confidentiality provisions of Dodd-Frank are insufficient to protect insured data. Perhaps you could enlighten us on that a bit.

Mr. LANZA. Our concern is over the transfer of that information from the FIO to the other agencies, and we just want to make sure that it is clear that any information we submit, wherever it goes, is confidential so that we don't lose that. Some of the information we submit is highly proprietary, and that is the concern.

Mr. SHERMAN. Could the relevant agency simply adopt confidentiality policies? Would they need to be formal regulations? Do we need a statute? What do we need to do to protect the confidentiality?

Mr. LANZA. Our suggestion is that you do it through the discussion draft. And that is what we support. We think it is the cleanest way to ensure it because of the nature of the data and its competitiveness.

Mr. SHERMAN. Mr. Schwarcz, one of the concerns of my constituents is that they are going to outlive their savings. The life insurance and annuity industry has created a product called longevity insurance. They might have called it life insurance, but that name had already been taken. And this is an annuity that starts paying you when you reach age 70, 80, 90, whatever it is, but none of them have been able to find it inflation adjusted.

I have talked to the insurance folks, and they have said, we don't want to take the risk of inflation, and I wondered why we have insurance companies if risk taking is not pretty much the job they are supposed to do.

What policy changes do we make so that in addition to Social Security, which is an inflation-adjusted longevity insurance that starts at age 65, what do we do to cause the annuity and life insurance industry to offer what people want, indeed, they may not focus on it with the technical terms, but an inflation-adjusted annuity that begins at an advanced stage?

Mr. SCHWARCZ. Thank you. This is something I can't offer definitive thoughts on right now. I would need to think about it.

Frankly, I am a little cautious about the idea of trying to say, people want this, therefore, we should try to sort of adopt some policy to encourage carriers to provide it. I think if people wanted it enough, carriers will provide it. They just probably don't want it enough and that people won't pay for it.

Mr. SHERMAN. They speak somewhat vaguely about it.

Mr. SCHWARCZ. Right. There are—

Mr. SHERMAN. I had a career in the financial world and one in politics and kind of focused on trying to take what people are saying about finance and translate it in a language that you would speak.

Mr. SCHWARCZ. Right.

Mr. SHERMAN. They are afraid of outliving their savings.

Mr. SCHWARCZ. Sure.

Mr. SHERMAN. They might buy a longevity policy. They would be making a mistake in that they would be fully insured except for inflation.

Mr. SCHWARCZ. Right.

Mr. SHERMAN. So maybe you could add to the record anything that you think could help people know that they need an inflation-adjusted longevity policy and/or let the companies know that they ought to be offering it.

Let me return to Mr. Lanza.

I am intrigued with your suggestion that Dodd-Frank asks insurers to help pay the resolution costs for other failing financial companies, but the other companies don't help to pay for insurance resolution costs, chiefly because there are State funds that do that. This doesn't exactly seem fair.

Can you tell us more about the State resolution system and why Dodd-Frank seems to recreate this inequity?

Mr. LANZA. The State resolution systems, through the guarantee funds, have the ability to only assess the industry, and that is the specific insurance industry, so it is property and casualty related, property and casualty failures. And so if you have the FDIC involved in any related company, the concern is that we would wind up paying guaranteed fund assessments and also be assessed for whatever additional amounts the FDIC wants to assess.

Mr. SHERMAN. I thank you for your answer, and some will remember I fought in this room successfully to leave companies under, I believe it is $75 billion, out of the main assessment program in Dodd-Frank. And I think my time has expired.

Chairwoman BIGGERT. I thank the gentleman for his questions.

I would now ask unanimous consent to insert the following material into the record: a November 15, 2011, letter from the National Association of Professional Surplus Lines Offices, Ltd.; November 15, 2011, testimony from the National Organization of Life and Health Insurance Guaranty Associations; November 15, 2011, testimony from the National Conference of Insurance Guaranty Funds; November 15, 2011, testimony from the Independent Insurance Agents & Brokers of America; a November 14, 2011, letter from the National Association of Mutual Insurance Companies; a November 14, 2011, letter from the Risk and Insurance Management Society; a November 13, 2011, letter from the Nationwide Mutual Insurance

Company; and a November 9, 2011, letter from the National Conference of Insurance Legislators.

Without objection, it is so ordered.

The Chair notes that some Members may have additional questions for this panel, which they may wish to submit in writing. Without objection, the hearing record will remain open for 30 days for Members to submit written questions to these witnesses and to place their responses in the record.

And I would like to thank the panel so much for being here and for your testimony. I really appreciate all the important information that you have given us today. Again, thank you so much.

With that, this hearing is adjourned.

[Whereupon, at 11:30 a.m., the hearing was adjourned.]

A P P E N D I X

November 16, 2011

Testimony of Michael H. Lanza
Executive Vice President and General Counsel
Selective Insurance Group, Inc.
On Behalf of the Property Casualty Insurers Association of America (PCI)

Insurance Oversight and Legislative Proposals
Subcommittee on Insurance, Housing and Community Opportunity
Committee on Financial Services
United States House of Representatives
Wednesday, November 16, 2011

Chairman Biggert, Ranking Member Gutierrez, Members of the Subcommittee: Thank you for the invitation to appear before you today. I am Michael Lanza, Executive Vice President and General Counsel of the Selective Insurance Group, Inc. Selective is an insurance holding company with seven property casualty insurance subsidiaries. In 2010, it was ranked by A.M. Best as 49th largest property and casualty group in the country. I am also testifying today on behalf of our national trade association, the Property Casualty Insurers Association of America (PCI). PCI, with more than 1,000 member companies, has the broadest membership of any national insurance trade association. PCI members write over $180 billion in annual premium, which represents approximately 38.3 percent of the nation's property casualty insurance market.

Selective and PCI strongly support the discussion drafts you are considering to clarify the treatment of insurers under various provisions of the Dodd-Frank Act (DFA). Home, auto, and business insurers, while important to our customers in times of need, did not cause the financial crisis and generally are not systemically important to the financial markets. The property casualty (P/C) industry is stable and healthy. Most importantly, as a whole, the industry did not need federal assistance during the recent financial crisis. There are five key reasons why P/C insurers are not systemically risky:

1. They have low financial leverage;
2. They are not highly interconnected with other financial firms;
3. They are in a highly competitive market with low individual company market penetration;

4. They have low failure rates and, through the state guaranty funds, have their own effective resolution authority; and
5. Most importantly, P/C insurers sell products that cannot result in a "run on the bank."

Let me elaborate further on this last point. Liability, property, and casualty policies do not have extra leveraged cash values or discretionary or other investment components that can be withdrawn, such as products issued by life insurers and banks. There is little likelihood that one failed P/C insurer will cause other financial institutions to fail.

In the financial crisis, one prominent insurer with P/C operations received a bailout. That was AIG. It is important to note, however, that the business practices that led to AIG's issues and bailout had nothing to do with its domestically regulated P/C operations.

For these reasons, we believe that it is important to distinguish between non-risky P/C insurers and other types of financial firms that can pose systemic risk to the national economy. Selective and PCI support the amendments proposed in the discussion drafts because they permit this distinction to be made more clearly. *We do not believe that the proposals – in any way – scale back any powers that Dodd-Frank granted federal agencies to regulate the types of risky activities that gave rise to the financial crisis.* The discussion drafts propose technical amendments that clarify Dodd-Frank's application to insurers and reduce the potential for unintended intrusions on state regulatory authority and other unintended consequences, such as significant administrative expense and burden. We anticipate that the proposals will enjoy bipartisan support, and we look forward to working with the Subcommittee to move these proposals forward.

I would like to comment on four areas that the discussion draft amendments address: Confidentiality; Subpoena Power; State Insurer Resolution Authority and Assessment; and Leverage, Capital, and Accounting Standards.

Confidentiality. Dodd-Frank created the Federal Insurance Office (FIO) and gave it authority to monitor all aspects of the insurance industry, including the ability to gather

information about the industry consistent with FIO's statutory functions. In our opinion, however, the Act, did not adequately acknowledge the role that state regulators play in regulating individual companies and the industry.

The Act included a very well-intentioned provision meant to ensure that the confidentiality of nonpublicly available data submitted to the FIO would be protected. We, however, are concerned that a provision protecting privileged information *submitted to* the FIO might not be tight enough to ensure that this information will continue to enjoy privilege if FIO were to share it with other federal agencies, such as the Office of Financial Research (OFR) or the Financial Stability Oversight Council, or with state insurance regulators. In addition, there is no guarantee that privileged information submitted to state regulators would retain that privilege when state regulators share it with FIO. The discussion draft would tighten these confidentiality protections and clarify that all privileged information flowing to or from FIO regarding insurers will not lose its privilege merely because it is being legitimately shared among various agencies and regulators. This is similar in concept to provisions of the National Association of Insurance Commissioners' (NAIC) Insurance Holding Company Model Act, which provides that privileged information shared by state insurance regulators with other state, federal or international regulators does not lose confidentiality protections.

Subpoena Power. Dodd-Frank gave FIO exceedingly broad subpoena powers. In fact, the powers are much broader than those most other Treasury agencies have. Treasury's usual subpoena powers generally fall into three categories: (1) formal administrative proceedings; (2) criminal or civil investigations and enforcement of laws/regulations; and (3) Inspector General investigative powers.[1] The subpoena power granted in 31 U.S.C. Section 313(e)(6) does not fit into any of these categories, thereby establishing a new precedent for granting subpoena power.

Although Dodd-Frank Section 313(e)(4) instructs FIO to coordinate with other state and federal agencies before seeking data from insurers, FIO's subpoena power is not otherwise constrained beyond a requirement that FIO must believe that the information it wants is relevant

[1] U. S. Department of Justice, Office of Legal Policy, *Report to Congress on the Use of Administrative Subpoena Authorities by Executive Branch Agencies and Entities*, (2001).

to its mission. No suspicion of criminal or civil violations of a law or regulation is required. No formal administrative proceeding must be initiated. Because FIO is not a regulator, FIO cannot issue a subpoena in furtherance of a regulatory function, such as a financial examination. The state insurance departments, however, are regulators and already have the legal power to obtain information and data from insurers, either by subpoena or otherwise (*See, e.g.*, NAIC Model Law on Examinations, NAIC Insurer Receivership Model Act; NAIC Unfair Trade Practices Model Act). In addition to subpoena power, state regulators have an even bigger stick to get information – the ability to withhold or revoke licenses or to take other disciplinary action against uncooperative insurers.

Our concern is that FIO may not always coordinate with the state insurance regulators and subpoena information that we are providing or have already provided to the state insurance regulators and significantly increase our administrative expenses and burdens. In addition, because the Office of Financial Research is required to obtain any information it needs on insurers from FIO, we are concerned that a lack of coordination could further exacerbate administrative expenses and burdens. We believe that the best process for getting federal agencies information about the insurance industry and specific companies is for FIO to use the power already given to it by Dodd-Frank to request it from the states (and then share it with OFR) and take advantage of the inherent regulatory authority the states have to compel production.

For this reason, we strongly support the discussion draft's elimination of the subpoena power granted to FIO andOFR. Dodd-Frank already permits FIO to get this information from the states. By duplicating the existing subpoena power of the states, there is a significant likelihood of redundant, costly, and burdensome data calls on insurers that, ultimately, will be borne by consumers.

State Insurer Resolution Authority and Assessments. The Dodd-Frank Act grants federal regulators the authority to resolve financial companies. Insurance companies are already subject to existing state solvency guaranty funds that protect consumers. In the last 40 years, the U.S. property-casualty guaranty system has paid out roughly $21 billion to

consumer/policyholders on behalf of insolvent insurers. While Dodd-Frank properly reserved to the states the authority to resolve failing insurance companies, the Act needs tightening in several ways to ensure that federal regulators do not have the power to intrude on state authority to resolve insurers.

Section 204(d)(4) of the Act permits the FDIC to take a lien on the assets of a covered financial company or its subsidiaries, but fails to exclude companies and subsidiaries that are insurance companies. This creates the potential for the FDIC to take a lien against insurance company assets to help shore up an affiliated non-insurance company. State insurance regulators comprehensively regulate insurer investments to ensure that adequate capital and surplus is available to keep the insurer solvent and able to pay claims to policyholders. By giving the FDIC authority to take a lien against insurer assets without consultation with state insurance regulators, the Act creates the potential for federal regulators to imperil the ability of insurers to honor claims to policyholders. We believe that the discussion draft appropriately would bar the FDIC from placing a lien on an insurance company's assets without the written consent of the insurance company's domiciliary state regulator.

We also believe that Dodd-Frank also unfairly asks insurers to help defray the costs of federal resolutions of other non-insurer financial firms. Insurers are already required to pay into state insurance resolution funds to help ensure that policyholders of other failed insurers are honored. The imposition of a federal resolution assessment on insurers by the Act imposes the potential for double assessment on insurers. Insurers already pay at the state level for resolution costs within the insurance sector. They should not pay a second time at the federal level for resolution costs outside of the insurance sector. Doing so creates inequity, as the Act does not require non-insurance entities to pay for insurer resolution costs.

Dodd-Frank requires the FDIC to use a risk-matrix in determining how to assess financial companies, and that matrix does include consideration of an insurer's payments of assessments into state guaranty funds. The matrix, however, does not absolutely bar the FDIC from imposing a double resolution assessment on insurers. We believe that the discussion draft appropriately

proposes prohibiting the FDIC from counting insurance assets, liabilities, or revenues in calculating its assessments on financial firms to pay for resolutions of other financial firms.

Leverage, Capital and Accounting Standards. Dodd Frank gives the Federal Reserve Board the power to impose heightened prudential standards on firms that the FSOC finds to be systemically risky. We are pleased that preliminary proposed FSOC rules governing systemic risk determinations would make it relatively unlikely that companies predominantly engaged in the property casualty insurance business will be so designated. Nevertheless, the FSOC rules may change over time and the statute does not absolutely prohibit designations of property casualty insurers. This means that, in the event a P/C insurer ever is designated, the FSOC would have the power to impose heightened prudential standards on that insurer.

Insurer financial standards are regulated by state insurance regulators, but the Act gives the Federal Reserve Board the power to impose its own standards on insurers without consideration of existing state regulatory standards and requirements. We believe that this is another example of the potential the Act creates for intruding inappropriately on state regulatory authority and for creating conflicts between state and federal regulators. To remedy this, the discussion draft requires the Board, in determining whether heightened prudential standards are to be applied to depository institutions and nonbank financial companies that own insurance companies, to take into account the regulatory and accounting procedures applicable to the capital structure of insurance companies and to give deference to applicable state laws governing risk-based capital for insurance companies. We note, in particular, that the Securities and Exchange Commission (SEC) in Section 10(e) of Rule S-K, already recognizes that statutory accounting standards are appropriate for insurers, and this proposal properly requires the Federal Reserve to recognize this as well.

In conclusion, the proposals put forward in the discussion drafts are technical and clarifying. They, however, provide much-needed refinement to the existing Dodd-Frank statutory language. These changes will (i) ensure that federal and state regulators do not impose conflicting or duplicative requirements on insurers, (ii) protect the confidentiality of privileged information shared by and among federal and state agencies, (iii) simplify the process by which

FIO and OFR will obtain information from insurers, and (iv) ensure that risk-based capital remains the foundation of state insurance regulation. We strongly urge the introduction and passage of these important proposals. We look forward to working with all members of the Subcommittee to move them through Congress.

Statement of Steven M. Monroe
Chief Compliance Officer, U.S. and Canada
Marsh, Inc.

on behalf of The Council of Insurance Agents & Brokers

Before a Hearing of the House Financial Services Subcommittee on Insurance, Housing and Community Opportunity

"Insurance Oversight and Legislative Proposals"

November 16, 2011

Good morning, Chairman Biggert, Ranking Member Gutierrez, and members of the Subcommittee. My name is Steven Monroe. I am Chief Compliance Officer for Marsh, Inc in the United States and Canada. Today, I am testifying on behalf of The Council of Insurance Agents & Brokers ("The Council"). Thank you for this opportunity to speak with you today regarding implementation of the insurance provisions of Dodd-Frank, and the legislation that has been proposed to clarify the applicability of certain provisions of Dodd-Frank to the insurance sector.

The Council represents the nation's leading insurance agencies and brokerage firms, including Marsh. Council members specialize in a wide range of insurance products and risk management services for business, industry, government, and the public. Operating both nationally and internationally, Council members conduct business in more than 3,000 locations, employ more than 120,000 people, and annually place more than 80 percent – well over $200 billion – of all U.S. insurance

products and services protecting business, industry, government and the public at-large, and they administer billions of dollars in employee benefits. Since 1913, The Council has worked to secure innovative solutions and create new market opportunities for its members at home and abroad.

Marsh, founded in 1871, is the world's leading insurance broker and risk adviser, with over 25,000 employees providing advice and transactional capabilities to clients in over 100 countries. Marsh, a unit of Marsh & McLennan Companies, provides thought leadership and innovation for clients and the insurance industry — introducing and promoting the concept and practice of client representation through brokerage, the discipline of risk management, the globalization of insurance and risk management services and many other innovative tools and service platforms.

Introduction

The Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank) was signed into law on July 21, 2010. The focus of the legislation, appropriately, was banking and securities. Although several important provisions of the law address insurance issues, the insurance-specific provisions of the law were limited and relatively noncontroversial. Dodd-Frank did not alter the basic state regulatory framework. In fact, outside the insurance-specific provisions of the bill, Dodd-Frank largely excludes insurance from its mandates, either specifically or by implication. The Council supports legislation under consideration that would clarify what we believe was the intent of Congress in enacting Dodd-Frank by specifically excluding the insurance sector from Federal Deposit Insurance Corporation (FDIC) resolution authority and from the so-called "Volcker Rule."

Although the insurance sector is largely excepted from the more widely-applicable provisions of Dodd-Frank, the law includes several provisions of significance to the sector, namely, the creation of the Federal Insurance Office (FIO), reform of surplus lines regulation, and, potentially, heightened regulation of insurance institutions deemed systemically important under the law's FSOC provisions.

In my testimony today, I will address two issues: First, The Council believes that insurance companies, particularly property and casualty insurers, generally are not systemically important and the

failure of an insurer would not give rise to systemic risk issues. The proposed legislation would help to clarify for regulators and the marketplace that this was the intent of Congress in enacting the law.

Second, I will discuss the implementation of the surplus lines regulatory reforms enacted under Dodd-Frank. These provisions are arguably the most important of the law for insurance brokers, and the botched implementation of the surplus lines reforms by the states is of significant concern to all of us.

P&C Insurers and Systemic Risk, the Volcker Rule and FDIC Resolution Authority

The intent of the Dodd-Frank Act was, generally, to put into place regulatory protections so that systemically important financial institutions, including banks and non-banks, (SIFIs) would be subject to heightened regulatory scrutiny to try to prevent failure. And if a SIFI did fail, Dodd-Frank puts into place a resolution system to provide for the orderly winding down of the institution by the FDIC.

The Financial Stability Oversight Council (FSOC) has issued a notice of proposed rulemaking setting forth proposed criteria for determining if a non-bank should be designated as a SIFI. Although unlikely, large property and casualty insurers could fall within the criteria and, therefore, become subject to heightened prudential oversight by the Federal Reserve and, potentially, FDIC resolution authority. The Council supports the proposed legislation, which would (1) limit the applicability of the so-called "Volcker Rule" to insurers and (2) exclude mutual insurance holding companies from FDIC resolution authority, and limit FDIC's ability to place liens on the assets of insurance companies. The proposed bills are in keeping with the intent of Dodd-Frank, which recognized the comprehensive regulatory structure governing insurers and took pains to avoid duplicating existing regulatory requirements. The Council believes that these bills would clarify that original intent, rather than altering it whole-cloth.

These bills are important because it is critical for Congress to send a message to FSOC, the federal banking regulators, and the insurance marketplace that except in the rare circumstance property and casualty insurers are very unlikely to pose systemic risk and to be designated SIFIs, and even less likely to be subject to FDIC's resolution authority.

P&C Insurers Generally Do Not Pose Systemic Risks

Core P&C insurance activities can create market risks but do not generate systemic risk. As the AIG situation demonstrated, it is always possible that a parent company or non-insurer affiliate of a P&C insurer will engage in unregulated, non-insurance transactions that are large scale and risky enough to generate systemic impact. By and large, however, P&C insurers and their holding companies limit their operations to their core insurance business, and, except in rare cases (again, see AIG), are not significant players in such potentially destabilizing investment vehicles. It is only outside the core P&C insurance operations that a large insurance holding company could engage in activities that could create systemic risk. This should be made clear under Dodd-Frank so that systemic risk regulators are clearly directed to focus on institutions' non-insurance activities. There is no need to expend limited regulatory resources scrutinizing core P&C insurance activities when those activities are already regulated by frontline insurance regulators.

