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SIDLEY GLOBAL INSURANCE REVIEW

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The insurance industry has a global reach. Insurers and reinsurers are critically important to the world economy. They assume and transfer all manner of risk across the globe, and serve as an enormous investor base for the world’s capital markets and beyond. Risk is increasingly shared globally among traditional and new market entrants. Risk generated in one part of the world is distributed immediately across multiple continents to other market participants, whether they be other insurers, reinsurers, private equity sponsors or capital market investors. The insurance industry is constantly evolving, and requires regulatory regimes and market participants to adapt on a frequent basis. Regulatory issues arising in one market may influence the way in which similar regulatory concerns are addressed in other markets. To understand the insurance industry, one must have a solid understanding of global developments. We prepared this publication as a tool to assist readers in obtaining such understanding.

We realize that no one publication could provide adequate coverage to each and every recent global development without becoming cumbersome. Accordingly, this publication attempts to provide an overview of major legal and market developments in the global insurance industry arising over the past year. We have focused on developments in the United States, United Kingdom, European Union, Asia and other markets with intense insurance activity, such as Bermuda.

This review has been produced by the Insurance and Financial Services group of Sidley Austin LLP. Sidley is one of the world’s premier law firms, with 1,900 lawyers across 19 offices in North America, Europe, Asia and Australia. Sidley is one of only a few internationally recognized law firms to have a substantial, multidisciplinary practice devoted to the insurance industry. We have more than 90 lawyers devoted to providing both transactional and dispute resolution services to the insurance industry throughout the world. Our Insurance and Financial Services group has an intimate knowledge of, and appreciation for, the insurance industry and its unique issues and challenges. Regular clients include many of the largest insurance and reinsurance companies, their investors and capital providers, brokers, banks, investment banking firms and regulatory agencies for which we provide regulatory, corporate, capital markets, securities, mergers and acquisitions, private equity, insurance-linked securities, derivatives, tax, reinsurance dispute, class action defense, insolvency and other transactional and litigation services.

We hope you enjoy this edition of the Sidley Global Insurance Review.
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I. The Global Mergers and Acquisitions Market

A. NORTH AMERICAN MARKET

1. Introduction

Following a robust 2014 in mergers and acquisitions (“M&A”), 2015 proved to be even busier in terms of both aggregate deal value and total number of deals. While the number of announced deals increased slightly year-over-year compared to 2014, aggregate deal value spiked from around US$24 billion in 2014 to nearly US$158 billion in 2015.1 2015 also marked the full-fledged return of the “mega-deal,” as seven deals were announced with values of at least US$5 billion. To put that figure in perspective, the period from 2006 to 2014 saw only four insurance M&A deals valued at over US$5 billion.2 A number of factors contributed to the banner year for activity. In the health sector, as U.S. health insurers continue to adjust to the new landscape of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (together, the “ACA”), several of the largest U.S. health insurers announced blockbuster mergers. On the life and P&C sides, the continuation of several trends we observed in last year’s Sidley Global Insurance Review drove further activity in 2015. As we discussed last year, cash-rich Asian acquirers continue to aggressively seek opportunities to increase their U.S. holdings, while U.S. and Bermuda-based property and casualty (“P&C”) reinsurers (and, beginning in 2015, primary insurers) have committed to consolidation as a means of achieving diversification benefits and other scale-related advantages in response to structural and cyclical challenges. On the life side in particular, domestic insurers were not significant acquisition players, leaving the field to pension plans, Asian acquirers and private equity-backed acquirers. In addition, 2015 saw the blockbuster merger of P&C giants ACE Ltd. (“ACE”) and Chubb Corp. (“Chubb”), as well as the merger of leading insurance advisory and brokerage firms Willis Group Holding PLC (“Willis”) and Towers Watson & Co. (“Towers Watson”).

2. Health Mega-Mergers

After several consecutive quiet years generally ascribed to uncertainty surrounding the roll-out of federal health care reform, 2015 marked a record-shattering year of health sector deal activity. Centene Corporation (“Centene”) kicked things off in early July when it announced its agreement to acquire Health Net, Inc. ("Health Net") for approximately US$6.8 billion, representing the teaming up of two strong players in the Medicare and Medicaid markets. One day later, Aetna Inc. (“Aetna”) announced an agreement to acquire Humana Inc. (“Humana”) for approximately US$37 billion. Finally, the end of July saw the announcement of a proposed US$54.2 billion merger of the second- and fifth-largest U.S. health insurers by revenue, Anthem, Inc. (“Anthem”) and Cigna Corporation (“Cigna”). The proposed merger of these commercial health insurance giants would create the largest health insurer in the United States, as measured by membership, and narrow the gap between the nation’s largest health insurer in terms of annual revenue, United Health Group Inc. ("UnitedHealth"), and Anthem. Each transaction remains subject to state regulatory approval, while the Aetna-Humana and Anthem-Cigna deals are also subject to U.S. antitrust approval.

3. Asian Acquirers

2015 marked the intensification of a trend we discussed last year, as Asian-sourced capital again played a central role in M&A activity in both the P&C and life and annuity markets. Over the course of the year, Chinese conglomerates Anbang Insurance Group Co. Ltd. (“Anbang”) and Fosun International Limited (“Fosun”) each demonstrated a substantial appetite for U.S. assets. Meanwhile, Japanese life insurers, driven by domestic demographic and rate/profitability challenges and rich valuations in nearby regional markets, also struck some noteworthy U.S. deals. However, the interest of Japanese insurers in the U.S. market was not just confined to life insurance. In June 2015, P&C insurer Tokio Marine Holdings Inc. ("Tokio Marine") reached an agreement to acquire specialty insurer HCC Insurance Holdings Inc. ("HCC") for US$7.5 billion.

a. Chinese Acquirers

After a busy 2014, Fosun added substantially to its existing P&C exposure in the United States with the November closing of its US$1.84 billion acquisition of the 80% of Bermuda-based Ironshore Inc. that it did not already own. Additionally, in July 2015, Fosun, acting through its Hong Kong-based Peak Re subsidiary, agreed to acquire a 50% stake in Caribbean insurer NAGICO Holdings for an undisclosed sum, a transaction that as of this writing remains subject to regulatory approval. However, having now committed a reported US$5.7 billion to acquire insurance assets over the past two years, Fosun has signaled that it intends to concentrate on integration, reduce its debt load and slow its acquisition pace, which may impact activity in 2016. In February 2016, Fosun terminated a pending deal to acquire a 52% stake in Israeli insurer Phoenix Holdings Ltd. from Delek Group Ltd. for approximately US$462 million. Based on some reports, Fosun’s decision to terminate the deal may have been related to issues with respect to Israeli regulatory review of the transaction. It remains to be seen whether news of this sort will heighten the scrutiny that Chinese bidders already face from many U.S. regulators and some potential sellers, particularly with respect to the ownership structure and business plan of Chinese bidders.

In November 2015, following a competitive auction process, Chinese life insurer Anbang announced its agreement to acquire publicly-traded Fidelity & Guaranty Life (“F&G”) for approximately US$1.58 billion. Anbang’s activity in the U.S. market may be driven in part by a desire to import U.S. management and underwriting expertise into its own operations. The acquisition by Anbang of F&G remains subject to regulatory approval, including the approvals of both the Iowa Insurance Division (the “IID”) and the New York Department of Financial Services (the “NYDFS”). Given the strong interest in U.S. targets demonstrated by Chinese insurers and industrial conglomerates, industry observers are closely watching Anbang’s discussions with the IID and the NYDFS; certainty of closing remains a key consideration for sellers evaluating proposals from Chinese bidders. A timely approval of the F&G acquisition could be conducive to more inbound investment from Chinese buyers, as sellers and regulators become more comfortable with Chinese

1 Morgan Stanley tops adviser rankings as insurance underwriter M&A deal value passed $150B mark in 2015, SNL Financial (January 8, 2016).

2 Big deals are back in 2015, SNL Financial (August 14, 2015).
bidders. By the same token, if the approval process proves to be challenging, the concomitant perception of execution risk could suppress Chinese participation in future competitive auctions.

b. Japanese Acquirers

Bolstering and diversifying its existing U.S. presence, in October 2015 Japan’s Tokio Marine consummated its US$7.5 billion acquisition of HCC, paying a 38% premium relative to HCC’s share price prior to the announcement of the transaction. Tokio Marine appears to have been motivated by a desire for additional product diversification, in particular with respect to specialty P&C coverage that has limited or no correlation with natural catastrophe risks. According to Tokio Marine’s public statements, it intends to use the acquisition of HCC as a platform for further U.S. expansion. Meiji Yasuda Life Insurance Company of Japan ("Meiji Yasuda") and Sumitomo Life Insurance Company ("Sumitomo") each executed large-scale acquisitions in the U.S. life market in 2015. In a deal that was announced in July 2015 and consummated in March of this year, Meiji Yasuda, Japan’s oldest life insurer, acquired StanCorp Financial Group ("StanCorp"), a provider of life insurance, annuities and other retirement products and services, for approximately US$5 billion in cash, a purchase price that represented a 50% premium over StanCorp’s share price as of the deal announcement. Then, in August, Japan’s Sumitomo made headlines with the announcement of its approximately US$3.8 billion all-cash acquisition of Symetra Financial Corp. ("Symetra"), which closed in February of this year. With the acquisitions by Meiji Yasuda and Sumitomo, together with the acquisition of Protective Life Corporation ("Protective Life") by The Dai-ichi Life Insurance Company, Limited ("Dai-ichi"), Japanese insurers have now been buyers in three of the four largest deals executed in the U.S. life and annuity market over the past two years. The recent prominence of Japanese buyers is likely attributable to a number of factors, including pressure from Japanese regulators to pursue asset diversification, demographic challenges to domestic growth poised by an aging, shrinking Japanese population, and Japanese macroeconomic conditions such as extremely low interest rates and elevated asset and stock prices. As long as these factors persist, it is likely that Japanese insurers will continue to look to the United States (and Europe) for inorganic growth opportunities.

4. Continued Consolidation Among P&C Reinsurers

As we noted in last year’s edition of the Sidley Global Insurance Review, property/casualty reinsurers have turned to large-scale M&A with increasing frequency both in hopes of enhancing their negotiating leverage with brokers and primary insurers and in pursuit of other scale-related cost advantages. As a soft market and diminished demand for traditional reinsurance stemming from the rapid rise of the alternative risk transfer market continued to present substantial structural challenges, traditional P&C reinsurance providers remained committed in 2015 to the consolidation strategy that had already gathered steam in 2014.

In January 2015, AXIS Capital Holdings Ltd. ("AXIS") and PartnerRe Ltd. ("PartnerRe") announced plans for a US$11 billion all-stock merger, with shareholders of AXIS and PartnerRe respectively owning 51.5% and 48.5% of the combined company post-closing. However, in April 2015, a surprise bid for PartnerRe was made by EXOR S.p.A. ("EXOR"), a conglomerate owned by Italy’s Agnelli family. EXOR’s unsolicited initial offer of approximately US$6.4 billion for 100% of PartnerRe was viewed by most analysts as superior to the AXIS bid, due to its higher per-share valuation and all-cash financing. Despite this, PartnerRe’s board of directors unanimously rejected EXOR’s offer in May 2015 and reaffirmed PartnerRe’s commitment to merging with AXIS on enhanced terms, including a special pre-closing dividend of US$11.50 per share. EXOR promptly increased its offer and invested US$572 million in PartnerRe shares, becoming its largest shareholder.

The parties continued to spar over the next several months. In mid-July, AXIS again sweetened the terms of its offer and PartnerRe scheduled a shareholder vote on the revised AXIS offer. However, after several proxy advisory firms came out against the AXIS deal prior to the vote, in August, PartnerRe terminated its deal with AXIS, paid a US$315 million breakup fee, and entered into an agreement with EXOR pursuant to which EXOR agreed to increase its purchase price to approximately US$6.9 billion. Having been left at the altar by PartnerRe, AXIS has not yet announced any plans to complete a strategic acquisition with a different partner.

The March 2015 announcement of the acquisition by Endurance Specialty Holdings Ltd. ("Endurance") of Montpelier Re Holdings Ltd. ("Montpelier Re") for a reported US$1.83 billion further evidenced the consolidation vogue among P&C reinsurers. Coming after its failed US$3.2 billion hostile bid for Aspen Insurance Holdings in 2014, Endurance successfully consummated the Montpelier Re acquisition in July 2015. Montpelier Re, because of its modest size, had faced increasing skepticism about its viability amidst the difficult conditions in the market. For Endurance, the addition of Montpelier Re provides geographic diversification benefits, via increased access to the lucrative Lloyd’s of London market, as well as an expected US$60 million in annual cost savings. In public statements regarding the transaction, Endurance’s CEO, John Charman, also cited an enhanced ability to access third-party capital and Montpelier Re’s successful catastrophe reinsurance business as being among the deal’s attractions.

Two other large mergers involving P&C reinsurers announced in 2014 closed in 2015. In March 2015, RenaissanceRe Holdings Ltd. ("RenaissanceRe") consummated its purchase of Bermuda-based reinsurer Platinum Underwriters Holdings Ltd. ("Platinum Underwriters") for approximately US$1.9 billion. Then, in May, XL Group Plc ("XL") finalized its US$4.2 billion acquisition of Catlin Group Limited ("Catlin"). While RenaissanceRe has historically focused on catastrophe reinsurance business, acquiring Platinum Underwriters provides it with a casualty and specialty reinsurance platform. Similarly, XL’s purchase of Catlin, a leading Lloyd’s of London participant, has increased its own market share in the specialty insurance and reinsurance markets.

5. Other Notable Activity

There were several other notable deals announced or consummated in 2015, including the US$28.3 billion acquisition by ACE of competitor Chubb and the merger of leading insurance advisory and brokerage firm Willis with human resources and actuarial consultant Towers Watson. When it was announced in early July, observers noted that the tie-up between P&C brand names ACE and Chubb represented the largest insurance M&A deal to date in...
the U.S. market. Following the consummation of the transaction in January 2016, the combined company, which now operates under the Chubb name globally (despite its 70% ownership by former ACE shareholders), is the world’s largest publicly traded P&C company. Coming amidst the consolidation wave in the P&C reinsurance market, the ACE-Chubb announcement set off a flurry of speculation about additional blockbuster deals among P&C underwriters, which has yet to materialize, perhaps in part because increased U.S. stock market volatility and rising global economic uncertainty during the latter half of 2015 and into early 2016 have put something of a damper on M&A activity generally.

Other 2015 highlights included notable deals in the U.S. long-term care (“LTC”) market and life and annuity market and further consolidation among Canadian P&C insurers.

a. LTC Market

While the LTC market has not been an asset class that has appealed to buyers recently given the considerable actuarial and pricing challenges associated with such products, 2015 saw some activity on the LTC front. In April 2015, Hc2 Holdings, Inc. (“Hc2”) announced an agreement to acquire the run-off LTC business of American Financial Group, Inc. (“American Financial”) for US$15 million, a transaction which closed in December 2015. In October 2015, Nassau Reinsurance Group (“Nassau”), which was founded in April 2015 by former executives of HRG Group and is backed by private equity firm Golden Gate Capital, announced its agreement to acquire the Traditional Insurance business of Universal American Corporation (“Universal American”), which includes a block of LTC business, for approximately US$43 million. This transaction is pending and subject to regulatory approval as of late February 2016.

b. Other Life Activity

Aside from the transactions involving Asian buyers noted above, 2015 saw few major transactions involving U.S. life insurers, although we note two such transactions here. In September 2015, Nassau announced its agreement to acquire Phoenix Companies, Inc. for approximately US$217 million in a transaction that is expected to close in the first quarter of 2016. Then, in November 2015, Pan-American Life Mutual Holding Company and Mutual Trust Holding Company completed a rare mutual holding company merger, creating a combined entity that provides life, accident and health insurance in the United States and 22 other jurisdictions throughout Latin America and the Caribbean.

These transactions aside, the evidence of recent years (including 2015) suggests that on the life insurance side, U.S. insurers with robust operating platforms do not view growth through domestic M&A transactions as a priority, and that they continue to be more focused on ancillary business opportunities (e.g., asset management) and geographic expansion (e.g., in Asia and Latin America). That said, some recent transactions suggest that large block mortality transactions may be part of the strategy for some leading U.S. life insurers. For example, in July 2015, New York Life completed the acquisition, through reinsurance, of a net 60% interest in a closed block of John Hancock Financial’s life insurance business, comprised primarily of approximately 1.3 million participating whole life insurance policies involving an aggregate face amount of approximately US$25 billion. Additionally, in September 2015, Protective Life entered into an agreement to acquire, through reinsurance, in force blocks of term life insurance from Genworth Financial, Inc. in a transaction involving a total capital investment on the part of Protective Life of approximately US$661 million. The latter transaction, which is expected to close in the first quarter of 2016, would be Protective Life’s first acquisition since it became a part of Dai-ichi earlier in 2015. Looking forward, large block mortality deals may continue to be of interest to U.S. life and annuity companies for a number of reasons, including: diversification into a “non-correlated” asset class; a continuing, post-financial crisis desire on the part of sellers to focus on inforce management and cull capital intensive businesses that impose operational complexity and offer lower returns; and the availability of buyers able to finance such deals, which appear to fall in a “sweet spot” between the low hundreds of millions of dollars and US$1 billion.

c. Continued Canadian P&C Consolidation

Much like some of their U.S. counterparts, Canadian P&C market leaders demonstrated a substantial appetite for consolidation in 2015. In January 2015, Desjardins Group (“Desjardins”) completed its acquisition of State Farm Canada’s P&C and life insurance business for a reported US$1.5 billion. One month later, Intact Financial Corporation (“Intact”), Canada’s largest P&C insurer, announced its fourth acquisition in four years, having reached an agreement to acquire Canadian Direct Insurance Inc. (“CDI”) for C$197 million (the transaction closed in May 2015). Through the first few months of 2016, the momentum in the Canadian market shows no signs of weakening. In January of this year, Aviva Canada, Inc. (“Aviva, Canada”) announced it had reached an agreement to acquire RBC General Insurance Company (“RBC General”) from Royal Bank of Canada. Upon the closing of the acquisition, Aviva Canada will become Canada’s second-largest P&C carrier. Several analysts have framed Aviva Canada’s acquisition of RBC General as something of a defensive measure given talk that it was being targeted for takeover by Intact. While some observers were surprised that Intact passed on RBC General, there is considerable speculation that Intact and other large Canadian insurers still have additional targets on their radar.

6. Outlook for 2016

The aftershocks of 2015’s mega-deals are sure to be felt in 2016, as many of them face regulatory approval before taking effect. On the life and annuity side, market conditions remain supportive of M&A due to excess capital, lack of organic growth and risk premiums increasing. In addition, continued volatility in the equity markets may lead companies to explore opportunities to sell blocks of variable annuity business, which they had previously held on to due to strong investment portfolio performance and an expectation of increased interest rates.

The first few months of 2016 have also seen intense speculation regarding the extent to which several of the largest U.S. insurers will end up divesting substantial portions of their businesses, both in

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3 The pending Anthem-Cigna and Aetna-Humana mergers, each of which was announced later that same month, if consummated in their current form, would both eclipse the size of the ACE-Chubb transaction.
hopes of avoiding the systematically important financial institution ("SIFI") regulatory regime and in response to calls by shareholder activists. Because a nonbank SIFI designation imposes additional federal oversight, regulatory compliance and is expected to require increased capital requirements, activist shareholders and others have argued that the SIFI label comes attached with a significant competitive disadvantage. In January 2016, MetLife, Inc. ("MetLife"), a recent SIFI designee, announced plans to dramatically shrink its company through a possible sale, spinoff or public offering of its U.S. retail life insurance unit, in hopes of removing itself from the SIFI regime. In late February of this year, MetLife began this process when it reached an agreement with Massachusetts Mutual Life Insurance Co. ("MassMutual") to sell its U.S. retail adviser force, its affiliated broker/dealer and certain related assets for approximately US$300 million. MetLife competitor AIG, also a SIFI designee, has found itself the target of demands by activist investors Carl Icahn and John Paulson to break the company up into three separate companies, comprising its mortgage, P&C and life and annuity businesses. Icahn and Paulson have argued that breaking up the company will unlock shareholder value and help AIG shed the costs and burdens associated with the SIFI label. While thus far resisting calls to split itself up, AIG has announced plans to conduct an IPO of its mortgage unit and recently sold its broker-dealer business to private equity firm Lightyear Capital LLC. This transaction, along with the MetLife/MassMutual transaction referenced above, was reportedly driven in part by concerns about the impact of the pending Department of Labor rule (the "DOL Rule") that is expected to heighten investment advice standards for retirement products (see Section IV.A.5 below for a discussion regarding the DOL Rule) and, potentially, lead to M&A activity. Furthermore, in February 2016, Icahn and Paulson agreed to drop their threat of a proxy battle in exchange for two seats on the AIG board of directors.

When coupled with the strong appetite Asian acquirers continue to display for U.S. assets and the ongoing embrace of consolidation in the health and P&C sectors (including, with respect to the health market, potential joint ventures or other strategic transactions involving Blue Cross and Blue Shield licensees), the various regulatory concerns and activist pressures some of the largest U.S. insurers are confronting could continue to drive activity in the U.S. M&A market in the coming months and years. However, it should be noted that prospects for activity driven by SIFI concerns are limited by the size of the businesses being discussed as there are few buyers capable of swallowing such units. In addition, any suitors would have to consider similar regulatory concerns to those referenced above in connection with any such acquisition.

B. EUROPEAN AND ASIAN MARKETS

1. Europe

As discussed above, M&A activity in the insurance sector surged globally in 2015, and all traditional indications suggest that a strong interest in consolidation will continue in 2016, including across the established European market. Acquisition activity is apparent as much across developed markets—including the European market—as across emerging markets. Indeed, one driver of the continued acquisitive thrust of insurers is the desire to link up companies in more mature markets (for example, Europe) with companies located in emerging markets, with those emerging market companies representing an opportunity, among other things, to realize significant growth in product distribution. Further, with interest rates remaining at near-negative levels, the pressure of the last few years towards consolidation in order to recognize synergies and thus efficiencies to support the bottom line, remains a driving force in motivating M&A activity across Europe and as instigated by European insurers outwardly.

Smaller brokers and carriers with niche markets were targets in 2015 and continue to be attractive to larger companies seeking to increase the amount of business they generate while holding costs in line—all of which speaks to further consolidation in the market and continuing M&A activity to achieve it. For reinsurers in particular, another consideration which has driven, and continues to drive, M&A activity is the continued pressure on rates and conditions. Because primary companies are well capitalized in the current environment as a consequence of several generally benign loss years (among P&C companies), the primary companies are retaining more risk. This has forced reinsurers to seek business beyond their traditional books, and the predominant way in which they are achieving increased premium income is through M&A activity. Additionally, brokers are continuing a trend of establishing smaller panels of reinsurers, focusing on such reinsurers’ expertise in specific business lines. In this context the size of a reinsurer’s balance sheet is seen as a negotiating asset—another reason for a reinsurer to want to grow, with consolidation providing the quickest means to increase scale.

The continuing pressure through 2015 and into 2016 of ever increasing competition—including competition from insurance linked securities funds—all further exacerbated, on the P&C side of the industry, by the soft market, further drives consolidation among market participants. With competition for business increasing, the pressure on companies to grow remains intense, with the obvious solution being growth through consolidation. A recent example (on the life side equally) is the January 2016 acquisition by Swiss Re, through its subsidiary Admin Re, of Jersey-domiciled Guardian Financial Services Ltd for £1.6 billion; the expectation put out in the press releases which followed completion is that the transaction would result in additional cash income to Swiss Re of US$1 billion over the three-year period following completion.

Against a macroeconomic backdrop of low interest rates and increasing competition, the interest of the Japanese and Chinese in opening and diversifying their markets continues to grow. The interest of Asian acquirers in the U.S. market, as noted above, also extended beyond the U.S. market to European and other markets.

Mitsui Sumitomo Insurance Company Limited’s recent acquisition (February 2016) of Amlin plc (now rebranded as “MS Amlin”) for approximately US$5 billion, highlights the trend. Given that the fundamental motivators of growth and diversification remain relevant, the year 2016 should see that interest and activity continue.

The finalization of the European market’s Solvency II Directive (2009/138/EC) ("Solvency II") also promotes the likelihood of continuing consolidation in the industry. Because the rules reward well diversified insurers with lower capital requirements, larger
insurers will continue to seek diversification and smaller insurers with specialized businesses but with less capacity to accommodate new compliance and reporting regimes will likewise seek to consolidate.

In summary, globalization of the insurance industry continues as a trend further driving M&A activity across Europe and the United Kingdom. For all but the most regional industry participants, remaining competitive requires a presence in all markets, including emerging markets in South America and Africa and broadly across Europe.

2. Asia Pacific
As discussed above, the trend of increased M&A activity in Japan and the pan-Asia market should also continue through 2016. In general and as noted, M&A activity in 2015 in Asia was driven by the same factors that will continue the trend in 2016: low interest rates, availability of capital and pressure from increased competition. These economic fundamentals, resulting in contracting margins, should continue to compel insurers and other market participants to seek efficiencies through scale.

Another contributor to continuing consolidation is shrinking regional markets. In this regard, dialogue throughout the sector has highlighted the interest of established Asian carriers in realizing growth, in particular, in the U.S. market and the emerging markets of Latin and South America. Chinese companies in particular have shown an interest in growth and diversification through acquisition, and continue to seek target companies not only in the United States but also in Bermuda and Europe.

Additionally, the more stringent minimum capital requirements adopted in 2015, reflecting the interest of certain jurisdictions in enhancing market efficiency and competitiveness, should continue to drive consolidation for the same purpose of seeking efficiencies of scale as is driving M&A activity in the European market as a consequence of Solvency II.

Unevenness country-to-country within the Asian market, in terms of regulatory structures and the health of local economies, continues to make certain jurisdictions more attractive than others. Political stability is another factor distinguishing one jurisdiction from another, with M&A activity within countries with a sustained history of political calm predictably leading the jurisdictions targeted for M&A transactions.

II. The Global Alternative Risk Transfer Market
A. LIFE & ANNUITY MARKET
The majority of the activity within the risk transfer market of the life insurance sector focused on perceived excess reserve requirements associated with blocks of level premium term insurance subject to Regulation XXX (“Regulation XXX” or “XXX”) or universal life products with secondary guarantees subject to Actuarial Guideline XXXVIII (AXXX) (“Regulation AXXX” or “AXXX”). There were a limited number of embedded value transactions completed as well. Also, we understand these techniques featured prominently in mergers and acquisitions, including block transfers.

1. The State of the Reserve Financing Market
   a. PBR Adoption Update
   As discussed in Section B.1 of “Global Regulatory and Litigation Developments,” the Principle-Based Reserving Implementation (EX) Task Force (the “PBR Task Force”) of the National Association of Insurance Commissioners (the “NAIC”) continues to prepare for the implementation of Principles-Based Reserving (“PBR”), which will become fully operative in the states that have adopted it when legislation is adopted by at least 42 states, representing 75% of total life insurance premiums written in the United States. As of March 1, 2016, 39 states have enacted legislation to implement PBR requirements, representing approximately 71.78% of total U.S. premiums. We believe that the adoption of PBR is likely to occur, potentially as soon as June 30, 2016, meaning it would be effective as of January 1, 2017.

   b. Adoption of AG 48
   Until PBR has met the adoption requirements, the interim regulations set forth in Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (“AG 48”), which was adopted by the NAIC on December 16, 2014, will continue to apply. AG 48 sets forth the requirements for life insurers using affiliated captive reinsurers (each, a “Captive”), particularly for Regulation XXX and AXXX transactions. Note that AG 48 does not apply to any other type of business written by life and annuity insurers, such as fixed annuities. The Reinsurance (E) Task Force (the “Reinsurance Task Force”) of the NAIC has been managing the implementation of AG 48 since its adoption.

   AG 48 applies to transactions in which a ceding company cedes to a Captive policies that meet the definition of “Covered Policies.” “Covered Policies” include those policies (i) written on or after January 1, 2015, or (ii) reinsured pursuant to a “New Reinsurance Agreement.” A “New Reinsurance Agreement” is defined as an agreement entered into (A) on or after January 1, 2015, or (B) prior to January 1, 2015 that is amended, renewed or restructured on or after January 1, 2015, with some exceptions. Although not specifically stated, the language regarding Covered Policies seems to imply that certain refinancing arrangements fall outside the scope of AG 48. Additionally, AG 48 provides exemptions from its requirements for certified reinsurers and operating accredited reinsurers that comply with statutory accounting and risk-based capital (“RBC”) rules.

   Pursuant to AG 48, if a transaction cedes Covered Policies to a Captive that is not otherwise exempt from AG 48, then reserves up to the level set forth in Standard Valuation Manual VM-20 Requirements for Principle-Based Reserves for Life Products (“VM-20”), as adjusted under the terms of AG 48, must be backed by “Primary Security.” The concept of “Primary Security” includes hard assets (cash and securities listed by the Securities Valuation Office of the NAIC (“SVO”)), and excludes synthetic letters of credit, contingent notes, credit-linked notes and other securities that operate in a manner similar to a letter of credit. There has been continued discussion as to what qualifies as an SVO-listed asset; currently bespoke securities, such as securities created in connection with regulatory transactions,
are excluded. For security held in connection with funds withheld and modified coinsurance reinsurance arrangements, AG 48 defines “Primary Security” as also including: (1) commercial loans in good standing (of CM3 quality and higher); (2) policy loans; and (3) derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance arrangement. Reserves that are required to be held by statute above the adjusted VM-20 level can be backed by “Other Security,” meaning any asset acceptable to the insurance commissioner of the ceding company's domiciliary state (“Other Security”).