Generally, the failure of a major P&C insurance company may have some market impact on the P&C insurance sector, but it would not have a systemic impact on the financial markets or the wider economy because of a unique combination of industry attributes, including:

(1) The nature of insurance products: Unlike banking and securities, where the failure of one institution could result in a ripple effect causing the failure of other firms, the unique nature of P&C insurance products insulates the insurance market from the risk of contagion. P&C insurance is different from banking and securities in several fundamental respects:

- P&C insurance products have no cash value and therefore cannot be cashed in. When a P&C insurer is impaired and in danger of failing, there is simply no immediate demand that policyholders can make on its assets.
- the risks taken on by insurers are generally uncorrelated to the rest of the financial markets, whereas the risks taken on by banks and securities firms are inherently tied to the performance of the financial markets; and

- P&C liabilities vary primarily according to actual claims of policyholders from independent loss events and are not correlated with the performance of the bond or equity markets interest rates or real estate cycles.

(2) The competitive insurance marketplace: The failure of a single major insurer or group of major insurers is unlikely to have a broad impact on the P&C insurance market as a whole because the market is not concentrated. The P&C insurance market is highly competitive, and, given the lack of concentration, there is every reason to believe that other insurers would be able – and willing – to absorb the business of the failed company. Moreover, because of the mandatory nature of most P&C insurance, the overall market for policies rarely if ever decreases dramatically.

(3) Limited type and scope of insurers' investment risks: The failure of a P&C insurer generally will not threaten the functioning or long-term stability of the financial markets for a number of reasons, including:

- State prudential regulation requires that the vast majority of insurers' assets be invested in highly liquid, high quality instruments. State insurance laws also require regulators to intervene early – when an insurer becomes impaired – in order to craft solutions short of liquidation.
- The nature of P&C liabilities (that is, insurance claims) results in payments over an extended period of time and therefore impose no risk of a sudden call on all outstanding financial obligations.
- Even when outright liquidation is necessary, state receivership laws and the nature of P&C liabilities will allow insurance commissioners to slow the payment of an insurer's claims in order to maximize the value of its assets.
- P&C failures are generally not correlated to the ups and downs of the financial markets. Instead, they tend to result from bad underwriting decisions and insurance risk management. Liquidation of an insolvent insurer may create some downward pressure on certain asset classes, but it is unlikely to contribute to a downward pricing spiral that

threatens the financial system as a whole. Because there is no demand feature to insurance liabilities, they are paid out over an extended period of time, which minimizes liquidity requirements and the need to sell large amounts of assets in a "down" market.

- Even when a P&C insurer engages in financial activities other than bond or equity investments, such as derivatives hedging or securities lending, those activities are generally not large enough to create a systemic threat.

(4) Comprehensive insurance regulatory and resolution systems: The insurance regulatory process governing insolvencies is designed to minimize disruption from an insurer's failure to policyholders, the insurance industry, the public, and financial markets. That is accomplished in multiple ways through:

- Early detection of an insurer's financial problems providing regulators time to respond appropriately;
- Rehabilitation of an insurer and continuation of its normal operations;
- Orderly and lengthy wind-down process in the event of insolvency; and
- The assurance that policyholders are protected by state guaranty funds.

Recently, the International Association of Insurance Supervisors (IAIS) reached the same conclusion in its report on "Insurance and Financial Stability" – that insurers engaged in traditional insurance activities do not generally pose systemic risk, but companies engaged in non-traditional or non-insurance activities may have systemic relevance. IAIS found that several characteristics of the insurance business model and the industry as a whole keep insurance activities from triggering or amplifying systemic risk. Those characteristics include: underwriting risks are not correlated with economic cycles or financial market risks; investment portfolios are able to absorb large losses; liabilities are triggered by insured events, not sudden cash runs; strong competition exists in most lines of insurance business; there are low barriers to market entry and high degrees of substitutability, allowing for inflow of new capital to restore any capacity losses; disciplined, liability-driven investment approaches; and a robust regulatory framework for monitoring and supervising insurers, including orderly resolution processes.

The IAIS report supports The Council's position that insurers are generally not systemically risky, and their traditional insurance activities should not be subject to duplicative regulatory oversight or requirements.

Implementation of Dodd-Frank's Surplus Lines Regulatory Reforms By the States is Falling Short of Congress's Intent

The Dodd-Frank Act included a key provision that The Council and insurance brokers had been advocating for years: reforming state regulation of the surplus lines insurance market. Most of the law's surplus lines provisions went into effect on July 21 of this year. Unfortunately, despite Congress's best intentions in drafting the law, the state implementation process has been marked by confusion and frustration. Instead of taking advantage of the opportunity the Dodd-Frank reforms presented to the states to devise a single, uniform approach to surplus lines regulation (while maintaining regulatory control at the state level), the states have gone the opposite way – devising multiple approaches that are causing confusion and compliance headaches. This is particularly problematic with respect to the law's most important reform – surplus lines premium taxation.

Background:

Dodd-Frank's surplus lines provision, taken directly from the "Nonadmitted and Reinsurance Reform Act" (NRRA) which passed the Financial Services Committee and the full House four times in the past several years, addresses the full spectrum of surplus lines regulation. Based on the concept of "home state rule," the law limits regulation of a surplus lines transaction to the home state of the insured; establishes uniform standards for insurer eligibility that are applicable in every state that imposes such requirements; allows automatic export to the surplus lines market for sophisticated commercial purchasers in every state; and requires state participation in a national producer licensing database by July 2012. Perhaps most important, the NRRA says that only a single state – the home state of the insured – can require the payment of surplus lines premium tax. The law allows, but does not

require, the states to allocate surplus lines premium taxes paid to an insured's home state among themselves in accordance with an interstate compact or other procedures established by the states, but does not contemplate multiple allocation compacts or arrangements. In other words, the home state can require risk allocation information from the broker in addition to payment, but it is up to the states to allocate (or not) among themselves. And only the insured's home state can require a surplus lines broker's license. Prior to NRRA, large brokerage firms had thousands of non-resident surplus lines licenses.

State Implementation:

Many, but not all, states have revised their surplus lines requirements to conform their state laws to the new federal requirements. Although it is clear that the NRRA will preempt state laws that are inconsistent with its standards, in order to eliminate the possibility of confusion and conflict, it is important that all states revise their laws to comport with the NRRA's standards.

Although we are hopeful that the NRRA's non-tax provisions will be implemented as Congress intended, we are very concerned by the implementation of the tax provisions of the law. The collection and distribution of surplus lines premium taxes has been a confusing and complex challenge for surplus lines brokers for many years. The NRRA reforms address this problem through single state regulation; that is, by permitting only the home state of the insured to require the payment of premium taxes in connection with a surplus lines transaction or direct nonadmitted insurance placement. The statute leaves no ambiguity about the intended goal and provides that "[n]o state other than the home state of an insured may require any premium tax payment for nonadmitted insurance." Moreover, the NRRA acknowledges that states may enter into an interstate compact or agreement in order to allocate premium taxes for multistate surplus lines risks, but allocation is not required by the law.

Although the NRRA's tax provisions are straightforward, because of the uncoordinated and cumbersome way in which the states are implementing the law, we are increasingly concerned that this simple provision may lead to an unintended result that actually exacerbates existing compliance burdens and challenges.

The states are following five basic approaches to implement the NRRA's tax provisions.[1] States that choose to allocate are working through either NIMA (the Nonadmitted Insurance Multi-State Agreement) or SLIMPACT (the Surplus Lines Insurance Multi-State Compliance Compact). Some states have chosen to tax the surplus lines transaction based on the proportion of the insured exposure in each state, at each state's tax rate, but keep 100% of the tax. A number of other states have chosen a fourth option: foregoing both interstate approaches completely, opting to tax – and keep – 100% of surplus lines premium tax for coverage provided to home state insureds based solely on the home state rate. Still others have taken no action at all, instead maintaining their old laws, which, in most cases, means they tax only the portion of the risk located in their state. To confuse matters further, the multi-state allocation schemes – NIMA and SLIMPACT – are not yet operational, leaving brokers to determine what – and how – to calculate, collect and pay applicable taxes in those states.

The states can be categorized as follows for surplus lines premium tax purposes:

(1) Pro-Rata States: A number of states have not changed their premium tax laws to conform to the NRRA. Nonetheless, they still must comply with the NRRA's requirement that only the home state of the insured may require surplus line premium tax payments. Most, if not all, of these states currently impose tax only on the portion of the risk located in the state. This means that, for transactions on and after July 21, 2011, if one of these "Pro-Rata States" is the home state of the insured, the tax will be imposed only on the portion of the risk located in the insured's home state.

(2) 100% Retention States at one rate: As of July 21, 2011, a number of states tax 100% of the premium on surplus lines policies and do not allocate the taxes to other states where covered risks are located. This means that, for transactions on and after that date, if one of these "100% Retention States" is the home state of the insured, the broker will be required to pay tax to the home state of the insured on the entire amount of the premium, most likely at the home state's tax rate.

[1] Exhibit A attached to my testimony is a chart depicting jurisdictions by surplus lines tax regime type.

(3) 100% Retention States at multiple pro-rata rates: Ten states enacted laws whereby they would tax the surplus lines transaction based on the proportion of the insured exposure in each state, at each state's tax rate, and then retain 100% of the tax. This method thwarts the clear intent of Congress to streamline and simplify how surplus lines taxes were collected. Moreover, it unnecessarily increases the frictional costs for consumers and insurance producers who must allocate risks across multiple states and then collect taxes at the different state rates.

(4) NIMA States: NIMA is a multi-state agreement that addresses only surplus lines premium tax. The states that have signed on to NIMA are creating a central clearinghouse for reporting and collecting surplus taxes, and for distributing surplus lines taxes among participating states in accordance with a uniform risk allocation formula. When NIMA's clearinghouse is operational, if a "NIMA State" is the home state of the insured, the broker will be required to pay tax and submit allocation and report information to the NIMA clearinghouse on a quarterly basis (February 15 for the quarter ending the preceding December 31; May 15 for the quarter ending the preceding March 31; August 15 for the quarter ending the preceding June 30; and November 15 for the quarter ending the preceding September 30).

The effective date of NIMA was recently delayed until January 1, 2012, because the NIMA clearinghouse is not operational. Reportedly, the goal is to have the clearinghouse functioning by May 15, 2012, which is the due date for first quarter 2012 surplus lines premium taxes. In the meantime, however, brokers are scrambling to determine what – and how – to calculate, collect and pay the applicable taxes for transactions occurring in the third and fourth quarter of 2011.

(5) SLIMPACT States: SLIMPACT takes an approach that is both more comprehensive and less defined than NIMA to satisfy the reforms provided for in the NRRA. SLIMPACT is more comprehensive because it addresses not only the tax collection and allocation issues, but also the other regulatory issues addressed in NRRA such as insurer eligibility, insured "home state" determinations, commercial purchaser exemptions, and so forth. At the same time, SLIMPACT is less defined because, although it establishes a clearinghouse for tax payment and allocation,

the agreement itself does not establish standards for the clearinghouse or all the regulatory issues it covers. Instead, the compact creates a commission comprised of the compacting states that will, essentially, have authority to set standards and make decisions in connection with these surplus lines regulatory policy issues.

SLIMPACT will not become effective for purposes of adopting rules and creating a clearinghouse until ten states, or states representing 40% of all surplus lines premium volume, enter into the compact. As of November 16, 2011, only nine states have enacted SLIMPACT. Under the terms of the compact, neither the SLIMPACT clearinghouse, nor the compact's rules and allocation formula, will be effective until those thresholds are met.

Nonetheless, if SLIMPACT's clearinghouse becomes operational (which will not be until at least January 2013), if a "SLIMPACT State" is the home state of the insured, the broker will be required to pay tax and report allocation information to the SLIMPACT clearinghouse in accordance with the rules and timeframes mandated by the SLIMPACT Commission. In the meantime, however, just as with the NIMA states, brokers are left scrambling to determine how to comply.

The Council is extremely concerned about the manner in which the surplus lines premium tax reforms are being implemented in the states. The NIMA allocation formula, the lack of a single allocation formula for both NIMA and SLIMPACT states, and the taxation of foreign risks are the most urgent compliance issues facing brokers.

Premium Tax Allocation: The Council believes that, to the extent states choose to allocate surplus lines premium taxes, allocation should be done in accordance with a single, efficient allocation formula that does not result in increased burdens and compliance obligations for brokers and consumers.

To date, approximately 20 states have signaled that they intend to allocate surplus lines premium taxes through either NIMA or SLIMPACT. Neither multi-state allocation scheme is operational yet, but when (if) the clearinghouses and rules are put into place, each scheme will operate under a different

allocation formula, rather than a single formula. That is problematic enough, imposing unwarranted costs and compliance difficulties on brokers and consumers across the country. The NIMA allocation formula poses further problems. The NIMA formula currently contemplates an allocation methodology that would be more complex and cumbersome than any allocation formula in place in any state prior to enactment of NRRA, and would require the collection of information that is not even utilized in the underwriting process. This turns the intent of NRRA on its head. Rather than simplifying and streamlining the regulatory and tax payment process, the NIMA allocation formula would make it more difficult and costly to comply.

Meanwhile, there is an alternative allocation formula that would get the states the information they need without placing undue burdens on brokers and consumers. Kentucky Insurance Commissioner Sharon Clark, who chairs the NAIC's Market Regulation and Consumer Affairs Committee, has proposed a methodology that has considerable merit and addresses the biggest problems associated with the current NIMA allocation system. The SLIMPACT states have endorsed the so-called "Kentucky Compromise," and the NIMA states have been urged to adopt it in lieu of their current cumbersome formula. Unfortunately, despite the efforts of many who understand the process and the issues to educate and explain why the "Kentucky Compromise" works, the NIMA states have yet to budge.

International Taxation: The NRRA limits surplus lines premium tax authority to the home state of the insured. This change was needed because, prior to enactment of NRRA, multistate surplus lines transactions could be subject to taxation by more than one state depending upon the locations of the risk. In other words, consumers could be subject to double taxation – or worse. The NRRA was intended to do away with that potential conflict. Unfortunately, since the enactment of NRRA, a number of states have considered, and one (to date) has implemented, policies to tax 100% of the premium on a surplus lines transaction including premium covering risks located outside the United States.

We do not believe that this was Congress' intent when enacting the NRRA. The language of the statute provides not only that the insured's home state is the only state that may regulate or impose taxes on a nonadmitted insurance transaction, but also that the states may form a compact to share taxes

among themselves if they so wish. The NRRA defines "State" as any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Marianas Islands, the Virgin Islands and American Samoa. Foreign countries are excluded from this definition by their omission from the definition. This evidences Congress' intent that premiums attributable to risks in a foreign jurisdiction were not considered to fall within the ambit of the NRRA.

Taxation of non-U.S. risks not only goes against the intent of the NRRA to focus surplus lines taxation and regulation on the home state of the insured, it turns it on its head. States did not allocate or collect taxes on risks in foreign jurisdictions prior to the enactment of the NRRA. To use the NRRA as an excuse to tax such foreign risks mis-reads the law and the intent of Congress. Although a state may wish to tax the non-U.S. portion of a risk, the non-U.S. jurisdiction where the risk is located may also expect to receive taxes on the portion of the risk located there. This exposes the insured to the possibility of double taxation on the premium, which, among other things, may violate the Due Process Clause of the U.S. Constitution. It is also inherently unfair and goes against Congress' clear intent in enacting the NRRA to simplify, rather than complicate, surplus lines taxation. Imposing tax on foreign risks would leave brokers and insureds in the same position as before NRRA's enactment – except that instead of potential double taxation among the states, they would face double taxation by the state and foreign jurisdictions. The NRRA did not intend such a result. Moreover, it seems unlikely that the enforcement of such a rule by any single state could be allowed to impinge on the federal government's exclusive province of speaking with one voice for the United States on matters of foreign affairs and international trade.

There is an additional consideration that makes the collection of taxes on non-U.S. risks particularly problematic. The collection of such taxes has the potential to expose insurance agents and brokers to professional liability claims from insureds who – after being told by their agent or broker to pay 100% of the premium tax to a state – are informed by a non-U.S. jurisdiction that such payments are insufficient to satisfy their tax liabilities to that non-U.S. jurisdiction.

To date, several jurisdictions, including New Jersey, New York, and Texas, have indicated that they will not impose or collect taxes on premiums attributable to non-U.S. risks. At least two

jurisdictions, including California, one of the largest insurance markets in the world, are enacting practices to collect tax non-U.S. risks, while a third state is considering following suit.

Conclusion

In conclusion, I would like to emphasize The Council's belief the intent of Congress, in enacting Dodd-Frank, was not to bring the insurance industry under a federal regulator through the creation of FSOC, the Volcker Rule and FDIC non-bank resolution authority. Rather, the intent was to include only the out-liers, the unique entities, such as AIG, that engage in activities that are not otherwise regulated by insurance regulatory authorities. The proposed legislation will help clarify that intent for the federal regulators implementing the law.

In addition, with respect to The Council's signature issue in Dodd-Frank – surplus lines regulatory reform – we face significant implementation difficulties caused not by the federal law itself, but by poor state implementation of the law. Despite the clear intent of the NRRA, the states have not yet adopted nationwide uniform requirements, forms, and procedures that provide for the reporting, payment, collection, and allocation of premium taxes for nonadmitted insurance. We believe the situation will improve, but, once again, the states have demonstrated that they will not modernize insurance regulation without federal pressure, and, even then, they will not go easily.

Thank you for your consideration of our views.

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Jurisdictions by Surplus Lines Tax Regime Type		EXHIBIT A
Last Updated 11/15/11		
This chart categorizes jurisdictions by general tax regime type. For further explanation of surplus lines tax laws in each jurisdiction, please consult the		
NRRA Compliance Guide on the CIAB website or contact the state insurance department. "Per DOI" indicates that the jurisdiction's department of insurance		
represents that this is the jurisdiction's approach to taxation, whether or not that approach is actually reflected in the law or regulations.		
100% Jurisdictions (24)		
No legal Authority to Allocate via Multi-State Agreement	**Legal Authority to Allocate via Multi-State Agreement, but Authority Not Yet Exercised**	**Authorizing Studies of Multi-State Agreements (* denotes agreement authorized following study)**
CA	AR	AZ*
ID	MT (per DOI)	DE*
IL (per DOI)	NH	GA*
MN	NJ	ME*
MO	OK	MD*
NY	TX	MA* (public notice and comment required)
PA	WV	NC
VA		OH*
WA		
Total - 9	**Total - 7**	**Total - 8**
Pro Rata Jurisdictions (7)		
No legal Authority to Allocate via Multi-State Agreement	**Legal Authority to Allocate via Multi-State Agreement, but Authority Not Yet Exercised**	
CO	OR	
DC (per DOI)		
IA		
MI (per DOI)		
SC (per DOI)		
WI		
Total - 6	**Total - 1**	

Jurisdictions with Tax Allocation Agreements (21)		
SLIMPACT	**NIMA**	
AL	AK	
IN	CT	
KS	FL	
KY	HI	
NM	LA	
ND	MS	
RI	NE	
TN	NV	
VT	PR	
	SD	
	UT	
	WY	
Total - 9	**Total - 12**	

TESTIMONY OF DANIEL SCHWARCZ

Associate Professor, University of Minnesota Law School

before the

House Subcommittee on Insurance, Housing and Community Opportunity

regarding "Insurance Oversight and Legislative Proposals"

November 16, 2011

Thank you for the opportunity to address this subcommittee regarding several discussion drafts of proposed amendments to the Dodd-Frank Wall Street Reform and Consumer Protection Act ("Dodd-Frank"). Collectively, the proposed amendments limit the authority of federal entities to regulate and monitor insurers that may pose systemic risks. In particular, they exclude systemically significant insurers from heightened prudential standards set by the Federal Reserve, completely exempt insurers from the FDIC's orderly liquidation authority, and limit the capacity of federal entities such as the Office of Financial Research (OFR) and the Federal Insurance Office (FIO) to collect data directly from insurers. Accepting a core premise of Dodd-Frank – that systemic threats must be monitored and managed in a unified manner at the federal level – the proposed legislation implicitly embraces the assumption that insurance companies do not pose systemic risks. The proposals also limit the tools available to FIO to assess the state of the insurance industry with respect to issues extending beyond systemic risk, including the adequacy of state-based consumer protections.

Based on my preliminary review and analysis, I have four substantial concerns about the desirability of these proposed amendments.

First, the proposed legislation seems to ignore one of the central lessons of the 2008 Global Financial Crisis: that we do not always know what we do not know when it comes to systemic risk. Prior to 2008, of course, the vast majority of regulators, economists, and legal experts embraced various orthodoxies regarding systemic risk that turned out to be incorrect. In many ways, it was the failure of these people to consider the possibility that their views might be wrong that precipitated the Global Financial Crisis and consequent Great Recession. In my view, the proposed legislation makes this same mistake: it ensconces the traditional view that insurance activities pose limited systemic risk and restricts the capacity of federal regulators to learn as they go and adapt to evolving research and knowledge. It does this by effectively exempting insurers from the heightened prudential standards that ought to apply to systemically risky firms, by limiting the tools available to federal agencies to investigate systemic risk within insurance companies, and by undermining the capacity of federal regulators to respond to facts on the ground that reveal the threat of systemic risk.

This inflexible approach would perhaps be defensible if we could be completely confident in the view that insurance could never pose any systemic risk. But while it is indeed true that insurance is generally thought to pose limited systemic risks, this conclusion is hardly unassailable or absolute. Even traditional insurance activities can pose some systemic risks, particularly in the domain of life

insurance. In part, this is because life insurers, like banks, are theoretically susceptible to policyholder runs, as many life insurance products allow policyholders to borrow against their policy or cash out their savings. As a result, policyholders who become concerned about their carriers' solvency can demand withdrawals, producing a downward spiral analogous to those found in classical bank runs. In fact, several life insurers have experienced exactly these types of runs by their policyholders.

While there is limited historical evidence of policyholder runs at one insurer triggering runs at other insurers, this is hardly impossible, especially since state guarantee funds are much less reliable and complete than FDIC insurance. Such guarantee funds are not generally pre-funded, they are not backed by the full faith and credit of the federal government, and they limit payouts to amounts that are often well below the face value of policies. Moreover, state-based guaranty funds are premised on the capacity of non-troubled insurers to cover the obligations of failing insurers. As such, their capacity to handle several major insolvencies concurrently is highly doubtful. Indeed, attempting to force surviving carriers to shoulder the burden created by several large insolvencies could actually endanger the health of otherwise solvent insurers, thus generating a downward spiral in insurance markets.

Nor can it be said that the limited availability of insurance would be without systemic consequences. For instance, without property insurance or title insurance, real estate transactions become virtually impossible. Similarly, various vital

professional services can become seriously disrupted in the absence of liability insurance.

Perhaps most importantly, our experience with AIG in 2008 taught us that we do not fully understand the systemic risks involved in insurance holding company systems. To be sure, AIG's Financial Products division, which caused much of AIG's trouble, was not regulated as an insurer. Similarly, AIG was regulated on a consolidated basis by the Office of Thrift Supervision. But it is also true that AIG's various insurance companies engaged in securities lending transactions that exposed them to extensive, and largely unanticipated, risks. These risks were exacerbated by the actions of AIG's Financial Products unit, whose risk-taking had the impact of severely limiting AIG's liquidity and thus its capacity to meet collateral calls associated with its securities lending program. In short, the AIG experience suggests that, before 2008, state insurance regulation had largely failed to appreciate the risks that affiliates of insurance companies can pose to otherwise healthy insurers.

To be sure, the NAIC is currently studying and adjusting its approach to the supervision of insurance groups. Traditionally, insurance regulation has focused almost entirely on ring fencing individual insurance companies from the risks of their affiliates. But the NAIC is now embracing a "windows and walls" approach to group supervision, which would both strengthen the ring-fencing of insurance entities while attempting to appreciate the ways in which insurance entities may be subject to enterprise risk. Whether these approaches prove successful remains to

be seen. But what is clear based on the AIG fiasco is that state regulators do not have a proven track record of effectively managing non-insurance risk within insurance groups.

The second broad concern I have with the proposed legislation is that it may promote regulatory arbitrage. Another crucial lesson of the 2008 Global Financial Crisis is that, all else being equal, financial companies will seek to structure their operations to avoid regulatory scrutiny and costs. This is particularly true of firms that embrace systemically risky strategies, as these strategies can prove massively profitable in the short term if they are not restrained by effective regulation.

By defining a sphere of financial activity that is largely immune from systemic risk regulation, the proposed legislation could actually induce firms and individuals to conduct systemically risky activities within insurance structures. For instance, it may be possible under the proposed legislation for a non-insurance affiliate to conduct systemically risky activities within an insurance holding company, and thereby avoid scrutiny by systemic risk regulators. As noted above, insurance regulators generally do not have experience or a strong track record in identifying or accounting for the risk posed by such non-insurance affiliates. Nor is this the only way that the proposed legislation could produce regulatory arbitrage. For instance, it is possible that insurers seeking to embrace systemically risky activities could attempt to circumvent state insurance regulations restricting investment options.

The third concern I have regarding the proposed legislation is that it insulates the NAIC and state regulators from federal scrutiny. If there is one single theme in the history of insurance regulation, it is that state regulators and the NAIC are often woefully ineffective unless and until they face the prospect of scrutiny or preemption by the federal government or other state regulators. Thus, state solvency regulation was pitiful until several high-profile insurer insolvencies prompted a scathing congressional report in 1990, which led state regulators to embrace a more thoughtful and considered approach to safeguarding the financial health of insurers. Similarly, state insurance regulators entirely ignored the highly problematic compensation schemes for insurance brokers and agents until the New York Attorney General engaged in a series of high-profile lawsuits centered on this issue in 2004. Parallel stories can be told to explain virtually all of the significant advances in state-based insurance regulation over the last fifty years, including the streamlining of product filing and review, the coordination of agency licensing, the crack-down on mail-order insurance, and the establishment of investment restrictions for life insurers.

The proposed legislation essentially ignores this lesson by defining a domain in which state insurance regulators would not even face *the prospect of scrutiny* from federal officials. With this pressure removed, state insurance regulators are much less likely to police against systemic risks and identify problems that could pose systemic consequences. Indeed, engaging in this regulation is hard work: it involves rejecting the assurances of a knowledgeable and well-resourced industry that employs hordes of lobbyists who frequently were themselves insurance

commissioners, senior regulatory staff, and leaders within the NAIC. Regulators will naturally be more likely to succumb to these pressures if they are not held accountable by the prospect of scrutiny at the federal level.

My fourth, and final, broad concern about the legislation is that it substantially undermines the capacity of FIO to fulfill its mission of "monitoring all aspects of the insurance industry," as described in Dodd-Frank. Several months ago I testified before the Senate Subcommittee on Securities, Insurance and Investment regarding the substantial failures of state insurance regulators and the NAIC to facilitate transparent insurance markets. Now is not the time to restate that testimony. But one of my core themes was that insurance regulators have done a remarkably poor job of making data and information available to consumers, academics and the general public. FIO now has an important opportunity to highlight these failures and induce corrective measures either by the states themselves or by federal action. By depriving FIO of its capacity to collect data directly from carriers when necessary, the proposed legislation would substantially undermine the agency's capacity to achieve these objectives. In some cases, FIO would be unable to gather relevant information because state regulators do not themselves possess it and are unwilling or unable to acquire it. And even when states do possess requested information, the legislation would render FIO completely beholden to state insurance regulators, thus limiting the agency's capacity to identify state level regulatory failures or to act on those failures.

In the face of these various concerns, the proposed legislation is based on the claim that the underlying provisions in Dodd-Frank cause excessive regulatory uncertainty for the industry. In my view, though, the costs of any regulatory uncertainty are limited and, in any event, are substantially outweighed by the costs of the proposed amendments. In fact, each of the relevant provisions of Dodd-Frank already includes sufficient safeguards for the industry.

First, under recently proposed rules, the vast majority of insurers can be assured that they will not be subjected to heightened prudential standards under Title I of Dodd Frank. These rules provide a safe-harbor for any insurer with less than $50 Billion dollars in global assets. Additionally, the rules would also exempt from scrutiny companies that do not meet any specified quantitative thresholds corresponding to interconnectedness, leverage, liquidity risk, and maturity mismatch. Insurers that exceed the $50 Billion threshold as well as one additional quantitative threshold are subject to a more searching, and less mechanical, assessment of their systemic risk. But the number of carriers that will fall within this group is extremely small and is hardly likely to produce widespread regulatory uncertainty for the insurance industry.

Second, Dodd Frank already provides for substantial deference to the traditional state-based procedures for resolving insolvent insurers. Under 203(e) of Dodd Frank, insurance companies are generally resolved under state law processes by state regulators. The FDIC can only take over this process if the state fails to act after 60 days. Thus, Dodd Frank's current provisions regarding orderly liquidation

of insurers are principally geared towards allowing federal regulators to initiate the liquidation of an insurer. They also allow the FDIC to wind down non-insurance affiliates of insurers. These provisions present virtually no regulatory uncertainty for insurers: the bar that must be met for federal regulators to determine that a carrier presents a systemic risk such that it must be liquidated under Dodd-Frank is substantially higher than the bar that must be met for liquidation at the state level. Thus, the only time when federal regulators would be likely to act under this provision is when state regulators should have already acted, but failed to do so.

Third, Dodd-Frank's provisions regarding the subpoena powers of FIO and OFR are extremely limited. In particular, FIO is authorized to issue a subpoena "only upon a written finding by the Director that such data or information is required to carry out the functions described under subsection (c) and that the Office has coordinated with such regulator or agency as required under paragraph (4)." Similar restrictions apply to the OFR's subpoena authority. In either case, it is hard to imagine that this power will impose any meaningful costs on the insurance industry as a whole.

In sum, based on my review of the proposed legislation, it is my view that its costs well exceed its benefits. In particular, I believe that the legislation not only ignores the prospect of systemic risk arising from the insurance industry, but hamstrings federal regulators from even considering or responding to this risk. It does this even though we currently possess a deeply limited understanding of systemic risk and we know that insurance can, at least in certain circumstances,

pose such risk. At the same time, the rationale for these amendments is simply not convincing: the existing provisions of Dodd-Frank that the legislation targets create only minimal costs and uncertainty for the insurance industry. Ultimately, it is simply premature to embrace a regulatory approach to systemic risk that defines away the domain of insurance.

Testimony of the
National Association of Insurance Commissioners

Before the
Subcommittee on Insurance, Housing and
Community Opportunity
Committee on Financial Services
United States House of Representatives

Regarding:

Insurance Oversight and Legislative Proposals

November 16, 2011

Joseph Torti, III
Deputy Director and Superintendent of Insurance and Banking
Rhode Island Department of Business Regulation

Introduction

Chairman Biggert, Ranking Member Gutierrez, and Members of the Subcommittee, thank you for the opportunity to testify today. My name is Joseph Torti, and I am Deputy Director and Superintendent of Insurance and Banking for the State of Rhode Island. I am also the Chair of the National Association of Insurance Commissioners (NAIC)'s Financial Condition (E) Committee and I present this testimony on behalf of the NAIC. Through the NAIC and its committees, state insurance regulators establish standards and best practices, conduct peer reviews, and coordinate their regulatory oversight. The NAIC's members working together with the central resources of the NAIC, form the national system of state-based insurance regulation in the United States.

Specifically, I am here to report on the NAIC's engagement with the federal financial agencies to ensure that the implementation of the Dodd-Frank Wall Street Reform and Consumer Protection Act follows congressional intent and appropriately recognizes the uniqueness of the insurance business model and the strength of the national state-based insurance regulatory system.

To be clear, the NAIC has no position on the Dodd-Frank Act or any current legislative proposals to modify it. The NAIC does, however, strongly believe that the implementation of Dodd-Frank by the federal financial agencies or any legislative efforts to amend it should be consistent with Dodd-Frank's recognition of the uniqueness of the insurer business model and the strength of the national state-based system of insurance regulation.

My testimony today will cover three areas: 1) the characteristics of insurance products that make them different from banking and other financial products, 2) an overview of key aspects of the insurance regulatory system, which ensures the protection of insurance consumers, and 3) the efforts of the NAIC in working with federal financial agencies as they implement provisions of Dodd-Frank that could impact the insurance sector.

The Uniqueness of the Insurance Business Model

Insurance products are fundamentally different from banking and securities products. Bank products involve money deposited by customers and are subject to withdrawal on demand, which the bank is liable for at any time. Insurance policies involve up-front payment in exchange for a

legal promise to pay benefits upon a specified loss-triggering event in the future. The very nature of insurance significantly reduces the potential of a run-on-the-bank scenario for property/casualty, health and most life insurance products. For those limited products sold by insurers that could be subject to some level of run risk, mitigating factors exist such as policy loan limitations, surrender/withdrawal penalties, and additional taxes. Additionally, insurers typically maintain a diverse product mix so only a portion of the company's products would be subject to the already reduced level of run risk.

Importantly, insurance products unlike other financial products, do not transform short term liabilities into longer term assets. Insurance has short tail liabilities in many of the property/casualty and health product lines, and the assets held are similarly short term. Insurance has longer tail liabilities in life and annuity product lines, and these liabilities are matched against similarly longer term assets. This is a critical distinction from banking and other financial products. The reason many other financial firms suffered during the financial crisis was that the duration of their assets and liabilities were not matched in a way that enabled them to fund their liabilities when they came due.

National State-Based System of Insurance Regulation

The current, comprehensive solvency regulatory framework of insurance regulation has been in place since the 1990s and continues to evolve as regulators respond to emerging issues, new products and changes in the financial landscape. The strength of this system was evident during the financial crisis. For example, in 2009, 140 banks failed, but only 18 insurers did. The system's fundamental tenet is to protect policyholders by ensuring the solvency of the insurer and its ability to pay insurance claims. To fulfill this mission, insurers are subject to stringent laws and regulations and insurance regulators have broad authorities to examine all licensed insurers to identify and address issues before they become a threat to insurer solvency. Though insurers are subject to a broad array of regulatory requirements, I will focus on three key areas: 1) the detailed reporting and disclosure requirements, 2) the risk-based capital system, and 3) the state-based receivership to resolve troubled insurers.

Reporting and Disclosure Requirements

The foundation of the national state-based system of insurance regulation's solvency framework is the detailed and transparent insurer reporting and disclosure requirements. Insurers are required to prepare comprehensive financial statements using the NAIC's Statutory Accounting Principles (SAP). SAP utilizes the framework established by Generally Accepted Accounting Principles (GAAP), but unlike GAAP which is primarily designed to provide key information to investors of public companies, SAP is specifically designed to assist regulators in monitoring the solvency of an insurer. While GAAP stresses measurement of earnings of a business from period to period, SAP measures the ability to pay claims in the future. GAAP also recognizes certain assets that SAP treats as "non-admitted" assets or are immediately expensed because they cannot be used to pay the claims of policyholders. However, even though "non-admitted" assets are not included in a SAP statement as total assets and capital, they are still reported on the annual statements filed with the NAIC and available for regulatory review.

Financial statements are filed with NAIC on a quarterly and annual basis and include a balance sheet, an income statement, and numerous required schedules and exhibits of additional detailed information. For example, insurers are required to report on Schedule D all the long-term bond, preferred stock and common stock investments that they own and have acquired or disposed of in the current reporting period. Schedule DB requires each life insurer to report each individual derivatives position held, by type; whether that position is used for hedging purposes; and identification of the position being hedged. Schedule DL requires reporting on securities lending programs including the detail listing of collateral received by the lender, reinvested collateral held, and the ability to match the fair market value of the reinvested cash collateral to the value of the cash to be returned. The NAIC serves as the central repository for this data, including running automated prioritization indicators and sophisticated analysis techniques enabling regulators around the country to have access to national-level data while reducing the redundancy of reproducing this resource in every state. This centralized data and analysis capability has been cited by the IMF as world leading.

Insurance regulators utilize the financial statements and other information as part of their continuous, intensive financial analysis to identify issues that could impact solvency. On an ongoing basis, insurance regulators assess business plans, material transactions, and any reputational or contagion risk posed by such transactions to determine whether to approve, deny, or require additional solvency protections. They analyze impacts of major economic and insurance events through the use of special data requests and stress testing. As part of our solvency system's "Windows and Walls" approach to group supervision, insurers are required to report on any reputational or other contagion risks posed by non-insurance affiliates, the "windows" into the rest of the group. At least every quarter, regulators assess a company's reserve adequacy, leverage, liquidity, surplus, asset quality, investment concentration, or other trends reflected in the filings. Every 3-5 years, regulators engage in full scope on-site examinations. Such exams are risk-focused and are used as a means of validating that the insurer's systems are performing as claimed in their financial statements and regulatory filings.

In addition to this comprehensive analysis, as part of our coordinated national system of state based regulation, the NAIC facilitates the state accreditation program. Accredited insurance departments are required to undergo a comprehensive review by an independent review team every five years, as well as an interim review annually, to ensure the departments continue to meet baseline financial solvency oversight standards. The accreditation standards require state insurance departments to have adequate statutory and administrative authority to regulate an insurer's corporate and financial affairs, as well as the necessary resources to implement and enforce that authority. Currently, all 50 states and the District of Columbia are accredited.

NAIC compiles the information contained in the comprehensive financial statements to advise insurance regulators of trends in the insurance industry and the impact of exogenous events. For example, the NAIC's Capital Markets Bureau publishes a weekly special report, available on the NAIC's website, that provides industry analysis on a variety of topics that range from insurer use of derivatives, the impact of the low interest rate environment on insurance companies, and insurer investment exposures to Europe. These "macro prudential analyses" conducted by NAIC staff help NAIC members fulfill their regulatory mission by providing important information on how external events in the insurance or other financial markets could impact insurers.

Risk-Based Capital (RBC) Framework

The information provided by financial statements, which is audited by an independent accountant, is also used in the system's risk-based capital framework. This framework requires an insurer to hold at least a minimum amount of capital based on analysis of risks on the insurer's balance sheet. This framework is comprised of a RBC calculation as well as statutory authority for successive levels of regulatory intervention based upon risks assessed in the formula compared to the insurer's capital amount. The formula applies factors to audited annual statement amounts for assets, premiums, claims, expenses, and reserves, and such factors increase for items with greater underlying risk. The RBC formula provides a minimum capital and surplus to support insurer risks such as: asset risk, specifically the risk of default or fluctuation in fair value of investments; insurance risk or the risk of inadequacy of premiums and reserves; and interest rate, credit, or other market risk. A separate RBC formula is used for the life, fraternal, property and casualty, and health industries that reflect the unique investment, underwriting, and other risks to the sector.

Insurance Company Receivership

In the event of the insolvency of an affiliate of an insurer, regulators have the authority to "ring-fence" the insurance company, thereby preventing the affiliate from endangering the solvency of the insurer and protecting policyholders. These are the "walls" in the "Windows and Walls" approach.

In the unlikely event that an insurer becomes troubled, state insurance receivership laws provide authorities for regulators to attempt to prevent insurer insolvencies or to minimize losses and provide protection to policyholders and other claimants in the event of insolvency. Under state receivership laws, regulators dealing with a troubled company have a number of options. They can seek mergers with healthier companies, reinsurance arrangements, non-renewal of part or an insurer's entire book of business, or place the insurer in "run-off mode" where no new business is written, but claims continue to be paid. In 2004, we utilized our broad receivership authority in Rhode Island to place a troubled insurer into rehabilitation, preventing its insolvency while ensuring full payment to policyholders and claimants. We were also able to restructure the insurer making it possible to find a group of highly experienced insurance executives to purchase the company and continue writing personal lines property & casualty insurance in Rhode Island

and several other northeast states. Today, the company continues to pay all claims, provide significant employment opportunities for our residents and is on track to write $100 million in premiums for the year.

If an insurer does become insolvent, the state receivership laws give policyholders priority over most claimants. In cases where the assets of an insurer are insufficient to pay policyholder claims, the states have guaranty funds to serve as a backstop and protect policyholders of most lines of life and property and casualty insurance. Similar to FDIC backing for bank depositors, guaranty funds cover an insured's financial obligation to policyholders, annuitants, beneficiaries, and third party claimant's up to statutory limits. Together, the broad authorities provided to state insurance regulators under the state receivership laws and the guaranty fund backstop ensure that policyholders are protected and insurance companies are resolved in an orderly manner.

Federal/State Regulator Cooperation in Implementing Dodd-Frank

At its core, Dodd-Frank acknowledges the differences between insurance and other financial products, and the stringent regulation of insurers by state regulators. While not directly focused on the business of insurance, authorities either created or amended by Dodd-Frank Act do impact the insurance sector. Such authorities include the Federal Reserve's regulation of designated non-bank financial institutions, bank holding companies or thrift holding companies that may have insurers as affiliates; the authorities for federal financial agencies to plan for and resolve an orderly liquidation of a systemically risky firm; or the authorities granted to certain agencies to collect information for the purposes of monitoring the financial system or the insurance sector more specifically.

The NAIC works closely with the federal financial agencies, and there is a mutual recognition that the NAIC and its members are a valuable partner and resource to the federal financial agencies. We exchange data and other information, provide trainings to the federal agencies on various insurance regulatory topics, and participate in federal agency seminars and initiatives including those relating to data access and analysis. Beyond these ongoing regulatory dialogues, the NAIC is actively engaged with the federal financial regulators on a variety of issues relating to implementation of the Dodd Frank Act, but I will focus on 6 main areas: 1) the Financial Stability Oversight Council (FSOC); 2) the Federal Deposit Insurance Corporation's (FDIC)

implementation of Title II orderly liquidation authorities; 3) the Federal Reserve's new authorities to oversee FSOC designated non-bank financial institutions and thrift holding companies; 4) derivatives regulation; 5) the implementation of the Volcker Rule; and 6) the ongoing activities of the Federal Insurance Office (FIO).

Financial Stability Oversight Council

State insurance regulators are represented on FSOC through John Huff, the Missouri Director of Insurance, Financial Institutions, and Professional Registration. As you know, FSOC has the authority to designate non-bank financial institutions, potentially including insurance companies, for heightened supervision by the Federal Reserve. Through Director Huff, the NAIC has been educating FSOC members that traditional insurance activities do not pose systemic risk and providing extensive data and analysis to illustrate this reality. That said, we also recognize that unregulated affiliates or other large scale non-traditional insurance activities could potentially pose such risks and might create a basis for such designation.