As discussed in further detail below, valuation and collateralization questions with respect to Primary Security are currently under consideration by the Reinsurance Task Force. When the Reinsurance Task Force completes a draft of the model regulation that will contain uniform standards governing Regulation XXX and Regulation AXXX transactions that are subject to AG 48 (the “A/XXX Model Regulation”), the Reinsurance Task Force will resolve these issues. Current thinking is that the A/XXX Model Regulation will be finalized in the Spring of 2016.

In addition to outlining the types of security available to support reserves, AG 48 provides guidance concerning the NAIC Actuarial Opinion Memorandum Regulation (the "Memorandum"). Section 3 of the Memorandum gives insurance commissioners authority to specify methods of actuarial analysis and assumptions necessary for an acceptable opinion to be rendered concerning adequacy of reserves. AG 48 requires that an opinion actuary for a ceding company must: (a) follow the methods and assumptions developed as individual components of the NAIC's XXX/AXXX Reinsurance Framework (the "Framework") to determine whether the ceding company's net reserves are appropriate; and (b) issue a qualified actuarial opinion if the ceding company has entered into a reserve financing transaction that does not adhere to the Framework.

c. Adoption of RBC

Implementation of the Framework and AG 48 requires certain RBC and capital adequacy-related changes. In 2015, the NAIC adopted three Framework-related proposals.

The first proposal relates to the RBC “cushion” required under the Framework for an insurer ceding policies subject to Regulation XXX/AXXX reserving. The proposal adjusts Authorized Control Level RBC of the ceding company dollar for dollar by the amount of any shortfall in Primary Securities posted under AG 48.

The second proposal relates to the effect on a ceding company’s RBC following the issuance of a qualified actuarial opinion. Such an opinion is required when the ceding company has entered into a reserve financing transaction that does not adhere to the Framework. Under the current RBC formula, a qualified actuarial opinion would result in a C-3 (interest rate risk) charge to the ceding company's RBC, impacting all lines of business of such ceding company. The proposal adopted by the NAIC, in contrast, eliminates the RBC C-3 charge if the qualified actuarial opinion was issued solely due to the directions of AG 48. However, failure to meet the requirements of AG 48 are reflected elsewhere in the RBC shortfall cushion and affect only the lines of business covered by AG 48.

The third proposal adopts public disclosures concerning RBC shortfalls. Such disclosures identify the total adjusted capital and RBC shortfalls of a ceding company’s XXX and AXXX captives and are required in the annual statements of ceding companies beginning with year-end 2015 financial statements. Under this proposal, the ceding company bears any captive shortfall below 300% of Authorized Control Level RBC.

d. Significant Proposals

i. Credit for Reinsurance

As discussed in Section B.2.a.i of “Global Regulatory and Litigation Developments,” the NAIC has adopted various amendments to the Credit for Reinsurance Model Law (the “CFR Model Law”) granting authority to state insurance commissioners to adopt regulations implementing the Framework and AG 48. Such amendments provide state insurance commissioners the authority to adopt regulations with respect to: (A) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits; (B) universal life insurance policies that have provisions resulting in a policyholder's ability to keep a policy in force over a secondary guarantee period; (C) variable annuities with guaranteed death or living benefits; (D) long-term care policies; and (E) such other life and health insurance and annuity products as to which the NAIC may adopt model regulatory requirements that make reference to credit for reinsurance. Such regulations, however, would not apply to business ceded to a reinsurer that: (1) qualifies as a “certified reinsurer” in certain states; or (2) is licensed and/or accredited in a certain number of states and maintains at least US$250 million in capital and surplus. In addition, these amendments to the CFR Model Law contain a grandfathering provision whereby regulations may apply to any treaty covering: (a) policies issued on or after January 1, 2015; and/or (b) policies issued before January 1, 2015, if risk pertaining to such policies is reinsured, in whole or in part, on or after January 1, 2015.

Although not yet finalized, the NAIC plans to adopt revisions to the A/XXX Model Regulation this year. Concerns have been raised regarding the proposal’s method for valuing Primary Securities. Specifically, the initial draft of the A/XXX Model Regulation was viewed as having the effect of mixing book value and market value accounting, creating a situation where a credit for reinsurance trust holds assets valued under both approaches. In contrast, AG 48 was intended to value trust assets on a book value basis. Although some industry participants had suggested that the issue of mixing book and fair market valuation under the A/XXX Model Regulation should be tackled by closing a gap in the Framework and incorporating asset adequacy testing for business ceded to captives, there has been a movement toward requiring all trust assets to be valued at their book value for purposes of AG 48 and the determination of reserve credit under the CFR Model Law. In response to this movement and feedback from various industry participants, including recommendations by the American Council of Life Insurers, the NAIC recently released a revised draft of the A/XXX Model Regulation providing that trust asset valuations are to be determined according
to statutory accounting procedures as if such assets were held in a ceding company's general account and without taking into consideration the effect of any prescribed or permitted practices (i.e., book value).

Another concern is the result of a ceding company's failure to fully collateralize. AG 48 utilizes a “dollar-for-dollar reduction” approach whereby credit for reinsurance is reduced by the amount of shortfall in Primary Securities, or, if applicable, Other Securities. However, for purposes of the A/XXX Model Regulation, the Reinsurance Task Force instead incorporated an “all or nothing” approach pursuant to which a ceding company receives no credit for reinsurance in the event of a shortfall in Primary Securities or Other Securities. In deciding on the “all or nothing” approach, the Reinsurance Task Force also considered the AG 48 “dollar-for-dollar” approach as well as two additional options: (i) a “proportional percentage” approach whereby a ceding company experiences a reduction in its credit for reinsurance by a proportional percentage of the amount of the shortfall in Primary Securities; and (ii) a “Primary Securities limitation” approach whereby a ceding company receives, (A) if there is no shortfall in Primary Securities, full credit for reinsurance, but (B) if there is a shortfall in Primary Securities, credit for reinsurance limited to the amount of the Primary Securities. Although both the initial and current draft of the A/XXX Model Regulation reflect the “all or nothing” approach, it remains to be seen which approach will ultimately be included in the A/XXX Model Regulation once finalized. The Reinsurance Task Force held a close vote in October 2015 to retain the “all or nothing” approach, and spirited discussions among the NAIC's relevant drafting group are likely to continue.

ii. Accreditation

In late 2015, the NAIC introduced amendments to accreditation program requirements. Unless the Framework is followed for an applicable reinsurance transaction, the amendments subject the regulation of U.S. captives reinsuring XXX or AXXX business to the accreditation requirements. However, the amendments do not apply to: (A) a state's domestic insurers licensed or organized under special purpose vehicle statutes or other similar statutory constructs; or (B) captives that reinsurance policies subject to the grandfathering provision under AG 48.

Amendments were also adopted with respect to accreditation standards applicable to captives reinsuring variable annuities and long-term care business, although such adoption is not yet effective and the effective date for applicability has yet to be determined. In addition, the NAIC has noted that the application of such amendments to in-force variable annuity and long-term care business requires further discussion.

iii. Variable Annuity Captives

In March 2015, the NAIC responded to concerns regarding insurers utilizing captive structures to reinsure variable annuity business by forming the Variable Annuity Issues (E) Working Group (“VAIWG”) to determine whether the use of such variable annuity captives could be reduced. Generally, these captive reinsurer structures are set up as internal transactions with parental guarantees or other self-funded solutions. The VAIWG retained Oliver Wyman to assist it in the evaluation of existing rules applicable to variable annuity business, particularly RBC, reserving and accounting requirements. Such rules include the capital charge requirements in C3 Phase II (“C3P2”) adopted by the NAIC in 2006 and reserve requirements in Actuarial Guideline XLIII (“AG 43”) adopted by the NAIC in 2008, to be effective December 2009 (collectively, the “VA Regulatory Framework”). Based on its examination of the VA Regulatory Framework, Oliver Wyman concluded that the most prominent reason for the use of variable annuity captive structures is to avoid the complexities in the current VA Regulatory Framework, particularly the interplay between the capital charge requirements in C3P2 and the reserve requirements in AG 43. As a result, the VAIWG has proposed amendments, intended to apply retroactively, to both AG 43 and C3P2 to reduce non-economic reserves and more closely align the requirements of each. The amendments are anticipated to become effective January 2017 with their stated goal being the elimination of the use of variable annuity captives altogether. The VAIWG is recommending that domestic regulators require variable annuity business to be recaptured from captives and the captives subsequently dissolved. See Section B.2.b of “Global Regulatory and Litigation Developments” for further information regarding developments relating to variable annuity captives.

2. Transactions

a. Regulation XXX/Regulation AXXX Transactions

The adoption of AG 48 in the fourth quarter of 2014 provided life insurance companies with some clarity as to how transactions within the reserve financing marketplace can be accomplished. During 2015, two different types of Regulation XXX/Regulation AXXX transactions were completed: grandfathered refinancing transactions that were not required to comply with the requirements of AG 48, and new transactions that are AG 48 compliant.

The non-AG 48 compliant refinancings tended to involve one or more of the following structural changes to previously executed transactions: (i) the addition of a syndication of risk takers to allow the original risk taker to spread the risk under the transaction among additional counterparties; (ii) the replacement of the original risk taker; or (iii) the change from a funded approach, where the excess reserves are funded with actual hard assets, to an unfunded approach, where the excess reserves are funded with a note, letter of credit or similar asset.

From our understanding, the AG 48 compliant deals that were completed in 2015 involved risk takers financing the excess reserves above the VM-20 level with Other Securities, while the applicable insurance company self-funded the excess reserves below the VM-20 level with Primary Securities. As of the time of this writing, we are not aware of any transaction completed where the reserves in excess of the economic reserves but less than the VM-20 level have been funded by a third party.

b. Embedded Value/Closed-Block Transactions

There has been little activity in the embedded value market since the financial crisis, other than the 2011 offering by Vecta I Limited, an indirect subsidiary of Aurigen Capital Limited (“Aurigen”), of C$120 million in embedded value linked notes that securitized profits
from a closed block of life reinsurance business, and the offering in December 2014 by Chesterfield Financial Holdings LLC, an indirect subsidiary of RGA, of US$300 million in embedded value linked notes sold in a 144A offering. This trend continued in 2015 with only one embedded value transaction occurring in mid-January 2015, a second embedded value transaction from the Aurigen group. This transaction was a private placement by Valins I Limited, an indirect subsidiary of Aurigen, of C$210 million in embedded value linked notes, covering a closed block of Canadian life insurance policies reinsured by Aurigen Reinsurance Ltd. between 2008 and 2013. This structure allows for the increase in size and extension of the maturity of the notes. These features allow Aurigen the flexibility to add future new business to the facility, and continuous access to capital funding to support its growth.

3. Market Outlook

The past year saw the completion of the first reserve financing transactions following the adoption of AG 48. As we anticipated, the reserve levels that exceed the VM-20 level have been financed using solutions developed since the financial crisis. The question remains whether insurance companies will obtain third-party financing in the form of cash or assets listed by the NAIC’s Securities Valuation Office that meet the Primary Security requirements for reserves in excess of the economic reserves but less than the VM-20 level.

Looking ahead, we expect that market participants will continue to focus on structuring solutions for third-party financing of reserves in excess of the economic reserves but less than the VM-20 level. We also anticipate that the pace of reserve financings will pick up as market participants become increasingly more familiar with the new regulatory framework required for such transactions. As guidelines relating to VM-20 calculations are finalized, there will be further clarity in the marketplace surrounding reserve financing transactions, and specifically regarding whether Regulation AXXX transactions will be feasible. Outside of Regulation XXX and AXXX transactions, we expect to see these financing techniques featured in mergers and acquisitions.

B. P&C MARKET

The extensive use of alternative risk transfer (“ART”) products in the P&C market proved once again that the ART market is a viable solution to traditional capital models. In the catastrophe bond market, although the total issuance amount decreased from the record set in 2014, the number of transactions increased year-over-year. Alternative reinsurance capital, in the form of catastrophe bonds, reinsurance sidecar and other insurance-linked securities (“ILS”), industry loss warranties (“ILWs”) and collateralized reinsurance, reached between US$68 billion and US$70 billion in 2015 and continued to contribute to the decline in rates in the property catastrophe reinsurance market in 2015. The following provides an overview of the global P&C ART market’s highlights and trends of 2015.

1. Catastrophe Bonds

After seeing the dollar volume of issuances of catastrophe bonds increase for three straight years, issuances of catastrophe bonds fell in 2015 to US$6.5 billion as compared to US$8.3 billion in 2014. Total catastrophe bond risk capital outstanding at the end of 2015 remained nearly flat at US$24 billion.6

As in 2014, the growth was mainly achieved during the first half of the year with US$4.3 billion of catastrophe bonds issued, the second largest amount on record. Issuance slowed in the second half of 2015 primarily due to increased competition from traditional and collateralized reinsurers.6 There were 27 “public” 144A catastrophe bond transactions of which nine transactions totaling US$2.2 billion closed during the second half of 2015. In addition to the “public” catastrophe bond transactions, approximately US$903 million of limit was transferred to the capital markets via 20 “private” catastrophe bond transactions.7

Only two new sponsors entered the “public” 144A catastrophe bond market in 2015, one of which was Amtrak’s Bermuda captive insurance company which accessed the capital markets through PennUnion Re.

The catastrophe bond market also saw its first loss since 2011. Following Hurricane Patricia’s landfall as a category 5 hurricane in October 2015, MultiCat Mexico Ltd Series 2012-I Class C incurred a 50% loss of principal.

Spreads remained mostly stable to only slightly wider in lower risk bonds issued in 2015. The Aon Benfield All Bond ILS Index posted a return of 3.51% (compared to 4.39% in 2014) as the index was affected by mark-to-market losses for the year as spreads in the underlying bonds widened.8 The Swiss Re Global Cat Bond Total Return Index showed a modest annual return of 4.2% in 2015 as compared to 6.0% in 2014. The lower return was mainly driven by maturing bonds which had higher average spreads than newly added bonds.9

Three noteworthy catastrophe bonds are highlighted below.

- **PennUnion Re Ltd. (Series 2015-1)**

  This bond, the first sponsored by Passenger Railroad Insurance, Ltd., a Bermuda insurer owned by Amtrak, provides an efficient source of insurance to Amtrak’s high concentration of assets and infrastructure along the East Coast for risks similar to those posed by Superstorm Sandy, and features a novel structure tailored to Amtrak. (October 2015).


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6 See Aon Benfield Securities Insurance-Linked Securities, Year-End 2015 Update.


8 See Aon Benfield Securities Insurance-Linked Securities, Year-End 2015 Update.

• Compass Re II Ltd. (Series 2015-1)

This AIG-sponsored bond was the first to use Rewire, a new online marketplace for catastrophe risk assets. This, along with the bond’s unique investor repayment structure, made Compass Re II an especially cost-effective issuance for AIG. (June 2015).

• Kizuna Re II Ltd. (Series 2015-1)

This Tokio Marine & Nichido Fire-sponsored bond, denominated in yen, provides protection against earthquake exposures for Tokio Marine’s portfolio of property across Japan, and received an investment grade rating from Standard & Poor’s, the first for a property catastrophe bond since 2008. (March 2015).

2. Traditional Reinsurers in the ILS Market

New third-party capital continued to flow into the reinsurance market in 2015. Alternative reinsurance capacity reached more than US$68 billion in 2015, representing an increase of 8% over 2014. As of December 31, 2015, alternative reinsurance capacity represented more than 17% of the approximately US$400 billion total capital dedicated to global property catastrophe reinsurance. Some market sources predict that alternative reinsurance capacity could reach up to US$150 billion by 2018.

Despite the decrease in the dollar volume of new catastrophe bonds, other forms of alternative capital (including collateralized reinsurance, sidecars and ILWs) experienced growth in 2015. Collateralized reinsurance grew more than 10% over year-end 2014 and now represents nearly 50% of the overall capacity provided by the alternative markets. Sidecar capacity increased by approximately 30% from 2014 to 2015. Recent sidecar transactions include additional capital raises by existing vehicles Mt. Logan Re (sponsored by Everest Re), K-Cessions (sponsored by Hannover Re), Silverton Re (sponsored by Aspen), Versutus (sponsored by Brit) and Eden Re II (sponsored by Munich Re).

Recent amendments to Rule 2a-7 under the U.S. Investment Company Act of 1940 regarding money market funds, and the possibility of banks imposing charges or fees on cash holdings, have caused alternative reinsurance market participants to reconsider the scope of eligible investments and waterfall provisions. Alternative reinsurance market participants should carefully consider these changes in defining the boundaries of, and selecting, eligible investments into which the reinsurance vehicle will invest capital. Another regulatory consideration that figures prominently in sidecar transactions and ILS funds is compliance with the Alternative Investment Fund Managers Directive (“AIFMD”) in European Union (“EU”) countries. In marketing sidecar transactions and ILS fund securities, market participants should be sure to consider potential AIFMD implications.

The reinsurance pricing environment in 2015 continued to face downward pressure though the rate of decline moderated in comparison to 2014, driven in large part by two prior years of steep declines and an increased demand in property and certain other lines. Pricing in the alternative reinsurance market also stabilized as ILS investors showed discipline by requiring adequate compensation for risk. As discussed above in Section A.4 of “The Global Mergers and Acquisitions Market,” the competitive landscape in the P&C reinsurance market has resulted in increased M&A activity involving traditional reinsurers, with a focus on building scale and diversification across lines of business and geography. Recent examples include Mitsui Sumitomo’s September 2015 announcement of its acquisition of Amlin, China Minsheng Investment’s July 2015 announcement of its acquisition of Sirius, ACE’s July 2015 announcement of its acquisition of Chubb, Tokio Marine’s June 2015 announcement of its acquisition of HCC Insurance and Fosun’s May 2015 announcement of its acquisition of Ironshore. Further M&A activity is expected, with market sources identifying additional reinsurers as potential acquisition targets.

While third-party capital has created challenges for traditional reinsurers, it has also created opportunities. Many traditional reinsurers have continued to incorporate third-party capital into their own business models by acquiring, developing or growing their own alternative capital programs, sponsoring catastrophe bonds and/or sidecar facilities, retroceding business to third-party capital providers and acting as transformers for “public” 144A and “private” catastrophe bonds. A recent example of a traditional insurance organization growing its third-party capital program is the purchase of assets of CATCo Investment Management by Markel Corporation’s newly formed ILS fund investment manager, Markel CATCo Investment Management. We expect to see this trend continue, as traditional reinsurers continue to explore new ways to use third-party capital to their benefit.

3. Investment Manager Activity

While the global financial market volatility in 2015 presented many investment manager-related reinsurers with a challenging environment, investment manager-related reinsurance structures continued to gain traction in 2015. ACE partnered with BlackRock to create ABR Re, a Bermuda-domiciled reinsurer, which underwrites reinsurance treaties placed by ACE with the traditional reinsurance market, and invests its assets in an alternative portfolio managed by BlackRock. Fidelis Insurance Holdings, led by British insurance-industry veterans, is a Bermuda-based specialty insurer that was formed with backing from three private equity firms and other
investors. Fidelis received an A- financial strength rating from A.M. Best and underwrites insurance and reinsurance business focused on property, energy, aviation and marine risk classes. Other investment managers have continued to express interest in participating in the establishment of offshore reinsurers; however, rating agencies are making it more difficult for newly-formed offshore reinsurers to obtain the A- rating necessary to write third-party property casualty reinsurance business.

4. Outlook Ahead

Catastrophe bond broker-dealers seem to be generally optimistic about 2016 despite the recent contraction. However, the trend of large maturities will continue. Nearly US$5.2 billion of catastrophe bonds are scheduled to be redeemed in 2016 (compared to US$6.8 billion in 2015). Several fairly large transactions again will be required for the catastrophe bond market to meet its potential US$6 billion to US$7 billion target in 2016. Another uncertainty is how rising interest rates in the high-yield corporate bond market will affect pricing in the catastrophe bond market. We expect property peril risks, such as Florida hurricane and California earthquake, to continue to dominate the catastrophe bond market in 2016.

2015 saw increased life and accident and health activity in the ILS space. The broader ILS market should continue to see a trend of expanding lines of business, perils and loss triggers in 2016 and, in particular, emerging insurance needs for flood and cyber risks are potential growth opportunities for reinsurers who have the expertise to underwrite these risks. Another potential area of growth for the ILS market may come from non-insurance corporate buyers of protection.

While rate pressures, the flight-to-quality of protection buyers and the abundance of alternative capital will likely continue to challenge many traditional reinsurers and drive more consolidation in the coming years, these conditions have helped better positioned carriers to set themselves apart. As in 2015, we expect that ART mechanisms in the P&C market will become more prevalent in the year ahead, and the insurance asset class, as a whole, will continue to attract new participants and new capital.

C. TRADITIONAL CAPITAL MARKETS

In 2015, the pace of capital markets transactions has continued to slow for initial public offerings (“IPOs”) while remaining fairly constant in the case of traditional debt offerings and funding agreement-backed note issuances.

Due in part to the unpredictability in the stock market during the latter half of 2015, very few IPOs closed in the U.S. market, and those that did were fairly small in size. Despite this continued volatility in the U.S. market, a few insurers are considering IPOs or spin-offs, with MetLife’s plan to sell, spinoff or conduct an IPO in the latter half of 2015, very few IPOs closed in the United States pursuant to Rule 144A. 2015 saw the usual participants in the funding agreement-backed notes market (which include MetLife, New York Life, Massachusetts Mutual and Principal Life) as well as the life insurance companies that entered (or re-entered) the market in 2014 (which include AIG and Reliance Standard Life Insurance Company). One notable new participant is Protective Life Insurance Company, which returned to the market with the establishment of a funding agreement-backed GMTN of Protective Life Global Funding, a newly organized Delaware statutory trust established to issue notes collateralized by funding agreements issued to it by Protective Life Insurance Company, the largest subsidiary of Protective Life, which was recently acquired by Dai-ichi. Protective Life Global Funding’s initial issuance of US$400 million 2.70% fixed rate notes due in 2020 closed at the end of November of 2015. Additionally, Athene Annuity & Life Assurance Company entered the market with the establishment of a funding agreement-backed GMTN of Athene Global Funding, whose initial issuance of US$250 million 2.875% fixed-rate notes due in 2018 also occurred in the fourth quarter of 2015.

III. The Global Longevity Market

The two principal sources of longevity risk are defined benefit pension schemes and books of annuity business written by life insurers. There has been a significant increase in the level of transaction activity in relation to the latter, with many European-based life insurance groups looking to hedge longevity exposure in light of the additional regulatory capital required under Solvency II in respect of annuity business. This, coupled with the continuing demand from...
defined benefit pension schemes, has led to the development of an active secondary market for longevity risk in which reinsurers have been the principal participants.

With increases in life expectancy in recent decades, pension schemes have increasingly been looking for methods to hedge against the risk that their members live longer than is currently predicted. The United Kingdom is the most mature market for the “de-risking” of pension schemes. This has been driven by the large number of defined benefit pension schemes in the United Kingdom and improvements in life expectancy and poor investment returns that have left many schemes in deficit. This in turn has adversely affected the balance sheets of corporate sponsors who are liable to make good such deficits. The vast majority of transactions executed to date have taken the form of traditional bulk annuity deals either in the form of pension buy-outs or involving the issue of a buy-in policy. However, since their emergence in 2009, longevity swaps have also now become a well established alternative option for hedging longevity exposure.

A. TRANSACTION STRUCTURES

To put into context our review of recent developments and transactions in the longevity market, we first briefly recap below the principal longevity risk transfer methods.

1. Buy-Outs

A pension buy-out involves an insurer taking over the liability to pay all or some of the member benefits from the trustees of the relevant pension scheme. This is achieved by the insurer issuing individual annuity policies to the relevant scheme members in return for a payment of premium by the trustees, usually by way of a transfer of assets from the pension scheme to the insurer. In the case of a buy-out, there is a direct insurance contract between the insurer and the individual scheme member; and in the event of a full buy-out, where individual policies are issued to all of the members of the pension scheme, the trustees can proceed to wind-up the scheme, with all future administration being performed by the insurer. The buy-out option is accordingly the ultimate form of pension scheme de-risking.

2. Buy-Ins

Pension buy-in solutions were developed as a de-risking option for pension schemes that were unable to afford the often prohibitive costs of a full buy-out. Under a pension buy-in, there is no direct contractual link between the insurer and the individual scheme members. Instead, the pension scheme trustees hold the buy-in policy in their name as an investment of the scheme, and the scheme continues to deal with the payment and administration of benefits. The trustees pay a premium (usually by transferring over an equivalent amount of pension scheme cash, bonds and other assets under management) and, in return, receive an income stream from the insurer to cover some or all of the scheme’s liability to pay member benefits. In the case of some of the larger buy-in transactions, trustees will also require the insurer to post collateral or otherwise secure its obligations to make payments under the policy.

3. Longevity Swaps

In their purest form, longevity swaps are derivatives and not contracts of insurance. However, it is possible to achieve the same economic effect on an insurance basis; and there have been examples of insurers issuing policies to pension schemes structured in the same way as a longevity swap. Although it is clearly important to ensure that the contract is properly structured as a derivative or insurance policy according to whether the protection provider is a bank or insurer; in either case, the core economics are very similar. In return for the pension scheme paying a fixed monthly amount to the insurer or bank, the counterparty makes a payment to the pension scheme on a monthly basis (the floating amount) referable to the benefit payable to a defined group of pensioners.

In cases where the front end arrangement involves a longevity swap with a bank as a counterparty, the longevity risk is in derivative form and not capable of being directly reinsured. In situations such as this, transformer vehicles (typically based off-shore) are used to convert the derivative exposure into insurance risk that can then be reinsured.

Whereas buy-ins and buy-outs involve a transfer of inflation, interest rate, investment and longevity risk, longevity swaps offer a purer hedge against the risk of scheme members living longer than is actuarially predicted; and the fact that there is no upfront payment of a lump sum premium means that the investment, interest rate and inflation risk remain with the trustees. Accordingly, longevity swaps are typically a less expensive alternative to buy-ins and buy-outs, albeit more complex to structure and negotiate. Longevity swaps almost invariably require the two-way posting of collateral to protect against the possibility of early termination by reason of the other party’s default or insolvency. The collateral is typically based upon the present value of the covered benefits and will also include a fee element payable to the insurer/bank in the event of termination arising by virtue of trustee default.

4. Index-Based Trades

A further alternative structure involves the purchase of longevity protection by reference to an index. Given the inherent basis risk that exists within these types of transactions, there have been relatively few index-based trades to date and these types of transactions are perhaps more likely to remain of greater interest to insurers and ILS investors than to pension schemes.

B. U.S. AND CANADIAN MARKET

Beginning with the GM and Verizon deals in 2012, the pension de-risking market in the United States experienced significant growth, although concentrated primarily with one direct writer (as The Prudential Insurance Company of America (“Pru”) still dominates the market). In addition to the GM and Verizon deals, other very large pension de-risking transactions have been consummated, including the Kimberly-Clark transaction and, in Canada, the Sun Life transaction (both of which are described below), each of which closed in the first quarter of 2015, while the middle and smaller markets involving deals with less than US$1 billion of liabilities has grown significantly. Unlike the variety of transactions executed in the United Kingdom, transactions in the United States have generally used only the buy-out approach outlined above. According to the LIMRA Secure Retirement
Institute, the pension buy-out sales in the United States in the first three quarters of 2015 totaled over US$8 billion, an increase of over 450% as compared with the same period in 2014.

As mentioned above, two larger deals closed in the first few months of 2015. Kimberly-Clark Corp. (“Kimberly-Clark”) entered into an agreement with Pru and MassMutual to purchase a US$2.5 billion group annuity contract for its retirees, thereby transferring pension obligations associated with approximately 21,000 retirees in the United States to Pru and MassMutual. Pru and MassMutual each provided half of the monthly benefits to the group of retirees. Like the Motorola transaction, Kimberly-Clark administered the group annuity payments and handled interactions with the retirees.

Similarly, Sun Life Financial Inc. (“Sun Life”) and BCE Inc. (“BCE”) entered into a longevity insurance agreement to transfer C$5 billion of pension plan liabilities associated with The Bell Canada Pension Plan (“Bell Plan”) to Sun Life Assurance Company of Canada. Pursuant to the agreement, Sun Life paid retiree benefits to current retirees, while BCE administered the Bell Plan and paid monthly premiums to Sun Life. Sun Life received reinsurance support from both RGA Life Reinsurance Co. of Canada and SCOR Global Life. This deal was the first longevity transaction in Canada and one of the largest transactions completed globally.

In the latter half of 2015, a number of additional companies entered into pension de-risking transactions in the United States ranging from approximately US$500 million to US$4 billion, including J.C. Penney’s purchase of a group annuity contract from Pru, Timken Co.’s purchase of a second group annuity contract from Pru, and Lincoln Electric Company’s purchase of a group annuity contract from The Principal Financial Group.