The FSOC recently released additional guidance to the public regarding the process that it intends to follow in evaluating and eventually designating non-bank financial institutions for enhanced supervision by the Federal Reserve. Insurance regulator participation in the non-bank designations process is mandated by statute and we were heartened to see a commitment by FSOC to involve regulators of any insurance companies under consideration early in the process. This ensures the Council will benefit from our expertise and knowledge of any insurance company that may be under consideration. My fellow regulators and I are in the process of reviewing this guidance and will provide our comments to our FSOC representative, Director Huff. We strongly encourage insurance sector participants to review the guidance themselves and provide comments to FSOC to further inform the process.

We are also pleased that FSOC now has its full complement of insurance expertise with the participation of Director Huff; the Federal Insurance Office (FIO) Director, and former Illinois Insurance Commissioner Michael McRaith; and former Kentucky Insurance Commissioner Roy Woodall as the independent insurance expert. We continue to encourage the FSOC to enable Director Huff to consult with his fellow regulators in other aspects of FSOC's work that could impact insurance. To date, Director Huff remains limited in the discussions he can have with

fellow state regulators regarding FSOC deliberations, including discussion of systemic risk and the review of resolution plans, even though insurance companies are resolved pursuant to state law. Despite the good working relationships we have with the federal financial agencies in other contexts and the great faith we have in Director Huff, his inability to consult with us regarding confidential issues that impact the insurance sector remains of great concern to those of us that have the responsibility of regulating insurance companies.

Orderly Resolution

The NAIC has been engaged in the implementation of new orderly resolution authorities under Title II. The NAIC's Dodd-Frank Receivership Implementation Working Group is composed of insurance receivership regulatory experts and is charged with examining the impact this new regime may have on existing state insurance receivership processes. Recently, the NAIC adopted a new chapter in its NAIC Receivers' Handbook, "Procedures for Prompt Initiation of State Receivership under Dodd-Frank." This addition establishes procedures at the state level to ensure the state receivership mechanism will respond effectively to a receivership arising from a systemic failure.

Over the past year, members of this group and others have been in active discussions with the FDIC regarding other Title II implementation issues that could affect insurance, and have reviewed and responded to specific rules proposed by the agency. We have commented on proposals regarding the circumstances in which the FDIC could exercise its authorities to take a lien on insurance company assets. Regulators have requested that the FDIC allow for the resolution of any mutual insurance holding companies pursuant to state insurance receivership laws, as the statute is unclear in this regard. Both of these comment letters are part of the FDIC's administrative record and we are pleased to provide copies of those letters for this hearing's record (Appendices A and B). While we hope there is never an occasion where the FDIC has to exercise its authorities on a company with insurance operations, the NAIC's solid working relationship with the FDIC will be critical to ensuring that policyholders are protected during such an event.

Supervision of Thrift Holding Companies and Non-Bank Financial Institutions

We also have a strong relationship with the Federal Reserve Board and the Federal Reserve Banks. Even before the passage of Dodd-Frank, the NAIC was in regular contact with the Federal Reserve to discuss items of mutual concern and to share information. That relationship has grown even closer and more important since the passage of Dodd-Frank as the Federal Reserve now has additional regulatory authorities that could impact insurers. An example of this authority is the transfer of the regulation of thrift holding companies from the now defunct Office of Thrift Supervision to the Federal Reserve and establishing the Federal Reserve as the consolidated supervisor of systemically risky non-bank financial companies designated by FSOC. Insurance regulators are meeting with Federal Reserve representatives to exchange information, discuss how we will work together in the regulation of such entities, and provide trainings on insurance regulatory topics and insurance data analysis. The NAIC very much values the relationship with the Federal Reserve Board and the Federal Reserve Banks.

Derivatives

The NAIC has been working closely with the Commodity Futures Trading Commission (CFTC) and the Securities and Exchange Commission (SEC) by providing them technical assistance and actively responding to rules they have proposed to implement their new authorities to regulate the over-the-counter derivatives market under Title VII of Dodd-Frank. An important proposed rule involves the additional definitions of swaps and security-based swaps. Under the definition contained in Dodd-Frank, these items could erroneously include certain regulated insurance products, and the NAIC has sought clarification from the SEC and CFTC to ensure these definitions do not include certain insurance products sold by regulated insurance companies. The proposed rules by the SEC and CFTC confirm our view, though we believe that certain changes still need to be made to clarify that all regulated insurance products are appropriately excluded. We recently provided comment to the SEC and CFTC (Appendix C) and continue to work with them as they finalize the rule.

The "Volcker Rule"

The NAIC is monitoring the federal financial regulatory agencies' implementation of the Volcker Rule. The Volcker Rule prohibits insured depository institutions and their affiliates from engaging in proprietary trading, and also mandating additional capital requirements and

quantitative limits for designated non-bank financial companies that engage in such activities. Dodd-Frank provided that the implementation of the Volcker Rule should "accommodate the business of insurance." Recently, the federal financial agencies proposed lengthy regulations implementing the Volcker rule. The NAIC is in the process of reviewing those regulations to determine whether they do in fact appropriately exclude insurer investments from its prohibitions. Once that review is complete, we will determine whether filing a comment with the federal financial agencies is necessary. We encourage insurance sector participants to do the same and provide comments as appropriate.

The Federal Insurance Office

The NAIC continues to engage directly with the FIO as the office takes shape. The NAIC has a long history of cooperation and collaboration with the Treasury Department in issues such as implementation of the Terrorism Risk Insurance program, ensuring a stable financial infrastructure, anti-money laundering, coordinated response to the Financial Stability Board, and response to the World Bank/IMF Financial Sector Assessment Program. We have had a similar experience to date with FIO, and we look forward to continuing that relationship, working with our friend and former colleague, Michael McRaith. Dodd-Frank provides FIO with the authority to collect information on insurance directly from companies; but it is required to get this information from the states and other sources, such as the NAIC, if available. The NAIC has provided all requested data and information and is committed to providing Mr. McRaith any assistance he needs to fulfill his responsibilities. It is worth noting that several NAIC members, including the NAIC's new Secretary-Treasurer, Montana Commissioner of Securities and Insurance, Monica J. Lindeen will be serving on the FIO's recently established Federal Advisory Committee on Insurance. The FIO has a critical role to play as the voice of the federal government on international insurance matters, and we are working with FIO to identify those issues most relevant to our sector, from the implementation of the IAIS ComFrame project to equivalence of US insurance regulation under Europe's Solvency II regime. The NAIC will continue to serve as the voice of insurance regulators on these key issues, but the voice of the US government is essential, so we look forward to partnering with FIO to demonstrate a united front whenever possible on key issues.

Dodd-Frank requires the FIO to issue a report on insurance regulation by January 2012. The report will include legislative recommendations and look at the potential for federal regulation of insurance, among other requirements. We remain strongly opposed to federal regulation of insurance but hope to have constructive and meaningful input into this report to ensure our views are reflected. State insurance regulation has been subject to stringent review at the federal level before including Congressional hearings, to GAO and CRS analysis, to review as part of legislative developments ranging from the Gramm Leach Blilely Act to Sarbanes Oxley and now the Dodd- Frank Act. This type of review is healthy for our system but historically this scrutiny has focused on the obvious challenges inherent to our multi-jurisdictional approach with emphasis on cost and redundancy. Rarely have these issues been balanced against the strengths of our regulatory system's check and balances and peer review that helped the insurance sector weather the financial crisis far better than others. We look forward to meeting directly with FIO to encourage a balanced view as it finalizes its study and we also look forward to reviewing comments submitted by the insurance sector as regulators are continually seeking input to improve our national state-based insurance regulatory system.

Conclusion

Throughout the debate of Dodd-Frank, the NAIC strongly advocated that the unique nature of the insurance business model and the strong national state-based system of insurance regulation be recognized. That work continues today as the federal financial agencies issue rules and engage in other implementation efforts. I greatly appreciate the open and constructive dialogue we have had with Congress and the agencies. I look forward to continuing our work with you and our fellow financial regulators.

Thank you for this opportunity to testify, and I look forward to your questions.

APPENDIX A

NAIC National Association of Insurance Commissioners & The Center for Insurance Policy and Research

November 18, 2010

Robert E. Feldman
Executive Secretary
Federal Deposit Insurance Corporation
550 17th St., N.W.
Washington, D.C. 20429

Re: Notice of Proposed Rulemaking Implementing Certain Orderly Liquidation Provisions of Dodd-Frank Wall Street Reform and Consumer Protection Act

Dear Mr. Feldman:

We write on behalf of the National Association of Insurance Commissioners (NAIC) to submit this comment in response to the Federal Deposit Insurance Corporation's (FDIC) Notice of Proposed Rulemaking Implementing Certain Orderly Liquidation Authority Provisions of the Dodd-Frank Wall Street Reform and Consumer Protection Act (the Act) [1] published in the Federal Register on October 19, 2010. Founded in 1871, the NAIC is the voluntary association of the chief insurance regulatory officials of the 50 states, the District of Columbia and the five U.S. territories. The NAIC serves the needs of state insurance regulators as they protect consumers and maintain the financial stability of the marketplace.

Section 209 of the Act provides the FDIC authority to implement through rulemaking the provisions relating to the Orderly Liquidation of certain systemically important financial companies. However, the FDIC's authority is not without limits.[2] As with all rulemaking proceedings, any new rules must be consistent with the language of the statute and Congressional intent.

For decades, the state insurance regulatory regime has had an "orderly resolution" process for financially distressed or insolvent state licensed insurance companies. State insurance receivership laws are primarily designed to protect the policyholders of such insurers, and ensure policyholders can continue to have any claims paid. In furtherance of this goal, state receivership laws generally provide that policyholders receive higher payment priority than other unsecured creditors and state insurance regulators are given broad authorities to rehabilitate or liquidate insolvent insurance companies in a manner that protects policyholders and preserves the value of the insurance company for their benefit.

Title II of the Act recognizes this time-tested insurance company resolution regime already in place under state law. It explicitly requires that an insurance company be resolved pursuant to state law as opposed to the procedures set forth in Title II and requires that the FDIC harmonize any new rules involving insurance companies with the state insurance receivership regime already in place.[3] The

[1] Pub. L. No. 111-203.
[2] Id. at § 209.
[3] Id. at §§ 203, 209.

NAIC has reviewed the proposed rules promulgated by the FDIC and has significant concerns that proposed rule 380.6 is inconsistent with the language of the Act and Congressional intent in this regard.

§380.6: Limitation on Liens on Assets of Covered Financial Companies That Are Insurance Companies or Covered Subsidiaries of Insurance Companies.

Under the proposed rule, whenever the FDIC "makes funds available" to a covered financial company that is an insurer, an affiliate of an insurer, or a subsidiary of insurer, the FDIC can take a lien on "some or all" of the assets of such entities to secure repayment when the FDIC in its "sole discretion" determines that 1) taking such lien is necessary for the orderly liquidation of the entity and 2) taking such lien will not unduly impede or delay the liquidation or rehabilitation of the insurance company or recovery by its policyholders.[4] While we acknowledge, based on the section by section analysis accompanying the proposed rule, that the stated intent of this rule is to "limit" the ability of the FDIC to take liens on the assets of insurance companies or covered affiliates of such companies in order to protect policyholders[5], this proposed rule does precisely the opposite —it effectively provides the FDIC the unilateral right to impose a lien on the assets of an insurer whenever the FDIC deems it appropriate. This is in clear violation of the explicit language of the Act and Congressional intent.

Application to Insurance Companies

First, the proposed rule as applied to insurance companies would violate the explicit language of the Act. This rule implements authorities provided to the FDIC under Section 204 of the Act. However, that section only applies in circumstances where Title II orderly liquidation procedures are utilized and the FDIC is appointed receiver by a Federal District Court pursuant to Section 202 of the Act. However, insurance companies are not subject to Title II orderly liquidation procedures. In cases involving insurance companies, Section 203(e) applies. That section requires that ". . . the liquidation or rehabilitation of [an] insurance company . . . shall be conducted as provided under applicable State law." Indeed, even in the unlikely event that the state insurance regulators do not file a receivership petition in state court within 60 days and the FDIC has to utilize its backstop authority provided in Section 203(e)(3), that authority only allows the FDIC to stand in the place of the insurance regulator, file the appropriate action in state court and conduct the receivership pursuant to state law. Under no circumstances would Section 202 apply to the resolution of an insurance company. Therefore, the application of this rule to insurance companies violates the explicit language of the Act and, for this reason, the NAIC requests that the rule be changed so it does not apply to insurance companies.

Even if it could somehow be interpreted that Section 204 applies to resolutions conducted under Section 203(e), the proposed rule would, in circumstances where funds were "made available" to an insurer during the resolution process, allow the FDIC to impose a lien "in its sole discretion." As explained above, Title II requires that insurance companies be resolved pursuant to state law and that any rules implementing Title II be harmonized with the state laws and regulations governing state insurance receiverships. At bare minimum, state law provides that the imposition of such a lien could be voidable by the Court under some circumstances upon petition by the receiver, creditors, or other interested parties.[6] Under certain state's laws, post-petition liens, transfers of property, and other post-petition obligations can only be incurred by an insurer when authorized by 1) the receiver appointed by the state

[4] Notice of Proposed Rulemaking Implementing Certain Orderly Liquidation Authority Provisions of the Dodd-Frank Wall Street Reform and Consumer Protection Act, 75 Fed. Reg. at 64182 (October 19, 2010).
[5] Id. at 64179.
[6] *See, e.g.,* Iowa Code § 507C.28 (1992); New York Ins. Law § 7425(c)(1989).

insurance regulators and/or 2) the state court.[7] In either event, the FDIC would not have "sole discretion" to impose such a lien. In light of the proposed language's clear conflict with the Act and state law, the rule should be amended to state that such liens can only be imposed on an insurance company in consultation with the receiver, and with the approval of the receiver or Court in accordance with the law of the state where the insurance company is domiciled.

Application to Non-Insurance Subsidiaries and Affiliates of Insurers

Second, even as applied to non-insurance subsidiaries and affiliates, the language is potentially inconsistent with the letter of the law requiring harmonization with the state regulatory regime and with Congressional intent. As presently drafted, if funds are made available to a non-insurance subsidiary or affiliate, the FDIC can impose a lien on some or all assets of the company, potentially including assets of an affiliated insurer or, in the case of a parent, any majority ownership interest. We understand the intent of this provision is to allow the FDIC to protect its interest when it injects funds into a non-insurance subsidiary or affiliate it is resolving, but are concerned that such actions may interfere with the regulation or resolution of an insurance company under state law. Typically, state law requires that any material lien or change of control exercised on an insurance company be approved by the insurance regulator. If the intent of this language is to enable, among other scenarios, the FDIC to reach into the affiliated insurance company and exercise a lien on its assets or, alternatively, to exercise a lien on any majority ownership interest in that insurance company without the approval of the state insurance regulators, such an application would be in conflict with state law, and, therefore, inconsistent with Congressional intent in passing this Act.

In passing the Act, Congress intended to preserve the state regulation of insurance and its receivership regime. Section 203 of Title II explicitly preserves the role of the states in resolving insurance companies. Title X specifically excludes the business of insurance from regulation by the newly formed Bureau of Consumer Financial Protection. Title V significantly limits the newly formed Federal Insurance Office's ability to preempt state insurance laws. Importantly, Title II specifically preserves the state law regime for insurance company receiverships and requires the FDIC to harmonize its actions with that regime. To this end, the NAIC respectfully requests that the rule be clarified that the imposition of such liens be limited only to the assets of non-insurance subsidiaries or affiliates and, where the exercise of such a lien could result in a change of control, require the approval of the appropriate state insurance regulator in accordance with state law.

"Making Funds Available"

Third, as presently drafted, the language "making funds available" in the rule could lead to unintended results. We understand the need and desire of the FDIC to ensure that when government funds are actually provided to a covered financial institution, it must, to the best of its ability, ensure the repayment of such funds. As drafted, however, the proposed rule is triggered when the FDIC "makes funds available" to the insurer or affiliate, not when funds are actually provided by the FDIC and used by the company. On its face, the language allows the FDIC to take a lien when it provides a backstop guaranty even though the guaranty is never triggered and the FDIC may never provide a single dollar to the insurer or the affiliate under its terms. This language also allows the FDIC to impose a lien on an insurer upon the mere announcement of a program to provide funds to troubled companies by application along the lines of some of the TARP funding programs administered by the Treasury Department during the financial crisis. The imposition of a lien in such circumstances would be

[7] *See, e.g.*, Texas Ins. Code Ann. § 443.203 (Vernon 2009).

unnecessary and be disruptive to what will likely be an already complex resolution process. For this reason, we respectfully request that the language be changed to ensure that the rule is triggered only in circumstances where funds are actually provided to and used by the insurer.

Liens on Affiliates

Last, Section 380.6 of the proposed rule refers to FDIC authority to impose liens on affiliates in addition to covered financial companies and covered subsidiaries. Section 204(d) of the Dodd-Frank Act does not reference any authorities provided to the FDIC to impose liens on affiliates. We, therefore, respectively request that the references to affiliates in Section 380.6 be removed.

In conclusion, we appreciate the opportunity to comment to these proposed rules. Should you wish to discuss this response or any other matter relating to the NAIC's views on the rulemaking process, please do not hesitate to contact Ethan Sonnichsen, Director of Government Relations, at (202) 471-3980, Moira Campion McConaghy, Government Relations Manager, at (202) 649-4997, or Mark Sagat, Government Relations Analyst and Counsel, at (202) 471-3987.

Sincerely,

Jane L. Cline, Commissioner
West Virginia Insurance Department
NAIC President

Therese M. Vaughan, Ph.D.
NAIC Chief Executive Officer

APPENDIX B

NAIC National Association of Insurance Commissioners & The Center for Insurance Policy and Research

January 18, 2011

Robert E. Feldman
Executive Secretary
Federal Deposit Insurance Corporation
550 17th St., N.W.
Washington, D.C. 20429

Re: Notice of Proposed Rulemaking Implementing Certain Orderly Liquidation Authority Provisions of Dodd-Frank Wall Street Reform and Consumer Protection Act

Dear Mr. Feldman:

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The NAIC previously submitted comment to the proposed rule contained in the Notice on November 18, 2010. In that comment, we explained our concerns with proposed rule 380.6 relating to the limitations on liens on assets of covered financial companies that are insurance companies or covered subsidiaries of insurance companies. Specifically, we noted that Title II of the Act recognized the time-tested insurance company resolution process already in place by requiring that an insurance company be resolved pursuant to state law. We also noted that the FDIC must harmonize any new rules involving insurance companies with the state receivership regime already in place.[2]

As part of the Notice, the FDIC also requested comments identifying specific areas relating to the FDIC's orderly liquidation authority that would benefit from additional rulemaking.[3] In this regard, we have identified two specific areas that we believe require additional rulemaking.

[1] Pub. L. No. 111-203.
[2] Id. at §§ 203, 209.
[3] Notice of Proposed Rulemaking Implementing Certain Orderly Liquidation Authority Provisions of the Dodd-Frank Wall Street Reform and Consumer Protection Act, 75 Fed. Reg. at 64180 (October 19, 2010).

Consultation with Insurance Regulators

Section 204(c) of the Act requires that the FDIC consult with 1) the primary financial regulatory agencies of covered financial companies for the purpose of ensuring an orderly liquidation of such companies, and 2) the primary financial regulatory agency of any covered financial companies' subsidiaries that are not covered subsidiaries to coordinate on the treatment of such subsidiaries when solvent or the resolution of such subsidiaries when insolvent. As we indicated in our comment of November 18, 2010, the state insurance regulatory regime presently has an orderly resolution process for financially distressed or insolvent state licensed insurance companies. This process is primarily designed to protect the policyholders of such insurers, by safeguarding, marshaling and distributing assets in accordance with payment priorities of each class of claim specified under state law. As a result, state receivership laws are somewhat different than the bankruptcy laws and the rules used to resolve failing banks.

Because of the unique nature of the state insurance regulatory system, we believe, as the Act requires, that it is critical that the FDIC consult with state insurance regulators of any insurance company involved in or affected by the orderly liquidation of a covered financial company. We respectfully urge the FDIC to put processes in place through rulemaking to ensure prompt and robust coordination with the appropriate regulators. Such an effort should include processes to provide the domestic insurance regulator advance warning if the FDIC, as a part of a resolution of a covered financial company, is considering taking any action with respect to an insurance holding company or a subsidiary of an insurer.

Mutual Insurance Holding Companies

Another area that requires rulemaking is the treatment of mutual insurance holding companies as insurance companies for purposes of Title II of the Act. Under Section 203(e), insurance companies are to be resolved pursuant to state law. Section 201 defines "insurance company" as an entity that is "1) engaged in the business of insurance, 2) subject to regulation by a state insurance regulator, and 3) covered by a state law that is designed specifically to deal with rehabilitation, liquidation, or insolvency of an insurance company."[4] As holding companies, mutual insurance holding companies do not specifically engage in the "business of insurance", but are nevertheless subject to regulation by state insurance commissioners and state receivership authorities. We are concerned that even though such entities are subject to state receivership laws, the FDIC could interpret Title II to require such entities be resolved pursuant to the new authorities granted the FDIC rather than pursuant to state law as is required for all other insurance companies. The legislative history of the Act is clear that such mutual insurance holding companies should be treated as insurance companies and be resolved pursuant to state laws and regulations.[5] We therefore urge the FDIC to confirm Congressional intent through rulemaking and clarify that mutual insurance holding companies are resolved pursuant to state law.