C. UK AND EUROPEAN MARKET

The UK pension de-risking market continued to be very active through 2015. In the traditional bulk annuity market (pension buy-ins and buy-outs), the marked reduction in the volume of sales of new individual annuities following the introduction of the “pension freedom” reforms in April 2015 has led to increased competition among life insurers for bulk transactions. Other factors fueling the continuing growth of this market include the healthy levels of capacity within the reinsurance market. The demand from reinsurers has been driven by a number of factors, but perhaps the most significant for life reinsurers with catastrophe books is that longevity risk acts as a natural hedge against mortality exposure and can create diversification benefits for regulatory capital purposes. This competition is in turn driving more attractive pricing and encouraging more pension schemes to evaluate their de-risking options.

Other trends emerging in the traditional bulk annuity market include an increase in the number of medically underwritten transactions and the willingness of some insurers to provide cover in respect of deferred (i.e., non-pensioner) members of schemes. This was a key element of the Pension Insurance Corporation’s £2.4 billion buy-out of the Philips UK Pension Fund, which was one of the larger 2015 transactions. Although not reaching the record levels of the prior year, there also continued to be high levels of activity in the longevity swap market in 2015. One of the higher value transactions involving the de-risking of a pension scheme was the £2.5 billion transfer of longevity risk from the Scottish & Newcastle Pension Plan to Friends Life, with back-to-back protection for a proportion of this risk being secured with Swiss Re.

There has also been a significant increase in the number of UK and continental European life companies buying longevity protection in the form of reinsurance. Some such transactions have been structured as longevity swaps. Legal & General’s US$2.9 billion longevity swap with Prudential Financial falls into this category. Equally, there has also been considerable activity in the market for reinsuring longevity and asset risk by means of single premium reinsurance policies on a collateralized basis, often to reinsurers based outside of the EU.

Against this backdrop, the United Kingdom’s prudential regulator, the Prudential Regulation Authority (“PRA”), has indicated that it is carefully monitoring the trend of UK insurers reinsuring longevity risk exposure. The PRA also commented in a Solvency II Directors’ update in November 2015 on its expectations in respect of UK-regulated insurance firms making use of risk transfer through reinsurance. The PRA observed that where a firm reinsures to a single or only to a few counterparties, that firm can be exposed to significant concentration of counterparty default risk. The PRA emphasized that it expects firms to manage and mitigate reinsurance counterparty default risk under Solvency II; and that this includes a requirement on firms to have a risk management system covering concentration risk management. The PRA added that it may not be sufficient to refer to the solvency capital requirement components covering counterparty default risk and risk concentration; and that additional measures besides capital may be required. The PRA commented that “this mitigation may take various forms, and will often be uniquely tailored to the firm’s specific business.”

More specifically in the context of longevity risk transfers, the PRA issued a letter on February 9, 2016 setting out its views on issues arising from longevity transactions and clarifying the PRA’s expectations on UK insurers and reinsurers carrying out these transactions as either the buyer or the seller of longevity protection. The PRA observed that it would be concerned if firms became active in this market for reasons other than seeking genuine risk transfer. In addition to referring back to its prior observations in relation to the need to monitor, manage and mitigate counterparty concentration risks, the PRA also stipulated that it expects to be notified of longevity risk transfer arrangements and a firm’s proposed approach to risk management well in advance of completing such a transaction. The PRA made it clear that this notification expectation applies whether a firm is buying or selling longevity protection and is intended to facilitate the PRAs understanding of the potential build-up of risk concentrations as a result of these transactions.

While there have been some concerns expressed in the market that the PRAs increased scrutiny of longevity risk transfer transactions may lead to a reduction in longevity risk transfer from UK insurers, it does not seem to us that this should necessarily follow. The PRAs observations in relation to the need for there to be effective risk transfer, and for ceding companies to appropriately manage counterparty default exposure, do not represent new requirements, and have been carefully considered in any event by ceding
companies and their reinsurers when structuring transactions to ensure appropriate credit for reinsurance under Solvency II. In particular, longevity reinsurance risk transfer arrangements (whether in swap form or otherwise) are typically collateralized and the quality and nature of the collateral is carefully structured in order to ensure that it effectively mitigates counterparty default risk within the requirements of Solvency II.

In practical terms, therefore, the principal point to note from the PRA’s February 9, 2016 letter is its expectation that all longevity risk transfer arrangements involving UK insurers and reinsurers are to be pre-notified (and effectively approved) by the PRA before the transaction is concluded. In the majority of cases, ceding companies will in any event have been liaising with the PRA in relation to the proposed capital treatment of a particular longevity risk transfer arrangement, so in practice this is unlikely to have a significant impact on the market.

IV. Global Regulatory and Litigation Developments

In 2015, the global insurance industry continued to examine difficult questions regarding the interpretation and intersection of U.S. federal, state and non-U.S. insurance regulation. In the United States, state and federal regulators continued to tackle ongoing initiatives, including (among others) the implementation of principle-based reserving, the regulation of life insurers’ use of affiliated captive reinsurers to finance non-economic reserves, the development of standards that should apply in the global reinsurance marketplace, the regulation of unclaimed life insurance and annuity benefits, the effect of health care reform implementation on the U.S. health insurance marketplace, the regulation of insurer investments and financial solvency, and the development of consistent international regulatory standards. In the United Kingdom, key developments pertain to Solvency II, which was finally implemented on January 1, 2016. Developments have included, for example, the introduction of new remuneration rules in the insurance sector and the Senior Insurance Managers Regime (“SIMR”) as well as other corporate governance-related changes. In China, key developments pertain to amendments to the Insurance Law, implementation of the new solvency regime, relaxation of licensing for Internet business and the emergence of the first Chinese catastrophe bond. These and other important insurance regulatory topics are discussed in more detail below.

A. U.S. FEDERAL ACTIVITY

1. Federal Reserve Board – Bailout Limitation

On November 30, 2015, the Board of Governors of the Federal Reserve System (the “Federal Reserve Board”) issued a rule implementing the restrictions set forth in the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (the “Dodd-Frank Act”) on the Federal Reserve Board’s emergency lending authority. Before the Dodd-Frank Act, the Federal Reserve Board could authorize the Federal Reserve Bank to lend to individual companies under certain conditions. However, due to concerns over individual company “bail outs” during the 2007-2008 financial crisis, the Dodd-Frank Act eliminated the Federal Reserve Board’s authority to serve as a “lender of last resort” to individual distressed firms. Instead, emergency lending was restricted to programs and facilities with “broad-based eligibility” with the approval of the Secretary of the Treasury.

The rule, which went into effect January 1, 2016, implements these restrictions and defines “broad-based” as a program or facility that is not designed for the purpose of aiding any number of failing firms (i.e., does not aid specific companies to avoid bankruptcy) and in which at least five entities would be eligible to participate. The rule also establishes procedures that prohibit emergency lending to insolvent borrowers and broadly defines “insolvency” to cover borrowers failing to pay undisputed debts as they become due during the 90 days prior to borrowing or who are determined by the Federal Reserve Board or Federal Reserve Bank to be insolvent.

2. Federal Insurance Office Activities

a. Covered Agreements

On November 20, 2015, the U.S. Department of the Treasury (the “Treasury Department”) and the Office of the U.S. Trade Representative (the “USTR”) by formal written letters notified the U.S. House of Representatives (the “U.S. House”) and the U.S. Senate that they intend to initiate negotiations to enter into “Covered Agreements” with the EU in accordance with the Dodd-Frank Act. Authority for such Covered Agreements stems from the Federal Insurance Office Act of 2010 (Title V of the Dodd-Frank Act), which authorizes the Federal Insurance Office (the “FIO”) to assist the Treasury Department in negotiating a “Covered Agreement” with one or more foreign governments or regulatory authorities in order to achieve a “level of protection for insurance or reinsurance consumers that is substantially equivalent to the level of protection achieved under state insurance or reinsurance regulation.”

Covered Agreements would address concerns that the United States might not be deemed “equivalent” under Solvency II, which came into effect on January 1, 2016. According to the notice letters, Covered Agreement negotiations with the EU will seek to accomplish the following prudential measures: (i) obtain treatment of the U.S. insurance regulatory system by the EU as “equivalent” to allow for a level playing field for U.S. insurers and reinsurers operating in the EU; (ii) obtain recognition by the EU of the integrated state and federal insurance regulatory and oversight system in the United States, including with respect to group supervision; (iii) facilitate the exchange of confidential regulatory information between lead supervisors across national borders; (iv) afford nationally uniform treatment of EU-based reinsurers operating in the United States, including with respect to collateral requirements; and (v) obtain permanent equivalent treatment for the solvency regime in the United States and applicable to insurance and reinsurance undertakings.

With respect to the fourth measure, the FIO has consistently expressed its belief that direct federal regulation is appropriate for addressing reinsurance collateral matters concerning non-U.S. unauthorized insurers. The FIO has pointed to inconsistencies among states in implementing reinsurance collateral reform and
has questioned the wisdom of relying on credit rating agency assessments of insurers as opposed to “risk-based empirical factors” to determine applicable reinsurance collateral requirements.

State insurance regulators and the NAIC have argued against the necessity of Covered Agreements, noting that progress has been made among states in modernizing and making more consistent the credit for reinsurance rules applicable to reinsurance agreements with unauthorized insurers, particularly collateral requirements. However, thus far only 33 states representing approximately 68% of gross premium have adopted the new collateral requirements applicable to such agreements as set forth in the NAIC’s CFR Model Law and A/XXX Model Regulation (collectively, the “CFR Model Laws”).

Further, when the reinsurance collateral reform revisions to the CFR Model Laws were adopted, the NAIC decided not to make adoption of such revisions an NAIC “accreditation standard” and states have not been required to adopt reinsurance collateral reform as set forth in the CFR Model Laws.

In late 2015, the NAIC began the process of making the new reinsurance collateral requirements set forth in the CFR Model Laws an accreditation standard. See also Section IV.B.3.a.ii.b. It is unclear what effect, if any, this will have on how the Treasury Department/USTR proceeds with Covered Agreement negotiations. In any event, the Treasury Department/USTR notice letters expressly provide that “state insurance regulators will have a meaningful role during the covered agreement negotiation process.”

b. Process for Certifying an “Act of Terrorism” Under the Terrorism Risk Insurance Act

In October 2015, the Treasury Department issued a report entitled, “The Process for Certifying an ‘Act of Terrorism’ under the Terrorism Risk Insurance Act of 2002,” which addresses the process by which an event may be certified as an “Act of Terrorism” under the Terrorism Risk Insurance Program (“TRIP”). TRIP is administered by the Treasury Department with the assistance of the FIO, pursuant to the January 2015 legislation reauthorizing the Terrorism Risk Insurance Act (“TRIA”). The process for certifying an Act of Terrorism is considered important, as TRIA provides that the Treasury Department’s determination to certify (or not certify) an act as an “Act of Terrorism” is final and not subject to judicial review.

The October 2015 report emphasizes the importance of obtaining full and detailed information before reaching a decision on certification and notes that such information will be obtained through consultation with state and federal law enforcement, intelligence resources (including the U.S. Department of Justice and the U.S. Department of Homeland Security) and through the Treasury Department’s own collection of information regarding “property and casualty insurance losses.” The decision whether to certify an Act of Terrorism will also be based upon the severity of losses resulting from the act under consideration, as TRIA prohibits certification of an act which results in P&C insurance losses of US$5 million in the aggregate or less. The report notes that the Treasury Department will be developing a methodology for collecting and validating loss data during the certification process, particularly from claims estimates and other loss information provided by insurers. The Treasury Department will also be working with state insurance regulators and data aggregators to establish a system for collecting, storing, and analyzing loss data.

The report recommends publication of an initial public notice announcing that an event is being considered for certification, followed by public updates on the status of the certification process. While the Treasury Department is not currently obligated to provide such public notices, the report explains how doing so would assist insurers and insureds in better assessing their positions and evaluating the potential effect of an event being certified as an Act of Terrorism.

3. Recent Appointments to the National Association of Registered Agents and Brokers

On January 11, 2016, President Obama nominated four individuals to serve on the 13-member board of the National Association of Registered Agents and Brokers (“NARAB”), an independent non-profit corporation established pursuant to the National Association of Registered Agents and Brokers Reform Act of 2015 (“NARAB II”) to create a centralized insurance producer licensing process. NARAB II reflects a longstanding effort by legislators, industry and trade groups to ensure uniformity among states with respect to insurance producer licensing procedures. NARAB II requires that President Obama appoint a 13-member governing board for NARAB (consisting of eight insurance commissioners and five industry leaders with professional expertise in producer licensing).

Although the law requires that the appointments be made by mid-April 2015, the appointments were made only after a December 15, 2015 formal request from a bipartisan group in the U.S. Senate. The appointments include regulators from two states (South Carolina and Minnesota) as well as an insurance producer representative for each of the life/health and property/casualty insurance industries.

Before the NARAB board can function, the four appointments will need to be confirmed by the U.S. Senate and nine additional board members will need to be appointed (and confirmed). Once constituted, the NARAB board will need to establish operating procedures, membership rules and a plan for funding. The NARAB board will establish criteria for insurance producers to obtain non-resident authority to sell, solicit or negotiate insurance outside their home state of licensure.

4. Federal Housing Finance Agency Issues Final Federal Home Loan Bank Membership Rule

Under a newly issued final rule of the Federal Housing Finance Agency (the “FHFA”), captive insurers are excluded from Federal Home Loan Bank (“FHLB”) membership (unless they fall within another category of institution, other than “insurance company,” that may be eligible for membership). The final rule provides a transition period for captives that currently are FHLB members to terminate their membership and restricts their ability to obtain FHLB advances during the transition period. The transition period is five years from the effective date of the final rule for captives that became FHLB members prior to the publication of the FHFA’s proposed rule in
2014 and one year for captives that became FHLB members after the publication of the FHFA’s proposed rule. The final rule became effective on February 19, 2016.

The FHFA proposed the changes to the rule out of concern that entities such as hedge funds, investment banks and finance companies, which may not be eligible themselves for FHLB membership, would establish captives to gain access to low-cost FLHB funding and other benefits of FHLB membership in a manner that the FHFA considered inconsistent with the provisions or purposes of the Federal Home Loan Bank Act. The final rule included the captive exclusion, notwithstanding the fact that none of the approximately 400 comment letters that the FHFA received that addressed the proposal to exclude captives from FHLB membership expressed support for the proposal and almost all of the comment letters expressed opposition to the proposal. The FHFA has suggested that if Congress wants captives to be eligible for FHLB membership, Congress should amend the Federal Home Loan Bank Act.

5. Department of Labor – Proposed Fiduciary Rule

On April 14, 2015, the U.S. Department of Labor (“DOL”) issued a new proposed regulation defining “fiduciary,” which would expand the circumstances under which consultants, advisers, appraisers and others become fiduciaries for purposes of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), and the prohibited transaction provisions of the Internal Revenue Code of 1986, as amended (the “Code”), as a result of providing “investment advice.” This new definition could make insurance companies and their agents fiduciaries with respect to ERISA plans and individual retirement accounts (“IRAs”). The prior proposed regulation was issued in 2010 and was subsequently withdrawn after much protest from members of the financial community.

In addition to the proposed regulation, the DOL issued two new proposed prohibited transaction class exemptions and proposed amendments to, and partial revocations of, several existing prohibited transactions. In general, it appears that the DOL issued these proposed exemptions and proposed amendments to existing exemptions in order to permit current business practices to continue even if financial institutions become fiduciaries under the proposed regulation. However, to continue these business practices, significant new conditions must be satisfied by the applicable fiduciaries. There is concern in the insurance industry that these new conditions cannot be satisfied in the case of certain insurance products and commission arrangements.

Currently, a prohibited transaction exemption exists that permits sales commissions to be paid to fiduciary insurance brokers in connection with the sale of insurance products to ERISA plans and IRAs. The DOL issued a proposed amendment to this exemption that would add additional conditions including, among others, that the fiduciary insurance brokers adhere to impartial conduct standards that require the broker to act in the best interests of the ERISA plan or IRA without regard to the financial interests of the broker or the insurance company. In addition, the proposed amendment would make the exemption inapplicable to sales of variable and certain other annuity contracts to IRAs. Instead these products could be sold to IRAs if the conditions of a new proposed exemption were satisfied.

The new proposed exemption that could apply to the sale to IRAs of variable and certain other annuities, among other types of transactions involving ERISA plans and IRAs, is referred to as the “Best Interest Contract Exemption.” This proposed exemption contains many conditions, including that the fiduciary advisor or broker enter into a written contract with the ERISA plan or IRA that, among other things (a) acknowledges the advisor’s or broker’s fiduciary status, (b) contains warranties that the fiduciary will act in the best interests of the ERISA plan or IRA without regard to the financial interests of the fiduciary and (c) discloses any material conflicts of interest. Many comments were provided to the DOL explaining the difficulty of meeting the conditions of the proposed exemption.

The proposed regulation was sent to the Office of Management and Budget (“OMB”) for final review at the end of January and the OMB has up to 90 days to review the proposal. The DOL has indicated that it tried to address the concerns raised in the comments it received but has given no indication of the scope of the changes. There have been attempts in Congress to stop the issuance of the proposed guidance but none have been successful. If approved by OMB, the final regulation is expected to be issued by the end of April 2016.

6. Derivative Transactions

a. Prudential Regulators and CFTC Adopt Margin Rules for Non-Cleared Swap

During 2015, the five prudential regulators (the Comptroller of the Currency, the Board of Governors of the Federal Reserve System, the Federal Deposit Insurance Corporation, the Farm Credit Administration and the Federal Housing Finance Agency, collectively the “Prudential Regulators”) and the U.S. Commodity Futures Trading Commission (the “CFTC”) each adopted final rules (the “Final Rules”) that require swap dealers and major swap participants registered with the CFTC and security-based swap dealers and major security-based swap participants registered with the U.S. Securities and Exchange Commission (“Swap Entities”) to post and collect initial margin and variation margin for non-cleared bilateral swaps and security-based swaps (“Non-Cleared Swaps”). Insurance companies are generally considered “financial end users” under the Final Rules. As a result, each Non-Cleared Swap entered into between a Swap Entity and an insurance company will be subject to variation margin (the cumulative mark-to-market value of the Non-Cleared Swap) on a daily basis. In addition, insurance companies with “material swaps exposure” must also post and collect initial margin for each transaction with a Swap Entity to the extent that the initial margin required for the insurance company exceeds US$50 million. An insurance company will be deemed to have a “material swaps exposure” if the entity and its affiliates have an average daily 17 See Prudential Regulators, Margin and Capital Requirements for Covered Swap Entities, Final Rule, 80 Fed. Reg. 74840 (November 30, 2015), available at: http://www.gpo.gov/fdsys/pkg/FR-2015-11-30/pdf/2015-28671.pdf; see also CFTC, Margin Requirements for Covered Uncleared Swaps for Swap Dealers and Major Swap Participants, Final Rule, 81 Fed. Reg. 636 (January 6, 2016), available at: http://www.cftc.gov/idc/groups/public/@lrfederalregister/documents/file/2015-32320a.pdf.
aggregate notional amount of Non-Cleared Swaps, foreign exchange forwards and foreign exchange swaps with all counterparties during June, July, and August of the previous calendar year that exceeds US$8 billion. Initial margin is required to be calculated by either using an approved risk-based model or the notional amount percentages published by the CFTC and Prudential Regulators. Additionally, for Non-Cleared Swaps governed by an eligible master netting agreement the initial and variation margin requirements may be calculated on a net basis. Initial margin generally may not be rehypothecated, must be segregated and must be held at a third-party custodian that is not affiliated with the counterparties.

The effectiveness of the Final Rules will be phased in, beginning on September 1, 2016. The initial margin requirements will be phased in over a four year period by September 1, 2020 depending on the aggregate notional amount of certain swaps and foreign exchange transactions outstanding for each party, and the variation margin requirements will be phased in for all parties by March 1, 2017.

b. Implications of 24-Hour Stay on Qualified Financial Contracts in Liquidation

Previously the NAIC Receivership and Insolvency (E) Task Force (the “Task Force”) adopted a “Guideline For Stay on Termination of Netting Agreements and Qualified Financial Contracts” (the “Stay Guideline”) which recommends that states that adopt Section 711 of the NAIC Insurer Receiver Model Act (“IRMA”) also consider adopting a 24-hour stay on the ability of swap counterparties to terminate or close-out swaps with insurers in receivership. The Task Force adopted this guideline in order to match the 24-hour stay that applies to banks under the Federal Deposit Insurance Act (“FDIA”). The 24-hour stay applicable to banks under the FDIA is a well recognized and practical provision in light of the fact most bank receivers are appointed on a Friday afternoon, and the bank is typically resolved over the course of the weekend. The practicality and utility of a 24-hour stay in the context of an insurer receivership (which typically moves much more slowly than a bank receivership) under the FDIA raises significant questions.

Notwithstanding the issues with the Stay Guideline and its practicality, recently, the State of Wisconsin signed into law Section 645.75 of the Wisconsin Insurance Statutes which adopts IRMA Section 711 in Wisconsin. In adopting Section 645.75, the Wisconsin legislature followed the Task Force’s Stay Guideline and included a 24-hour stay on the right of any counterparty to terminate qualified financial contracts (such as swaps). We also understand that the Connecticut legislature is considering an amendment to its IRMA Section 711 provisions to incorporate a 24-hour stay in accordance with the Stay Guideline. One of the primary benefits of a state adopting IRMA Section 711 provisions is that insurers domiciled in such states are then able to execute swap and derivatives transactions with banks at lower costs, as such swaps and derivatives transactions qualify for netting treatment. However, under the Basel III rules adopted by the Office of the Comptroller of the Currency, the Board of Governors of the Federal Reserve System and the Federal Deposit Insurance Corporation and the Final Rules adopted by the Prudential Regulators and CFTC, the applicable banking regulators only recognize a swap or derivatives agreement as a qualified netting agreement if “the agreement provides the [bank] the right to accelerate, terminate and close-out on a net basis all transactions under the agreement and to liquidate or set-off collateral promptly upon an event of default, including upon an event of receivership or insolvency, liquidation, or similar proceeding…provided that, in any case any exercise of rights under the agreement will not be stayed or avoided under applicable law… other than under the FDIA, Title II of the Dodd-Frank Act or under any similar insolvency law applicable to [Government Sponsored Entities]” (emphasis added). Because the applicable provisions of the Basel III rules and the Final Rules do not recognize stay periods such as those recommended by the Task Force in the Stay Guideline, unfortunately states that adopt such a stay will not be benefiting their domiciled insurers. Instead, insurers domiciled in states that adopt the Task Force’s Stay Guideline will be subject to the same higher costs that banks are required to impose with counterparties that are not able to net their swap and derivative transactions under a qualifying netting agreement.

B. U.S. NAIC AND STATE ACTIVITY

1. Principle-Based Reserving

a. State Activity – PBR Legislation

It has been over three years since the NAIC approved PBR through adoption of the NAIC Standard Valuation Manual (the “Valuation Manual”) in December 2012. Since then, states continue to introduce and adopt legislation that would allow for PBR. PBR will become operative when legislation is adopted by 42 states representing 75% of total U.S. life insurance premiums. As of March 1, 2016, 39 states have enacted legislation to implement PBR requirements, representing approximately 71.78% of total U.S. life insurance premiums. California, a key state due to its significant portion of total U.S. life insurance premiums (6.79%), recently enacted such legislation. Another key state is New York, which represents 9.2% of U.S. life insurance premiums. While New York has recently expressed a willingness to at least discuss PBR, a formal legislative process has not yet begun and the NYDFS has been consistently vocal in its opposition to PBR. In the meantime, state insurance regulators continue working through the NAIC to address the mechanics of implementing PBR and to consider related issues, such as the appropriate use of reinsurance captives for life insurance reserve transactions pending implementation of PBR.


18 See House Bill No. 6951 (CT 2015).
b. NAIC Activity – PBR Implementation

As states consider PBR legislation, the NAIC continues to address PBR implementation issues, primarily through its PBR Task Force, which serves as the coordinating body for NAIC technical groups involved with PBR implementation. Pursuant to a PBR Implementation Plan adopted by the NAIC’s Executive (EX) Committee in 2013, the PBR Task Force also consults with state insurance departments and insurers regarding the appropriate resources, training and regulatory/actuarial guidance that will be necessary when PBR is effective. Within the past year, the PBR Task Force has addressed the PBR-implementation initiatives discussed below.

c. Small Company Exemption

At the Summer 2015 National Meeting, the NAIC adopted an exemption (the “Small Company Exemption”) to the requirements set forth in VM-20, pursuant to which certain small insurers would be relieved from performing certain complicated tests that would otherwise determine whether such companies are subject to certain principle-based reserving requirements.

VM-20 allows less risky products to be exempt from additional reserve calculations. However, the tests that insurers must perform in order to qualify for that exemption (“Exclusion Tests”) involve substantial work and documentation in order to demonstrate the relative absence of risk. As adopted, the Small Company Exemption makes the Exclusion Tests less burdensome for companies by incorporating an assessment of company risk, rather than product risk. In order to qualify for the Small Company Exemption, a company must have (i) less than US$300 million of ordinary life insurance premiums (or, if the company is a member of an NAIC group of insurers, the group must have combined ordinary life insurance premiums of less than US$600 million); (ii) reported Total Adjusted Capital of at least 450% of the authorized control level RBC in its most recent RBC report, and the appointed actuary must have provided an unqualified opinion on reserves; and (iii) no material universal life with premiums of less than US$600 million); (ii) reported Total Adjusted Capital of at least 450% of the authorized control level RBC in its most recent RBC report, and the appointed actuary must have provided an unqualified opinion on reserves; and (iii) no material universal life with secondary guaranty business in force.

d. PBR Operative Date

PBR becomes operative when a certain number of states have passed legislation that is “substantially similar” to the NAIC’s Standard Valuation Law (the “SVL”), at which time the Valuation Manual becomes “operative.” In November 2015, the NAIC adopted a plan for determining which states have passed “substantially similar” legislation (the “PBR Operative Date Plan”). Pursuant to the PBR Operative Date Plan, states will complete a survey documenting their conformances and deviations from the SVL and a small group of NAIC staff and regulators will then compile this data. The PBR Task Force will then recommend whether a state can be counted toward the required threshold that triggers the PBR operative date (with the NAIC’s Plenary Committee making the final decision).

The PBR Operative Date Plan addresses state laws containing small company exemptions that differ from the Small Company Exemption. (See Section IV.B.1.c above for a discussion of the Small Company Exemption.) The PBR Operative Date Plan provides that states that have adopted lower premium thresholds than those provided in the Small Company Exemption (potentially exempting fewer companies) can still be considered to have “substantially similar” legislation. States that have adopted higher thresholds (potentially exempting more companies) would not be disqualified automatically, but certain issues would need to be addressed, such as whether a state would continue to use the formulaic method currently in effect (pre-PBR) with respect to excluded companies and the overall effect if other states in which the exempted insurer is licensed have a lower threshold for the small company exemption than the domiciliary state.

e. Other PBR Implementation Measures

The NAIC is working on a number of practical measures to effectuate PBR, including an annual statement blank and instructions to incorporate PBR, hiring additional actuaries to support states in their analysis and examination of PBR valuations, and ensuring that states apply PBR requirements uniformly. Additionally, the PBR Task Force is considering the appropriate manner for collecting and disseminating an insurer’s experience data in accordance with the Valuation Manual, which requires that reserve calculations include experience reporting. In this regard, the PBR Task Force is facing certain challenges, such as state procurement rules and the authority of states to disseminate data directly to third parties. Accordingly, the PBR Task Force is evaluating whether the NAIC should serve as the reporting entity for such data.

Before PBR becomes operative, the NAIC may be conducting “pilot programs” that test and evaluate the PBR mechanisms in the SVL and the Valuation Manual and determine whether changes are necessary. Data for the pilot programs would be submitted by volunteer insurers that plan on utilizing PBR, as well as their domiciliary state insurance regulators. Insurers would complete VM-20 calculations as of December 31, 2015, as well as other reports and calculations through November 2016, resulting in a final report presented to the PBR Task Force in December 2016.

2. Affiliated Captive Insurers and Reserve Transactions

a. Framework for Captive Reserve Transactions

Throughout 2015, the NAIC focused on implementing the Framework and AG 48. The Framework and AG 48, each adopted in November 2014, set forth an action plan for creating interim regulations specific to life insurance reserve financing transactions pending the full implementation of PBR. For a discussion of certain RBC and capital adequacy-related changes related to implementation of the Framework and AG 48, see Section IV.B.4.b.ii below.

i. Credit for Reinsurance Model Act Amendments

On January 8, 2016, the NAIC adopted amendments to the CFR Model Law to provide state insurance commissioners with the authority to adopt regulations implementing the Framework and AG 48. Such amendments provide state insurance commissioners the authority to adopt such regulations as they relate to: (A) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits; (B) universal life insurance policies that have provisions resulting in a policyholder’s ability to keep a policy in...
force over a secondary guarantee period; (C) variable annuities with guaranteed death or living benefits; (D) long-term care policies; and (E) such other life and health insurance and annuity products as to which the NAIC may adopt model regulatory requirements that make reference to credit for reinsurance. Regulations may apply to any treaty covering: (1) policies issued on or after January 1, 2015; and/or (2) policies issued prior to January 1, 2015 if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

The CFR Model Law amendments also contain a so-called “professional reinsurer” exemption, which provides that a regulator’s authority to promulgate a regulation does not apply to cessions to a reinsurer that qualifies as a certified reinsurer in certain states, or is licensed and/or accredited in a certain number of states and meets minimum capital and surplus requirements (US$250 million). The exempted reinsurer must be either: (a) licensed in at least 26 states; or (b) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

ii. A/XXX Model Regulation

The NAIC’s Reinsurance Task Force is drafting a new model regulation that will contain uniform standards governing XXX/A/XXX reserve transactions that are not exempt or grandfathered. On February 26, 2016, the Reinsurance Task Force exposed for a 30-day comment period a revised draft of the A/XXX Model Regulation which is entitled, Model Regulation on Credit for Reinsurance of Life Insurance Policies Containing Nonlevel Premiums, Nonlevel Gross Benefits and Universal Life with Secondary Guarantees. In connection with drafting the A/XXX Model Regulation, the Reinsurance Task Force has been focused on three main issues: (A) the consequences for cedents that experience a shortfall in Primary or Other Securities (terms defined under AG 48); (B) the mixing of book value and market value accounting; and (C) appropriate exemptions to the A/XXX Model Regulation.

With respect to the first issue, the Reinsurance Task Force considered four potential approaches to addressing such shortfalls: (1) an “all or nothing” approach whereby the entire reserve credit is lost if there is a shortfall in either Primary Securities or Other Securities; (2) a “dollar-for-dollar reduction” under which credit for reinsurance is reduced dollar for dollar by the amount of the shortfall between Primary Security holdings and the amount required under PBR; (3) a reduction in credit for reinsurance by a proportional percentage of the amount of the shortfall between Primary Security holdings and the amount required under PBR; and (4) calculating credit for reinsurance based on the amount of the cedent’s Primary Security holdings, as follows: if they are equal to the required level under PBR, full credit for reinsurance is allowed; however, if there is a shortfall between Primary Security holdings and the required level, credit for reinsurance is limited to the Primary Security holdings. Thus, under the second and third options, a cedent would need to establish a liability equal to the difference between the ceded AG 48 reserve and the credit for reinsurance allowed; but under the fourth option, a cedent would need to establish a liability equal to the difference between the ceded AG 48 reserve and the cedent’s Primary Security holdings.

The first draft of the A/XXX Model Regulation included the first option (the “all or nothing” approach), along with a suggestion from the Reinsurance Task Force’s drafting group that the three other options be considered. Each option was discussed at length by Reinsurance Task Force members and interested parties, many of whom believe that the “all or nothing” approach is inconsistent with AG 48, as well as the current CFR Model Law, which allows a cedent to reduce its liabilities for reinsurance ceded to an unauthorized reinsurer in an amount equal to the total collateral provided (i.e., a dollar-for-dollar reduction in reserve credit). After a 12-8 vote, the Reinsurance Task Force decided to retain the “all or nothing” approach. However, the A/XXX Model Regulation likely will not be finalized until the Spring of 2016 and it remains to be seen which option will ultimately be included when the A/XXX Model Regulation is adopted.

The book/market value accounting issue arises from language in the draft A/XXX Model Regulation setting forth the requirements applicable to Covered Policies (as defined in the A/XXX Model Regulation) to obtain credit for reinsurance. The first draft of the A/XXX Model Regulation provided that a trust used to satisfy such requirements must comply with state laws governing credit for reinsurance, except that reinsurance agreements must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the Primary Security within the trust below a certain level. However, due to concerns that such requirement would result in a mix of book value and market value accounting, the February 26, 2016 draft now provides that trust assets should be measured at book value.

The Reinsurance Task Force will also need to make a final determination on appropriate exemptions to the A/XXX Model Regulation. The February 26, 2016 draft of the A/XXX Model Regulation expressly states that it does not apply to reinsurance ceded to an assuming insurer that: (a) is reinsuring Yearly Renewable Term Insurance or certain n-Year Renewable Term Insurance policies; (b) maintains a trust fund in a qualified U.S. financial institution in accordance with the CFR Model Law; (c) is licensed or accredited in the cedent’s domicile (or in another state that has similar CFR standards) and the assuming insurer, or U.S. branch of an alien insurer, maintains policyholder surplus of at least US$20 million and submits to examination of its books and records and is not in a company action level or other event as set forth in state RBC rules; (d) meets the professional reinsurer exemption provided in the CFR Model Law; or (e) is determined by a state insurance commissioner to be reinsuring risks that are clearly outside the intent and purpose of the A/XXX Model Regulation and are only included as a technicality and applying the regulation to such risks is not necessary for policyholder protection. With respect to the last exemption, a drafting note clarifies that such exemption is not to be used with respect to “normal course” reinsurance transactions and was only added to address the possibility of “unforeseen or unique transactions” and to recognize that it is impossible to foresee “every conceivable type of reinsurance transaction.” The drafting note refers to unanticipated transactions that might get caught up in the regulation purely as a technicality and recognizes that regulatory relief in such instances...
might be appropriate. The drafting note includes as an example of such a transaction a bulk reinsurance arrangement where the cedent is exiting the type of business ceded.

iii. Disclosures for RBC Shortfalls
On December 17, 2015, the NAIC adopted public disclosures concerning RBC shortfalls resulting from the Framework. Such disclosures will identify the total adjusted capital and RBC shortfalls of a cedent’s XXX and AXXX captives and are required in the annual statements of cedents beginning with year-end 2015 financial statements.

b. Variable Annuity Captive Reinsurance Transactions
The VAIWG was formed in March 2015 to address concerns with insurers using captives to reinsure variable annuity business and to determine whether such use could be decreased by amending the existing rules applicable to variable annuity business, particularly RBC, reserving and accounting requirements. Such rules include the capital charge requirements in C3P2 adopted by the NAIC in 2006, and reserve requirements in AG 43 adopted by the NAIC in 2008, to be effective December 2009. To that end, the VAIWG retained a consultant (Oliver Wyman) to evaluate the VA Regulatory Framework.

Based on its examination of the VA Regulatory Framework, including interviews with regulators, variable annuity insurers and onshore and offshore captives, Oliver Wyman issued a report concluding that the most prominent reason for VA insurers using captive structures is to avoid the complexities in the current VA Regulatory Framework, particularly the interplay between the capital charge requirements in C3P2 and the reserve requirements in AG 43. The report outlines potential amendments that could be made to the current VA Regulatory Framework in order to obviate the need for insurers to continue using captive structures for variable annuity business. The report notes that two of the motivations for captive use will not be affected by changing the VA Regulatory Framework, namely, an insurer’s desire to consolidate business/risks into discreet entities (for economies of scale purposes) and tax motivations. However, insurers have expressed that neither of these two factors would by themselves motivate them to use a captive structure.

Based on the input from Oliver Wyman, on October 22, 2015, the VAIWG adopted a report that was sent to its parent committee, the Financial Condition (E) Committee (the “(E) Committee”), outlining potential changes to the VA Regulatory Framework and noting that Oliver Wyman will be assisting with performing a quantitative impact study (“QIS”) of proposed changes in order to evaluate whether the changes will be feasible from a time and cost perspective for both industry and regulators. The VAIWG’s report outlines its commitment to changes to the VA Regulatory Framework “in concept,” but notes that specific details of the changes will be determined in 2016. Further, any specific changes to RBC and reserve requirements (e.g., C3P2 and AG 43, respectively) could not be determined until completion of the QIS.

3. Reinsurance
a. Credit for Reinsurance Update
i. State Activity
More than four years after the NAIC amended the CFR Model Laws in November 2011, 33 states have adopted the amended CFR Model Laws or otherwise allow for a reduction in posted collateral from an unauthorized reinsurer that is approved by states as a “certified reinsurer.” However, as discussed above in Section IV.A.2.a, it is possible that an individual state’s collateral requirements could be preempted with respect to reinsurance cessions placed with certain unauthorized reinsurers (i.e., reinsurers domiciled in countries that have entered into a Covered Agreement with the United States).

ii. NAIC Activity
a. Uniform Application Checklist for Certified Reinsurers
The Reinsurance Task Force finalized the Uniform Application Checklist for Certified Reinsurers (the “Uniform Certified Reinsurer Application”), which describes the requirements for a reinsurer to apply for certified reinsurer status (including through “passporting”).

Under the process outlined in the final version of the Uniform Certified Reinsurer Application, to become a certified reinsurer, an application must be submitted to one “lead” state (that has passed laws similar to the amended CFR Model Laws), and such state must then decide the percentage (i.e., 0%, 10%, 20%, 75% or 100%) at which the certified reinsurer must collateralize reinsurance obligations. “Passporting” means that a reinsurer has applied for and has become a certified reinsurer in one “lead” state and then is added to the certified reinsurer lists in other states, without having to apply separately in such other states. Once a reinsurer has been certified by one state, the reinsurer may request that the lead state refer its paperwork to the NAIC’s Reinsurance Financial Analysis (E) Working Group (“RFAWG”), a forum for multistate review of certified reinsurer applications and “peer review” by state insurance regulators of decisions made by other states on applications. RFAWG will then decide whether to recommend that the reinsurer automatically be “passported” in other states. If RFAWG makes such a recommendation, other states will decide whether to accept the recommendation and add the certified reinsurer to its certified reinsurer list. So far, no state has declined to accept RFAWG’s recommendation (although in a handful of instances, RFAWG has declined to recommend a reinsurer for passporting). If RFAWG or a state decides against automatically passing a certified reinsurer, the reinsurer must apply separately for certified reinsurer status in other states.

b. Certified Reinsurer Provisions as an Accreditation Standard
In late 2015, the Financial Regulation Standards and Accreditation (F) Committee began the process of making the certified reinsurer provisions in the NAIC’s most recent amendments to the CFR Model Laws an accreditation requirement. NAIC staff were directed to draft specific revisions to the current guidance to incorporate this standard.
Accordingly, those states that have not enacted reinsurance collateral reform will need to pass a law that is substantially equivalent to the amended CFR Model Laws in order to maintain NAIC accreditation.

Although many states have passed collateral reform legislation, states currently are not required to do so and many have not. When adopted, the CFR Model Laws providing for reduced collateral were not made an NAIC accreditation standard. The NAIC’s recent decision to make the certified reinsurer provisions of the CFR Model Laws an accreditation standard was motivated primarily by the prospect of federal preemption of state insurance regulation addressing reinsurance collateral matters. Specifically, the NAIC took this action in an effort to promote state uniformity and strengthen the NAIC’s argument against the necessity of Covered Agreements that could preempt state reinsurance collateral laws that are inconsistent with such Covered Agreements. (See Section IV.A.2.a above, addressing Covered Agreements.)

b. Reinsurance With Risk-Limiting Features

In March 2015, the Risk-Limiting Contracts (E) Working Group (“Risk-Limiting Working Group”) was formed to address concerns expressed by insurance regulators regarding whether certain reinsurance contracts are meeting risk-transfer requirements under insurance accounting rules. Thus far, insurance regulators have identified potential problems in the following types of agreements: reinsurance contracts issued by risk retention groups, reinsurance ceded by mortgage insurers to affiliated captives, contracts with unusual commission features, contracts where underlying events would be so severe that they would cause the cedent to become insolvent if they occurred, and quota share reinsurance agreements that essentially function as excess of loss treaties. At this juncture, the Risk-Limiting Working Group is preparing a detailed list of the agreements at issue so that interested parties can assist in determining whether accounting or other guidance already exists that would address the issues raised by regulators. Such existing guidance may include SSAP No. 62R, Property and Casualty Reinsurance, Statement of Financial Accounting Standards No. 113, American Academy of Actuaries guidance created in 2007 and the audit guidelines of large accounting firms that evaluate risk transfer elements in reinsurance contracts. It will then be determined whether additional guidance is needed.

4. Corporate Governance/Solvency Initiatives

a. Corporate Governance Annual Disclosure Model Act and Model Regulation

In several states, beginning in 2016, insurers will have to start complying with the requirements of the Corporate Governance Annual Disclosure Model Act and Model Regulation (the “Corporate Governance Models”), as adopted by the NAIC in 2014. The Corporate Governance Models impose a new reporting requirement on insurers and insurance groups but do not impose any new substantive corporate governance requirements. As of February 2016, five states (California, Indiana, Iowa, Louisiana and Vermont) had adopted a version of the Corporate Governance Models. The first corporate governance annual disclosure is due in these states on June 1, 2016. The Corporate Governance Models contemplate that an insurer that is a member of an insurance group should submit the report to its lead state. However, as adopted by the states, the law applies to all insurers domiciled in the state, regardless of whether or not the lead state for the applicable insurance group has also adopted the Corporate Governance Models. As a result, some insurers may elect to prepare the report on an individual entity level to facilitate filing with a domiciliary (non-lead) state that has adopted the Corporate Governance Models. Alternatively, if an insurance group prefers to prepare the report at the ultimate controlling parent or intermediate holding company level, the group may want to confirm with its lead state what role the lead state anticipates playing in connection with coordinating the review of the report, notwithstanding the fact that the lead state has not yet adopted the Corporate Governance Models.

b. Capital Adequacy

i. RBC for P&C Insurers’ Investment Affiliates

The NAIC’s Capital Adequacy (E) Task Force (the “CA Task Force”) has been re-examining RBC charges related to P&C insurers’ investments through their affiliates. On September 30, 2015, the Property and Casualty Risk-Based Capital (E) Working Group (the “PC RBC Working Group”) resubmitted a proposal to the CA Task Force (originally submitted in 2014) that would simplify RBC charges for a P&C insurer’s ownership of investment affiliates so that the RBC charge would be a fixed factor multiplied by the carrying value of common stock, preferred stock and bonds.

The calculation proposed by the PC RBC Working Group is currently applied to health insurers, which must set an RBC charge for an investment in an affiliate equal to 30% of the book/adjusted carrying value of the common and preferred stock of the investment affiliate. In contrast, RBC charges in the P&C context are currently based on a “look through” approach under which an RBC charge for ownership of an investment affiliate is based upon the RBC of the underlying assets of the investment affiliate, prorated to account for the extent of the insurer’s ownership of such assets. Accordingly, an insurer’s assets held by an investment affiliate are treated in the same fashion as if the assets were held by the insurer directly.

On November 19, 2015, the PC RBC Working Group agreed to defer further action on the issue until it is further examined by the Investment Risk-Based Capital (E) Working Group.

ii. RBC Initiatives Related to XXX/AXXX Reinsurance Framework

Implementation of the Framework and AG 48 (discussed in detail in Section IV.B.2 above) requires certain RBC and capital adequacy-related changes. In late 2015, the NAIC adopted three Framework-related proposals drafted by the Life Risk-Based Capital (E) Working Group (the “Life RBC Working Group”).

The first proposal relates to the RBC “cushion” required under the Framework (the “RBC Shortfall Cushion”) for an insurer ceding risks subject to Regulation XXX/AXXX reserving when the assuming reinsurer does not file an RBC report using the RBC formula and instructions. The proposal adjusts Authorized Control Level RBC dollar for dollar by the amount of any shortfall in an insurer’s Primary Securities under AG 48.
The second proposal relates to the effect on a cedent’s RBC when, as required under AG 48, a cedent’s opinion actuary issues a qualified actuarial opinion because the cedent has entered into a reserve financing transaction that does not adhere to the Framework. Under the current RBC formula, such a qualified actuarial opinion would result in a C-3 (interest rate risk) charge to the cedent’s RBC, which would impact all lines of business of the cedent, rather than only business covered by AG 48. The proposal adopted by the NAIC eliminates the RBC C-3 charge if the qualified actuarial opinion was issued solely due to directions in AG 48. Instead, failure to meet the requirements of AG 48 would be reflected elsewhere in the RBC Shortfall Cushion and would affect only the lines of business covered by AG 48.

The third proposal adds a new consolidated schedule to the RBC Blank showing calculation of the RBC shortfalls for all captives with an adjustment to total adjusted capital and no offset for surplus.

iii. Operational Risk
The CA Task Force’s Operational Risk (E) Subgroup continues work on adding an “operational risk” component to RBC formulas for health, life and P&C insurers. Operational risk has been defined as “the risk of financial loss resulting from operational events, such as the inadequacy or failure of internal systems, personnel, procedures or controls, as well as external events. Operational risk includes legal risk but excludes reputational risk and risk arising from strategic decisions.” Operational risk is currently addressed through other NAIC-led initiatives, such as the requirement that insurers conduct an Own Risk and Solvency Assessment (“ORSA”) and prepare ORSA summary reports and enhanced corporate governance disclosures, which require analysis of risks that include underwriting, credit, market, liquidity, as well as operational risk. An operational risk charge would account for operational risks other than those that are already reflected in existing RBC risk categories.

Throughout 2015, the Operational Risk (E) Subgroup has been preparing a list of “event types” that could fall within the category “operational risk” and examining ORSA summary reports filed by insurers in order to identify the types of operational risks reported by insurers. In March 2015, the Life RBC Working Group began working on a proposal for establishing an operational risk component to RBC and is also considering the effect of “growth risk” on RBC (i.e., risk of negative consequences caused by excessive premium increases). On June 30, 2015, the CA Task Force adopted specific operational risk factors for informational purposes only, to be used for year-end 2015 reporting purposes.

5. Unclaimed Property
   a. State Adoption of the National Conference of Insurance Legislators Model Unclaimed Life Insurance Benefits Act
As of January 2016, 19 states had enacted legislation based on the National Conference of Insurance Legislators (“NCOIL”) Model Unclaimed Life Insurance Benefits Act (the “NCOIL Model”) to require insurers to perform searches of the Social Security Administration’s Death Master File (the “DMF”) in order to become aware of potentially deceased insureds, annuitants and owners of polices, annuities or retained asset accounts. The applicable states are Alabama, Arkansas, Georgia, Idaho, Indiana, Iowa, Kentucky, Maryland, Mississippi, Montana, Nevada, New Mexico, New York, North Carolina, North Dakota, Rhode Island, Tennessee, Utah and Vermont.

Nine of the states (Idaho, Iowa, Maryland, Montana, Nevada, New York, North Dakota, Rhode Island and Vermont) enacted laws that apply retroactively (i.e., to existing life insurance policies); six of the states (Alabama, Arkansas, Georgia, Indiana, Kentucky and Mississippi) enacted laws that apply prospectively (i.e., to life insurance policies issued after the effective date of the laws); and four of the states (New Mexico, North Carolina, Tennessee and Utah) enacted laws that apply asymmetrically. “Asymmetric” application refers to laws providing that insurers that did not use the DMF prior to a specified date (usually the law’s effective date) need only perform comparisons of the DMF with respect to insureds, annuitants and owners of policies, annuities or accounts issued on or after the specified date; for all other insurers, the law would apply retroactively to policies, annuities and accounts that had been issued before the specified date.

b. NAIC Development of Unclaimed Life Insurance and Annuities Model Act
The NAIC is in the process of developing a new NAIC model law to address the issue of unclaimed life insurance proceeds. This process was initiated almost two years ago when the Life Insurance and Annuities (A) Committee (the “(A) Committee”) was charged with studying the unclaimed life insurance benefits matter. The (A) Committee appointed the Unclaimed Life Insurance Benefits (A) Working Group, chaired by Tennessee. That working group first met in March 2014. In March 2015, after analyzing the matter for a year, the working group submitted a request to develop a new NAIC model law to address the issue. Upon approval of such request in the Spring of 2015, the working group appointed a drafting subgroup, chaired by California, to prepare the new model. Following an almost nine-month process of comparing the provisions of two possible approaches (i.e., the NCOIL Model and the “Lead States” Model Act), on November 16, 2015, the drafting subgroup released a new Model Unclaimed Life Insurance and Annuities Act (the “NAIC Draft Model”) for public comment.

As of February 2016, the drafting subgroup is in the process of discussing comments received on the NAIC Draft Model and is revising the NAIC Draft Model accordingly. Certain key provisions of the NAIC Draft Model, such as exemptions from the definition of “policy,” the frequency of required DMF searches and the specific fuzzy matching criteria, remain subject to further discussion. The current draft of the NAIC Draft Model also does not take a definitive position with respect to the prospective or retroactive application of the law, a key area of concern for many in the life insurance industry. Instead, the NAIC Draft Model presents states with three options related to the applicability of the law: prospective application, retroactive application or asymmetric conduct application. As a nod to the constitutional law issues presented in litigation related to states adopting the NCOIL Model on a retroactive basis, the NAIC Draft Model includes a drafting note that instructs each state to “select which option is appropriate for it given a number of issues that have
arisen in some states particularly related to retroactive application," and advises each state to "conduct its own legal analysis of its laws, including case law, to determine which option is appropriate for it to include."

Nearly half of the states have adopted a version of the NCOIL Model (see Section IV.B.5.a above), and it is expected that additional states will adopt the NCOIL Model before any state is in a position to adopt the NAIC model on this issue (assuming that the NAIC Draft Model is adopted by the NAIC at some point this year). As a result, it is likely that the NAIC's development of a model law will have a limited opportunity to impact the enactment of legislation addressing this issue of great importance to the life insurance industry.

c. Lost Policy Locator Tools

In a move to assist consumers who are potential beneficiaries, a growing number of states have implemented “lost policy finder” services which permit potential beneficiaries to provide data through a website that is used to poll all insurers writing insurance in such state for any matching policy information. Published advice on searching for lost life insurance has also become available on the websites of numerous state insurance regulators and insurance trade groups. The (A) Committee is exploring the feasibility of the NAIC developing a life insurance policy locator service. NAIC staff has been investigating technology requirements and potential security risks related to developing such a tool. The (A) Committee requested that NAIC staff survey NAIC members to determine state interest in the NAIC developing such a tool.

d. Settlements and Litigation Dealing With Unclaimed Life Insurance Matters

In 2015, four additional life insurance companies or affiliated groups entered into multi-state insurance regulatory settlements with insurance regulators. The same companies also entered into multi-state settlements with unclaimed property agencies and auditors. This brings the total publicly announced multi-state settlements to 20 insurance regulatory and 25 unclaimed property agency settlements, with two insurer groups having been determined to be in compliance (and therefore, no insurance regulatory settlements were entered into). In addition to the multi-state settlements, some states are individually pursuing similar investigations of life and annuity insurers.

Turning to litigation, the Supreme Court of Appeals of West Virginia issued its ruling in West Virginia ex rel. Perdue v. Nationwide Life Ins. Co., 777 S.E.2d 11 (2015). The Court held that West Virginia law required life insurers to take steps to search for evidence of deceased insureds that are consistent with “standards of commercial reasonableness.” The Court based this holding on its conclusion that the obligation to pay death benefits for a life insurance policy is triggered by the insured’s death, rather than by the insurer’s receipt of due proof of death or the insured’s attainment of the limiting age. The Supreme Court of Appeals also found that West Virginia law did not require a particular method for determining if insureds are deceased, such as searching the Social Security Administration’s Death Master File (“DMF”). The Court’s ruling reversed the decision below, in which the trial court had held that a life insurer did not have an obligation to search the DMF to determine whether an insured is deceased and to escheat unclaimed policy proceeds upon the insured’s death.

In Finley v. Transamerica Life Ins. Co., 2015 WL 3919598 (N.D. Cal. Jun. 25, 2015), a federal district court dismissed a complaint brought by a pro se litigant against an insurer, claiming that the insurer had an obligation to check the DMF and alert the beneficiary that the policy benefits were due. The Court held that “the plain import” of contractual “due proof of death” requirement is that the insurer only has an obligation to pay benefits after the claimant satisfies that condition. The Court further held that the insurer had no obligation to search the DMF and that “[a] finding that [the insurer] was obligated to ‘solicit or gather information’ of [the insured’s] death would thus be ‘contrary to the terms of the policy.’”

Several cases have examined the extent to which regulators may compel life insurers to produce in-force policy records for a comparison against the DMF. In United Ins. Co. of. Am. v. Boron, No 13-CH-20383 (Ill. Cir. Ct. Jul. 29, 2014), the Illinois Department of Insurance had directed certain insurers to produce extensive policy-level data during the course of a multi-state market conduct examination. The Department stated that it anticipated some or all of that data would be compared against the DMF as part of the examination. The insurers objected and filed suit. Denying in part a motion to dismiss the action, the Court found that while the Department had the statutory authority to obtain “all books, records, [and] documents” of an insurer, the Department may do so only for the purpose of “ascertaining the non-financial business practices” of the insurer. The parties later reached a settlement and in December 2015, the action was dismissed.

In Yee v. American Nat’l Ins. Co. (ANICO), 235 Cal. App. 4th 453 (Cal. App. 3d Dist. 2015), the California Court of Appeals reversed a lower court’s injunction against ANICO, holding that the trial court could not resolve without a trial the question of whether the California Controller has the statutory authority to compel production of a life insurer’s in-force file. The case is progressing towards trial.

Finally, in Thrivent Financial for Lutherans v. Yee, No. CGC-13-535156 (Cal. Super. Ct. Sept. 2, 2014), a San Francisco trial court denied the California Controller’s motion for a preliminary injunction to compel the insurer to produce in-force policy records for a DMF search, finding that the Controller had failed to prove the information was “reasonably relevant” to a failure to report property subject to escheat under California law and so a preliminary injunction was not warranted.

6. Health Insurance Regulation – Consumer Operated and Oriented Plans

Consumer operated and oriented plans (“Co-Ops”) are non-profit, member-run health insurance companies that were established under the ACA. Co-Ops were eligible for low-interest federal loans to assist with start-up activities and state reserve requirements. In fact, failed Co-Ops received at least US$1.17 billion in federal loans. The Centers for Medicare & Medicaid Services (“CMS”) oversees the Co-Op program, but Co-Ops are required to obtain state insurance licenses and comply with state insurance laws. Co-Ops were touted as a means of increasing competition in the health insurance marketplace by providing a low-cost alternative to individual and small group plans offered by traditional for-profit insurance companies. Co-Ops began providing coverage on January 1, 2014. More than half of...
the 23 approved Co-Ops have failed, leaving questions regarding the continued viability of the program, as well as the potential implications for larger health insurers.

A separate (but related) provision of the ACA established the risk corridors program, which was intended to protect insurers from extreme gains and losses during the initial years that major substantive changes were implemented under the ACA. Under the risk corridors program, qualified health plans with lower-than-expected claims are required to make payments to CMS, while plans with higher-than-expected claims receive payments from CMS. For the 2014 program year, insurers paid US$362 million into the risk corridors program but requested US$2.87 billion in payments to cover losses. As a result, on October 1, 2015, CMS announced that it would only be able to reimburse 12.6% of the payment requests under the risk corridors program. This event has adversely affected many Co-Ops, which arguably had wagered that the risk corridors program would offer protection against extreme losses in the event that low premium levels did not cover all outlays and necessary reserves.

The failure of a majority of Co-Ops may indicate that the program is founded on unsound financial principles. The financial viability of the remaining Co-Ops is yet to be determined. Certainly, financially sound insurers have been and may continue to be impacted by the transition of members of failed Co-Ops to other health care coverage. Notwithstanding these initial difficulties, federal and state supporters of the program argue that Co-Ops have benefited consumers by expanding consumer choice and potentially driving down prices. As a result, in 2016, the industry could also be impacted by new federal and state rules that would prop up this otherwise failing program.


The NAIC’s former Private Equity Issues (E) Working Group, which was formed to develop best practice recommendations relating to acquisitions of control of insurance or reinsurance companies by private equity and hedge funds, drafted new narrative guidance for state insurance examiners to consider in reviewing Form A applications for an acquisition of an insurer by a private equity firm. Such guidance, as adopted by the NAIC in 2015, will apply to an acquisition of an insurer by any acquiring party (not just private equity firms) and is included in the 2015 Annual/2016 Quarterly edition of the NAIC’s Financial Analysis Handbook.

In addition to the statutory standards that apply to any Form A review, the new guidance includes a suggestion that examiners consider the risks (in particular, credit, market and liquidity risks) that the acquiring entity and the entire group of insurance and non-insurance affiliates under its control may pose to the target domestic insurer. To this end, the guidance allows the examiner to request detailed information regarding investments, including investments in limited liability companies, equity and other fund holdings and other invested assets and, if necessary, to engage an investment specialist and actuary to analyze the investment strategy and the proposed transaction. Further, the guidance includes a recommendation that the Form A review should consider the reasonableness of equity firm fees and other fee structures, if any, to be charged to the insurance company. The guidance also includes a suggestion that examiners review proposed transactions with parties that do not fall within the strict definition of affiliates, but nonetheless seem to be engaging in a manner similar to affiliates, for purposes of reviewing whether charges to the insurer are excessive and ensuring that the entirety of activities within the insurer’s holding company system are properly disclosed.

The guidance also includes a number of conditions that regulators may consider imposing in connection with approving a proposed transaction. The suggested stipulations include, but are not limited to, requiring:

- RBC to be maintained at a certain level above company action level;
- quarterly RBC reports rather than annual RBC reports;
- prior approval of the domestic insurer’s payment of any ordinary or extraordinary dividends or other distributions;
- a capital maintenance agreement or prefunded trust account;
- material changes in the domestic insurer’s plan of operation (including revised projections) to be filed with the regulator; and
- review of all affiliated agreements and affiliated investments, regardless of statutory materiality thresholds that would otherwise apply.