[4] Pub. L. No. 111-203 at § 201.

[5] *See*, 156 Cong. Rec. S5903 (daily edition July 15, 2010)(statements of Sen. Nelson and Sen. Dodd); 156 Cong. Rec. H5216 (daily edition June 30, 2010)(statements of Rep. Frank and Rep. Carson).

Conclusion

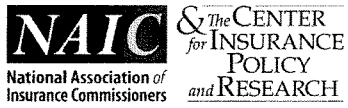
In conclusion, we would appreciate the opportunity to comment on these issues with you further. We look forward to reviewing any other proposed rules relating to these issues and providing comments as appropriate. Should you have any questions regarding this response or any other matter relating to the NAIC's views on the rulemaking process, please do not hesitate to contact Ethan Sonnichsen, Director of Government Relations, at (202) 471-3980, Moira Campion McConaghy, Government Relations Manager, at (202) 649-4997, or Mark Sagat, Government Relations Analyst and Counsel, at (202) 471-3987.

Sincerely,

Susan E. Voss, Commissioner
Iowa Insurance Division
NAIC President

Therese M. Vaughan, Ph.D.
NAIC Chief Executive Officer

APPENDIX C



July 22, 2011

Elizabeth M. Murphy
Secretary
U.S. Securities and Exchange Commission
100 F St., NE
Washington, D.C. 20549

David A. Stawick
Secretary
U.S. Commodity Futures Trading Commission
Three Lafayette Centre
1155 21st Street, NW
Washington, D.C. 20581

Re: S7-16-11: Further Definition of "Swap," "Security-Based Swap," and "Security-Based Swap Agreement"; Mixed Swaps; Security-Based Swap Agreement Recordkeeping.

Dear Ms. Murphy and Mr. Stawick:

We write on behalf of the National Association of Insurance Commissioners (NAIC) regarding the Securities and Exchange Commission and Commodity Futures Trading Commission proposed rule to further define the terms "swap" and "security-based swap" contained in Title VII of the Dodd-Frank Wall Street and Consumer Protection Act (the Act)[1] and related implementing regulations. Founded in 1871, the NAIC is the voluntary association of the chief insurance regulatory officials of the 50 states, the District of Columbia and the five U.S. territories. The NAIC serves the needs of state insurance regulators as they protect consumers and maintain the financial stability of the marketplace. The NAIC respectfully submits the following comment to the proposed rule published in the May 23, 2011 issue of the Federal Register as well as on the Commissions' websites.

Insurance Contract Exclusion

We are in agreement with the Commissions' proposal to exclude insurance contracts from the definitions of "swap" and "security-based swap." As we indicated in our letter of September 20, 2010, we believe that Congress did not intend for these definitions to cover insurance contracts. We do have some additional comments and concerns regarding the Commissions' general approach to implementing such a standard by establishing both a per se exclusion for certain defined types of insurance products and a legal test to distinguish insurance from swaps and security-based swaps based on the nature of the product and its regulation.

[1] Pub. L. No. 111-203.

EXECUTIVE OFFICE 444 N. Capitol Street, NW, Suite 701 Washington, DC 20001-1509 p | 202 471 3990 f | 816 460 7493
CENTRAL OFFICE 2301 McGee Street, Suite 800 Kansas City, MO 64108-2662 p | 816 842 3600 f | 816 783 8175
SECURITIES VALUATION OFFICE 48 Wall Street, 6th Floor New York, NY 10005-2906 p | 212 398 9000 f | 212 382 4207
www.naic.org

List of Specific Insurance Products

While we agree with the identification of certain insurance products that in the Commissions' view are not swaps or security-based swaps, we strongly urge you to include this list in the rule text itself and not just the preamble to the rule. Such inclusion is critical to create the necessary legal certainty that such products will in fact not be treated as swaps and security-based swaps by the Commissions. In addition, there are certain products, such as mortgage guaranty, accident, and disability insurance that are not on the Commissions' current list of specifically identified insurance products. These items are traditional insurance products sold by regulated insurance companies and should also not be considered swaps or security-based swaps. **Therefore, we respectfully request that mortgage guaranty, accident, and disability insurance be added to the list of excluded products, and that the entire product list be included in the actual rule text.**

In addition, there are other state-regulated products such as service contracts that are not on this enumerated list, and may not necessarily meet the legal test established by the Commissions' rule. We hope to continue to work with you to determine whether such products should be regulated as swaps, security-based swaps or insurance.

Test for Identification of Insurance Contracts

Under the proposed rule, an insurance contract is excluded if it meets the requirements set forth by the Commissions to identify an insurance contract ("Insurance Product Test") and is provided by an entity organized as an insurance company and subject to supervision by an insurance regulator ("Insurance Company Test").

Insurance Company Test

Of significant concern is that if an insurance contract met the requirements of the Insurance Product Test but failed to meet the Insurance Company Test, it would be possible for a non-insurance company to write traditional insurance products and evade the state-based insurance regulatory system designed to protect policyholders. Currently, state insurance regulators have the regulatory authority to prohibit such activities by unlicensed companies and vigilantly pursue wrongdoers. However, since Title VII of the Act provides that swaps shall not be considered insurance and prohibits swaps to be regulated as insurance contracts under the laws of any state,[2] an insurance product that met the Insurance Contract test but failed the Insurance Company Test would have the unintended consequence of being treated as a swap rather than insurance. Importantly, such a company would not be subject to the type of regulation that has been specifically designed to protect policyholders including stringent solvency, reporting, disclosure, investment limitations, and other important consumer protections. For example, property and casualty insurance offered by an unlicensed company that failed the Insurance Company Test would be treated as a swap rather than insurance and by virtue of the Act, state regulators would be prohibited from using their regulatory authority to prohibit such unlicensed activities.

Furthermore, the Insurance Company Test appears to capture insurance contracts written in foreign countries where the risk is reinsured by domestic reinsurers, yet appears to exclude insurance contracts written domestically where the risk is reinsured by companies located abroad. Such an approach would inevitably create an unlevel playing field as between domestic and foreign reinsurers.

[2]Pub. L. No. 111-203. §722(a).

For these reasons, we strongly urge you to amend ii(A) of the proposed rule to read as follows:

"By a person or entity that is subject to the insurance laws of any State, the United States, or a foreign jurisdiction."

Insurance Product Test

The Insurance Product Test in the proposed rule generally states that the term "swap" does not include an agreement, contract, or transaction that by its terms or by law, as a condition of performance on the agreement, contract, or transaction:

> (1) requires the beneficiary to have an insurable interest that is the subject of the agreement, contract, or transaction and thereby carry the risk of loss with respect to that interest continuously throughout the duration of the agreement, contract or transaction;
> (2) requires the loss to occur and to be proved, and that any payment or indemnification thereof be limited to the value of the insurable interest; and
> (3) is not traded, separately from the insured interest, on an organized market or over-the-counter.

However, most insurance products would not qualify under this three prong test. Therefore, the proposed new requirements are not effective criteria for determining whether a product is insurance.

With regard to the first prong, most insurance products do not require a person or entity to have an insurable interest continuously throughout the duration of the insurance policy or contract. For example, if a person wishes to procure insurance on the life of another person, then he or she only needs to have an insurable interest at the time that he or she procures the life insurance policy. With regard to insurance covering property damage, in many jurisdictions, a person only needs to have an insurable interest at the time of the loss. Indeed, an insurable interest is not even required for a liability, surety or accident and health insurance policy or contract.

While we recognize that you may be concerned that certain entities could seek to evade the rule by creating swap products that meet a test designed to exclude insurance products, we believe that the additional requirements that the product be sold by a company that is subject to insurance laws and regulation, coupled with the Commissions' anti-evasion authorities, will prevent such scenarios from taking place.

There are also difficulties with the third prong. The preamble states that with limited exceptions (such as settled life insurance policies), insurance products traditionally have not been either entered into on or subject to the rules of an organized exchange or traded in secondary market transactions. While we recognize that this is the case for most insurance products, a limited number of states including New York, Illinois, and Florida have had insurance exchanges through which reinsurance and excess or surplus line insurance was sold. In addition, the federal health care act requires states or the federal government to establish health benefit insurance exchanges through which insurers will sell health insurance to individuals and small groups. As a result, we do not believe that the test should contain the requirement that such contract should not be traded on an exchange.

In light of these concerns, we believe that a more appropriate test for an insurance contract would be an agreement or contract that by its terms:

1) **Exists for a specified period of time;**
2) **Where one party (the "insured") to the contract promises to make one or more payments such as money, goods or services;**
3) **In exchange for another party's promise to provide a benefit of pecuniary value for the loss, damage, injury, or impairment of an identified interest of the insured as a result of the occurrence of a specified event or contingency outside the parties' control; and**
4) **Where such payment is related to a loss occurring as a result of the contingency or specified event.**

We believe that such a test along with the portion of your proposed Insurance Company Test as modified above will appropriately capture regulated insurance products.

Contracts Based on Price, Rate, or Level of Financial Instrument or Asset

Finally, the Commissions also request comment as to whether they should require that an agreement, a contract, or a transaction not be based on the price, rate, or level of a financial instrument, asset, or interest or any commodity in order to meet the definition of an insurance agreement. We do not believe such a requirement would be appropriate, as it would not meaningfully distinguish swaps and security-based swaps from certain products sold by regulated insurance companies such as variable annuities, indexed annuities, guaranteed investment contracts, financial guaranty insurance, and mortgage guaranty insurance. While swaps and security-based swaps were historically unregulated, products such as those referenced above have been subject to stringent regulatory requirements including policy form filing, financial statement reporting, disclosure, capital, and reserve requirements designed to protect the policyholders. **For these reasons, we believe that the Commissions should not include an additional requirement for an agreement to be treated as insurance that the agreement not be based on the price, rate or level of a financial instrument, asset, or interest or any commodity.**

Conclusion

We appreciate the opportunity to comment and look forward to continuing the open and constructive dialogue we have had with the Commissions to date about the rulemaking process. Should you wish to discuss this comment or any other matter relating to the NAIC's views on the rulemaking process, please do not hesitate to contact Ethan Sonnichsen, Director of Government Relations, at (202) 471-3980, Moira Campion McConaghy, Government Relations Manager, at (202) 649-4997, or Mark Sagat, Government Relations Policy Counsel, at (202) 471-3987.

Sincerely,

Susan E. Voss

Susan E. Voss, Commissioner
Iowa Insurance Division
NAIC President

Therese M. Vaughan

Therese M. Vaughan, Ph.D.
NAIC Chief Executive Officer

STATEMENT
ON BEHALF OF THE
INDEPENDENT INSURANCE AGENTS & BROKERS OF AMERICA

BEFORE THE

COMMITTEE ON FINANCIAL SERVICES
SUBCOMMITTEE ON INSURANCE, HOUSING
AND COMMUNITY OPPORTUNITY

UNITED STATES HOUSE OF REPRESENTATIVES

November 16, 2011

The Independent Insurance Agents & Brokers of America (IIABA or the Big "I") and our more than 300,000 members nationwide thank you for holding today's hearing entitled "Insurance Oversight and Legislative Proposals" focusing on the three important pieces of legislation under discussion. IIABA sees value in each bill and looks forward to working with the Subcommittee and the full House Financial Services Committee as you move forward.

The business of insurance is governed by a strong system of regulation at the state level. While in need of reform and modernization, the state system has met the two key components of regulation: financial oversight and consumer protection, as evidenced by

its performance throughout the recent financial crisis. Consequently, we believe that any federal involvement in the insurance market needs to be limited, targeted, and warranted, and this includes the role played by the newly created, non-regulatory, Federal Insurance Office (FIO).

It is for this reason that the bill to strike the subpoena authority of the FIO and the Office of Financial Research (OFR) to collect data from the insurance industry is of particular interest to the Big "I". Congress rightfully recognized and codified in statute as part of the Dodd-Frank Wall Street Reform Act that independent insurance agencies are not subject to the mandatory data collection powers or subpoena authority of FIO or OFR. Likewise, we see merit in further limiting the ability of these new entities to subpoena information from our company partners, since state regulators already have the power to collect such data. These duplicative data requests would undoubtedly become an undue burden on private business, unnecessarily adding to costs for consumers. The Congress should strongly consider striking this authority from statute.

The Big "I" also sees value in the measures that would clarify that insurers should not be subject to the application of the FDIC's orderly liquidation authority and the Federal Reserve's capital requirements and accounting standards. State insurance regulation already has in place proven safeguards and broad authority to guard against the risk of insolvency, protect policyholders, and ensure that companies meet their obligations to consumers. In the rare event of an insurer insolvency, the state guaranty fund system already provides a strong safety net. Potentially subjecting the insurance marketplace to FDIC liquidation authority would be redundant and unnecessary. In addition, it is important to note that insurance companies, and especially property casualty insurers, present very little systemic risk to the economy. The insurance market is very different from the banking and securities markets, and requiring insurers to participate in an FDIC resolution structure meant for banks or subjecting insurers to Federal Reserve capital standards makes little sense. State regulators already ensure that insurers maintain low leverage ratios and have large capital cushions to insulate against any market shocks. The Big "I" sees no merit in imposing requirements that duplicate or conflict with the proven standards and effective mandates that exist at the state level.

Thank you again for holding this hearing today and for your attention to these important matters.

NAMIC
NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES
www.namic.org

3601 Vincennes Road, Indianapolis, Indiana 46268
Phone: 317.875.5250 | Fax: 317.879.8408

122 C Street N.W., Suite 540, Washington, D.C. 20001
Phone: 202.628.1558 | Fax: 202.628.1601

November 14, 2011

The Hon. Judy Biggert
Chairman, House Financial Services
Subcommittee on Insurance, Housing
and Community Opportunity
U.S. House of Representatives
2113 Rayburn House Office Building
Washington, D.C. 20515

The Hon. Luis Gutierrez
Ranking Member, House Financial Services
Subcommittee on Insurance, Housing
and Community Opportunity
U.S. House of Representatives
2266 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Biggert and Ranking Member Gutierrez:

The National Association of Mutual Insurance Companies (NAMIC) strongly supports the three recently released legislative drafts intended to clarify the authorities of various federal agencies with respect to the insurance industry. We would like to thank you for your hard work and attention to these important issues and believe that the proposed bills respect the legislative intent of the Dodd-Frank Wall Street Reform Act while at the same time preventing unforeseen disruptions to insurance markets and harm to insurance consumers.

NAMIC is the largest and most diverse national property/casualty insurance trade association in the United States. Its 1,400 member companies write all lines of property/casualty insurance business and include small, single-state, regional, and national carriers accounting for 50 percent of the automobile/ homeowners market and 31 percent of the business insurance market. NAMIC has been advocating for a strong and vibrant insurance industry since its inception in 1895.

First, we support the proposed legislation to strike the authority of the Federal Insurance Office (FIO) and the Office of Financial Research (OFR) to issue subpoenas directly to insurers to collect data. Throughout the debate over Dodd-Frank one of our foremost concerns was the granting of new powers to federal agencies to make data calls and request document productions. These requests are costly and time-consuming – particularly for small insurers with few employees and scarce resources – and insurers already regularly submit information to state regulators on all aspects of their operations.

Creating even the potential for an additional reporting layer goes against the goal of simplification and coordination, and we believe that any needed information can be obtained through the systems and processes already in place. Also, any authority to demand data and document productions would resemble regulatory authority over insurance, which runs counter to the legislative intent of the Dodd-Frank Act.

Secondly, we support legislation that would prevent the Federal Reserve Bank Board of Governors from requiring an insurance company to comply with accounting standards different from those

required by the company's state insurance regulator. It is important to recognize the striking differences between the activities of many of the institutions that are traditionally regulated by the Fed and those of insurers. Information that is critical to supervising an entity which is overwhelmingly engaged in insurance activities is fundamentally different than the information critical to regulating traditional bank holding companies. One size does not fit all, and consequently, the system of reporting should be tailored to this economic reality.

Furthermore, using Statutory Accounting Principles (SAP) instead of Generally Accepted Accounting Principles (GAAP) would allow the Fed to gather the kind of information that is most useful in assessing an insurer's financial health. SAP forms the foundation for insurers' Risk Based Capital requirements, which we believe better reflect the risks for which capital is needed by insurance enterprises. The tremendous expenditures required to convert accounting systems from SAP to GAAP far outweigh any practical utility the Fed could plausibly generate in mandating GAAP reporting. For all of these reasons, it is important for Congress to make clear to the Fed that new reporting standards not be required of insurers.

Finally, NAMIC believes that it is important to clarify that insurance companies do not fall under the Federal Deposit Insurance Corporation's orderly liquidation authority. Policyholders are already protected from the consequences of insurer insolvencies by the guaranty fund system. Covering insurance claims can be complex and is different than the way bank deposits are backstopped by the FDIC. The guaranty funds know how to operate within the guidelines of specific state laws and requirements and can navigate the intricacies of the insurance claims-paying function, allowing the government to avoid getting into the business of adjusting and paying policyholder claims. Codifying that insurers are not subject to the FDIC's liquidation authority is a prudent move to avoid the possibility of a mishandled insurer wind-down and will confirm the role and importance of the guaranty fund system.

In addition to the three proposed bills, NAMIC would urge the committee to consider legislation that would strike the Financial Stability Oversight Council's (FSOC) authority to designate an insurance company as a Systemically Important Financial Institution (SIFI). There are four key reasons for considering such legislation:

1. Evidence shows that the insurance industry is highly competitive and well capitalized;

2. Owing to the nature of its products, the insurance industry is unique within the financial services sector in that it poses no risk to the financial system;

3. Recent history demonstrates the effectiveness of the state-based system of insurance regulation for protecting the solvency of insurers; and

4. The legislative history of Dodd-Frank makes clear that lawmakers did not believe that insurers generally pose a systemic risk.

Insurance companies – particularly mutual property/casualty insurance companies – should not be subject to SIFI determination by the FSOC. Given the complexity of financial markets in the U.S. and across the globe, Congress should assist the FSOC with its difficult responsibility by limiting its focus to those entities that could potentially pose a systemic risk.

In conclusion, NAMIC believes that the three legislative proposals under discussion represent an excellent first step toward bringing much-needed certainty to insurance markets. However, we also believe that more can and should be done to limit any unintended consequences for insurers from the effects of the Dodd-Frank Act – one example being the prevention of new and unnecessary regulation of insurers by the FSOC.

Again, we want to thank the chairman, ranking member, and subcommittee members and staff for their hard work on these issues. We look forward to working with the subcommittee to move legislation quickly toward passage.

Sincerely,

Charles M. Chamness
President & CEO

National Association of Professional Surplus Lines Offices, Ltd.
200 N.E. 54th Street • Suite 200 • Kansas City, MO 64118 • 816/741-3910 • Fax 816/741-5409
www.napslo.org

Brady Kelley
Executive Director

November 15, 2011

House Financial Services Committee
2129 Rayburn House Office Building
Washington, DC 20515

House Financial Services Committee:

On behalf of its membership, the National Association of Professional Surplus Lines Offices (NAPSLO) is pleased to support the House Financial Services Committee's continued efforts to address the unresolved issues of the Dodd-Frank *Wall Street Reform and Consumer Protection Act* as they relate to insurance industry regulation. NAPSLO appreciates the Committee's efforts to ensure that the statutory interpretation and implementation of the Dodd-Frank legislation is consistent and workable throughout the insurance industry.

NAPSLO is the trade association representing the surplus lines industry and the wholesale insurance marketing system. NAPSLO has over 750 members representing 1,600 offices representing approximately 15,000 – 20,000 individual brokers, agents, company professionals, underwriters and other insurance professionals in 48 states and the District of Columbia.

In particular, NAPSLO is pleased to support the Committee's recent legislative draft on Federal data collection which will be discussed during its November 16th hearing. The Committee's proposed legislation on data collection would enact sensible, much needed reforms to eliminate the Federal subpoena authority as it relates to insurance data and require that any Federal entity only secure such data through the appropriate State insurance regulator. These changes recognize the unique issues related to the insurance industry and its state-based regulation.

NAPSLO also thanks the Committee, its Members and staff, for its continued interest in ensuring the appropriate implementation of the *Nonadmitted and Reinsurance Reform Act* (NRRA). The ongoing state-based implementation of NRRA is vital to the long-term health of the surplus lines industry and we appreciate the Committee's desire to work with states and industry during this transition period.

Sincerely,

Robert T. Sargent
President

Brady R. Kelley
Executive Director

Chief Financial Officer
Nationwide

On Your Side®

November 13, 2011

The Honorable Judy Biggert
Chairman, House Financial Services Subcommittee on Insurance, Housing, and Community Opportunity
2113 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Biggert:

As the Chief Financial Officer of Nationwide Mutual Insurance Company ("Nationwide"), I am writing to express our appreciation for your efforts and those of the Subcommittee to further clarify certain provisions of the Dodd-Frank Act ("the Act") affecting insurance companies. While we strongly support the goal of reducing systemic risks in the financial sector, we also support efforts to minimize the unintended consequences of the Act on traditional lines of insurance.