As a matter of practice, several regulators were already implementing some variation of certain of these measures before the new guidance was adopted. In 2014, New York also promulgated regulations that expressly authorize the NYDFS to take similar actions in connection with reviewing a Form A. However, the documentation of these measures in the NAIC’s Financial Analysis Handbook will likely result in increased use of these measures in connection with insurance company mergers and acquisitions, whether or not the acquiring party is in private equity.

8. Sharing Economy Issues

a. Ridesharing

The Sharing Economy (C) Working Group’s white paper, “Transportation Network Company Insurance Principles for Legislators and Regulators” was adopted by both the Property and Casualty Insurance (C) Committee and Executive Committee/Plenary at the Spring 2015 National Meeting in March 2015. Just a few days prior, a group of interested parties, including transportation network companies (“TNCs”), personal auto insurers and industry trade groups, announced their agreement on a model bill to establish insurance requirements for TNCs. The model bill requires either a TNC or TNC driver to maintain primary insurance for all three phases of ridesharing activity, including (albeit at lower coverage amounts) the period during which a TNC driver has logged into the application but has not yet accepted a ride request. All mandatory coverages, such as uninsured/underinsured motorists and personal injury protection, are required to be included. The bill also clarifies the right of personal auto insurers to exclude coverage for TNC-related driving and mandates cooperation among insurers in the event of a
claim. Although the Sharing Economy (C) Working Group declined to postpone adoption of the white paper, a drafting note was added to mention the compromise model bill.

States and municipalities continue to enact legislation regarding TNCs, and insurers continue to develop products for TNC drivers to close potential gaps in coverage created by the drivers’ involvement in TNC activities.

b. Homesharing
Although the Sharing Economy (C) Working Group continues to study insurance issues relating to home sharing, it has yet to take any specific action or make any specific recommendations.

9. NAIC Activity Relating to International Insurance Activities – NAIC to Develop Group Capital Standard

As an additional group supervision tool for U.S. regulators, and at the recommendation of the International Insurance Relations (G) Committee (the “(G) Committee”), the NAIC adopted a charge for the (E) Committee to develop an NAIC group capital calculation using an RBC aggregation methodology.

The specific charge, as adopted, is for the (E) Committee to “(c)onstruct a U.S. group capital calculation using an RBC aggregation methodology; liaise as necessary with the ComFrame Development and Analysis (G) Working Group on international capital developments and consider group capital developments by the Federal Reserve Board, both of which may help inform the construction of a U.S. group capital calculation.”

In developing the recommendation, the ComFrame Development and Analysis (G) Working Group considered the following three methodologies for the proposed group capital calculation: (1) an RBC aggregation approach, (2) a Statutory Accounting Principles (SAP) consolidated approach, and (3) a Generally Accepted Accounting Principles (GAAP) consolidated approach.

The (G) Committee has noted several challenges and key decisions that will need to be addressed by the (E) Committee, including: (a) the scope of entities to be included within the group capital calculation; (b) how to aggregate legal entity capital requirements from other jurisdictions and those legal entities not subject to existing capital requirements; (c) whether the group capital calculation should be based on a conservative RBC-style “gone concern” or a less conservative “going concern” view of financial strength; (d) whether and to what extent a holding company’s senior debt will be counted toward available group capital; (e) how to avoid double counting when aggregating available capital for each legal entity; and (f) how stress testing could be used in connection with the group capital calculation.

The (G) Committee expects to use the NAIC’s work in developing the group capital calculation standard to inform discussions on related issues with the Federal Reserve Board and the International Association of Insurance Supervisors.

10. Life Insurance and Annuities
a. Contingent Deferred Annuities

The NAIC has adopted a guidance document entitled, “Guidance for the Financial Solvency and Market Conduct Regulation of Insurers That Offer Contingent Deferred Annuities,” which is intended to serve as a reference for states determining how to apply their existing annuity laws and regulations to contingent deferred annuities (“CDAs”) and whether to modify their annuity laws to clarify their applicability to CDAs.

CDAs are defined as “an annuity contract that establishes a life insurer’s obligation to make periodic payments for the annuitant’s lifetime at the time designated investments, which are not owned or held by the insurer, are depleted to a contractually defined amount due to contractually permitted withdrawals, market performance, fees and/or other charges.” Thus, CDAs protect against both investment risk and longevity risk and are akin to adding a living benefit to an investment account. For example, where a CDA is attached to a mutual fund held in an individual or employer-sponsored retirement account, the CDA issuer can contractually limit the CDAs attachment to certain allowable mutual funds, but the CDA issuer has no control over the assets that make up those mutual funds because the underlying account is not held or managed by the insurer but is instead held by a related or unrelated third party.

The guidance document summarizes regulatory guidance recently developed by several NAIC committees, working groups and task forces. The guidance document makes certain observations and recommendations regarding the financial and non-financial regulation of CDAs. While the Contingent Deferred Annuity (A) Working Group (the “CDA Working Group”) charged with drafting the guidance document made no recommendations as to whether nonforfeiture benefits should be required for CDAs, the guidance document mandates that a minimum cancellation benefit should be included in every CDA contract filed after the date the guidance document was adopted.

With respect to the financial regulation of CDAs, the guidance document identifies certain categories of risks that are unique to CDAs. The (E) Committee is currently developing a checklist for state regulators to use in reviewing the risk management program of insurers offering CDAs. With respect to reserve requirements applicable to CDAs, the Life Actuarial (A) Task Force found that CDAs are similar enough to variable annuities with guaranteed lifetime withdrawal benefits to apply the same reserving requirements (i.e., AG 43) to both types of products. Similarly, the preliminary conclusion of the Life Risk-Based Capital (E) Working Group is that CDA capital requirements should be determined using C3P2 (with the potential for CDA-specific changes thereto in the future, but no changes proposed at this time).

With respect to the non-financial regulation of CDAs, the guidance document summarizes the conclusions of various NAIC groups regarding the applicability of several NAIC model laws and regulations to CDAs. Those conclusions appear to be guided by the general observations that (i) CDAs do not fit neatly into the category of fixed or variable annuities and should be treated as a third category of annuities, and (ii) most insurers historically have
registered CDAs with the U.S. Securities and Exchange Commission (the “SEC”), and therefore CDAs often are subject to federal laws and regulations governing disclosure, suitability and fiduciary duties in sales practices. As a result of these findings, several NAIC model laws and regulations that include exceptions for SEC-registered products have been amended to clarify whether CDAs are included in such exceptions, but the general rule appears to be that if CDAs are SEC-registered products, conflicting or duplicative state insurance laws and regulations are preempted by applicable federal regulation.

The guidance document also mandates that, in the event that a CDA is cancelled for reasons beyond the control of the insured, one (or in some cases, two) of three industry-developed cancellation benefits must be made available to the insured. The three types of cancellation benefits are: (A) a replacement annuity that replicates the CDA benefit accrued at the time of cancellation; (B) a lump sum payment in an amount equal to the present value of the guaranteed withdrawal amount minus the CDA account value and present value of future fees at the time the CDA was cancelled; and (C) the return of a portion of the fees incurred by the insured. The guidance document includes recognition of the fact that the appropriate cancellation benefit will depend on a number of factors related to product design and other circumstances related to the cancellation of the CDA. The guidance document also includes a recommendation that regulators allow insurers flexibility to design a cancellation benefit that best fits their products. Finally, the guidance document requires the CDA contract to include additional disclosure regarding cancellation of CDAs and the availability of cancellation benefits.

b. Variable Annuity Financial Statement Disclosures

i. Valuation of Contractually Guaranteed Obligations in Annuities

On November 19, 2015, the VAIWG submitted a Blanks proposal to add a new note to financial statements (to be effective December 2016) that would increase disclosure concerning valuations of contractually guaranteed obligations in annuity contracts. Such additional disclosure is meant to “[provide] stakeholders (e.g., regulators, consumers, and investors) with more transparency and additional insights into how the contractual obligations could change over time as well as the insurance company’s ability to manage those obligations.” The proposed note to financial statements would require insurers to fully disclose the following: “All key risk driver assumptions (e.g., interest rates, lapse rates, volatility assumptions and benefit utilization) and the impact of ‘shocks’ to the key risk driver assumptions (e.g., benefit utilization becomes more efficient, interest rates drop by 1%, etc.).”

On February 12, 2016, the VAIWG voted to form a drafting group to prepare the new note. However, interested parties continue to express their concerns with the initiative, noting that sensitivity results are not appropriate for public disclosure and contain proprietary, confidential trade secret information. Interested parties also asserted that hypothetical sensitivity tests are not appropriate for inclusion in an annual financial statement, which should only be providing a snapshot of factual information at a specific point in time in a format that allows for comparisons between companies. There are also concerns that publicly displaying the results of “what if” scenarios could cause confusion about what value should be used to assess current financial condition and comparisons between insurers could be inappropriate to the extent the sensitivity tests are based on different assumptions or different product risk characteristics.

ii. Income Benefit Paid Disclosure

In its Blanks proposal noted in Section IV.B.10.b.i above, the VAIWG also recommends development of a new exhibit for variable and fixed annuities that discloses the annual income benefit paid if all policyholders elected benefits on (A) the valuation date, (B) the valuation date plus five years, (C) the valuation date plus 10 years, and (D) the valuation date plus 15 years.

c. Factored Structured Settlement Annuities

In late 2015, the Executive (EX) Committee approved the request of the Receivership and Insolvency (E) Task Force (“RITF”) to develop an amendment to the NAIC Life and Health Insurance Guaranty Association Model Act to clarify that guaranty association coverage does not apply to factored structured settlement annuity benefits. The proposed amendment is the culmination of the RITF’s recent investigation into the existing and proposed treatment of factored structured settlement annuity benefits under state insurance guaranty fund laws, as informed by interested parties representing industry, trade groups and consumers. The NAIC does not currently intend to open the model law for further revisions beyond this specific topic.

d. Life Insurance Policy Illustrations

In June 2015, the NAIC adopted Actuarial Guideline XLIX (“AG 49”) governing illustrations for indexed universal life (“IUL”) insurance policies. The main goal of AG 49 is to create a uniform methodology for determining the annual rate of index-based interest used to calculate policy values included within IUL illustrations and thus to create a more realistic view of how a product may perform. A new methodology, effective September 1, 2015, will require calculation of a benchmarked index account (“BIA”), which is determined in part by identifying an average annual rate through the use of several 25-year rolling averages (i.e., look-back periods).

Additionally, effective March 1, 2016, AG 49 will limit certain interest rate differentials that can be shown in an IUL illustration. For example, there must be a difference of 100 basis points or less between interest rate credited to loaned amounts versus the loan rate charged to the balance (i.e., loan leverage). Effective March 1, 2016, certain additional disclosures must be included in IUL illustrations so that they provide better explanations to consumers regarding how IUL insurance policies may perform.

C. INTERNATIONAL (NON-U.S.) INSURANCE ISSUES

1. Solvency II Equivalence Update

a. Introduction

After more than a decade in the making, a number of delays in implementation and much negotiation, Solvency II, the new solvency and supervisory regime for (re)insurers operating in the EU, was finally implemented on January 1, 2016. Solvency II also has implications for those insurance groups headquartered outside the European Union (”EU” or “the EU”).
Economic Area (“EEA”) (i.e., “third countries”) which have operations in the EEA, and EEA groups that have third-country subsidiaries. Equivalence under Solvency II relates to three separate areas to determine whether (i) the solvency regime with respect to reinsurance activities; (ii) the supervisory regime; and (iii) the prudential regime of firms in a third country are equivalent to the rules under Solvency II.

b. Equivalence Update

Over the course of 2015, the position regarding equivalence has become clearer, at least for those countries that had originally sought an equivalence determination (i.e., Switzerland, Bermuda and Japan) and for a number of those countries that had expressed an interest in being part of a transitional regime.

i. The United States, Switzerland, Australia, Bermuda, Brazil, Canada and Mexico

In June 2015, the European Commission adopted its first third country equivalence decisions under Solvency II, which concerned the United States, Switzerland, Australia, Bermuda, Brazil, Canada and Mexico. Switzerland received a determination of “full” equivalence (i.e., equivalence for an unlimited period) with respect to the three areas of the Solvency II equivalence regime: (A) group solvency; (B) group supervision; and (C) reinsurance. Other than in respect of Switzerland, the European Commission’s June 2015 decisions all relate to provisional equivalence in respect of group solvency.

Group solvency applies to EEA groups with third-country subsidiaries. In short, if a determination of equivalence is made in respect of group solvency, EEA groups will be allowed to apply the local calculation of capital requirements in respect of their third-country subsidiaries, instead of applying a Solvency II calculation. As stated above, these countries were deemed provisionally equivalent in respect of group solvency. Provisional equivalence is granted where a third country may not meet all the conditions for full equivalence, but is likely to adopt a fully equivalent solvency regime in the foreseeable future.

ii. Bermuda and Japan

In its more recent announcements, on November 26, 2015, the European Commission adopted decisions on the equivalence of the solvency regimes in Bermuda and Japan. Bermuda has now achieved a determination of full equivalence. This new decision for Bermuda replaces the previous decision made by the European Commission in June last year, in which Bermuda was granted only provisional equivalence for group solvency. The June decision was made on the basis of advice issued to the Commission by the European Insurance and Occupational Pension Authority (“EIOPA,” an independent advisory body to the European Parliament, the Council of the European Union and the European Commission). Following Bermuda’s adoption of new insurance legislation in July 2015, EIOPA updated its advice and the Commission determined that the solvency regime in Bermuda for (re)insurers and groups meets the criteria for full equivalence, with the exception of captives and special purpose insurers, which are subject to a different regulatory regime.

Japan, which was noticeably absent from the Commission’s first wave of decisions, has been granted provisional equivalence for group solvency and temporary equivalence in relation to reinsurance.

A determination of temporary equivalence is valid for five years and will end on December 31, 2020. At that point, the Commission can undertake assessments of the development in the third country’s regime, which would give rise to either a determination of full equivalence or non-renewal of temporary equivalence. Temporary equivalence may be extended by up to one year where necessary to allow EIOPA and the Commission to assess how the regime has evolved over the period.

A determination of provisional equivalence, on the other hand, is valid for 10 years, at the end of which period, the Commission has the option to: grant full equivalence; not renew the determination; or, as distinct from the position with temporary equivalence, renew its determination of provisional equivalence.

Although Japan had originally sought full equivalence for reinsurance only, it has been granted equivalence for a limited duration for both reinsurance and group solvency. The Commission has the ability to make an equivalence determination in relation to group solvency without a country expressly seeking it.

iii. Effect of Equivalence for Bermuda and Japan

The decisions regarding Bermuda and Japan provide long-awaited certainty in the treatment of reinsurance contracts between reinsurers in these countries and EEA cedents.

A reinsurance equivalence decision means that EEA Member States cannot give less credit for third country reinsurance than for equivalent reinsurance with an EEA reinsurer. In addition, Member States cannot require the pledging of assets to cover unearned premiums and outstanding claims provisions in relation to such reinsurance contracts, nor can they require the localization of assets representing reinsurance recoverables within the EEA.

If a third country is deemed not to be equivalent, reinsurers in that third country could be required to post collateral with respect to the risks they are reinsuring in the EEA, placing them at a competitive disadvantage to EEA reinsurers. Unrated reinsurers in non-equivalent jurisdictions are at a particular disadvantage as, under the standard formula, EEA cedents are required to apply higher capital charges for counterparty default risk for unrated reinsurers in non-equivalent jurisdictions compared with the charges applied to unrated reinsurers in equivalent jurisdictions.

The equivalence decisions regarding Bermuda and Japan are subject to review and ratification by the European Parliament and Council, for which the time limit is three months, with a potential extension period of a further three months. Once the decisions enter into force, they shall apply from January 1, 2016.

With respect to the United States, the European Commission and the U.S. Department of Treasury met on February 3, 2016 to discuss, among other matters, the launch of the negotiation process for a covered agreement on insurance matters. As addressed in Section IV.A.2.a above, the expectation is that the United States will eventually be granted temporary equivalence for reinsurance.
iv. Group Supervision and the PRA’s Expectations

Other than Switzerland and Bermuda, which have been granted full equivalence for all three areas of Solvency II, no other decisions for equivalence with respect to group supervision have yet been made. In the absence of a determination of equivalent group supervision, EEA Member States can apply the relevant Solvency II requirements to the worldwide group as if it were based in the EEA, or they can apply “other methods” to ensure appropriate supervision of the group. The only specific example of “other methods” given in the Solvency II Directive is the establishment of an insurance holding company in the EEA.

A key remaining issue is how group supervision will apply to UK insurance subsidiaries in groups headquartered in non-equivalent third countries, notably the United States. The PRA has been coordinating with the UK insurance subsidiaries of those groups with a view to agreeing appropriate “other methods” to be adopted to avoid implementation of group supervision at the level of the third-country parent. In the absence of such agreement and given that the PRA does not have jurisdiction over the wider non-EEA group, the PRA could instead seek to increase the capital requirements for those UK insurers that do not agree appropriate waivers with the PRA.

2. UK Implementation of Solvency II Remuneration Requirements


a. Overview of Requirements

Solvency II's remuneration requirements pertain to the governance structure and risk management of (re)insurance businesses. These include requirements for the establishment and maintenance of remuneration policies and procedures to avoid conflicts of interest and promote sound and effective risk management, so as not to encourage excessive risk-taking.

In short, Article 275 of the delegated regulation can be broken down into two limbs: (i) Article 275(1), which sets out overarching governance requirements; and (ii) Article 275(2), which requires specific arrangements that take into account the tasks and performance of: (A) the (re)insurer’s administrative, management or supervisory body; and (B) persons who effectively run the firm or have other key functions and other categories of staff whose professional activities have a material impact on the firm’s risk profile (“material risk takers”).

i. Article 275(1) – Overarching Governance Requirements

The overarching governance requirements of Article 275(1) of the delegated regulation are as follows:

- A (re)insurance firm’s remuneration policy and practices must: (A) be in line with its business and risk management strategy and the long-term interests and performance of the undertaking as a whole; and (B) incorporate measures aimed at avoiding conflicts of interest.
- The remuneration policy must apply to the firm’s whole employee base and contain specific arrangements relating to material risk takers. Material risk takers would likely include members of the executive board, senior sales executives, heads of support and control functions (such as risk management, legal, compliance, actuarial and internal audit) and other individuals within their control (each of whom the firm considers could potentially have a material impact on its risk profile).
- There should be clear, transparent and effective governance over the remuneration policy.
- An independent remuneration committee must be established, if appropriate taking into account the size and internal organization of the undertaking, in order to oversee the design of the remuneration policy and practices, their implementation and operation.
- The remuneration policy must be disclosed to each employee of the firm.

ii. Article 275(2) – Specific Requirements for Material Risk Takers

The specific requirements for material risk takers under Article 275(2) of the delegated regulation are as follows:

- The fixed and variable (e.g., bonus payments) components of remuneration should be balanced so that the fixed element represents a sufficiently high portion of the total remuneration.
- Performance-related variable remuneration should be based on a combination of individual performance (the assessment metrics for which should contain both financial and non-financial measures), business unit performance and overall performance of the firm or group to which the firm belongs.
- A substantial portion of the variable remuneration should be deferred for a minimum of three years. The deferral period should be appropriately aligned with the nature of the business, its risks and the activities of the relevant employees.
- The measurement of performance, as a basis for variable remuneration, must include a downwards adjustment or exposure to current and future risks, taking into account the firm’s risk profile and the cost of capital.
- Termination payments must be related to performance achieved over the whole period of activity and must not reward failure.
- Material risk takers must not use any personal hedging strategies or remuneration and liability-related insurance which would undermine the risk alignment effects embedded in their remuneration arrangement.
The variable remuneration of employees engaged in control functions (i.e., risk, compliance, internal audit and actuarial) must be independent from the performance of the operational units and areas that are submitted to their control.

b. UK Regulatory Guidance

Neither the PRA or the Financial Conduct Authority (the “FCA,” together with the PRA, the “UK Regulators”) has to date issued detailed guidance on the Article 275 requirements. However, the PRA, in 2015, conducted a comprehensive survey on remuneration practices in the insurance industry (which included questions on deferral and clawback) in the context of developing its supervisory framework for 2016, so it seems likely that the UK Regulators will ultimately issue guidance on how they will supervise compliance with Article 275 of the delegated regulation.

Possible areas for future regulatory guidance, particularly with respect to the remuneration of material risk takers, include the following:

- **Striking the Right Balance between Fixed and Variable Remuneration**
  Article 275 neither stipulates bonus caps for material risk takers nor indicates when the fixed element of a material risk taker’s remuneration would be considered a “sufficiently high” portion of the total remuneration.

- **Deferral of Variable Remuneration**
  Article 275 does not specify what would constitute deferral of a “substantial portion” of the material risk taker’s variable remuneration.

- **Clawback**
  Article 275 does not expressly require (re)insurance firms to adopt a clawback policy (“clawback” being a form of ex-post risk adjustment, whereby past awards of variable remuneration may be adjusted to reflect subsequent information about the underlying risks, including emerging evidence of poor risk management). However, arguably the central tenet of Article 275—namely, that firms should establish, implement and maintain a remuneration policy and practices that are consistent with and promote effective risk management—means a firm should at least consider adopting a clawback policy if to do so would allow that firm to manage the risks it faces more effectively.

### 3. Senior Insurance Managers Regime

On January 1, 2016, the initial tranche of rules for the new SIMR came into force with the remaining elements coming into force on March 7, 2016. The SIMR amends and replaces the PRA’s Approved Persons Regime and implements certain measures under Solvency II which relate to governance and the fitness and propriety of relevant individuals.

a. Scope of the SIMR

The new regime applies to (re)insurers and UK branches of third-country undertakings within the scope of Solvency II as well as to the Society of Lloyd’s and managing agents.

The aim of the SIMR is to ensure that senior individuals who are effectively running insurers, or who have responsibility for other key functions at those firms, behave with integrity, honesty and skill. These key individuals are responsible and accountable for the sound and prudent management of their firms. In order to achieve this, the SIMR covers:

- Senior insurance managers, who are subject to pre-approval by the PRA for a controlled function; and
- “key function holders,” who are senior persons effectively running an insurer or who have responsibility for key functions at the insurer, as defined by the insurer, and who will need to be assessed as fit and proper by the PRA.

Under the new regime, the list of individuals who are subject to regulatory pre-approval for a controlled function (now a Senior Insurance Management Function (“SIMF”)) has been narrowed to those who perform a critical role within an organization. It also identifies the individuals who will be held responsible for ensuring the ongoing safety and soundness of their firms. The list of SIMFs include: the Chief Executive Officer, Chairman, Chief Finance Officer, Chief Risk Officer, Head of Internal Audit, Chief Actuary, Chief Underwriting Officer, Group Entity Senior Insurance Manager and Third-Country Branch Manager. Of the above listed SIMFs, all firms must ensure they have, as a minimum, a Chief Executive Officer, Chief Finance Officer and Chairman; it is not mandatory for a firm to fill the other SIMFs.

Given the granular and role-specific focus of the PRA’s controlled functions, the FCA incorporated certain other controlled functions, which the PRA will not maintain, into the scope of its own approved persons regime, as FCA Significant Influence Functions and those individuals are therefore subject to the FCA’s pre-approval.

b. Allocation of Responsibilities

Firms will now have to allocate certain prescribed core responsibilities to one or more individuals who have been approved as an SIMF. Such core responsibilities include: (i) ensuring that the firm has complied with the obligation to satisfy itself that persons performing a key function are fit and proper; (ii) production and integrity of the firm’s financial information and regulatory reporting; and (iii) allocation and maintenance of the firm’s capital and liquidity.

This approach is designed to ensure that responsibility for certain significant activities relating to effective governance and the ongoing safety and soundness of a firm are allocated to a designated senior person.
c. Governance Map and Scope of Responsibilities

Under the new regime, firms are required to compile and maintain a “governance map” containing the names and positions of those who effectively run the firm as well as those with responsibility for a key function. This document is also intended to record the allocation of significant management responsibilities and reporting lines for each of these senior individuals within the firm and group. The governance map is a live document and must be updated at least quarterly and in the event of a significant change to: (i) the firm’s governance structure; (ii) the significant responsibilities allocated to a key function holder; or (iii) the reporting lines of a key function holder.

In addition to a governance map, firms will also have to keep and maintain up-to-date records of the scope of responsibilities each key function holder has under the new regime. Like the governance map, the scope of responsibilities record must be updated when changes are made. Each version of both the governance map and the scope of responsibilities record must be retained for a period of 10 years from the date on which it was superseded by a more up-to-date document and must be provided to the PRA on request.

d. Conduct Standards

The SIMR sets out new conduct standards in the PRA’s Handbook which replace the old standards under the Statements of Principle and Code of Practice for Approved Persons (“APER”). The new conduct standards must be complied with on an ongoing basis. The first three conduct standards apply to SIMFs, key function holders and any person performing a key function and are generic in nature, for example, the first conduct standard is to “act with integrity.” SIMFs and key function holders must also observe a further five conduct standards. These include: (i) taking reasonable steps to ensure that the business of the firm is controlled effectively; and (ii) disclosing appropriately any information of which the FCA or PRA would reasonably expect to have notice.

e. Fit and Proper Assessment

Firms are required to ensure that all persons who perform key functions are at all times fit and proper. This rule applies to SIMF holders and key function holders (as well as others who perform key functions, but are not responsible for them). However, the assessment of SIMF holders in relation to fitness and propriety is more stringent. For example, firms must obtain the consent of prospective SIMF holders to request a criminal records check and firms must obtain references for prospective SIMF holders from current and previous employers for the last five years. In contrast, key function holders and those individuals performing a key function will be assessed by their firms on an ongoing basis with respect to their fit and proper status. While SIMF holders will be PRA-approved persons, firms only need notify the PRA after they have assessed a key function holder as fit and proper. The PRA will assess the firm’s conclusion on an “ex-post basis,” or after the key function holder’s employment has commenced.

It should also be noted that, under the new regime, where a firm makes a request to another firm for a regulatory reference in respect of a potential SIMF holder, key function holder, non-executive director or a notified non-executive director (as defined below), then the firm subject to the request must, as soon as reasonably practicable, provide the reference and disclose all the information it believes to be relevant to the assessment of that individual to the requesting firm.

f. Non-Executive Directors

The SIMR extends to the following non-executive directors (“NED”): the Chairman, Senior Independent Director, and Chairs of the Risk Committee, Audit Committee and Remuneration Committee all of whom must be pre-approved by the PRA. The PRA recognizes that NEDs in the scope of the SIMR do not manage a firm’s business in the same way an executive SIMF holder does and therefore the responsibilities for which they are accountable are limited. The PRA has restricted the accountability of PRA-approved NEDs to those activities for which they are responsible. NEDs within the scope of the SIMR are expected to take on certain responsibilities, which are non-executive in nature and are either inherent to or derive from their Chair or Senior Independent Director roles.

Other NEDs, termed “notified non-executive directors,” or those not subject to PRA-approval, will still need to be assessed by the firm as being fit and proper and will be expected to observe certain of the conduct standards.

g. Next Steps

As a result of the feedback received from the most recent consultation paper on regulatory references, the PRA expects to publish a policy statement and final rules in this area in the summer of 2016.

4. Solvency II: Insurers Face Tough Environment for Investing in Securitizations Despite EU Reform Agenda

In the wake of the financial crisis EU regulators brought in sweeping reforms to the regulation of securitizations, targeted at institutional investors as well as issuers. But with the European securitization market having remained subdued, regulators are now looking for ways to revive investment in securitizations, recognizing their utility in generating liquidity in the financial system.

In September 2015, the European Commission published a proposal for a new Securitisation Regulation. The proposal aims to harmonize existing rules on disclosure, due diligence and risk retention across all financial services sectors, and introduces a framework for simple, transparent and standardized (“STS”) securitizations of homogeneous assets such as residential loans, commercial loans and auto loans, which will be eligible for more risk-sensitive prudential treatment.

With regards to insurers, Solvency II already provides that securitization investments meeting certain requirements (“Type 1”) receive preferential capital treatment as compared with securitizations that do not (“Type 2”). The requirements include that the instrument is rated BBB or higher and represents the most senior tranche. The Commission intends to bring the Solvency II requirements in line with the proposed STS regime.
The Commission has also published proposed amendments to the EU Capital Requirements Regulations for banks and investment firms, with the aim of making the capital charges applying to securitizations more risk-sensitive, including reducing the charges applied to STS securitizations. However, the Commission has not given a clear indication that it is looking to reduce the capital charges currently applying to securitizations under the Solvency II regime, which are considered prohibitively high by many in the industry, especially when compared to other asset categories such as corporate bonds. In the explanatory memorandum to the draft Securitisation Regulation, the Commission stated that it would look to amend the Solvency II legislation to allow for reduced charges in the case of non-senior tranches of securitization instruments (currently not eligible for Type 1 treatment) but did not indicate that it would be reviewing the capital charges more generally.