As you know, the traditional business of insurance was not a contributing factor in the economic crisis, and the Act was largely aimed at the banking sector. However, as your thoughtful legislation reflects, insurance companies such as Nationwide are now subject to several substantial new regulations under the Act, many of which are far-reaching and unprecedented. While Nationwide is fully prepared to adjust to these regulations in compliance with our legal requirements, we greatly appreciate your efforts to raise appropriate policy concerns.

From a public policy perspective, we believe that it is important to carefully examine the regulatory structures affecting insurance companies under the Act, because of the robust state-based regulatory system that already applies to insurance companies. Nationwide, like many insurers, is currently regulated by 50+ state and territorial jurisdictions in which we do business. These regulations include many of the areas addressed in the Act, including capital requirements, investment restrictions (including use of derivatives), financial audits, and financial reporting and data-gathering.

Again, thank you for your efforts to examine the effects of the Act on traditional lines of insurance. We stand ready to assist you and the Subcommittee as the legislative process unfolds.

Sincerely,

Mark R. Thresher

cc: The Honorable Luis Gutierrez
The Honorable Steve Stivers

One Nationwide Plaza, 1-37-06
Columbus, OH 43215-2220

Tel 614-249-6950
Fax 614-249-9351

NCIGF
National Conference of Insurance Guaranty Funds

TESTIMONY FOR THE RECORD

OF

THE NATIONAL CONFERENCE OF INSURANCE GUARANTY FUNDS

BEFORE THE

HOUSE FINANCIAL SERVICES SUBCOMMITTEE ON INSURANCE, HOUSING AND COMMUNITY OPPORTUNITY

HEARING ENTITLED

"INSURANCE OVERSIGHT AND LEGISLATIVE PROPOSALS"

NOVEMBER 16, 2011

While they may not know it, American insurance consumers are protected by a nationwide system of insurance guaranty associations (sometimes also called "guaranty funds"). State lawmakers and insurance regulators formed this system over 40 years ago to pay the claims of the average property/casualty and life/health/annuity insurance policyholder if an insurance company fails. The safety net operates in every state and territory and is coordinated by two national entities – the National Conference of Insurance Guaranty Funds (NCIGF) and the National Organization of Life & Health Insurance Guaranty Associations (NOLHGA). NCIGF is pleased to submit the following testimony regarding the state based property/casualty insurance guaranty system to the House Financial Services Committee, Subcommittee on Insurance, Housing and Community Opportunity. NOLHGA is submitting similar testimony describing the life/health/annuity guaranty system.

THE CURRENT SYSTEM OF INSURANCE RECEIVERSHIP

To understand the property/casualty insurance safety net, it is important to understand some of the fundamentals of state insurance receivership. Just as insurance companies are regulated almost entirely at the state level, insurance receiverships are administered by the insurance commissioner of the state where the company is chartered – in effect, its state of incorporation – pursuant to the insurance receivership laws of that state, and under the supervision of a court in that state. The insurance receivership laws in each state have as a primary goal to make sure that a failed insurer's policyholder obligations are honored to the greatest extent possible. The guaranty funds work with state receivers to ensure that this happens quickly and efficiently.

How the Property/Casualty Insurance Guaranty System Works

How the Guaranty Fund System is Structured.

Generally speaking, every state and the District of Columbia have a property/casualty fund created by state law, overseen by the state's insurance regulator, and typically operated as a non-profit association.[1] Each property and casualty insurance company licensed to do business in that state is required by state statute to be a member of the guaranty fund. Typically, a guaranty fund is governed by a board of directors, drawn mostly from the fund's member insurance companies. Some guaranty funds also have public members when mandated by statute.

A state guaranty fund manager (often assisted by staff) delivers the policyholder protections required by statute, working in coordination with the receiver of the failed insurer. Although most guaranty funds are subject to the supervisory oversight of their state insurance commissioner, they are not generally[2] or in any meaningful sense operated by state government, and they do *not* have a role (even in their own states) in monitoring or policing the solvency of insurers. Similarly, guaranty funds almost never serve as the receiver of a failed insurer.

Protection for consumers generally is provided by the guaranty fund of the state where the consumer resides or, in the case of property insurance, where the property is located. Each guaranty fund responds to an insolvency by paying claims of the residents of that fund's state, regardless of where the failed company may have been domiciled, regulated, or placed in receivership.

How the Guaranty Fund System Protects Policyholders.

The nationwide property/casualty insurance guaranty system honors the contractual commitments made by failed insurers to their *policyholders*. The safety net does not provide liquidity support to failed (or failing) insurers, nor does it protect their general creditors.

Guaranty funds are "triggered" once a state court finds that an insurance company is insolvent and orders it into liquidation. Once that occurs, the receiver of the failed company physically transfers the claim files (either in paper or electronic form) to the state's guaranty fund. Essentially, the guaranty fund "steps into the shoes" of the insolvent company to pay claims consistent with a state's insurance code and, by law, policyholders are at the "head of the line" of an estate's creditors. Covered policyholders are paid promptly by means of the guaranty association mechanism.

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[1] Several states have separate guaranty mechanisms to provide protection in respect of certain specific types of benefits or programs, such as workers' compensation insurance.

[2] The form of most insurance guaranty funds is that of a special, non-governmental, not-for-profit entity established by specific state enabling legislation. However, in four states (Arizona, Arkansas, New York and Pennsylvania), at least some elements of the guaranty mechanism are operated as part of state government

When an insurer fails, there are two overriding policyholder concerns addressed by existing public policy– (1) the continuation of the insurance coverage that the policyholder has lost as a result of the insurer's failure and (2) payment of valid outstanding claims.[3]

The answer to the first concern is fairly straightforward; in a competitive insurance marketplace, consumers can find another company to underwrite a potential loss. Policyholders who do not have a claim pending with the failed carrier do not need significant protection from the guaranty fund system; they need only purchase a new insurance policy. In most states the guaranty funds cover claims for unearned premium, thereby helping policyholders pay for replacement coverage.

The second concern – payment of claims – is the core responsibility of the guaranty system and is much more than simply writing checks to policyholders with claims. Guaranty fund representatives adjust the pending claims, just as claims adjusters in a solvent company would do. This requires insurance claims specialists qualified to analyze contract duties under the law of their state, analyze bodily injury claims and assess liability as well as the litigation risk associated with the claim.

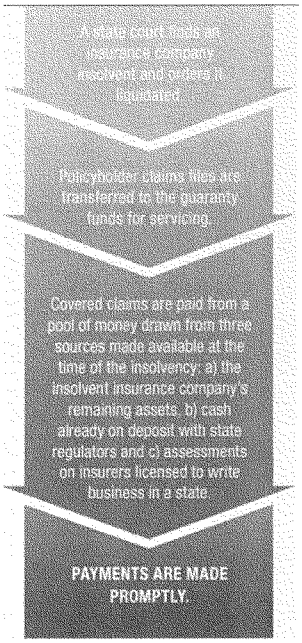
Each state's law establishes the coverage for the residents of its state. Nearly all states have guaranty fund laws adapted to local conditions by each state legislature from the model property/casualty guaranty fund statutes promulgated by the National Association of Insurance Commissioners (NAIC). Guaranty funds pay covered claims within the limits set by individual state laws and the insurance contract. Typically, the claim limit for personal injury and property damages is $300,000 on covered claims, with some states covering as much as $500,000 to $1,000,000. Notably there is one state with a covered claim cap of $5 million. (Nine states provide limits higher than $300,000, and eight states and territories have somewhat lower limits.) Most guaranty funds pay 100% of statutorily-defined workers' compensation benefits. Claim caps allow the system to have sufficient money to pay claims and ensure "capacity" needed to serve all claimants. Guaranty funds play no role in setting coverage caps.

[3] Under insurance liquidation laws, virtually all property and casualty insurance contracts are cancelled within thirty days of the date of liquidation, leaving the guaranty funds responsible for the adjudication and payment of claims that had accrued prior to liquidation and thirty days thereafter.

How the Guaranty Fund System is Funded.

Guaranty funds do not have the same immediate funding requirements that banks require because of the long-term nature of many insurance obligations. State laws require guaranty funds to pay claims "promptly," but many claims become due, and consequently are paid out, over a period of several years. By design, guaranty funds draw from several sources of funding to pay claims:

- The assets remaining in the insurance company, including those from ongoing reinsurance collections, which can be made available to the guaranty funds on an expedited basis. These assets are usually substantial and provide the primary source of funding guaranty fund payments to consumers in most insolvencies.[4]
- Statutory deposits that may have been collected in some states to secure the insurance company's claim payment obligations.
- Assessments collected from member insurance companies.



This funding mechanism was designed to use as much of the failed company's remaining cash as possible. The guaranty funds levy assessments on viable insurance carriers only to the extent that a shortfall remains after the available estate assets have been exhausted. In that case, the state guaranty fund assesses the healthy insurers who do business in that state, up to annual statutory limits, typically 2% of net direct written premium in the year prior to the assessment. The amount of the assessment is determined by the amount of money needed by the guaranty fund to supplement the initial sources of funding.

The guaranty fund system delivers on its policyholder protection mission economically. Nationwide, annual guaranty fund general operating expenses are about $66 million, with a staffing level of approximately 650 employees. The fact that guaranty funds deliver maximum consumer protection at a low cost is underscored by the system's overall operating costs when contrasted with those of the insurance industry. Research by the NCIGF shows that historically, the Loss Adjustment Expenses and General Operating Expenses of guaranty funds were on par with those of the insurance industry.

National Coordination – The Role of NCIGF. The protections provided by as many as 50 or more property/casualty guaranty funds are coordinated through the National Conference of

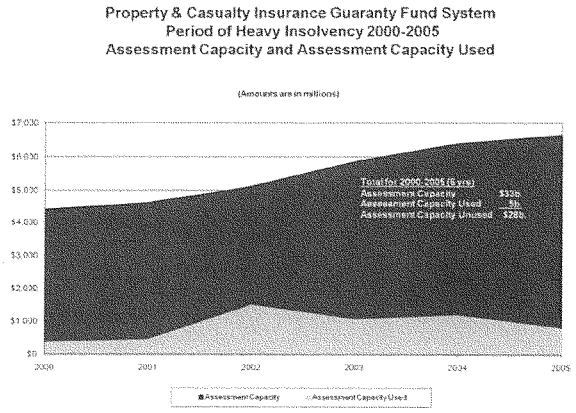
[4] Estate assets typically are sufficient to cover 55-65% of policy level claims in property and casualty insolvencies.

Insurance Guaranty Funds, a 501(c)(6) not-for-profit organization incorporated in Illinois and based in Indianapolis, Indiana and made up of independent property and casualty insurance guaranty funds in every state and the District of Columbia. NCIGF does not pay claims, but rather coordinates the multi-state claims-paying activities of its member guaranty funds, monitors litigation that may affect guaranty funds, coordinates with the property and casualty insurance company trade associations on state legislative matters, conducts education and training seminars for guaranty funds, provides financial information concerning the guaranty system, serves as a clearinghouse of relevant information, and provides a national forum for discussion and liaison with the NAIC and insurance receivers.

HISTORY OF DEPENDABLE CONSUMER PROTECTION

The existing property/casualty insurance guaranty system has a proven track record of protecting policyholders. Since the early 1970s, the guaranty system has provided protection to policyholders in more than 550 cases of insurer insolvencies, paying a total of approximately $27 billion in claims and expenses. The insurance guaranty system has met all of its obligations and promptly provided protection to all consumers for whom they are responsible in each and every case of insurer failure.

During the heaviest period of insolvency activity – 2000-2005 – the guaranty fund system paid out $10 billion against assessment capacity of about $33 billion. Of that $10 billion paid, $5 billion came from the insolvent companies' assets and statutory deposits.



Today, the overall assessment capacity of the property and casualty guaranty fund system is about $6.7 billion, renewable every year. Reliance on assessments to pay claims has never exceeded 35 percent of capacity in a single year. When assessment capacity is laid on top of estate assets (again, the primary funding source for guaranty fund payments) and statutory

deposits, the guaranty system has more than ample funding available to handle multiple large insolvencies – especially considering the often long-term nature of insurance obligations.

THE GUARANTY SYSTEM IS PREPARED TO DEAL WITH FUTURE INSOLVENCIES

The nationwide network of property/casualty insurance guaranty funds has proven extremely effective at achieving its principal mission the protect ion of policyholders. As with any effective organization, the insurance guaranty system has evolved over the years and operates with a high level of cooperation, coordination, and consistency that comes only with experience.

NCIGF has also evolved over the years into a national coordinating mechanism that has established effective and credible working relationships with both insurance regulators and industry members. NCIGF employs a complete complement of full-time staff professionals who are well versed in the technical and practical complexities inherent in any insolvency.

The resources and coordination NCIGF provides helps minimize costs by facilitating a national response plan for protecting policyholders in multi-state insolvencies. This coordination of effort also reduces the length of time it takes to respond to a multi-state insolvency and provide policyholders their statutorily prescribed benefits.

While NCIGF serves as the national coordinating body for protecting policyholders, its individual guaranty fund members are aware of and sensitive to local circumstances and respond quickly to the concerns of resident policyholders when an insolvency occurs. The volume of calls and letters from concerned policyholders is understandably high in the aftermath of an insolvency. Individual guaranty fund staffs respond quickly to explain coverage benefits and the claim submission and payment process; provide status reports; and resolve specific inquiries. NCIGF's member funds understand their states' tort law and court systems and how to adjudicate claims promptly and efficiently. For these reasons, the existing insurance guaranty system is able to enjoy the operational efficiencies of a national system, while effectively responding to the often-local concerns of insurance consumers experiencing financial and other stresses associated with the failure of their insurance company.

Given its significant experience, operating efficiency, and credibility, the current state-based insurance guaranty system is prepared to fulfill its statutory duty: protection of the nation's insurance consumers from future insolvencies of property/casualty insurers.

* * * * *

NCIGF and NOLHGA have worked together the past several years to educate Congress, federal agencies, and other policy and decision makers about the insurance consumer safety net. We appreciate this opportunity to continue that effort.

Roger H. Schmelzer, President
National Conference of Insurance Guaranty Funds
300 North Meridian Street, Suite 1020
Indianapolis, IN 46204
Phone: 317.464.8155
Email: rschmelzer@ncigf.org

NCOIL
National Conference of Insurance Legislators
...for the States

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November 9, 2011

Representative Judy Biggert, Chair
U.S. House Committee on Financial Services
Subcommittee on Insurance, Housing & Community Opportunity
2113 Rayburn House Office Building
Washington, DC 20515

Dear Chairperson Biggert:

As NCOIL president, I am pleased to provide comments for your November 16 hearing on *Insurance Oversight and Legislative Proposals.*

As state lawmakers with a sole focus on insurance public policy, NCOIL believes strongly in our state-based system of insurance regulation. We have worked hard to promote regulatory modernization in certain key areas and will continue to advocate strategies that protect insurance consumers while making regulation more efficient and effective.

NCOIL in 2008, 2009, and 2010 made the case for continued state regulation as Congress considered bills that evolved into the Dodd-Frank Act (DFA). State lawmakers argued that the relative success of the insurance market throughout the financial crisis evidenced the strength of the state system and proved that insurance should not be swept into the broader reform package. Indeed, NCOIL opposed the establishment of the Federal Insurance Office (FIO) because, in part, its scope of authority was seemingly drawn to extend beyond that of an informational office. While we remain concerned about possible FIO mission creep, this letter will focus on other areas of the DFA that I understand your hearing will address.

Systemically Important Financial Institutions (SIFIs)
NCOIL has consistently argued that insurance companies in general should not be viewed as SIFIs and should not be subject to duplicative and "heightened" Federal Reserve regulation. In March 2010, lawmakers unanimously adopted a resolution that declared, "insurance activities in general do not create systemic risk to the rest of the financial system or the U.S. economy at large, because of the industry's low concentration, low barriers to entry and policyholder and beneficiary protection through the state rehabilitation, insolvency and guaranty fund system."

State legislators historically have enacted, and continue to enact, strong financial solvency and consumer protection laws that should not be interrupted by new federal strictures. We fear that subjecting companies to another level of supervision would jeopardize the ability of the states to continue providing robust solvency protection and could present insurers with additional compliance costs that would ultimately be felt by the insurance-buying public.

Liquidation Authority
To ensure that consumers are protected in instances when insurance companies fail, state legislators and regulators have cooperatively developed processes to rehabilitate and, when necessary, resolve failing insurers. NCOIL legislators appreciate that under Dodd-Frank troubled insurers would continue to be directed to state guaranty fund mechanisms. We believe that state regulators, acting in accordance with state law, are best-suited to address troubled insurers.

Regarding SIFI liquidation costs, NCOIL argued during DFA debates that since failing insurers would be directed to state mechanisms—which typically provide for post-event funding from the industry—insurers should not be required to also contribute to the federal liquidation system. Such double-dipping seemed inherently unfair as it would increase costs on insurers to fund a system not used by the industry.

FIO Data Collection
Though NCOIL has no formal position on FIO subpoena power, it is hard to imagine a circumstance where it would be necessary or warranted, as insurance information can be found without subpoena use through state, federal, and public sources. State law requires insurers to submit extensive amounts of data to state insurance departments and/or to the National Association of Insurance Commissioners (NAIC). As Members of Congress have stated that their intent was that FIO serve as a source of insurance information for the federal government, subpoena authority may provide an opportunity for mission creep without offering any tangible benefits.

NCOIL hopes that you find these comments helpful as you investigate Dodd-Frank Act impacts on insurance oversight. We encourage you to view NCOIL as a resource should you have any questions.

Best regards,

Rep. George Keiser, ND
NCOIL President

K/NCOIL/2011DOCS/2007537b

National Organization of Life and Health Insurance Guaranty Associations
13873 Park Center Road, Suite 329 | Herndon, VA 20171
Phone: 703.481.5206 | Fax: 703.481.5209
www.nolhga.com

TESTIMONY FOR THE RECORD

OF

THE NATIONAL ORGANIZATION OF LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATIONS

BEFORE THE

HOUSE FINANCIAL SERVICES SUBCOMMITTEE ON INSURANCE, HOUSING AND COMMUNITY OPPORTUNITY

HEARING ENTITLED

"INSURANCE OVERSIGHT AND LEGISLATIVE PROPOSALS"

NOVEMBER 16, 2011

The National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) is pleased to submit these comments in response to the invitation of the Subcommittee Chair. NOLHGA's 52 members are the guaranty associations (sometimes called "GAs") formed by the 50 states, Puerto Rico, and the District of Columbia to provide protection for consumers facing financial harm from the failure of a life or health insurance company. NOLHGA's members, along with the state property and casualty insurance guaranty funds belonging to the National Conference of Insurance Guaranty Funds (NCIGF), have provided a nationwide insolvency "safety net" for American insurance consumers since the 1970s.

The objective of this written testimony is to provide the Subcommittee with an overview of the life and health insurance guaranty system and its operations, history, and ability to protect consumers—even in a challenging economic environment. NCIGF is concurrently submitting parallel testimony on the property and casualty insurance guaranty system.

THE LIFE AND HEALTH INSURANCE GUARANTY SYSTEM TODAY

From its inception in the early 1970s, the life and health insurance guaranty system has evolved into an effective national network that has fully performed its obligations to provide protection to consumers. The system has protected consumers in 80 insolvencies of insurers who wrote business in multiple states, and in another 326 instances where smaller single-state or regional

carriers failed.[1] In those cases, the system has protected, in the aggregate, more than 2.8 million policyholders, and it has guaranteed policyholder values in an aggregate amount of about $25 billion.

Although the recent financial crisis laid waste to a number of financial service providers of many kinds, operating insurance companies stood up well to the many challenges of the period: Only 13 life and health insurers (8 life and 5 health) were placed in liquidation from January 1, 2008, through November 16, 2011, with aggregate liabilities to policyholders of about $900 million.[2] And while the insurance industry has fared comparatively well through the crisis, the guaranty system's financial and operational resources are greater now than they have ever before been, supporting the conclusion that the system can and would protect consumers in a challenging future financial environment, as it has done in the past.

Development of the Current Life and Health Insurance Guaranty System

There was no organized national consumer insurance safety net before the early 1970s, but by then a consensus had developed that such a system was needed. As a result, insurance regulators, legislators, and the industry developed guaranty association model legislation (the "Model Act"[3]) that states adopted widely in the 1970s and 1980s as the foundation of the current guaranty system.[4]

By 1991, life and health insurance guaranty associations had been established by the legislatures of all 52 of NOLHGA's current member jurisdictions.

NOLHGA was formed by the guaranty associations in 1983 to provide a process, facilities, and staff to coordinate and support the activities of the member guaranty associations, particularly in connection with the insolvencies of insurers writing business in multiple states.

How Guaranty Associations Work

Insurance guaranty associations provide protection to consumers; they do not provide rescue or "bailout" financing for financially troubled companies. The fundamental responsibility of an insurance guaranty association is to assure the provision of insurance protection to consumers, up to a statutorily established maximum level of guaranteed protection, once the duties of the guaranty association have been "triggered" by a judicial determination that an insurer is insolvent and should be liquidated.[5]

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[1] Also included in the larger number are some cases where failed property and casualty insurers wrote a small amount of health insurance, and where the insolvency case triggered obligations of both property and casualty guaranty funds and some life and health guaranty associations.