Moreover, as with other financial institutions, insurers are only permitted by Solvency II to invest in securitizations where the original lender, sponsor or originator retains a 5% material net economic interest (“risk retention”) in the manner prescribed. The rule covers all instruments issued after January 1, 2011 or issued before January 1, 2011 where new underlying exposures have been added or substituted after December 31, 2014. It therefore applies not only to prospective investments, but potentially to current holdings, and has meant that insurers have had to consider divesting their holdings in any non-compliant instruments. Under the Securitisation Regulation, a direct risk retention and reporting requirement will be imposed on original lenders, sponsors and originators in the EU. This is intended to make it easier for investors to know whether the securitization is compliant, but insurers will continue to face the possibility of serious capital sanctions for holding non-compliant investments.

The Securitisation Regulation is currently passing through the EU legislative process and a final version is likely to be agreed in the second half of 2016. While the insurance industry has welcomed the Commission’s intention to make investing in securitization more attractive and sustainable for institutional investors, the current proposals are unlikely to make a significant difference to insurers while capital charges remain set at the current levels.

5. Developments in the Lloyd’s Market
   a. Lloyd’s Solvency II Internal Model Receives Approval

The Society of Lloyd’s is among the 19 firms which have had their Solvency II internal models approved by the PRA, following an announcement on December 5, 2015. This means that Lloyd’s will be permitted to employ a tailored Solvency II capital calculation, rather than the standard model set out in the Solvency II legislation.

The Lloyd’s market’s solvency capital is regulated as a whole by the PRA, taking into account the funds held by each syndicate (including members’ Funds at Lloyd’s), as well as the Society’s Central Fund. The fact that Lloyd’s internal model has been approved means that the PRA has confidence in the intensive efforts undertaken in the Lloyd’s market over the last few years to ensure that each managing agent is prepared for the implementation of Solvency II on behalf of the syndicates that it manages.

Lloyd’s continues to work with individual managing agents to agree adaptations to the model used to determine individual syndicates’ Solvency Capital Requirement. Lloyd’s plans to continue to review the process by which managing agents can request changes to their models through 2016 and is now working to integrate its Solvency II compliance monitoring more generally into its “business as usual” processes, moving away from the project-based activity of the last few years.

b. Launch of New Lloyd’s Index

In December 2015, Lloyd’s announced plans for an index based on the performance of the Lloyd’s market, expected to be launched in mid-2016. Initially the index will show loss ratios based on aggregated data from the market, produced on a quarterly basis, with the possibility that the index could be expanded to show performance by class of business in future.

As well as providing a tool for managing risk, it is anticipated that the index could be used for new index-based ILS. Lloyd’s chairman, John Nelson, commented that new investment products such as these could help to lower the cost of capital to the industry and that he believed the index would be advantageous to both Lloyd’s and non-Lloyd’s participants.

This development can be seen within the broader context of increasing participation by alternative capital in the (re)insurance market. Statements by Lloyd’s over recent months indicate that Lloyd’s is interested in finding ways to work with and embrace this trend, rather than view it simply as a threat to traditional reinsurance providers. Lloyd’s has, for example, participated in the London Market Group’s taskforce established to work with the UK government on legislative proposals to attract ILS business to London.

c. Overseas Developments

Lloyd’s has continued its strategy of expanding its presence in international markets, particularly in Asia. In October 2015, Lloyd’s signed a memorandum of understanding with China Taiping Insurance during China’s President Xi Jinping’s state visit to the United Kingdom. Lloyd’s announced that both parties had committed to collaborate in the development of Chinese and global insurance markets and that Lloyd’s would support Taiping Reinsurance Company to establish a Lloyd’s syndicate and Taiping Reinsurance Brokers Ltd to become a Lloyd’s registered broker.

Lloyd’s CEO, Inga Beale, recently reiterated that China was at the heart of Lloyd’s long-term strategy, and in March 2015 Lloyd’s opened a Beijing branch to add to its well-established operation in Shanghai. Lloyd’s is now licensed to provide non-life insurance and reinsurance within the Beijing municipal area, which it hopes will facilitate stronger ties with Chinese cedents in the city. The year 2015 also saw Lloyd’s open an office in Dubai and announce that it was applying for a license to open an office in Malaysia. Lloyd’s hopes to increase its reach in Southeast Asia where insurance penetration is low.

6. UK Insurance Act 2015 to Come into Force

The United Kingdom’s Insurance Act 2015 will come into force on August 12, 2016 and will apply to insurance and reinsurance contracts entered into on or after that date. The Act has been brought in to
reform certain longstanding aspects of the current law considered to be unjust or not reflective of market practice, and has largely been supported within the industry.

Parties to commercial (i.e., non-consumer) insurance contracts will be free to contract out of most of the provisions, provided that the insurer takes sufficient steps to draw the relevant contracting-out term to the attention of the insured before the contract is entered into if it disadvantages the insured. Whether parties will agree to contract out will in a large part be determined by market practice. Some commercial lines insurers are already advertising that their policies are “Insurance Act 2015 compliant,” but parties to reinsurance contracts and more bespoke commercial policies in particular may look to contract out of certain elements.

The key reforms, which relate to the law of warranties and the insured’s duty of disclosure, are summarized below.


Under the existing law, where an insured is required to comply with a particular warranty during the period of the insurance, for example a warranty that it will maintain a fire alarm in operation, breach of that warranty can discharge the insurer from all future liability, even in respect of losses occurring after the insured has rectified the breach, for example by reinstalling the fire alarm. The insurer is discharged automatically as from the date of the breach (this was confirmed in the 1991 case Bank of Nova Scotia v Hellenic Mutual War Risks Association (The Good Luck)).

The Act addresses this by providing that a breach of a warranty will only affect the insurer’s liability for events occurring after the breach and before the breach has been rectified. In other words the insurer’s liability will be suspended during the period when the breach is occurring, but if that breach is rectified so that the insured is in compliance, the insured would be entitled to claim for subsequent events.

b. Warranties: Remedy for Breach of Warranty Now Contingent on Relevance

Under the existing law insurers are, as a general rule, discharged from all liability under a contract of insurance following a breach of a warranty by the insured, irrespective of the subject matter of the warranty. This is codified in section 33(3) of the Marine Insurance Act 1906, which states that a warranty “must be exactly complied with, whether it be material to the risk or not.”

The Insurance Act 2015 now provides that the insurer will be unable to rely on a breach of warranty by the insured, if the breach is irrelevant to the risk of loss. An insured will be able to make a claim, despite having breached a warranty, where it can show that its breach could not have increased the risk of the loss occurring. For example, where an insured suffers loss through burglary, but has breached a warranty that it would maintain a fire alarm in working order, the insured should be able to show that had the alarm been operational, it would have made no difference to the risk of burglary and, accordingly, the insured should be able to make a claim under the policy.

c. Duty of Fair Presentation: Proportionate Remedies

In the context of commercial insurance contracts, the law currently provides insurers with the “all or nothing” remedy of avoiding the contract ab initio for breach by the insured of its duty of disclosure. This will now be superseded by a regime which is intended to be more proportionate.

The Act introduces a new “duty of fair presentation” on commercial insureds. Before entering into an insurance contract, insureds will be required either (i) to disclose all material circumstances which the insured knows or ought to know, or (ii) to disclose sufficient information to put a prudent insurer on notice that it needs to make further enquiries.

The existing statutory duty of disclosure under section 18 of the Marine Insurance Act 1906 requires the insured to disclose every material circumstance. The application of the lower threshold (sufficient information to put the insurer on notice) reflects developments in case law but will now be given a statutory status. This is intended to help ease confusion among insured businesses which often have difficulties judging how to comply with the current disclosure requirement given that the onus is on the insured to know which circumstances are material to the insurer and to volunteer all such information.

If the insured deliberately or recklessly breaches the duty of fair presentation, the insurer will still be entitled to avoid the policy and refuse all claims and will not be required to return any premium. However, if the breach is not deliberate or reckless: (A) where the insurer would not have entered into the contract on any terms, the insurer will still be entitled to avoid the policy and refuse all claims, returning the premium; (B) if the insurer would have entered into the contract but would have charged a higher premium, the insurer will not be entitled to avoid the policy but will have a right to reduce any claim payment proportionately; and (C) where the insurer would have entered into the contract on different terms, other than premium terms, the insurer will again not be entitled to avoid the policy but will have a right to treat the contract as though entered into on those different terms.

d. Duty of Fair Presentation: Insured’s Knowledge

The Act provides that an insured “ought to know what should reasonably have been revealed by a reasonable search of information available to the insured.” This potentially places a higher burden on the insured than the current law which, under section 18 of the Marine Insurance Act 1906, includes the qualification that the insured is deemed to know every circumstance which it ought to know “in the ordinary course of business.” Insureds may look for clarification from their insurers as to what a reasonable search may entail.

In the context of reinsurance, the reinsured may need to consider the extent to which this provision will require it to increase the

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level of enquiry it makes of its inwards insureds, and whether such an obligation is acceptable. This is particularly the case now that an insured will be able to discharge its duty of fair presentation by providing the insurer with sufficient details to put the insurer on notice that it needs to make further enquiries regarding a particular matter.

7. Insurance Distribution Directive

On December 14, 2015, the European Council formally adopted the Insurance Distribution Directive (the “IDD”). The IDD will replace the Insurance Mediation Directive 2002/92/EC (the “IMD”) and introduce refreshed minimum regulatory standards for insurance sales in the EU. The IDD came into force on February 22, 2016 and the deadline for member states to transpose the IDD into their national laws is February 23, 2018.

The IMD has been part of the EU regulatory landscape since January 14, 2005. An overhaul of the IMD provisions was prompted by: inconsistency in the way the IMD regime had been implemented by member states; development of a more complex insurance market and product offerings since the IMD was enacted; and a greater focus on consumer protection across all financial sectors since the 2008 financial crisis.

a. Key Changes Under the IDD

The IDD, like the IMD, is a minimum harmonization directive. This means that the IDD sets a threshold which national legislation must meet but, beyond which, member states are free to maintain or introduce stricter provisions relating to insurance selling.

i. Direct Sellers to Be in Scope

The IDD will apply not only to intermediaries but also to insurance undertakings that sell directly to their customers, including sales through aggregator websites, and certain ancillary sales (collectively, “distributors”). This extension of scope reflects the view that consumer protection should be the same regardless of the channel through which customers buy an insurance product.

The mere provision of information to a customer or data to insurers about potential customers, and claims management on behalf of an insurance undertaking, loss adjusting and expert claims appraising are out of scope.

ii. Enhanced Professional Requirements and Internal Policies

The IDD will require a minimum of 15 hours per year for professional training and development for certain persons involved in insurance distribution, including “relevant persons within the [distributor’s] management structure” and those who are “directly involved” in insurance distribution. Competency and continuing professional development requirements must match the complexity of the activities connected with the insurance product being sold and the type of distributor.

Further, insurance undertakings must implement, document and regularly review internal policies and procedures for ensuring that the “good repute” (carried over from the IMD) and enhanced competency and continuing development requirements under the IDD are met by the relevant employees involved in insurance distribution.

iii. “Customer’s Best Interests” Principle; Conflict Management and Product Governance Rules

The IDD will introduce a general principle that distributors must “always act honestly, fairly and professionally in accordance with the best interests of its customers,” and they are not to remunerate, incentivize or assess the performance of their employees in a way that conflicts with this duty.

The IDD further requires insurance undertakings and any intermediaries that design insurance products—other than those relating to large risks—to maintain, operate and periodically review a product approval process. Where a distributor advises on or proposes an insurance product that it did not manufacture, that distributor must have in place adequate arrangements to obtain the information it needs in order to understand the product characteristics and its identified target market.

The existing UK regulatory framework on management of conflicts of interest (including the FCA’s “Treating Customers Fairly” Principle) already embraces the high-level provisions being introduced under the IDD, but distributors in the United Kingdom should note that the IDD empowers the European Commission to: (A) adopt delegated acts to further specify product oversight and information principles; and (B) in relation to insurance-based investment products, prescribe steps for identifying, preventing, managing and disclosing conflicts of interest as well as establish criteria for determining the types of conflict which might adversely impact customers.

iv. New Remuneration Disclosures

Prior to conclusion of a contract, insurance intermediaries must disclose to customers the nature of any remuneration received in relation to the contract and whether the contract works on the basis of a fee, commission or other type of arrangement (including any financial or non-financial advantage, offered or given in respect of (re)insurance distribution activities). Where the fee is payable directly by the customer, the insurance intermediary must provide the amount of the fee or, where this is not possible, the method for calculating it.

The new remuneration provisions will not apply to mediation of large risks. The IDD leaves member states to decide whether to also disapply the rules in relation to “professional clients,” as defined in Article 4(1)(10) of the MiFID II Directive 2014/65/EU. A “professional client” is a client who: (A) possesses the experience, knowledge and expertise to make its own investment decisions and properly assess the risks that it incurs; and (B) complies with the criteria set out in Annex II of the MiFID II Directive.

In the United Kingdom, the IDD’s remuneration provisions will principally impact brokers’ dealings with retail customers in the context of non-investment insurance contracts, where currently no such remuneration disclosure requirements under ICOBS apply.
v. New Cross-Selling Rules
In the context of the IDD, a “cross-selling practice” involves an insurance product being offered together with a non-insurance product or service as part of a package or the same agreement. The requirements vary depending on whether the insurance product is the main or ancillary product within the package (and are subject to other EU legislation governing cross-selling practices in relation to certain categories of goods or services):

- Where the insurance product is offered together with an ancillary non-insurance product or service, distributors must inform the customer whether it is possible to buy the different components separately, and, if so, provide an adequate description of the different components of the package as well as information on the costs and charges of each component. It must be clear to customers how insurance coverage varies depending on whether the product is sold in or out of the package.

- Where the insurance product is ancillary to a non-insurance product or service (unless an investment service or activity, a credit agreement or a payment account), the customer must be able to buy the non-insurance product or service separately.

Furthermore, EIOPA may issue guidelines on cross-selling practices and examples of practices that may fall short of the “customer’s best interests” principle.

vi. Enhanced Sales Standards for Insurance-Based Investment Products
Similar to the sales standards applicable to non-insurance investment products under MiFID, these will include:

- Increased disclosure requirements relating to the nature and risks associated with the insurance-based investment product and all costs and associated charges, with such information to be given to customers in a comprehensible form such that they can reasonably be expected to understand the product offered and make an informed decision.

- For non-advised sales, a requirement to assess the appropriateness of an insurance-based investment product for each customer or, where the customer does not provide the information needed for such assessment, warn the customer that a determination on appropriateness cannot be made. If certain conditions are met, member states may derogate from this obligation in relation to non-complex insurance-based investment products.

- For advised sales, suitability assessment and suitability statement requirements, and a requirement to inform customers whether a periodic suitability assessment in respect of a recommended product will be conducted.

- Provision of periodic reports to customers, taking into account the type and complexity of the insurance-based investment product.

8. EU/UK Competition Law Enforcement Activity
a. EU-Level Enforcement by the European Commission
In the fall of 2014, the European Commission (“Commission”) launched a consultation on the functioning and future of the EU’s Insurance Block Exemption Regulation ("BER"), which will expire on March 31, 2017. The BER allows certain agreements among insurers (and among reinsurers) to benefit from an exemption from the prohibition of anti-competitive agreements under EU competition rules. The purpose of the consultation was to assess whether such a sector-specific block exemption for the insurance sector continues to be justified, and, if it is to be renewed, in what form it ought to be renewed.

It is still too early to know for certain how the Commission’s review process will pan out, but there is a reasonable chance that the BER will not be renewed, a move that would force insurers and reinsurers to “self-assess” the compatibility with EU competition rules of arrangements that might previously have benefited from the safe harbor created by the BER. Although the initial consultation period ended in November 2014, the Commission procured two studies in August 2015 to consider, among other things, different forms of co-operation among insurance companies. Industry roundtables also continued over the course of 2015. The Commission must submit its report and recommendations to the European Parliament and Council by March 2016.

b. National Level Enforcement in the United Kingdom
Although the Commission did not initiate any EU-level insurance-related cases in the course of 2015, there has continued to be significant enforcement activity at a national level, especially in the United Kingdom. The United Kingdom’s main competition authority, the Competition and Markets Authority ("CMA"), has continued its insurance-related investigations. Its fellow regulator, the FCA, acquired full, “concurrent” powers to enforce EU and UK competition law on April 1, 2015, and has also stepped up its investigatory activity in relation to the insurance sector, including in respect of the areas identified below.

i. Implementing Measures in Car Insurance Market Investigation
In March 2015, the CMA published its final order implementing measures identified in its report into the private motor insurance industry. From March 19, 2015, price-comparison websites for motor insurance must provide customers with certain standard information on the effect of no-fault claims on the price of their insurance policies. Providers of private motor insurance must also provide such information, as well as a formula for calculating any discounts for periods during which no claims are made and tables displaying the price for years with and without such a discount. Further, from August 1, 2016, providers of private motor insurance and price-comparison websites are prohibited from entering into agreements that contain most-favored nation clauses.
Providers of private motor insurance must submit a compliance statement to the CMA annually, and any price-comparison website with more than 300,000 sales of private motor insurance must do so both quarterly and annually.

ii. FCA General Insurance Add-On Market Study

Since completing its market study into general insurance add-ons in July 2014, the FCA has been working on four remedies to improve competition for general insurance products which are sold alongside primary products ("add-ons") (discussed in Section IV.C.9).

iii. FCA Review of Annuities and Retirement Income Market Study

In March 2015, the FCA issued a final report on findings from tests of its proposed remedies concerning annuities and the retirement income market, including a requirement that firms provide a quote comparison to their customers. The FCA stated that, in order to prompt consumers to consider shopping around or switching, such comparison need not be comprehensive, although it should exhibit a certain degree of consistency across consumer communication channels. Further, the FCA proposed that firms provide such comparisons only once there has been a customer-instigated communication, rather than at an earlier stage before consumers have decided how to take their retirement income or have obtained advice. The FCA anticipates firms will need to implement the proposed remedies in 2016. The FCA will also be making recommendations to firms on framing products in their sales to customers.

iv. FCA Thematic Review of the Provision of Premium Finance to Retail General Insurance Customers

On May 11, 2015, the FCA published its thematic review of the provision of premium finance to retail general insurance customers. The review found that the content and format of information provided on the cost of paying in installments, the terms of premium finance, and the role played by a firm in arranging finance could constitute a barrier to informed decision-making by retail customers and may hinder effective competition. The FCA advised firms to take reasonable steps to ensure that customers are provided with sufficient information at an appropriate stage, in their online sales, as well as their other sales channels, in order to readily compare the costs and requirements of paying up-front versus by installments.

v. FCA Consultation on Increasing Transparency and Engagement at Renewal in General Insurance Markets

On December 3, 2015, the FCA published a consultation on increasing transparency and engagement in the general insurance markets, following a request by the UK government in the July 2015 budget. In it the FCA set out proposals to introduce new rules and guidance for firms on steps they should take when renewing general insurance policies, in order to address an alleged lack of competition in the renewal of insurance products. The FCA is proposing rules that require firms to disclose the previous year’s premium on renewal notices and additional disclosure when customers have renewed the same product four times or more, as well as guidance on how firms can improve the renewal process and necessary record-keeping. The consultation closes on March 4, 2016, and the FCA aims to finalize rules and guidance by mid-2016, for implementation on January 1, 2017.

vi. Final FCA Guidance on Concurrent Competition Law Powers

On July 15, 2015, the FCA published its final guidance on the exercise of its concurrent competition law powers, which it acquired on April 1, 2015. The FCA confirmed that it expects to be notified promptly of any infringements of competition law by regulated persons. The final guidance explains that the fact that a regulated person may have applied to the CMA for leniency in respect of a competition law infringement will not prohibit the FCA from taking enforcement action under FSMA, using information obtained from other sources or the leniency applicant itself, pursuant to its self-reporting obligations to the FCA. In August 2015, however, the FCA made several amendments to its Supervisory Handbook in an effort to facilitate compliance by a leniency applicant with the self-reporting obligation, including permitting oral notifications to the FCA. The circumstances giving rise to a duty to notify the FCA are wide, however, the FCA requires notification as soon as a regulated person becomes aware, or has information which reasonably suggests, that a significant competition law infringement has, or may have, occurred. The CMA has also undertaken to remind leniency applicants that they may have a duty to notify the FCA.


The FCA has focused on four remedies to improve competition for general insurance products which are sold alongside primary products since completing its market study into general insurance add-ons in July 2014.

a. Remedy 1 – Deferred Opt-In Regime for Certain GAP Sales

With effect from September 1, 2015, a deferred opt-in regime was introduced into the Insurance Conduct of Business Sourcebook ("ICOBS") for certain GAP sales as well as a prescribed information requirement.

The deferred opt-in regime is about “pausing” the add-on GAP sales process so that add-on GAP cannot be introduced and sold to a customer on the same day. The deferral period starts when the customer is given certain prescribed pre-sale information (being Day 1) and ends on Day 4 when the distributor can contact the customer to conclude the add-on GAP sale. Customers can “break” the pause on Day 2, but customers must not be encouraged to shortcut the deferral period, and any customer-initiated contact must be monitored.

Before concluding any GAP contract sale in connection with a vehicle, firms should first consider whether it would be in the customer’s interest to receive the prescribed information again. Firms should have regard, among other things, to (i) the overall complexity of the...
policy being sold; (ii) the knowledge, experience and ability of a typical customer of that policy; (iii) the importance of the information to the customer's decision-making; and (iv) the point, if any, at which it may be most useful for the customer to receive it again. Situations which may trigger a firm to re-issue the prescribed information include changes to the price or policy terms, or a lengthy deferral period.

The new rules still apply where the add-on GAP cover is part of an unbreakable package (i.e., where it is a condition or requirement of the primary product purchase that the customer buy the other products forming part of the package).

b. Remedy 2 – Banning Opt-Out Selling for Certain Add-On Products

On September 28, 2015, the FCA published new Handbook rules banning opt-out selling across financial services, which will come into force on April 1, 2016.

The ban will apply to any add-on product, whether regulated or not, when sold alongside a regulated financial services primary product by an authorized firm (or its representatives), subject to a few exceptions. All sectors, including those outside of general insurance, will be affected and the primary product will not need to be insurance-based. This remedy complements the existing opt-out selling ban under the Consumer Contracts (Information, Cancellation and Additional Charges) Regulation 2013 (the “CCR”), which came into force on June 13, 2014 and applies where the primary product is non-financial (for example, GAP insurance sold alongside a car or mobile phone insurance sold alongside a handset). The new FCA rules will, therefore, close any gap in consumer protection (covering, for example, breakdown cover sold alongside motor insurance or card protection sold alongside a credit card) without overlapping with the CCR.

There will be a number of exceptions to the ban:

- auto-renewals of primary products;
- renewal of add-on products, provided the add-on product contains substantially the same terms and the customer has made an active decision to purchase the product at some point (i.e., on an opt-in basis, whether originally or subsequently);
- unbreakable bundles, where it is a condition or requirement of the purchase that the customer buys the other products forming part of the bundle;
- free add-on products, which are included at no extra cost (however, the customer's active and express consent must be obtained before any charge at a later date is to apply);
- overdrafts; and
- unregulated credit union loans.

Firms which receive information from a price comparison website (“PCW”) detailing what add-on selections a customer has actively made will not need to re-ask questions when the customer is taken through to the seller’s website, but they can do so if they wish.

c. Remedy 3 – Improving Provision of Information about Add-On Products

The FCA has introduced, with effect from April 1, 2016, new Handbook guidance in ICOBS, which clarifies that the requirement to provide customers with appropriate and timely information, in a comprehensible form, applies to both stand-alone and add-on products. The FCA also published, on September 28, 2015, with immediate effect, its finalized non-Handbook guidance for PCWs and other participants in the distribution chain on good practice in providing information to customers buying add-ons to general insurance products. The FCA expects firms to implement any necessary changes to their sales journey by April 1, 2016.

The Handbook guidance, together with the non-Handbook guidance, is intended to improve the information provided to customers about add-ons as well as when, and the way in which, such information is provided. The non-Handbook guidance sets out a clear expectation that firms identify and introduce to customers the most common add-ons earlier in the sales process, show to customers the annual (as well as monthly) price of add-ons, and improve customer comparability of primary product/add-on packages.

d. Remedy 4 – Introducing a Value Measure in General Insurance Markets

The FCA issued a discussion paper in June 2015, which identified three measures for increasing transparency over, and incentivizing firms to improve, product value; namely, by requiring firms to publish either:

- the claims ratio (i.e., claims paid out as a percentage of the premiums paid);
- a package of claims frequencies, claims acceptance rates (i.e., the proportion of claims accepted, relative to the total number of claims made) and average claims payouts; or
- the claims ratio plus claims acceptance rates.

Comments were invited by September 24, 2015, and the FCA has yet to respond to feedback received and consult on its preferred measure(s).

10. China: Regulatory Developments

a. Proposed Amendments to the Insurance Law

On October 14, 2015, the Legislative Affairs Office of the State Council of the PRC released a draft Decision on Amending the PRC Insurance Law for consultation. The proposed amendments constitute a substantial overhaul and include changes to rules regarding fund utilization, consumer protection, and solvency capital supervision, among other areas.

The draft text reflects recent relaxation of insurance fund regulations by the China Insurance Regulatory Commission (the “CIRC”),
confirming that insurance funds may be invested in equity, insurance asset management products and, for risk management purposes, financial derivatives. In addition, the capital guarantee fund deposited by an insurer is to be reduced from 20% to 10% of registered capital and capped at RMB 200 million.

There are increased protections for consumers, including administrative penalties for insurers which engage in misleading advertising or promotion. The statutory cooling-off period for long-term life and health products has also been doubled to 20 days, and the divulgence, sale or illegal provision of personal data by insurers, insurance agents, brokers, or their staff is expressly prohibited.

The draft amendments formally incorporate the China Risk Oriented Solvency System (“C-ROSS”), China’s second generation of solvency supervision system, now in force (see item b. below).

They also affirm the CIRC’s practice that investors must obtain approval when acquiring a 5% interest in an insurer, including where such interest is held through a subsidiary.

b. Implementation of C-ROSS

On January 25, 2016, the CIRC issued the Circular on Formally Implementing C-ROSS (the “Implementing Circular”), bringing C-ROSS into force as of January 1, 2016 and ending a transitional period during which insurers were required to calculate their solvency margins under both C-ROSS and the previous solvency regime in parallel.

C-ROSS is structured using a three-pillar approach consisting of quantitative capital requirements, qualitative supervisory requirements and disclosure requirements, and it has required Chinese insurers to review their capital management, fund utilization strategies, underwriting practices, and reinsurance arrangements in the lead-up to implementation.

The regime is set out under the Insurer Solvency Regulations 1-17 (the “ISR”) issued in February 2015. These require insurers to (i) evaluate the available capital and minimum capital, calculate the core capital solvency ratio and overall capital solvency ratio, and carry out stress tests (ISR 1-9); (ii) identify, evaluate, and manage solvency-related risks (ISR 10-12); and (iii) disclose, report, and communicate solvency-related information (ISR 13-16). ISR 17 governs group solvency capital management.

According to recent statements by CIRC Chairman Xiang Junbo, C-ROSS is a milestone in the reform and development of China’s insurance regulation and will have a revolutionary impact on China’s insurance market. Mr. Xiang expects that Chinese insurers will develop in a more balanced and sustainable way under the more sophisticated C-ROSS regime.

Internationally, commentators have noted that the counterparty risk capital charges applied to reinsurance taken out with an overseas reinsurer will be significantly higher than similar reinsurance taken out with domestic reinsurers, even when collateralized. This has prompted speculation that overseas reinsurers may look to avoid unfavorable capital treatment by establishing subsidiaries in China, transacting through the Lloyd’s China platform or by favoring retrocession.

c. Internet Sales: Relaxation of Licensing Requirements

On July 22, 2015, the CIRC promulgated the Interim Supervisory Measures on Internet Insurance Business (the “Internet Insurance Measures”), which took effect from October 1, 2015 and will remain effective for a period of three years. The Internet Insurance Measures are the first overarching rules governing China’s emerging internet insurance business, and they offer insurers an opportunity to expand their geographic coverage to provinces where they do not have established branches.

As a general rule, a Chinese direct insurer (unlike reinsurers) may not sell insurance policies in an area beyond the province of China where its headquarters is located, unless it has established branches and is licensed to do business in such area. For foreign-invested insurers in particular, the process of applying with CIRC to set up a branch is time consuming and subjects the insurer to additional capital requirements.

Under the Internet Insurance Measures, an insurer will have the opportunity to offer certain insurance products in provinces where it does not have a branch through the use of an internet platform. The permitted categories include (i) personal accidental injury insurance, fixed term life insurance, and ordinary whole life insurance; (ii) household property insurance, liability insurance, credit insurance and guarantee insurance, for which the policy holder or the insured is an individual; (iii) P&C insurance, for which the entire process of sale, underwriting, and claims management can be independently and completely concluded via internet; and (iv) insurance products otherwise specified by the CIRC.