[2] Compare, for example, the initial bank and bond debt of Lehman Brothers alone, which was reported on the first day of Lehman's bankruptcy as totaling approximately $765 *billion.*

[3] *See* NAIC Life and Health Insurance Guaranty Association Model Act ("Model Act").

[4] The development of the consensus favoring the guaranty system, the related model legislation, and enactment of the model legislation in the states are summarized in *The U.S. Guaranty Association Concept at 25: A Quarter Century Assessment*, Christopher J. Wilcox, 14 J. of Ins. Reg. 370 (Spring 1996).

[5] Certain conditions must exist in order for a guaranty association to have statutory responsibility to consumers. For example, in general the insured must be a "covered person" (*see* Model Act Section 3A); the contract under which

A working understanding of how guaranty associations protect consumers thus requires first a working understanding of the insurance receivership process.

The Conduct of Insurance Receiverships

Domestic U.S. insurance companies are excluded from the definition of "debtor" under the U.S. bankruptcy code, and thus their financial failure is resolved outside of the federal bankruptcy process.[6] Rather, an insurer receivership is an insolvency proceeding conducted in a state court of the state where the insurer is chartered and primarily regulated (the "domiciliary state").

Under the laws of most states, the receivership is commenced by the filing of a petition by the state's attorney general on the relation of the state's insurance commissioner, who is appointed statutory receiver if the court grants the petition.

Receiverships are of several different types. For example, in Illinois (and many other states), the mildest form of receivership is "conservation," under which the insurance commissioner is appointed conservator for purposes of securing the finances and records of the company, thus protecting the status quo pending a determination of whether a more serious form of receivership is required. If serious solvency concerns are raised, a company can be placed into "rehabilitation," where the commissioner, as rehabilitator, is expected to develop and propose to the court a rehabilitation plan aimed at addressing the causes for concern about the company. If a company is financially troubled and cannot be rehabilitated, the commissioner petitions for "liquidation," under which the commissioner is appointed liquidator and directed to marshal the assets of the failed company, evaluate claims against it, and distribute the assets to those with valid claims in the manner specified in the state's receivership law.[7]

Three aspects of the insurance receivership process are particularly relevant to how guaranty associations protect consumers.

First, insurance receivership judicial proceedings, like bankruptcy cases, generally provide for notice to and participation by creditors on material issues. While the development of a resolution plan for a failed insurer usually is proposed in the first instance by the domiciliary commissioner as receiver, this is done with knowledge that affected creditors will have opportunities to comment upon or object to all or part of the proposal.

Second, state receivership laws generally confer priority creditor status on claims against the "estate" of the failed insurer that arise from the insurer's direct policies of insurance. Since receiverships follow an "absolute priority rule," all claims at the insurance policy level must be paid *in full* before any payments may be made on lower-ranking claims, such as general creditor claims, claims in respect of subordinated financing, or equity claims.

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the insured seeks coverage from the guaranty association must be a "covered contract" (*see* Model Act Section 3B(1)); the failed insurer must have been a "member insurer" of the guaranty association (*see* Model Act Sections 3B(1) and 5(L)); and no coverage "exclusions" must apply to the insured's claim for coverage (*see* Model Act Section 3B(2)). These conditions are routinely satisfied in cases involving typical insolvent insurers that wrote traditional consumer lines of life or health insurance.

[6] *See* Bankruptcy Code, 11 U.S.C §§ 109(b) and (d), preventing domestic insurance companies from qualifying as "debtors" under Chapter 7 and Chapter 11 bankruptcy.

[7] *See, e.g.*, 215 ILCS 5/187 *et seq.*

Third, guaranty associations are subrogated to the claims of the insurance policy owners that the associations protect; that is, after protecting the consumers, the associations step into the shoes of those policyholders as creditors of the insolvent insurer at the (preferred) policyholder creditor level.[8] In effect, the associations are responsible—within coverage limits—for the entire amount of covered policy liabilities to consumers, but if the estate has significant assets when the insurer is placed in liquidation, the associations' subrogation claims to those assets effectively become part of the associations' financing. If the consumer has a claim exceeding association coverage limits, that "over limits" portion of her claim is *entirely* dependent on the availability of estate assets.

Viewed another way, since the obligation of a guaranty association is to assure that consumers are completely protected *up to* the association's limit of coverage, the amount of assets that can be marshaled by the receiver are critically important not only to the guaranty associations and those paying the associations' costs (by reducing the expense of providing coverage within the associations' limits), but also to policyholders with large claims (by maximizing the assets available to cover any portion of a policyholder's over-limits claim). Accordingly, the comparative success of a receivership—and how well (or badly) policyholders with over-limits claims and other stakeholders fare in the receivership—is primarily a question of whether the receiver marshals assets covering a significant percentage of policy-level liabilities. (For a more detailed discussion of this issue, see Appendix A – The Critical Role of "Prompt Corrective Action.")

As a consequence of the three receivership aspects described above, the activities and interests of insurance receivers and the guaranty system are closely inter-related, a fact recognized widely among state regulators and receivers.[9]

The Operations of the Guaranty System in a Receivership

Once a guaranty association is triggered by a judicial determination that an insurer is insolvent and should be liquidated, the association has two principal sets of duties to consumers. First, the guaranty association must pay, up to coverage limits, any claims that are or become ripe for payment. Second, as to contracts that the failed insurer had no right to cancel prospectively (e.g., annuities, most non-term life insurance contracts, and some types of health insurance contracts), the guaranty association must guaranty, assume, or reinsure the continuing insurance coverage. In other words, the association must make sure that the coverage continues, as long as the consumer pays any required premium.

Regarding the first set of obligations—payment of "ripe" claims—the duties of life and health guaranty associations are substantially similar to those of property and casualty guaranty funds. The function of the triggered guaranty association is to process, adjudicate, and pay claims coming due in much the same way that the insurer would have done, had it not failed.

However, because non-cancellable contracts, such as life and annuity contracts, are purchased to cover an extended period of time for contract terms and premiums that are often permanently established at the inception of the contract (unlike, for instance, property and casualty coverage,

[8] *See* Model Act Section 8K.

[9] *See generally,* "Communication and Coordination Among Regulators, Receivers, and Guaranty Associations: An Approach to a National State Based System," NAIC (2005).

which is purchased annually and may be subject to annual re-pricing, re-underwriting, contract term changes, or even cancellation by either party), the policy owner has an investment or "equity" interest that cannot be fully protected unless the contract is, in effect, kept in force. For example, a policyholder might have been in good health when she purchased a life policy 10 years before the insurer entered liquidation, but at the time the insurer failed, her health might have deteriorated to the point where she might be unable to purchase replacement coverage on similar terms, or at any price.

Consequently, for the "safety net" to work regarding non-cancellable contracts, the guaranty association must assure the continuing covered benefits promised by the contract on the terms originally agreed between the policyholder and the (now-failed) insurer. This is often accomplished by the negotiation of an arrangement known as an "assumption reinsurance" transaction. In such a transaction, a healthy carrier agrees to assume all or part of the policy liabilities of the failed insurer in exchange for a transfer of assets to support the liabilities—assets that are usually provided in part by the receiver from the estate of the insurer, and in part by guaranty associations. In other cases, guaranty associations simply assume the covered liabilities of the insolvent insurer for whatever period is required for the liabilities to run off. A combination of both approaches can also occur, in which the guaranty associations assume the covered liabilities for some period of time, after which a healthy carrier takes over the liabilities via assumption.

Coordination of Guaranty Association Responses

Guaranty association coverage responsibilities under current law are determined by the residence of the covered person: A covered person is protected by the guaranty association of the jurisdiction where the person resides, even though the insurer whose liquidation triggers the association's coverage responsibility may be domiciled in a different jurisdiction.

In some cases, an insurer may be licensed to do business only in its state of domicile and may only sell contracts to individuals in that state. If such a company fails, that state's guaranty association provides all of the available guaranty association coverage.

In many other cases, a failed insurer may have been licensed in (and may have contracts with residents of) many states, in which case coordination of the coverage responses of multiple guaranty associations is necessary. The guaranty associations effect that coordination through NOLHGA and its processes, with the result that the receiver and potential assuming carriers can deal with a single point of contact and contracting instead of having to engage in multiple discussions, negotiations, and contracts with a variety of different associations. That said, and though the process is essentially invisible from a consumer standpoint, the protection afforded each contract owner and the related funding for that consumer's protection always come from the guaranty association of the jurisdiction where the contract owner is deemed a resident.

NOLHGA's offices are in Herndon, Virginia, where a permanent full-time staff of 15 insurance, finance, MIS, and legal professionals and administrative staff members support the work of the member guaranty associations. Its management is overseen by a 13-member board of directors, and all significant decisions regarding major insolvencies are made by NOLHGA's member guaranty associations.

Guaranty Association Powers and Duties

Each guaranty association is a creature of statute whose powers and duties are established by legislation adopted in its state. Since all guaranty association enabling laws are drawn from the Model Act, many of the provisions are similar or identical from state to state, though there are some differences. In some cases, the differences exist because the state insurance commissioners have amended the Model Act several times since it was first promulgated, with the result that there is usually a time lag of several years before most states' legislatures will have had an opportunity to consider updating their guaranty associations' enabling statutes in light of Model Act changes. For example, the Model Act was amended in 2009 to (among other things) raise the coverage limit for annuities from $100,000 to $250,000. To date, the laws of 35 jurisdictions cover annuities to a limit of $250,000 or more and other states are considering amendments to that effect, but some states currently are still at the old $100,000 coverage limit. (For more detail on guaranty association coverage limits as of October 2010, please refer to the brochure, "The Nation's Safety Net," which accompanies this testimony.)

All insurers licensed to market covered lines of business in a jurisdiction are obliged to be members of the guaranty association of that jurisdiction. The costs of covering consumers and of operating the association that are not provided from assets of an insolvent carrier or any ongoing premiums in respect of contracts continued by the association are financed by assessments payable by member companies. Those assessments are levied in proportion to the insurers' market shares within the jurisdiction and are subject to an assessment cap each year (typically 2% of an insurer's gross premium in the assessed line of business—life, health, or annuity).

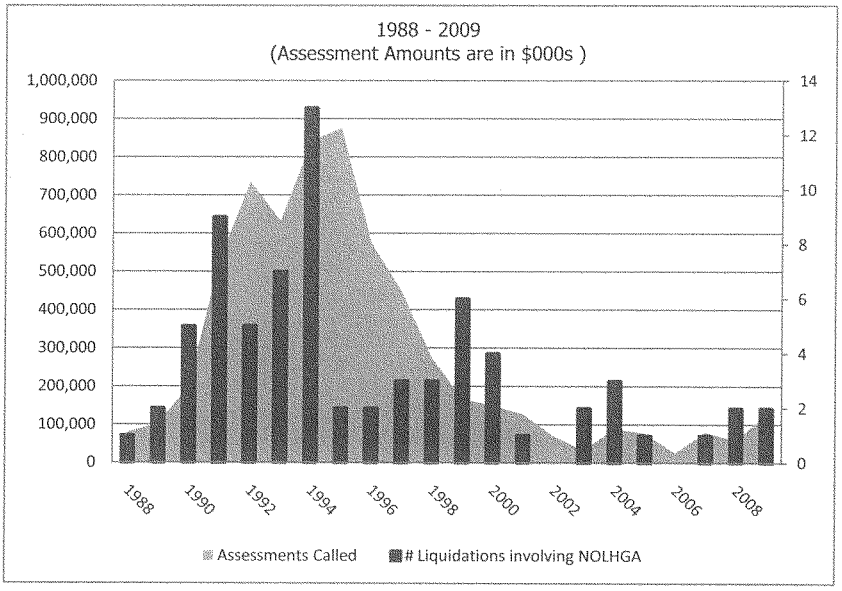
Under Section 13 of the Model Act, a state's legislature has the option of providing a "premium tax offset" to association members for portions of the assessments a member pays to that association to provide guaranty association protection for consumers. Many state legislatures have provided such premium tax offsets, in recognition of the practical difficulties preventing a member from recovering assessment expenses from any other source.

Each guaranty association is subject to regulatory supervision and examination by the insurance commissioner of its jurisdiction, and its responsibilities are prescribed by its enabling statute and by a plan of operation approved by the insurance commissioner. Operations are governed by a board of directors elected by the membership in accordance with the enabling legislation, plan of operations, and bylaws of the association.

Daily operations of guaranty associations are primarily the responsibility of an executive director, sometimes referred to as an "administrator," engaged on behalf of the association by its board of directors. Depending on the activity level of the associations, the administrators may supervise staff of varying sizes; the administrators also typically oversee work done for the associations by counsel or other professional advisors.

Historical Insolvency Performance of the Life and Health Insurance Guaranty Associations

Guaranty associations have protected consumers in 80 multi-state insolvencies coordinated through NOLHGA. In addition, they have protected consumers in approximately 326 smaller or single-state insolvencies in which NOLHGA was not directly involved. Set forth below is a chart displaying by year the frequency and cost (by assessments "called," or collected from guaranty associations' member insurers) of the 74 insolvencies from 1988–2009 coordinated through NOLHGA:



As the chart suggests, insolvencies have tended to increase and decrease—both in frequency and severity—in apparent "waves" or cycles that bear some relationship to broader economic and financial trends.

For example, the chart shows a marked increase in the frequency and cost of insurer failures in the first half of the 1990s, when the U.S. economy was emerging from a general recession and the financial sector was also still feeling the consequences of negative developments in the commercial real estate and corporate high-yield bond markets. A number of the more significant life company insolvencies in this period were precipitated by significant deteriorations in real estate or bond investments.

Interestingly, the recent financial crisis—which saw the failure of nearly 400 commercial banks and thrifts, several major investment banking firms and hedge funds, finance companies,

government-sponsored housing entities, and other firms—resulted in very few liquidations of operating life and health insurers. Of the 13 life and health companies that entered liquidation since January 1, 2008, almost all were comparatively tiny regional writers; none were remotely "systemically important;" and their aggregate liabilities to policyholders were approximately $900 million—compared to, for example, the initial general creditor liability of Lehman Brothers alone, which was reported at the start of its bankruptcy filing as being approximately $765 *billion.*

There are several reasons why the effect of the recent recession on the insurance industry and its consumers has been relatively mild. One reason is that standards for evaluating and managing investment and underwriting risk (by companies, their actuaries, regulators, and insurance rating agencies) have become considerably more sophisticated than they were in the years prior to the early-1990s recession. Another reason is that the methods and systems U.S. insurance regulators have employed in monitoring and responding to financial solvency concerns at operating insurance companies have become significantly more effective than they were in prior periods.

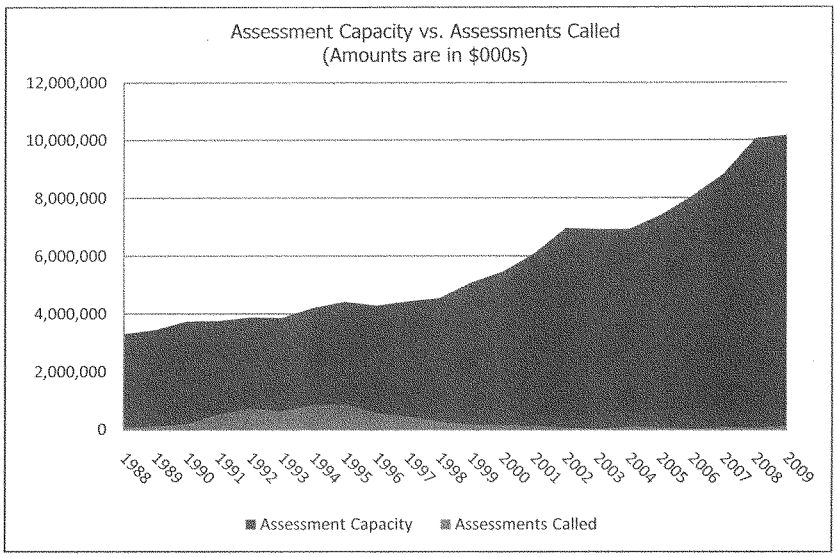
Ability of the Life and Health Insurance Guaranty System to Protect Consumers in Challenging Economic Environments

The experience of the recent financial crisis understandably has led people to inquire whether the insurance guaranty system has the financial ability to protect consumers if, for example, several major insurers were to fail simultaneously. Those who have reviewed the available evidence have been able to conclude both that the system has in fact met that challenge in the past, and that it could do so if necessary in the future.

Historical Performance

While the current recession has caused the liquidation of relatively few operating insurers, that was not true of the last significant U.S. recession. As a consequence of the recession in the early 1990s, a total of nearly 40 life and health carriers were liquidated, and their resolutions were addressed simultaneously by NOLHGA and its member guaranty associations. Three insurers ranking among the top 25 writers in the U.S. market were among those liquidation cases. Yet even in the worst years of that period, the costs to the guaranty system of protecting consumers (sometimes referred to as "assessments called," i.e., collected from member insurers) did not remotely approach the theoretical maximum annual assessment capacity of the life and health insurance guaranty system, as illustrated in the following chart[10]:

[10] The chart depicts the actual assessments collected from association member companies by year, charted against the aggregate theoretical maximum assessment capacity for all lines of insurance for all of NOLHGA's 52 member guaranty associations. The entire theoretical maximum capacity may not be available for a particular insolvency, since each individual guaranty association generally covers only residents of its jurisdiction, so that—in theory—an individual association could meet its annual capacity limit before satisfying all of its obligations. In practice, even individual association "caps" are seldom approached in an insolvency, and in the rare cases when they are, associations have the ability to borrow against the security of future assessments to meet current needs. Furthermore, insolvencies of life and annuity carriers generally tend to produce a relatively normal distribution of policyholders by state, with the result that association funding needs generally line up relatively well with association capacity, further minimizing the impact of what otherwise might be viewed as a "silo" issue.



Current and Projected Financial Ability

As depicted in the foregoing chart, the maximum annual assessment capacity of the life and health guaranty system now slightly exceeds $10 billion. That amount "refreshes" each year, meaning that, for a two-year period (at the same maximum capacity), the total available to protect policyholders would be $20 billion, and so on. By comparison, the total net assessments, from the inception of the guaranty system to date, required to provide all life and health guaranty protection—guarantying obligations on almost $25 billion of policyholder obligations for about 2.8 million policyholders—has been roughly $5.3 billion. In other words, the current year's assessment capacity, by itself, is almost twice the total net costs that have been required to protect consumers since the beginning of the system decades ago.

The ability of the guaranty system to respond in challenging times is not, however, limited to its annual assessment capacity. This is true for several reasons.

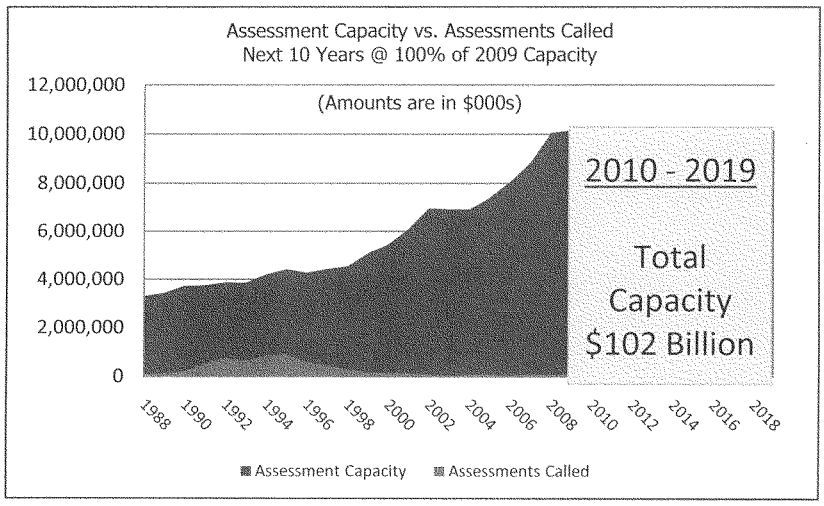
First, the liabilities of a troubled insurance company do not all come due on the date that an insurer enters liquidation; for a typical insurer, many or most of its liabilities will not come due until years, decades, or even generations after the company fails. For that reason, much less liquidity is required to meet the covered liabilities of a failing insurer than in the case of, for example, an FDIC-insured bank, whose consumer liabilities primarily consist of deposits contractually available to the consumer on demand.

Second, most life insurer insolvencies involve only small shortfalls of assets versus liabilities. The shortfalls are seldom more than 15% in larger cases and are more typically in the range of 5% to 10%. As a consequence, the need that must be funded currently by the guaranty

associations when the company fails is reduced to the extent that estate assets are available to the receiver in devising a resolution plan to protect policyholders. If the solvency problem is identified early by the regulator and prompt and effective regulatory intervention takes place, the cost of the insolvency is minimized—both for guaranty associations (and their funding sources) and for policyholders with claims exceeding guaranty association "caps." (For further discussion of this point, see Appendix A – The Critical Role of "Prompt Corrective Action.")

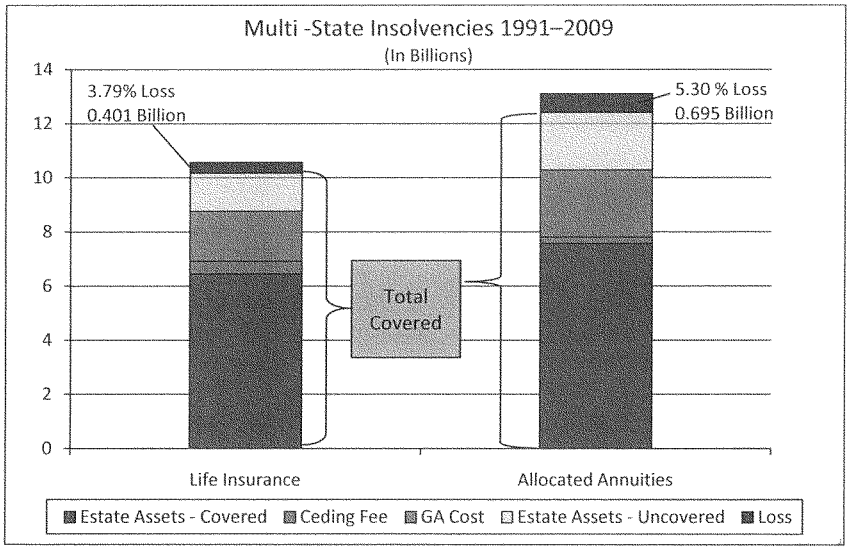
Third, even a financial crisis of unprecedented proportions, involving insurers with unusually large shortfalls of assets to liabilities, could be addressed by utilizing the assessment capacity of guaranty associations that would develop in the years following the initiation of receivership proceedings. Because a significant proportion of the insurers' liabilities would mature in future years, a resolution plan could provide for the "runoff" of those liabilities (i.e., payment of the liabilities from the receivership estate, "topped up" or enhanced as necessary by guaranty associations, over the years in which the liabilities would by their terms mature). Such a runoff would only be paid from the assessment capacity of the guaranty associations in the years in which the payments would be made—not all in the year in which the receiverships commenced. In addition, associations have the ability to borrow today against future assessment capacity, in the event a liquidity need might arise. Accordingly, an appropriate yardstick for the financial ability of the guaranty system to perform its mission is not the maximum assessment capacity of the system in the year a crisis arises, but rather the aggregate capacity of the system over the projected runoff period.

The point is illustrated in the following chart, which assumes, for illustrative purposes, that capacity would remain level for the next 10 years, producing an aggregate maximum financial capacity of more than $100 billion.



Average Recoveries by Policyholders

One final point should be noted regarding the protection that has been achieved for policyholders in prior life insurer insolvencies. Because of factors noted above—particularly the protections afforded through the guaranty system, the generally conservative nature of insurance company investments, and the effectiveness usually demonstrated by regulators in intervening promptly when life insurers face financial difficulties—actual losses typically suffered by consumers with life policy and annuity claims against insolvent carriers have on average been modest. The point is illustrated by the following chart, which shows that, after application of "estate" assets to both the claims covered by guaranty associations and those policy claims exceeding coverage limits (or otherwise not covered), average recoveries have exceeded 96% on life claims and 94% on annuity claims.[11]



[11] The figures in the chart reflect only multi-state life insurer liquidations in which NOLHGA was involved. A small number of health insurance insolvencies in which the companies wrote residual life and annuity business have been excluded, as has one life insurer liquidation for which we do not possess reliable financial data. The figures are based on guaranty association records, financial information provided by receivers, and estimates on recoveries on "above coverage limits" amounts derived from guaranty association recoveries of their subrogation claims. The figures do not reflect the time value of money.

Conclusion

The recent financial crisis, like other adverse financial periods before it, has challenged both individuals and institutions. Fortunately, the insurance industry has weathered the storm rather well and continues to meet its commitments to consumers. In the few instances when life or health insurers have failed, the life and health insurance guaranty system has ably discharged its mission to protect consumers. It stands ready to do so in the future.

We welcome the opportunity to provide any further information that may be required by the Subcommittee; please direct questions to:

Peter G. Gallanis, President
National Organization of Life and Health Insurance
Guaranty Associations
13873 Park Center Road, Suite 329
Herndon, VA 20171
Phone: 703-787-4116
Email: pgallanis@nolhga.com

APPENDIX A

THE CRITICAL ROLE OF "PROMPT CORRECTIVE ACTION"

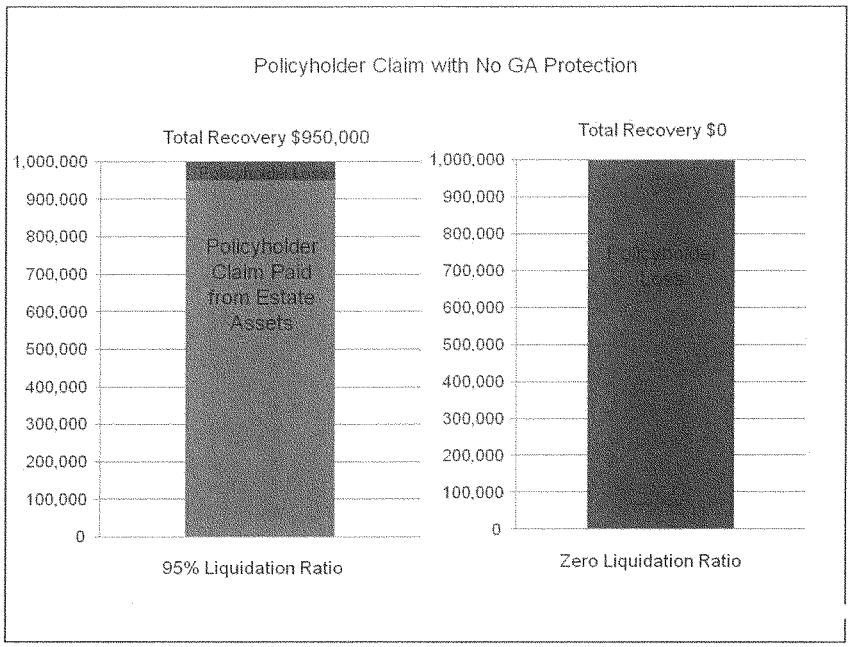
It is a common misunderstanding that policyholder recoveries in insurance liquidations are limited to guaranty association coverage limits or "caps." The truth is that whether a policyholder recovers all or most of her claim *above* guaranty association caps depends significantly on whether regulatory intervention occurs before the failed company's assets have been substantially dissipated, and whether assets are effectively protected and marshaled in the company's receivership.

This is a subtle but critical misunderstanding suffered even by financially sophisticated people who do not often work with insurer insolvencies and the guaranty system.

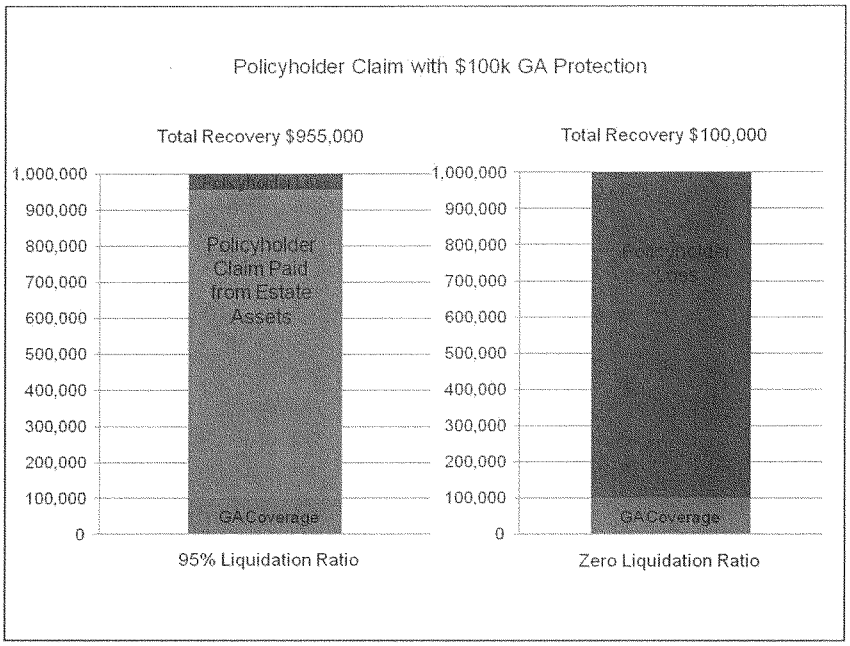
Policyholders with claims against their insolvent insurer in excess of guaranty association caps have a priority claim against the insurer's assets for the excess amount. That excess claim ranks *pari passu* with all other claims at the policyholder level. For that reason, a policyholder can—and often does—recover most or all of her claim in the insolvency, *even above* the level covered by guaranty associations. The point can be seen in the following illustrations.

Imagine an insolvency in which a policyholder has a claim of $1 million, and suppose further that there was no guaranty association to provide a financial safety net. What would the policyholder recover? The answer: It depends on the level of assets available in the insolvency estate, compared to the amount of the policy-level liabilities. This relationship is sometimes expressed as a *liquidation ratio,* or the number of "cents on the dollar" available for distribution to policy-level claimants.

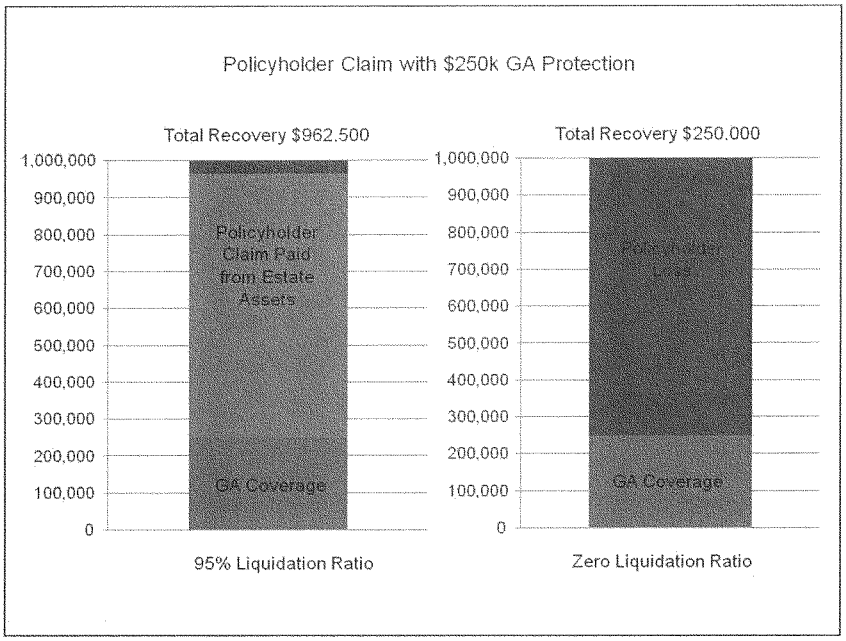
Consider the outcomes illustrated in the following chart. If the estate has 95 cents on the dollar available—a 95% liquidation ratio—the policyholder will recover $950,000 on that $1 million claim, even with no guaranty association protection. On the other hand, if the estate has zero cents on the dollar available at the policyholder level, the policyholder will recover nothing.



Now imagine that the policyholder has the same claim for $1 million and resides in a state where guaranty association coverage is $100,000. Consider the outcomes illustrated in the next chart. In this case the policyholder will recover (from the guaranty association) 100% of the claim up to $100,000, and she will recover on the rest of her claim an amount determined by multiplying the excess claim (here, $900,000) by the liquidation ratio for the insolvency. If the insolvency estate marshals 95 cents on the dollar for policyholder claims—which is a bit lower than average for life insurance claims in insolvencies—that policyholder will end up with a total of $955,000 on her $1 million claim: $100,000 from the guaranty association and $855,000 (95% of $900,000) in respect of her excess policyholder claim. On the other hand, if the estate marshals zero cents on the dollar, the policyholder's total recovery is limited to the $100,000 that will be paid by the guaranty association.

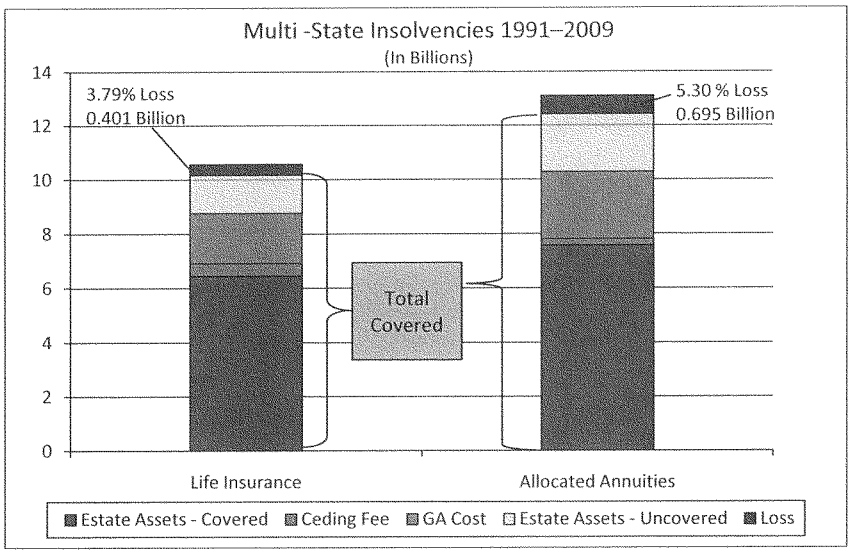


Imagine next a slightly different set of facts, illustrated in the next chart. Suppose the policyholder resides in a state with a $250,000 guaranty association "cap." In the first hypothetical outcome in this series of examples—a liquidation ratio of 95% —the policyholder's total recovery then would be $962,500 ($250,000 from the guaranty association and $712,500 from her excess claim): a modest increase of only $7,500 over what she would have received with guaranty association coverage to $100,000, even though the guaranty association "cap" is two-and-one-half times larger. But in the second hypothetical outcome—with a liquidation percentage of zero—the total policyholder recovery is still only $250,000. That is to say that a very large loss—$750,000—is borne by the policyholder, even with much more guaranty association coverage than in the prior case.



A guaranty association's coverage limit or "cap" does set a "floor" for policyholder recoveries, no matter what else happens in the receivership case. But as the foregoing illustrations demonstrate, the much more important factor—at least for policyholder claims significantly in excess of caps—is the liquidation ratio achieved in the insolvency. How many cents on the dollar is the receiver able to pay on policy-level claims?

On that score, the historical averages are significant. In the insolvencies of the past 20 years, claims on life policies have been paid, on average, at a level of 96.21 cents on the dollar. Claims on annuity contracts have been paid, on average, at 94.70 cents on the dollar.



In other words, in most (though unfortunately not all) life and annuity insolvency cases, the vast majority of policyholders have been made nearly whole, *regardless* of the guaranty association "caps" in their states. The obvious conclusion is that regulators, working with receivers and guaranty associations, have done an effective job of delivering real policyholder protection over the past two decades.

Prospectively, the key is to make sure that such outcomes (or better) are achieved in the future.

Experts in handling insolvencies of regulated entities—not just insurers, but other types of financial firms as well—have long recognized that the keys are, first, spotting financial problems early; and then acting promptly, decisively, and effectively to keep a bad situation from getting worse.

Spotting problems promptly is a function of financial supervision, and much of the success in delivering good receivership outcomes to policyholders over the past 20 years is a direct result of better financial supervision. In this sense, "financial supervision" is intended broadly to include assessments by companies of their own risks, risk-spotting by markets and insurance rating agencies, and better risk standards and evaluations by insurance regulators.

Beyond that, the recent financial crisis and attendant policy debates about regulatory reform have cast a bright light on the significance of effective resolutions of failing financial companies. Even if regulatory financial supervision is good, the regulated firm's stakeholders can still be harmed significantly by ineffective resolution of the failed company.

The two things critical to a successful resolution are early intervention—invoking the liquidation process at a time when the assets of the failed company have not yet been substantially dissipated—and professional execution of a resolution strategy that marshals the assets of the failed firm as effectively as possible and maximizes their prompt application to proven creditors' claims as directed by law. In the world of banking resolutions, these concepts are sometimes referred to, respectively, as "prompt corrective action" and "least cost resolution."

RIMS
the risk management society

November 14, 2011

Chair Judy Biggert
U.S. House Financial Services
Subcommittee on Insurance, Housing
and Community Opportunity

Ranking Member Luis Gutierrez
U.S. House Financial Services Committee
Subcommittee on Insurance, Housing
and Community Opportunity

Dear Chairwoman Biggert and Ranking Member Gutierrez:

As the Subcommittee undertakes a review of certain provisions of the Dodd-Frank Wall Street Reform and Consumer Protection Act (Pub.L.No. 111-203), I am writing to express the Risk and Insurance Management Society, Inc.'s (RIMS) support for "risk committee" requirements contained in the law. RIMS is the preeminent organization dedicated to advancing the practice of risk management, and is a global not-for-profit organization representing more than 3,500 industrial, service, nonprofit, charitable and government entities throughout the world.

Section 165 (h) of Dodd-Frank would empower the Federal Reserve Board to require institutions with concentrated assets of $10 billion or more to establish a risk committee. Under this provision, nonbank financial holding companies and financial holding companies would be required to establish a risk committee at the board of director level. Under Section 165, the committees would be responsible for oversight of a company's enterprise risk management practices and would consist of at least one risk management expert with experience in identifying, assessing and managing risk exposures of large, complex firms. Additionally, the risk committees shall be comprised of a certain number of independent directors, as deemed appropriate by the Federal Reserve Board. Section 165 (h) also permits the Federal Reserve Board to determine whether certain smaller institutions, with assets less than $10 billion, shall also be subject to the risk committee requirement.

RIMS
the risk management society

RIMS enthusiastically supports this bipartisan provision, narrowly applied to large financial institutions, as we believe it will go a long ways towards ensuring that all institutions of a certain size are engaging in appropriate management of risk throughout an entire enterprise. Ensuring board level interaction with qualified risk managers and adoption of generally accepted risk management standards would greatly diminish the prospects for a reoccurrence of the financial crisis that we experienced in 2008.

Ultimately, however, RIMS envisions and supports the proposition that all publicly traded companies of a certain size, not just financial institutions, should also install a risk committee as part of their Board level governance. We fear that the exclusive focus on financial institutions may leave a gaping hole in corporate risk management practices ripe for the next economic downturn. A broader application of risk committee requirements would help to ensure these organizations are practicing appropriate risk management practices, thereby protecting their shareholders as well as pension plans and qualified retirement plans.

Thank you for to opportunity to express RIMS views on certain provisions of the Dodd-Frank law. We appreciate your consideration of RIMS policy and would respectfully request submission of this letter for the November 16th, 2011, hearing record. Should you have any questions or need additional information, please do not hesitate to contact RIMS Government Affairs Director, Kathy Doddridge, at kdoddridge@rims.org

Best regards,

Scott B. Clark, AAI
2011 RIMS President
Risk and Benefits Officer
The School Board of Miami-Dade County, Florida

1065 Avenue of the Americas, 13th Floor, New York, NY 10018
t 212.286.9292 ■ f 212.655.5931 ■ www.RIMS.org

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Superintendent Torti's Responses to Questions submitted by Congressman Dold

In response to a question submitted during the July House Financial Services Committee hearing, the NAIC responded that it believed that NIMA was consistent with the congressional intent of the Nonadmitted and Reinsurance Reform Act. Could the NAIC elaborate on this, specifically:

1. How does NIMA increase uniformity for forms, rates, and procedures as specified in Section 521(b)(4) of P.L. 111-203?

   RESPONSE: Section 521(b)(4) of P.L. 111-203 states that the Congress intends that each State adopt nationwide uniform requirements, forms and procedures for the reporting, payment, collection, and allocation of premium taxes. The NAIC has supported efforts of states to enact enabling legislation to participate in a multistate allocation arrangement as well as amendatory legislation to otherwise conform state surplus lines statutes to the requirements of the Nonadmitted and Reinsurance Reform Act. NIMA is consistent with the Congressional intent set forth in Section 521(b)(4), including uniformity relating to premium taxes for nonadmitted business, because it is a template that provides for uniform allocation formulas and reporting methods.

2. Given that NRRA's intent was to create a more simple and efficient surplus lines system, what have NIMA states done since this July hearing to make the NIMA tax allocation methodology less burdensome and complex?

   RESPONSE: The NAIC disagrees with the premise that NIMA's tax allocation methodology is necessarily burdensome and complex. NIMA included an allocation methodology when it was adopted by the NAIC Surplus Lines Implementation Task Force, NAIC Executive Committee and NAIC Plenary in December 2010. The NAIC understands that industry stakeholders have objections to NIMA's allocation schedule, but points out that the NIMA allocation schedule was developed during a series of open meetings and conference calls of the Surplus Lines Implementation Task Force. The NAIC is aware that alternative allocations methods have been proposed by some industry stakeholders and insurance regulators. The NAIC welcomes efforts to achieve greater uniformity in surplus lines, but the NAIC emphasizes that any decision to amend the NIMA allocation method is a decision for those states participating in NIMA.

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