The Internet Insurance Measures should be good news for foreign-invested insurers operating in China, most of which do not have a wide network of branches across the country.

d. China Re Launches China’s First Catastrophe Bond

In July 2015, China Re issued the first ever catastrophe bond sponsored by a Chinese insurer or reinsurer. The US$50 million catastrophe bond was issued by Panda Re, a special purpose reinsurance vehicle established in Bermuda by China Property & Casualty Reinsurance Co., Ltd. (“China Re P&C”), a wholly owned subsidiary of China Re Group. China Re P&C ceded a book of earthquake insurance to Panda Re via reinsurance collateralized through the proceeds of the bond sale.

This transaction is being seen as an encouraging sign for the opening of Chinese catastrophe risks to the capital markets, a process that the Chinese government has recognized would help to address low catastrophe insurance coverage rates in China and that it appears keen to facilitate. The draft amendments to the Insurance Law now include a statement that a catastrophe insurance system will be established with financial support by the state, which follows a 2014 statement by the State Council calling for the establishment of a
comprehensive catastrophe insurance system based on a commercial insurance platform with financial support from the government. While the CIRC has not issued further detail on how such support may be provided nationally, on a local level certain municipalities have recently launched pilot schemes providing excess cover for commercial catastrophe products.

V. Cyber Risk

A. INTRODUCTION

Cyber risk is one of the most serious global risks, and “cybersecurity” is a top priority of both private companies and government entities. Cybersecurity generally focuses on the protection of computers, networks, programs and data from unintended or unauthorized access or destruction. In the insurance context, cybersecurity measures focus on safeguarding insurance consumers’ personal information, which is particularly sensitive because it often contains social security numbers, financial information and medical information.

Following the unprecedented number of high-profile cyber attacks in 2014, the insurance sector (including regulators, insurers and other entities that handle insurance-related data) stepped up efforts to increase cybersecurity. These efforts became particularly urgent in early 2015 after U.S. health insurer Anthem reported a massive data breach estimated to have affected around 80 million customers and employees.

Highlighted below are recent regulatory developments in the insurance sector concerning cybersecurity. These developments have encouraged insurance companies (like all financial services companies) to review and refine their information security practices and corporate governance protocols related to cybersecurity to meet the rising regulatory and compliance demands in the insurance and financial services sector.

B. U.S. CYBER RISK DEVELOPMENTS

1. NAIC Cybersecurity (EX) Task Force

The NAIC created the Cybersecurity (EX) Task Force in late 2014 in order to monitor and make recommendations concerning cybersecurity developments. In 2015, the NAIC adopted a number of cybersecurity-related initiatives developed through the Cybersecurity (EX) Task Force, including the following:

a. Principles for Effective Cybersecurity Insurance Regulatory Guidance

In June 2015, the NAIC adopted the Principles for Effective Cybersecurity Insurance Regulatory Guidance (the “Cybersecurity Guidance Document”). The Cybersecurity Guidance Document consists of 12 principles for effective insurance regulation of cybersecurity risks and is based on similar regulatory guidance adopted by the Securities Industry and Financial Markets Association. The Cybersecurity Guidance Document sets forth the types of cybersecurity controls expected of both state insurance regulators and “Covered Entities” (insurers and insurance producers) and are centered on the protection of the insurance sector’s infrastructure and data from cyber attacks. The 12 principles are as follows:

**Principle 1:** State insurance regulators have a responsibility to ensure that personally identifiable consumer information held by insurers, producers and other regulated entities is protected from cybersecurity risks. Additionally, state insurance regulators should mandate that these entities have systems in place to alert consumers in a timely manner in the event of a cybersecurity breach. State insurance regulators should collaborate with insurers, insurance producers and the federal government to achieve a consistent, coordinated approach.

**Principle 2:** Confidential and/or personally identifiable consumer information data that is collected, stored and transferred inside or outside of an insurer’s, insurance producer’s or other regulated entity’s network should be appropriately safeguarded.

**Principle 3:** State insurance regulators have a responsibility to protect information that is collected, stored and transferred inside or outside of an insurance department or at the NAIC. This information includes insurers’ or insurance producers’ confidential information, as well as personally identifiable consumer information. In the event of a breach, those affected should be alerted in a timely manner.

**Principle 4:** Cybersecurity regulatory guidance for insurers and insurance producers must be flexible, scalable, practical and consistent with nationally recognized efforts such as those embodied in the National Institute of Standards and Technology (NIST) framework.

**Principle 5:** Regulatory guidance must be risk-based and must consider the resources of the insurer or insurance producer, with the caveat that a minimum set of cybersecurity standards must be in place for all insurers and insurance producers that are physically connected to the internet and/or other public data networks, regardless of size and scope of operations.

**Principle 6:** State insurance regulators should provide appropriate regulatory oversight, which includes, but is not limited to, conducting risk-based financial examinations and/or market conduct examinations regarding cybersecurity.

**Principle 7:** Planning for incident response by insurers, insurance producers, other regulated entities and state insurance regulators is an essential component to an effective cybersecurity program.

**Principle 8:** Insurers, insurance producers, other regulated entities and state insurance regulators should take appropriate steps to ensure that third parties and service providers have controls in place to protect personally identifiable information.

**Principle 9:** Cybersecurity risks should be incorporated and addressed as part of an insurer’s or an insurance producer’s enterprise risk management (ERM) process. Cybersecurity transcends the information technology department and must include all facets of an organization.
Principle 10: Information technology internal audit findings that present a material risk to an insurer should be reviewed with the insurer’s board of directors or appropriate committee thereof.

Principle 11: It is essential for insurers and insurance producers to use an information-sharing and analysis organization (ISAO) to share information and stay informed regarding emerging threats or vulnerabilities, as well as physical threat intelligence analysis and sharing.

Principle 12: Periodic and timely training, paired with an assessment, for employees of insurers and insurance producers, as well as other regulated entities and other third parties, regarding cybersecurity issues is essential.

b. Roadmap for Cybersecurity Consumer Protections for Effective Cybersecurity Insurance Regulatory Guidance

In December 2015, the NAIC adopted the “Roadmap for Cybersecurity Consumer Protections” (“Cybersecurity Roadmap”). As stated in the Cybersecurity Roadmap’s preamble, the document describes the protections to which the NAIC believes consumers should be entitled from their insurance companies, agents and other businesses concerning the collection and maintenance of consumers’ personal information, as well as what consumers should expect when such information has been involved in a data breach. The Roadmap states that an insurance consumer has the right to:

- Know the types of personal information collected and stored by the consumer’s insurance company, agent or any business it contracts with (such as marketers and data warehouses).

- Expect insurance companies/agencies to have a privacy policy posted on their websites and available in hard copy, if a consumer asks, which explains what personal information is collected, what choices consumers have about their data, how consumers can see and change/correct their data if needed, how the data is stored/protected, and what consumers can do if the company/agency does not follow its privacy policy.

- Expect the consumer’s insurance company, agent or any business it contracts with to take “reasonable steps to keep unauthorized persons from seeing, stealing or using his or her personal information.”

- Get certain “data breach notices” from a consumer’s insurance company, agent or any business it contracts with if an unauthorized person has (or seems likely to have) seen, stolen or used his or her personal information.

- Get at least one year of identity theft protection paid for by the company or agent involved in a data breach.

- Place certain fraud alerts on the consumer’s credit reports if a consumer’s identity has been stolen, get fraudulent information related to the data breach removed or blocked from credit reports and stop creditor and debt collector contact and reporting of fraudulent accounts.

The Cybersecurity Roadmap was originally drafted as a “Cybersecurity Bill of Rights,” which suggested that insurance consumers were legally entitled to certain notices, information and actions related to data and data breaches that did not accurately reflect the law in many states. After prodding from industry, the Cybersecurity (EX) Task Force recognized this problem, and in October 2015, it adopted a revised version that included a statement that a consumer’s specific rights “may vary based on state and federal law.” Still, for many interested parties, the revised draft did not go far enough to clarify that the Cybersecurity Bill of Rights was more of an “aspirational” document that merely outlined rights that the states should adopt, rather than creating or codifying existing law.

Ultimately, a compromise was reached and, when adopted by the NAIC in December 2015, the document title was changed from the “Cybersecurity Bill of Rights” to the “Roadmap for Cybersecurity Consumer Protections.” In addition, the original draft’s statement that a consumer’s rights “may vary based on state and federal law” was removed and replaced with a statement, which clarifies:

This document describes the protections the NAIC believes consumers are entitled to from insurance companies, agents and other businesses when they collect, maintain and use your personal information, including what should happen in connection with a notice that your personal information has been involved in a data breach. Not all of these consumer protections are currently provided for under state law. This document functions as a Consumer Bill of Rights and will be incorporated into NAIC Model laws and regulations. If you have questions about data security, a notice you receive about a data breach, or other issues concerning your personal information in an insurance transaction, you should contact your state insurance department to determine your existing rights.

When adopting the Cybersecurity Roadmap, the NAIC also agreed to work with interested parties in drafting a new, comprehensive NAIC Model Cybersecurity Model Act and Regulation, rather than attempting to amend existing NAIC Model Laws to address cybersecurity rights. Many interested parties still disagree with certain provisions of the Cybersecurity Roadmap (including the right to one year of identity theft protection paid for by the insurer or agent involved in a data breach). However, rather than oppose adoption of the Cybersecurity Roadmap, they have agreed to discuss such provisions further during the process of creating a new NAIC Cybersecurity Model Act and Regulation.

c. NAIC Insurance Data Security Model Law

On March 2, 2016, the Cybersecurity Task Force exposed, for a 20-day comment period, a preliminary working/discussion draft of a new model law addressing cybersecurity entitled “Insurance Data Security Model Law” (the “IDS Model Law”). The IDS Model Law applies to insurance licensees, defined as all licensed insurers, producers and other persons licensed or required to be licensed, or
authorized or required to be authorized, or registered or required to be registered pursuant to state insurance laws. The IDS Model Law is intended to establish the exclusive standards for data security and breaches applicable to insurance licensees in states adopting the IDS Model Law. To emphasize its comprehensive nature, the IDS Model Law references the McCarran-Ferguson Act, noting that the IDS Model Law is intended to regulate the business of insurance, and emphasizes that no other state or federal law or regulation regarding data security (or investigation or notification of a data security breach) will apply to licensees subject to the IDS Model Law.

- **Information Security Program**

  Under the IDS Model Law, licensees must develop and maintain a written information security program ("ISP") containing safeguards for the protection of consumer personal information. The ISP must be appropriate to the size and complexity of the licensee's activities and to the sensitivity level of the information being protected. For purposes of risk assessment, licensees must designate specific employees to coordinate the ISP and to identify reasonably foreseeable internal or external threats that could result in unauthorized disclosure, misuse, alteration or destruction of personal information. Licensees must also assess the likelihood and potential damage of such risks and sufficiency of policies and procedures currently in place to address them.

  The ISP must be designed so that it controls identified risks, using as a guide the Framework for Improving Critical Infrastructure Cybersecurity developed by the National Institute of Standards and Technology ("NIST"), and it must adopt specific NIST security measures, including encryption of electronic information, multi-factor authentication procedures, and segregation of duties and background checks with respect to employees who have access to consumer personal information. A licensee must adjust its ISP in light of changes to technology, sensitivity of relevant personal information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements and changes to personal information systems.

- **Third-Party Service Providers**

  Third-party service provider arrangements are subject to intense scrutiny under the IDS Model Law and licensees must impose, by contract, specific requirements on their third-party service providers, including the obligation to implement certain specified security measures, notification to licensees of data security breaches and indemnification of licensees in the event of a cybersecurity incident that results in loss. Third-party service providers must also agree to cybersecurity audits and to represent and warrant their compliance with all requirements under the IDS Model Law.

- **Enterprise Risk Management**

  The IDS Model Law requires that a licensee address cybersecurity risks in the licensee's enterprise risk management process and that it use an Information Sharing and Analysis Organization ("ISAO") to share information and stay informed regarding emerging threats or vulnerabilities. A licensee's board of directors must approve the ISP and oversee its development and implementation, assigning specific responsibility for its implementation and reviewing reports from management. Licensees must annually report to the board, or appropriate committee of the board, certain information, including compliance with the IDS Model Law, risk assessment, risk management and control decisions, service provider arrangements, results of testing, security breaches or violations and management's responses, and recommendations for changes in the ISP.

- **Consumer Rights**

  Under the IDS Model Law, a licensee must also provide consumers with certain information before a potential data security breach, such as the types of personal information stored by the licensee or third-party service provider, the licensee's privacy policy and a consumer's rights if the licensee does not comply with the policy. When a licensee believes that a data security breach has or may have occurred, a licensee must conduct an investigation during which it must take reasonable measures to restore the security and confidentiality of the systems compromised in the breach. If a licensee determines that a data security breach is reasonably likely to cause substantial harm or inconvenience to consumers, the licensee, or a third party acting on behalf of the licensee, must notify: (i) an appropriate federal and state law enforcement agency; (ii) the state insurance commissioner; (iii) any relevant payment card network, if the breach involves a breach of payment card numbers; (iv) each consumer reporting agency that compiles and maintains files on consumers on a nationwide basis, if the breach involves personal information relating to 1,000 or more consumers; and (v) all consumers to whom the personal information relates.

  State insurance commissioners have the right to review and edit a licensee's proposed notice to consumers containing information about the data breach. Such notice must outline the consumer's rights and contain an offer by the licensee to the consumer to provide appropriate identity theft protection services free of cost to the consumer for at least one year. A licensee must also provide certain notifications in the event of a data security breach in a system maintained by a third-party service provider. After reviewing a licensee's data breach notification, the commissioner may prescribe the appropriate level of consumer protection required following the data breach and for what period of time such protection will be provided (minimum of 12 months identity theft protection offer).
• **Confidentiality**

The IDS Model Law contains a confidentiality provision concerning materials and other information in the control or possession of the state department of insurance. However, the insurance commissioner is authorized to use such materials in furtherance of a regulatory or legal action, and the insurance commissioner may share materials with other state, federal and international regulatory agencies and with the NAIC, provided that the recipient agrees to maintain the confidentiality and privileged status of the material. The commissioner may also enter into agreements governing sharing and use of information consistent with the IDS Model Law.

• **Examination and Enforcement Authority**

The IDS Model Law provides commissioners with the power to examine and investigate licensees to determine compliance with the law, such power being separate from any additional powers the commissioner has under state laws governing examination of insurers. When a commissioner has reason to believe that a licensee has been or is engaged in conduct in the state which violates the IDS Model Law, the commissioner must serve the licensee with a statement of charges and notice of a hearing to be held concerning the alleged violations. There are extensive provisions governing cease and desist orders against licensees that violate the IDS Model Law, as well as financial penalties and potential suspension or revocation of an insurance license. Licensees subject to orders and penalties are entitled to judicial review in state court.

• **Private Right of Action for Violations**

Finally, the IDS Model Law provides for a limited private cause of action. If a licensee fails to comply with the consumer rights aspects of the IDS Model Law, any person whose rights are violated may apply to state court, or any other court of competent jurisdiction, for appropriate equitable relief. Such court may award the cost of the action and reasonable attorney’s fees to the prevailing party. Actions must be brought within two years from the date the alleged violation is or should have been discovered.

2. **Individual State Initiatives**

In addition to participating on the Cybersecurity (EX) Task Force, state insurance regulators have been conducting separate cybersecurity-related activities in their individual states. Set forth below are examples of such initiatives.

  a. **Targeted Assessments**

In February 2015, the NYDFS issued a report addressing its 2013 and 2014 examinations of the state of security protections in a survey of 43 insurance companies. The report indicated that the NYDFS planned to integrate “regular, targeted assessments” of cybersecurity preparedness at insurance companies as part of its regular examination process, enhance regulations requiring institutions to meet heightened cybersecurity standards and explore stronger measures related to representations and warranties that insurance companies receive from third-party vendors.

b. **Proposed Regulations**

On November 9, 2015, in a published letter from the NYDFS to members of the Financial and Banking Information Infrastructure Committee (“FBIIIC”), the former Acting Superintendent of the NYDFS outlined key elements of potential new regulations by the NYDFS addressing cybersecurity risk (the “Cybersecurity Proposal”) and encouraged FBIIIC members to work with the NYDFS in developing a comprehensive cybersecurity framework for all regulated financial institutions. The stated goal of the NYDFS is to stimulate dialogue among federal and state financial regulators to promote collaboration and, ultimately, regulatory convergence.

The cybersecurity regulatory principles proposed by the NYDFS go well beyond safeguarding customer information and also cover business continuity, system availability and quality assurance, and other operational factors. The NYDFS’ Cybersecurity Proposal would require that entities subject to regulation (namely, banks and insurance companies, referred to in the proposal as “Covered Entities”) address the following:

• **Chief Information Security Officer and Cybersecurity Policies and Procedures**

Covered Entities would need to designate a Chief Information Security Officer (“CISO”) and maintain written cybersecurity policies and procedures (“Cybersecurity Policies and Procedures”) governing several topics such as information security, disaster recovery planning, system and network security, customer data privacy, vendor and third-party service provider management and incident response.

• **Third-Party Service Provider Management**

Cybersecurity Policies and Procedures would need to address the security of data that is accessible to or held by third-party service providers. Key terms of contracts with third-party service providers would need to be specified, including provisions specifying technical controls such as multi-factor authentication and data encryption, as well as more procedural protections, such as requiring notice to and indemnification of the Covered Entity in the event of a cybersecurity incident, provisions for cybersecurity audits and contractual representations and warranties. The NYDFS is particularly concerned with third-party service providers to the extent they have access to sensitive data and to a financial institution’s information technology systems themselves, which provides a potential point of entry for hackers. In its Cybersecurity Proposal, the NYDFS emphasizes, “A company may have the most sophisticated cybersecurity protections in the industry, but if its third-party service providers have weak systems or controls, those protections will be ineffective.”

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20 The FBIIIC is comprised of state and federal agencies that regulate companies and products in the financial services sector, including the SEC, the Office of the Comptroller of the Currency and the NAIC.
• **Multi-Factor Authentication**

Crossing into the specification of a particular technical control, the NYDFS stated that Cybersecurity Policies and Procedures would be required to address multi-factor authentication for accessing web applications and database servers that capture or display confidential information. Multi-factor authentication would be required in order to access a Covered Entity's internal systems or data from an external network. The Cybersecurity Proposal does not specify whether an entity could make a showing of a compensating control or demonstrate undue financial or operating burden in the implementation of multi-factor control. As written, the Cybersecurity Proposal suggests that multi-factor authentication would be an absolute requirement, regardless of cost, operational impacts, technical constraints, or the overall posture of information security protections.

• **Annual Report to be Submitted to the NYDFS**

A Covered Entity's CISO would oversee cybersecurity programs and submit annual reports to the NYDFS that have been reviewed by the Covered Entity's board of directors regarding the cyber risks to the entity and its cybersecurity program.

• **Application Security**

A Covered Entity would maintain written procedures, guidelines and standards (reviewed and updated by the CISO annually) to ensure the security of all applications that are utilized by the Covered Entity.

• **Cybersecurity Personnel and Intelligence**

Covered Entities would employ persons (or use third parties) to manage cybersecurity risks and perform five core cybersecurity functions: identify, protect, detect, respond and recover. Training on such risks would also be mandatory.

• **Audit**

Annual penetration testing and quarterly vulnerability assessments would be required. Covered Entities would also maintain an audit trail system that logs privileged user access to critical systems, protects log data stored as part of the audit trail from alteration or tampering, protects the integrity of hardware from alteration or tampering, and logs system events including access and alterations made to audit trail systems.

• **Notice of Cybersecurity Incidents**

Covered Entities would be required to “immediately” notify the NYDFS of cybersecurity incidents that have a reasonable likelihood of materially affecting the normal operation of the entity, including any incident that triggers New York’s data breach notification laws, is reported to its Board, or involves the “compromise” of certain protected personal information. Whether the risk of harm to the individuals involved could be considered was not mentioned, nor was any specification of a time period consistent with the “immediate” notification requirement.

### C. UNITED KINGDOM AND EUROPE

Cyber attacks in the United Kingdom have, to date, not been on as large a scale as those in the United States. However, recent events, such as the breach of a major telecoms company in October 2015, which potentially exposed the data of its four million customers and could cost the company up to £35 million, is a further example of the ongoing threat and significant cost of cyber attacks. Given the current climate, it is not surprising that one of the major themes of the UK Government’s 2015 national security approach paper entitled *National Security Strategy and Strategic Defence and Security Review* was cybersecurity and defense. UK initiatives on cyber protection and impending EU rules on reporting data breaches are all moves to foster greater cybersecurity. With these rules comes the increasing need for insurance protection against cyber risk.

#### 1. Cyber Essentials

In June 2014, the UK Government launched its voluntary “Cyber Essentials Scheme” in order to help SMEs implement basic cybersecurity measures on the premise that relatively simple steps might help to prevent some 80% of attacks to which they would otherwise be vulnerable. There are two elements to the scheme:

- it provides a clear statement of the basic controls organizations should implement to mitigate the risk from common internet-based threats; and
- it offers an “Assurance Framework” allowing organizations to demonstrate to consumers, investors, insurers and others that they have taken these precautions.

Under the Assurance Framework, a Cyber Essential certification is awarded on the basis of a verified self-assessment. Organizations can also opt to undergo external testing and be awarded a Cyber Essential PLUS certification, although in order to do this they must first be Cyber Essential certified.

The list of organizations opting to be certified under the regime has increased, with the scheme receiving an industry award for its simplicity and flexibility as well as the practical results it delivers. Organizations ought to consider the impact that the Cyber Essentials certification may have on their ability to obtain cyber insurance and, indeed, the effect certification could have on the cost of premiums.

From a compliance and risk management perspective, the Cyber Essentials measures should set a benchmark against which management may be held accountable: cyber risk management is, of course, a corporate governance issue. Standards like these may also be used in the determination of negligence; losses that could have been prevented by the adoption of the Cyber Essentials measures may turn out to be uninsured and may be more easily shown to be the responsibility of the organization that failed to prevent them. Cyber Essentials could also play a role as a benchmark for compliance with general data protection requirements on information security.
which is becoming an ever bigger issue, as demonstrated by the forthcoming Data Protection Regulation and the Network and Information Security Directive.

2. EU Data Protection Regime

On December 15, 2015, the European Parliament and the Council reached an informal agreement on the EU data protection reform package. It has been more than four years since the initial draft of the proposed Data Protection Regulation was released by the European Commission. The main changes under the proposed Data Protection Regulation, which is likely to be adopted within the next few months (and will apply two years from its publication in the Official Journal of the European Union) include:

- **Fines**
  
  Fines for non-compliance can total the greater of €20 million or 4% of annual worldwide turnover and an ability for individuals to bring claims, including for non-financial loss.

- **Extraterritorial Application**
  
  The Data Protection Regulation will apply to any company that processes the data of European citizens, even if the company is not physically present in Europe.

- **Security Breach Reporting**
  
  Companies are obligated to report security breaches likely to result in a high risk to the rights and freedoms of individuals without undue delay to the relevant data protection authority as well as to affected individuals and, where feasible, within 72 hours.

- **Enhanced Accountability Principles**
  
  Companies are obligated to adopt policies and implement measures to demonstrate compliance, including the appointment of a Data Protection Officer in some cases.

- **Profiling**
  
  The Data Protection Regulation adds new restrictions on profiling.

- **Foreign Data Requests**
  
  Data requests from regulators or courts in countries outside the EU will only be recognized or enforceable, if based on an international agreement between the relevant EU member state and the requesting country.

Businesses, including those outside the EU that have data on Europeans, ought to consider whether they are caught by the Data Protection Regulation and, if so, assess any gaps in their data protection practices and insurance policies which may leave them exposed after implementation. A key aspect to consider in respect of the above is data breach planning. Firms will need to consider how they report a data breach in the prescribed time frame. This mandatory reporting obligation will result in significant reputational repercussions for companies in the case of a security breach. Again, when considering cyber insurance, companies will need to ensure that cover for reputational damage as well as restoring lost or damaged data is reflected in their policy.


Under the proposed Network and Information Security Directive, digital service providers and operators of essential services, such as energy, transport, water production and supply, and financial market infrastructure, will be required to: (a) assess the risks they face; (b) adopt appropriate and proportionate measures to ensure network and information security; and (c) report without undue delay any incidents which have a significant impact on the continuity of the core services they provide.

The obligations under the Directive will be more onerous for essential operators than for digital services providers since cyber threats to the former pose a greater risk to society and the economy.

The agreed text of the Directive is likely to be adopted in spring this year, after which Member States will have 21 months to adopt the necessary provisions into national law and then a further six months to identify the essential services operators established in their territory. A draft of the Directive has recently been published, so businesses should clarify whether or not they will be classed as operators of essential services or digital service providers. Those who fall within scope ought to consider what the impact will be of these more stringent security requirements and to what extent cyber cover could mitigate some of the risks they face.

4. Potential for Government Protection

The cost of a cyber attack is still a difficult area for the UK insurance industry to quantify, in part due to the dearth of security breach reporting by companies. Given the potentially significant impact on the (re)insurance industry of a major cyber attack on multiple organizations, there has been debate as to whether there needs to be a Government backed cyber reinsurance scheme, similar to Pool Re. Pool Re is an insurance scheme set up in 1993 in cooperation with the UK Government to provide commercial property insurance following terrorist attacks. In spite of a growing cyber insurance market, many insurers are still unwilling to offer this type of cover because the risk is inherently difficult to assess. In recent reports, the chief executive of Pool Re has suggested that the UK Government should encourage growth in the cyber insurance market by providing a top layer of insurance to act as a buffer for insurers in the event of a systemic cyber incident occurring. If the UK Government were to cover the major cyber risks, it would free up the industry to provide cover which is within their risk appetite.

Whether a government-backed scheme will be created remains to be seen. In the meantime, the forthcoming security breach reporting requirements may provide the insurance industry with the data it needs to quantify the risk and thereby provide cover.
VI. Select Tax Issues Affecting Insurance Companies and Products

A. U.S. TAX ISSUES

1. Tax Legislation

a. Prospects for Tax Reform

Tax reform remains unlikely in the coming year, a presidential election year. George Callas, House Speaker Paul Ryan’s senior tax counsel, has stated that he anticipates few legislative opportunities for reform.21 The Republican Congress plans to use this year to develop a framework for tax reform in 2017.

There is some consensus among Republican leadership to focus initially on international tax reform. Optimism regarding how much progress can be made this year varies. House Ways and Means Chairman Kevin Brady has committed to making meaningful progress on U.S. international tax reform in 2016. He has stated that, although there is “no guarantee that an international tax proposal can or will make it to the president’s desk… it’s very important that we advance it as fast as we can in this year.”22 House Budget Committee Chair Tom Price does not anticipate a House vote on changes to international tax policy until the spring of 2017, and then only if the new president supports reform.23 The goals of reform likely would include alleviating the causes of corporate inversions, base erosion, and profit-shifting. The effects of international tax reform on the insurance industry will remain unclear until Congress provides more detail regarding changes to the tax code.

b. Active Finance and CFC Look-Through Rules

This year saw one significant legislative advancement for insurance companies: The cycle of one-year renewals of the active finance and controlled foreign corporation (“CFC”) look-through rules finally came to an end, removing the annual uncertainty that accompanied the renewal of these provisions. These rules, contained in Sections 953, 954(i) and 954(h) of the Code, generally allow foreign insurers that are CFCs and owned through commercial standard holding company structures to operate active insurance businesses in their home jurisdictions in a tax-efficient manner. Absent these rules, a U.S. corporate parent would be required to pay current taxes on the insurance income earned by a foreign subsidiary, even if that foreign subsidiary conducted an entirely foreign business reinsuring only risks with a U.S. trade or business. For treaty purposes, the foreign affiliate would have to attribute the income to a permanent establishment.

Prior to this year, the active finance and CFC look-through rules were generally passed with one-year extensions, forcing Congress to retroactively extend the provisions. The bipartisan

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22 Casey Wooten, Brady Hedges on Finishing International Overhaul This Year, 10 DTR G-2.
The proposed regulations are intended to curtail certain reinsurance companies as passive foreign investment companies (PFICs). On April 23, 2015, the Department of the Treasury issued proposed regulations which address a number of issues. These include:

- Change of net operating loss rules of life insurance companies to conform to those of other corporations
- Increased information reporting for private separate accounts of life insurance companies
- Imposition of a financial fee

This proposal would permit life insurance companies to carry back a loss from operations (the equivalent of a net operating loss) up to two years and forward for up to 20 years, the regime that applies to non-insurance companies. Currently, insurance companies can carry back a loss operation up to three years and forward up to 15 years.

- **Increased information reporting for private separate accounts of life insurance companies**

As in the 2016 budget proposal, the current proposal would increase the information that a life insurance company would be required to report to the Internal Revenue Service ("IRS") in connection with each contract whose cash value is partially or wholly invested in a private separate account for any portion of the taxable year and represents at least 10% of the value of the account. The information required would be: the policyholder's TIN, the policy number, the amount of accumulated taxable income, the total contract account value, and the portion of that value that was invested in one or more private separate accounts. A private separate account would be defined as any account with respect to which a related group of persons owns policies the aggregate cash values of which represent at least 10% of the value of the separate account.

- **Imposition of a financial fee**

The Obama budget calls for a fee imposed on banks and "nonbanks," including insurance companies and financial captives, with worldwide consolidated assets of more than US$50 billion. The fee would apply to "covered liability" of the financial industry, defined as assets less equity based on audited financial statements with a deduction for separate account liabilities. The current proposal seems to include insurance company reserves in the calculation of covered liabilities. The rate of the fee would be seven basis points, and its amount would be deductible from a company's corporate income tax. Companies would be required to make estimated payments of the fee on the same schedule as the company's estimated income tax payments.

### 2. Alternative Reinsurance

On April 23, 2015, the Department of the Treasury issued proposed regulations that address the status of non-U.S. insurance and reinsurance companies as passive foreign investment companies ("PFICs"). The proposed regulations are intended to curtail certain abuses believed to arise when an asset manager forms an offshore reinsurance company that invests in the funds it manages, with the intent of deferring U.S. tax on the income of the reinsurer.

Most investment funds are structured as flow-through vehicles, including most hedge funds. Accordingly, investors are taxed on the funds' income regardless of whether that income is distributed to the investors. In the late 1990s and early 2000s, certain asset managers formed non-U.S. reinsurance companies (typically located in the Cayman Islands or Bermuda) through which investors would make investments in the funds of that asset manager. Those structures became commonly known as "hedge fund/Re" structures. One alleged motivation for the creation of this structure was the beneficial tax treatment for investors (when compared with a direct investment in a fund), based on the reinsurance company not being a PFIC. The asset managers generally have taken the position that the reinsurance company would fall within the scope of the "active insurance business" exception of the PFIC rules. The IRS has, in certain circumstances, questioned this treatment. In particular, the IRS announced in IRS Notice 2003-34 that it intended to scrutinize the activities of purported insurance companies organized outside the United States, including insurance companies that invest a significant portion of their assets in alternative investment strategies such as hedge funds, and that it would apply the PFIC rules where it determines that a non-U.S. corporation is not an insurance company for U.S. federal income tax purposes. The proposed regulations are an attempt to provide more clarity around the concerns described in IRS Notice 2003-34.

By their nature, insurance companies hold financial assets such as securities, producing "passive"-type income such as interest. Because their assets and income are of a "passive" type, all foreign insurance companies would be PFICs but for an exception in the definition of a PFIC (the "Insurance Exception"). Under the Insurance Exception, income and the assets that produce the income are not considered passive to the extent such income is derived in the "active conduct" of an insurance business, by a corporation which is "predominantly engaged in an insurance business" and which would be subject to tax under subchapter L (relating to the taxation of U.S. insurance companies) as an insurance company if the foreign corporation were a U.S. corporation. Prior to the proposed regulations, there was no guidance as to the proper interpretation of the Insurance Exception. The proposed regulations provide some, but not all, of the sought-after guidance.

The most controversial aspect of the proposed regulations is the interpretation of the "active conduct" requirement. The proposed regulations provide that an insurance business will generally be considered to be "active" only if the officers and employees of the corporation carry out substantial managerial and operational functions. For this purpose, the activities of independent contractors and the activities of officers and employees of related entities are not taken into account; the relevant personnel must be employed directly by the foreign insurer. The proposed regulations do not specify any minimum number of employees or whether employees in specific roles, such as a general counsel, are required.

Most of the discussion in the industry has been around whether there should be a bright-line ratio or other quantifiable test for...
purposes of the “passive asset” test. Determining which assets are passive is critical to determining whether a non-U.S. corporation is more akin to a non-U.S. investment fund (i.e., mostly investment assets with an insurance business on the side) or more akin to an operating insurance business (i.e., investment assets needed to support reserves and surplus for the company’s predominant insurance business). The proposed regulations shed no light on this issue. Instead, the IRS requested comments on the point prior to the issuance of final regulations.

The IRS received numerous comments on the proposed regulations, including from industry associations. A public hearing was held on September 18, 2015. The comments have focused on two points. First, the proposed regulations’ interpretation of the “active conduct” requirement is inconsistent with existing industry practice under which many non-U.S. insurance and reinsurance entities are managed by independent contractors or employees of affiliates, with few or no direct employees. Second, regular insurance companies could be inadvertently treated as PFICs because they might fail a mechanical “passive asset” test (i.e., a minimum reserves-to-assets ratio). It is currently unclear when, or even whether, the IRS will either re-propose substantially revised proposed regulations, issue final regulations, or do both. The effective date of the proposed regulations is prospective from the time they are finalized.

3. FATCA

The IRS released additional guidance in the form of two Notices under the withholding and information reporting provisions commonly known as the Foreign Account Tax Compliance Act (“FATCA”). The Notices outline certain amendments that the Treasury Department and IRS intend to make to the regulations under FATCA, and the Notices provide that taxpayers may rely on the amendments prior to their issuance as regulations.

Notice 2015-66 was released in September 2015 and describes amendments that are intended to be made to certain transitional rules in the regulations under FATCA. The amendments would delay the start date for FATCA withholding on gross proceeds from the sale or other disposition of property of a type that can produce interest or dividends from sources within the United States, such that withholding is required only on sales or other dispositions occurring after December 31, 2018. Similarly, the start date for FATCA withholding on “foreign passthrush payments” would be delayed to the later of January 1, 2019 or the date final regulations are published defining the term “foreign passthrush payment.” The amendments would also (a) extend to January 1, 2017, the termination date for the “limited branch” and “limited FFI” statuses under FATCA; (b) extend to December 31, 2016, the deadline for sponsoring entities to obtain Global Intermediary Identification Numbers (“GIINs”) for their sponsored entities (the FATCA registration portal was updated in late 2015 to permit sponsoring entities to register and obtain GIINs for their sponsored entities ahead of the new deadline); (c) permit (but not require) secured parties holding collateral that secures both grandfathered obligations not subject to FATCA withholding, and non-grandfathered obligations, to withhold on all such collateral rather than apply a pro rata approach; and (d) treat as a grandfathered obligation any obligation that gives rise to substitute payments and that is created as a result of the payee’s posting of collateral that is otherwise treated as a grandfathered obligation because it is an obligation that was outstanding on July 1, 2014. Taxpayers are permitted to rely on the amendments identified in the Notice prior to the issuance of regulations.

Aside from the amendments mentioned above, Notice 2015-66 also acknowledges that many jurisdictions that have entered into a “Model 1” intergovernmental agreement on the implementation of FATCA (a “Model 1 IGA”) are still in the process of bringing their Model 1 IGAs into force and implementing the systems needed for automatic information exchange with the United States. The Notice helpfully provides that foreign financial institutions (“FFIs”) covered by a Model 1 IGA in such a jurisdiction will be treated as in compliance and not subject to withholding under FATCA, provided that the jurisdiction continues to work to implement the Model 1 IGA and meets certain requirements.

Notice 2016-8 was released in January 2016 addressing certain amendments to the regulations under FATCA and the terms of the so-called “FFI agreement.” The amendments would extend the date by which a “participating FFI” (including a “reporting Model 2 FFI”) must submit to the IRS its certification of compliance with the due diligence procedures for preexisting accounts under the FFI agreement. The FFI agreement currently requires that the certification be made not later than two years and 60 days after the effective date of the FFI agreement (i.e., by August 29, 2016, in the case of an FFI agreement with an effective date of June 30, 2014). Under the amendments outlined in the Notice, the due date for this certification would be aligned with the due date for the FFIs first periodic certification of compliance with the terms of the FFI agreement, which must be submitted to the IRS on or before July 1 of the calendar year following the FFI’s first “certification period.” The first certification period begins on the effective date of the FFI agreement and ends at the close of the third full calendar year following such effective date. Accordingly, for an FFI that has an FFI agreement with an effective date of June 30, 2014, both the preexisting account certification and the first periodic certification of compliance would be due on or before July 1, 2018.

Other amendments described in the Notice would (i) modify the certification requirements for “local FFIs,” “restricted funds,” and “registered deemed-compliant FFIs” (other than “reporting Model 1 FFIs”); (ii) except participating FFIs, reporting Model 2 FFIs, and registered deemed-compliant FFIs from gross proceeds reporting on accounts held by nonparticipating FFIs for calendar year 2015; and (iii) modify the standards of knowledge requirements in the regulations under both FATCA and the “chapter 3” withholding provisions to enable withholding agents to rely on IRS Forms W-8 and W-9 collected electronically by a non-qualified intermediary or nonwithholding foreign partnership or trust that is a direct or indirect account holder of the withholding agent, provided certain requirements are met.

4. Inversion Guidance

The Internal Revenue Service released welcome guidance last year revising and relaxing rules issued in 2014 that could have significantly restricted the ability of foreign insurance companies to acquire U.S. targets using stock consideration.
Under current law, if a domestic corporation is acquired by a foreign company in a transaction in which the former shareholders of the domestic corporation come to own 80% or more of the combined entity, the acquiring foreign corporation will be treated as a domestic corporation subject to U.S. income tax—such transactions are termed “inversions.”

IRS Notice 2014-52 provides that the IRS intends to issue regulations that expand the universe of transactions that will be treated as “inversions” by providing special rules for calculating the 80% ratio in the case of so-called “cash box” acquirers (i.e., acquirers that hold significant amounts of passive investment-type assets). The Notice provides that when a foreign-acquiring corporation has more than 50% investment-type assets, the “denominator” of the 80% fraction will be determined by excluding stock of the foreign acquirer attributable to the passive-type assets. This will tend to increase the proportion of stock of the foreign acquiring entity treated as being owned by former shareholders of the domestic target, increasing the likelihood that the transaction will be treated as an inversion.

The IRS had the commendable foresight to consider the special issues that would arise in the application of these rules to the insurance and financial services industry because of the operational need to hold passive-type assets, but the resolution offered by the IRS in the 2014 Notice was incomplete. The 2014 Notice provides that assets that give rise to certain exempt insurance income under the CFC insurance company rules will not count toward the 50% cash box limit. The CFC insurance company rules are quite narrow, however—in particular, only a company with predominantly “home country” risks will qualify. Thus, for example, a reinsurance company that accepts risk from a number of different countries might not satisfy the narrow requirements of this exception and, as a result, would be treated as a “cash box” acquirer. The 2014 Notice incorporates the CFC insurance company rules rather than the somewhat more lenient PFIC rule for active insurance companies. Curiously, the Notice provides that in the context of banking and finance companies, as opposed to insurance companies, foreign acquiring companies may rely on the PFIC and the CFC exceptions to avoid being treated as a cash box. Thus, the 2014 Notice takes two different approaches in the same guidance to solve what appears to be an analytically similar problem: the treatment of operating foreign businesses that are required to hold large amounts of passive assets for ordinary and legitimate business purposes.

A number of groups provided comments to the IRS in 2015 criticizing the decision to allow only the narrow CFC exception to insurance companies, and the IRS has helpfully addressed the industry’s concerns in Notice 2015-79. In the 2015 Notice, the IRS indicated that final regulations will provide that foreign acquiring companies will generally be permitted to rely on the PFIC and CFC exceptions to avoid being treated as a cash box, thus providing parity among the insurance, banking, and finance industries on this issue. In expanding the cash-box rule, the IRS was careful to note that it is still separately considering the scope of the insurance exception under the PFIC rules (as discussed above) and that any guidance in that area would be incorporated into the cash-box guidance as well. The IRS also helpfully clarified that passive-type assets owned by domestic insurance companies and used in the active conduct of an insurance business will not count as “bad” assets for purposes of the cash-box test. The industry had requested clarity on this issue as well, and the IRS has helpfully accommodated the industry’s concerns.

5. Cascading Federal Excise Tax

On May 26, 2015, a three-judge panel of the U.S. Court of Appeals for the D.C. Circuit ruled unanimously for the taxpayer in Validus Reinsurance, Ltd. v. United States, 786 F.3d 1039 (D.C. Cir. 2015). This is the first case to involve a challenge to the IRS’ position on the “cascading” application of the federal excise tax (“FET”) to reinsurance agreements between foreign parties covering U.S. insurance risks.

In this case, U.S. insurers ceded certain U.S. risks to Validus, a Bermuda reinsurer, transactions on which the FET was paid. Validus then retroceded some of these risks to other Bermuda reinsurers. The IRS assessed and collected a second or “cascading” FET from Validus on the retrocessions, and Validus sued for a refund. Based on the presumption against extra-territorial application of U.S. law, the Court of Appeals ruled that Congress did not intend to apply the FET to wholly foreign transactions between foreign parties operating outside the United States. Validus is therefore entitled to a refund of the second-level FET Validus paid.

In response to the Validus decision, the IRS released Revenue Ruling 2016-3 in late December, revoking the “cascading” FET ruling issued several years earlier (Revenue Ruling 2008-15). In the December ruling, the IRS made clear that its change of position relates only to situations where one level of FET has previously been imposed on an outbound transaction preceding the foreign-to-foreign transaction. The IRS still intends to collect a single level of FET on cessions of risk going outbound from the U.S. tax system (i.e., where the ceding company is a so-called “953(d)” company or is a U.S. branch of a foreign insurer or reinsurer).

The Court of Appeals decision and the prompt revocation of Revenue Ruling 2008-15 represent a major victory for the industry.

6. Limitations on What Constitutes Insurance for Tax Purposes

The Tax Court provided guidance this year on the always-difficult question of what arrangements constitute insurance for tax purposes in a decision handed down in R.V.I. Guarantee Co. Ltd. v. Commissioner, T.C. No. 27319-12. The case concerned “residual value insurance,” in which an owner of assets subject to a long-term lease (e.g., equipment or real estate) buys protection against the possibility that the “snapshot” residual value of the asset at the conclusion of the lease term may be lower than a target amount. In this litigation, the IRS had taken the position that the policyholder’s economic risk involved in this type of business is not an “insurance risk” and that any claims the insurer must pay do not arise from a casualty event.

The Tax Court concluded that residual value insurance policies constitute insurance for federal tax purposes and that the risks covered by the insurance policies constitute insurance risks (as opposed to investment risks). The decision contained helpful guidance on a number of points. First, while the court recognized...
that residual value insurance provided protection against a loss of market value (consistent with the view that residual value is merely an “investment risk”), it was not restricted to market risk. In this vein, residual value policies are very similar to mortgage guaranty insurance and municipal bond insurance, both of which are commonly accepted forms of insurance that Congress and the IRS have recognized as insurance for tax purposes. Second, while the court acknowledge that “fortuity” was an aspect of insurance risk, the court rejected the IRS’ contention that recovery under an insurance contract must happen immediately after the fortuitous event; thus, waiting for the end of a lease term would not negate the fortuity element of a decline in value that first occurred partway through the lease term. Finally, the court stressed that the inquiry into whether a policy is insurance “in the commonly accepted sense” properly places great emphasis on whether the policy is regulated as insurance by the relevant state regulator.

The industry is still waiting to determine the full impact of this case. Residual value insurance is a unique product which has a great deal of similarity to typical financial instruments such as derivatives and put options. We will continue to carefully monitor developments in this area.

7. Insurance Issues in the OECD BEPS Project

The Organisation for Economic Co-operation and Development (the “OECD”) is a Paris-based multi-national organization that develops policies for coordinated implementation by its 34 member countries (which include the United States) and “partner” countries for the purposes of improving global economic and social well-being. At the request of the G20, beginning in 2013, the OECD has worked to develop recommendations for reforming domestic and international law to reduce the “base erosion and profit shifting” (“BEPS”) activities that enable multi-national enterprises (“MNEs”) to reduce the amount of total income tax they pay.

OECD issued a report in 2013 containing 15 separate action points to address BEPS. In October 2015, it released final reports on all 15 action items:

1. Addressing the Tax Challenges of the Digital Economy
2. Neutralizing the Effects of Hybrid Mismatch Arrangements
3. Designing Effective Controlled Foreign Company Rules
4. Limiting Base Erosion Involving Interest Deductions and Other Financial Payments
6. Preventing the Granting of Treaty Benefits in Inappropriate Circumstances
7. Preventing the Artificial Avoidance of Permanent Establishment Status
8., 9. and 10. Aligning Transfer Pricing Outcomes with Value Creation
9. 11. Measuring and Monitoring BEPS
12. Mandatory Disclosure Rules
14. Making Dispute Resolution Mechanisms More Effective
15. Developing a Multilateral Instrument to Modify Bilateral Tax Treaties

Together, these reports propose “a comprehensive package of measures which are designed to be implemented domestically and through treaty provisions in a coordinated manner.”24

Many of the proposals will be of general interest to MNEs, including insurance companies. These include recommendations for domestic laws to standardize country-by-country reporting for MNEs’ worldwide activities, limit interest deductibility, and address hybrid instruments as well as recommendations for bilateral and multilateral treaties to prevent treaty shopping and reform dispute resolution. However, certain general recommendations—such as those on interest deductions, transfer pricing rules applicable to “low value-adding intra-group services,” and hybrid financial instruments—specifically do not apply to insurance companies or their products.

Several recommendations specifically address insurance companies or are particularly relevant to the insurance industry. Action 3, regarding rules for CFCs, recommends that every country define “controlled foreign corporations” by reference to both legal and economic control. It also includes insurance income in several definitions of income subject to CFC rules. These recommendations are not specific and would not necessarily require any change in current U.S. law to bring U.S. law into conformity with the recommendations.

Action 7 addresses the perceived practice that MNEs avoid creating a “permanent establishment” in jurisdictions to avoid tax in a way that distorts their economic connection to such jurisdiction. The reports recommend revising the OECD Model Tax Convention’s definition of “permanent establishment” to include the use of independent agents that are closely related to the foreign company. It also proposes a revision to the existing commentary regarding insurance to the model treaty stating that this change is intended to apply to insurance companies. The OECD report noted that, although there had been discussion earlier in the BEPS project of creating separate rules applicable to insurance companies, the participants determined that the proposed changes to the interpretation of “permanent establishment” were sufficient to address the issue and that insurance-specific rules were not warranted. Additionally, many countries are working to agree to a multinational treaty instrument that would implement many of the BEPS reports’ recommendations.

Actions 8 to 10 address transfer pricing, and Action 10 specifically addresses risk transfer. The report on these Actions recommends, among other things, changes to the Transfer Pricing Guidelines for

Multinational Enterprises and Tax Administrations. These changes include guidance on when a transaction between related parties should be recharacterized or disregarded because it would not occur between third parties at arm’s length. One of the examples offered in the revised guidelines provides that an “insurance” policy issued by an affiliated company that is priced at “commercially irrational” terms should be disregarded.

Now that the OECD has issued its recommendations, it remains to be seen how, and to what extent, its recommendations are incorporated into domestic and international law.

8. Tax Treatment of Ceding Commissions

The IRS published this year a Chief Counsel Advice memorandum (CCA 201501011) throwing into question the proper tax treatment of ceding commission paid in an indemnity reinsurance transaction. The IRS concluded in the memorandum that a taxpayer was not entitled to a current deduction for a ceding commission paid in an indemnity reinsurance transaction that constitutes an “applicable asset acquisition” under Section 1060 of Code.

The facts of the arrangement are particular and important to the memorandum. The memorandum describes a taxpayer that purchased a block of reinsurance business through indemnity reinsurance. The taxpayer also acquired workforce, fixed assets, software and other assets, and the memorandum indicated that the pool of assets constituted transfer of a business. Crucially, the agreement obligated the parties to use commercially reasonable efforts to novate the underlying reinsurance agreements to the taxpayer after closing. The memorandum indicates that the contracts were in fact novated to the taxpayer.

The question presented by the CCA was whether, on these facts, the ceding commission deemed paid under the indemnity reinsurance transaction was currently deductible or required to be amortized over 15 years. Prior to this memorandum, based on legislative history and regulations promulgated by the IRS, it was generally believed that (except for amounts required to be capitalized under Section 848 under the DAC rules) a ceding commission paid for indemnity reinsurance was deductible on a current basis.

The memorandum concluded that the ceding commission was required to be capitalized and deducted over time on two grounds. First, although the reinsurance was done on an indemnity basis as a matter of form, the reinsurance was in substance assumption reinsurance because of the obligation to use efforts to novate the agreements and because the agreements were in fact novated to the taxpayer. Second, the IRS argued that, even if the transaction was treated as indemnity reinsurance, a ceding commission paid in the context of the acquisition of a trade or business is required to be capitalized under the regulations under Section 1060 of the Code.

The arguments offered for this conclusion in the memorandum are quite technical and not altogether satisfying. Reaction in the industry to the memorandum was generally quite negative, and the memorandum was criticized both in print and at a number of conferences after its release. In particular, the memorandum introduced a great deal of uncertainty into the proper way to price reinsurance acquisitions, as a prospective buyer might not be able conclude with any certainty as to the proper tax treatment of ceding commission in an indemnity reinsurance transaction. It remains to be seen whether, and to what extent, the uncertainties introduced in the memorandum will affect transactions in the future.

9. Reinsurance and Section 351

The IRS issued an interesting ruling this year in PLR 201506008, in which the IRS ruled that indemnity reinsurance can be used as part of a tax-free capitalization of a new insurance company under Section 351 of the Code. In the ruling, a joint venture was established to hold a newly formed insurance company that wrote dental, life and health insurance contracts and also reinsured certain lines of business (which were not revealed in the ruling) written by certain “Branded Insurers” that were partners in the joint venture on a 100% co-insurance indemnity basis. Crucially, the consideration offered by the newly formed insurance company to reinsure the business from the Branded Insurers was its own newly issued stock—that is, no cash ceding commission was paid. The issue considered by the ruling was the proper tax treatment of the reinsurance and related receipt of stock of the newly formed company.

The ruling concludes that the reinsurance is part of a transaction described in Section 351 of the Code and, therefore, no gain or loss was recognized by the ceding companies on property transferred to the newly formed insurance company. A number of representations given by the taxpayer in the ruling are interesting, among them: (i) a representation that a portion of the fair market value of stock issued by the newly formed corporation is allocable to the value of the insurance in force and (ii) a representation that, at the time of the transaction, the ceding companies intend for the indemnity reinsurance to renew automatically pursuant to their terms and that no party has any plan or intention to termination any of the agreements. The ruling specifically notes on this point, “It is anticipated that the transfer under the reinsurance agreement will be permanent.”

The ruling can be read as an extension to 100% coinsurance arrangements of the principles announced by the IRS in Revenue Ruling 94-95, which applied Section 351 of the Code to assumption reinsurance between a parent and its wholly owned subsidiary. Interestingly, the recent ruling does not discuss the consequences to the ceding or assuming company relating to reserves. Arguably, practitioners can look to the principles of Revenue Ruling 94-95 to support a conclusion that adjustments to year-end reserves are made to prevent the ceding company and assuming company from recognizing deduction or gain attributable to the transfer of reserves.

10. Variable Life and Annuity Products

In June, the U.S. Tax Court issued the first court decision on the “investor control” doctrine in 30 years (Webber v. Commissioner, 144 T.C. No. 17 (6/30/2015)). The “investor control” doctrine is a set of principles based on IRS rulings under which the policyholder of a variable contract is treated for tax purposes as owning the policyholder’s pro rata share of the separate account assets that support his contract. If the policyholder, rather than the life insurance company, is treated as the tax owner of these assets, the policyholder loses the expected benefits of tax-deferred growth in the product.
value (“inside build-up”) and must pay current tax each year on the income derived from the separate account assets such as interest, dividends, or realized gains.

The taxpayer in Webber was a successful venture capitalist who formed grantor trusts to which he contributed cash, and which he used to pay sizable up-front premiums on variable life insurance contracts covering the lives of certain relatives of the taxpayer or the taxpayer’s spouse. The contracts were issued by a Cayman Islands insurance company called Lighthouse. The separate accounts supported only the contracts issued to Webber’s grantor trusts and no other contracts of any other policyholders. The separate account investments were mostly private placement securities issued by start-up companies in which Webber also invested his other personal funds. Moreover, the investor control violation was fairly blatant. Webber’s attorney advised him (erroneously) that he could avoid the investor control doctrine if his investment directions to the separate account investment manager were styled as “recommendations” and were communicated to the investment manager only indirectly through intermediaries (Webber’s attorney or his accountant). The investment manager hired by the life insurance company to manage the separate accounts was paid very little and did very little, having no ability to even attempt due diligence on the start-up companies in which the separate accounts were investing. Webber himself did the diligence and often negotiated the terms of the securities. The Tax Court had little difficulty concluding that Webber should be treated as the owner of the separate account investments.

The Tax Court also ruled that the long series of Revenue Rulings that constitute the “investor control” doctrine, issued between 1977 and 2003, are entitled to what is known as “Skidmore deference,” referring to a 1944 U.S. Supreme Court case. This essentially means that an agency rule or position, while not binding, should be followed if it is persuasive and consistently applied over time.

While not apparent from the court’s opinion, the investor control issue was raised against Webber because of a specific communication to the IRS from an individual described as a “whistleblower” regarding the investments Webber was making through the variable contracts held by his trusts. Thus, the case did not seem to arise out of any broad, organized effort on the part of the IRS to seek out and audit investor control violations.

Finally, strong interest continues to be seen on the part of various promoters, fund managers, and investors in the creation of new insurance-dedicated funds focusing on non-traditional asset classes (e.g., hedge funds) for the purpose of adding such funds to the variable product platforms of life insurance companies. These transactions often involve potential investor control issues that require careful attention.

B. EUROPEAN UNION/UNITED KINGDOM

1. EU/UK Tax Developments

Times continue to be challenging for multinational businesses looking to ensure that their arrangements remain both robust and efficient from a tax perspective. Insurance groups are no different in this respect. Although the greatest attention has been given to the OECD’s BEPS initiative (for which the final reports were delivered in October 2015), there is a range of tax issues of which insurance groups should be aware.

The most important recent tax developments for the insurance industry are: (a) the changes suggested to the definition of a permanent establishment (the “PE”) under BEPS Action 7; (b) the introduction of the new global information exchange regime, the Common Reporting Standard (the “CRS”); and (c) the consequences of the September 2014 decision of the Court of Justice of the European Union (the “CJEU”) in a case involving Skandia America Corporation which departed from the established principle that intra-entity transactions do not give rise to a supply.

a. BEPS Action 7: Prevention of the Artificial Avoidance of PE Status

The OECD intends to alter article 5 of its Model Tax Convention to lower the PE threshold and narrow the exemptions to PE status. The original discussion draft, published in October 2014, contained specific proposals targeting perceived permanent establishment issues in the insurance industry. These were removed in the revised discussion draft of May 2015 and were also left out of the final reports. General changes will still be made to rules on dependent and independent agents, and these will likely impact insurers. Paragraph 5 of article 5 broadens the previous “conclude contracts” threshold to situations where the intermediary “habitually concludes contracts, or habitually plays the principal role leading to the conclusion of contracts that are routinely concluded without material modification by the enterprise.” Paragraph 6 of article 5 is strengthened so that an agent will not be considered “independent” where that agent acts exclusively or almost exclusively for one or more enterprises to which it is closely related.

Where such proposals are implemented, they may have substantial tax and compliance consequences for certain cross-border insurance arrangements. In light of the understood complexities which arise, the OECD has agreed to provide further guidance and examples in respect of attribution of profits to PEs before the end of 2016.

b. Introduction of the CRS

The last few years have seen significant international focus on the transparency of the tax system and, in particular, the basis on which automatic exchange of information can be used as an effective means to combat perceived tax avoidance. In turn, this led to the United States introducing FATCA and, later, the United Kingdom introducing a series of bilateral agreements with jurisdictions such as the Cayman Islands and the Channel Islands (commonly referred to as UK FATCA).

In February 2014, the OECD published a global standard for automatic and multilateral exchange of financial information between tax authorities, known as the CRS and a model competent authority agreement, which the G20 finance ministers endorsed on February 23, 2014. To date, over 80 countries have agreed to implement the CRS.
The CRS is a new information exchange regime, pursuant to which participating countries automatically share information about residents’ assets and income. The CRS took effect for many countries on January 1, 2016.

c. Skandia: The Impact of VAT Grouping

The CJEU's September 2014 decision in Skandia America Corp. (USA), filial Sverige v Skatteverket (C-7/13) (Skandia) was of particular relevance to the insurance sector because of its potential to disrupt cross-border structures that, although in place for commercial reasons, also generate VAT savings. In Skandia, the CJEU decided that, because the Swedish branch of Skandia America was a member of a Swedish VAT group, it was effectively separated from its U.S. head office for VAT purposes. The Swedish VAT group was held to be a taxable person in its own right which was obliged to account for VAT on a reverse charge basis on the fees recharged to it by the U.S. head office.

EU member states have diverged in their interpretation of the practical implications of Skandia. The United Kingdom and Ireland have sought to limit its application by issuing guidance confirming that VAT will apply to supplies when a foreign establishment of a UK-established entity is in a member state that has VAT grouping rules similar to Sweden’s. In contrast, other member states, such as Belgium, have applied the Skandia decision more fully. The EC published a working paper (No 845) in February 2015 which called into question the approach to Skandia of the UK, Irish and Dutch tax authorities. However, HMRC brief 18, published October 30, 2015, retains the United Kingdom’s narrow interpretation, despite the concerns of the EC. The impact of Skandia for insurers will therefore vary across member states depending upon the interpretation of the relevant tax authority. Insurers will need to be aware of those differing interpretations and consider whether a VAT group remains the most efficient way to structure their activities.

As a result of both the BEPS action 7 proposals and the Skandia decision, insurance companies will require closer scrutiny of the potential tax impacts of their activities in each jurisdiction in which they operate, and they should consider ways to mitigate both PE and VAT risk.