The Actuarial Profession
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General Insurance
Current Issues Newsletter

The content of this newsletter is a summary of some of the current issues that might be of interest to UK general insurance actuaries and that have come to the attention of the Communications Committee. As such it is not a complete list. Anyone who feels that relevant issues have been omitted or that the summaries are in anyway misleading is invited to contact the Chairperson of the Committee, Kate Angell.

The information provided has been derived from a variety of sources. The Committee has not been able to check independently the veracity of all of the facts stated. Any opinions expressed are those of the Committee members, and do not necessarily reflect the position of the Institute and Faculty of Actuaries.

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1. Market news

Reinsurance cost to fall 1/1

Reinsurance premiums are expected to fall by as much as 5% to 10% at the January renewals in light of another benign loss year to the market. Although there were some major events, the insurance industry was spared the brunt of it due to a lucky escape. While the Deepwater Horizon oil spill might be the worst environmental disaster to date, BP chose to self insure. There were 19 named storms in 2010, none of which made US landfall. There were three major earthquakes (Haiti, Chile and New Zealand) with total expected insured losses less than $17 billion. With reinsurance capital now stronger than in 2007, and capacity in excess of demand, further rate reductions can be expected.

Lawsuits leave companies in deep water

In December, the US Government became the latest body to file lawsuits against BP, Transocean, Halliburton and other companies involved in the Deepwater Horizon oil spill. These suits will be aimed at recovering removal costs, economic losses and environmental damages under the Oil Pollution Act 1990 ("OPA") and civil penalties under the Clean Water Act.

The action, filed in New Orleans, does not specify damages, but potential penalties under just one of the laws cited - the Clean Water Act - could reach $21 billion, based on the number of barrels of oil spilt. The government is also seeking a declaration that the defendants are liable for "unlimited removal costs and damages" under the Oil Pollution Act, passed after the Exxon Valdez spill in Alaska. Any damages would be on top of the $20 billion (£17 billion) BP has agreed to pay into a fund to compensate people on the Gulf coast who have suffered financially because of the spill. The final damages figures depend on the US government's ability to prove gross negligence.

It was reported that there were also already more than 40 lawsuits filed by private organisations, many of which were class actions. Although BP did not purchase insurance cover, the event is still expected to generate significant insurance losses as any damages or recompense for chemical exposure or property damage related to the clean-up efforts found against the other defendants are likely to be paid by their relevant insurers.

The event is also expected to change the structure of the market, with the US Government planning to increase the loss cap (currently $75 million) under the Oil Pollution Act to around $10 billion. In addition, a new reinsurance consortium for sudden oil spills was launched before Christmas which will provide unprecedented levels of liability coverage, expected to rise to more than $10 billion from the current maximum level of coverage of $1.5 billion. The consortium (SOSCover) will be managed by Aon Benfield and involves a number of reinsurers, led by Munich Re.

UK personal motor insurance

A recent publication by consulting firm Towers Watson suggests that the introduction of the aggregator model has cost the personal motor insurance industry millions, channelling revenues to the advertising industry. The introduction of aggregators has brought a transparency that has completely commoditised the product offering where almost all purchases are now made purely on price rather than on brand, service or marketing. It has completely changed the economic structure of the market.

This publication follows a recent survey of UK insurers that suggested that the UK personal motor market is set to remain unprofitable until at least 2015. They found that the next five years of forecast poor performance is driven by a 30% annual increase in the cost of fraudulent claims and an over-reliance on pricing in an increasingly competitive sector. The report suggests that third-party bodily injury claims have almost doubled in ten years as a result of an increasing number of claimants per claim and a more aggressive claims management industry, despite a dramatic fall in the number of accidents over the same period. These developments have caused an industry loss ratio of 100% and a combined ratio in excess of 120% for 2009 - driven by an estimated 30,000 fraudulent accident claims for the same year.

Honest drivers bear the pain?

Staying with the topic of motor insurance, in October 2010 the House of Commons Transport Committee decided to hold a short inquiry into the cost of motor insurance which is concerned with what it calls the "escalating cost" of insuring vehicles. The inquiry is focusing on:

- The reasons and consequences of recent increases in the cost of motor insurance
- The impact on young people of the high costs of motor insurance
- The extent to which the cost of motor insurance is influenced by the prevalence of road accidents, insurance fraud, legal costs and the number of uninsured drivers
- Whether there are public policy implications of the rise in the cost of motor insurance and, if so, what steps the Government might take in response to them.

A number of representatives provided evidence (both written and oral) to the Committee, including David Brown, Chair of the Actuarial Profession's Third Party (Motor) Working Group and Duncan Anderson from EMB Consultancy LLP. Written evidence needed to be submitted by 15 December, and oral evidence was provided in two meetings on 9 November and 11 January. Both the written and oral evidence provided can be accessed via http://www.parliament.uk/business/committees/committees-a-z/commons-select/transport-committee/inquiries/cost-of-motor-insurance/.

The inquiry is coming at a time when motor insurance premiums have increased by more than 40% in the past year alone. However, motor insurers claim that they have not made a profit for 16 years - according to Fitch Ratings, the insurance industry pays out £123 in claims for every £100 in premiums collected. The reasons typically given for the increasing cost of claims are as follows:

- **Personal injury lawyers** - The number of companies offering claims management services and no-win, no-fee representation has almost doubled in the last year, and the effect these companies have on premiums is staggering. Personal injury claims have increased insurers' costs by at least 30% a year, while figures from the Association of British Insurers show that motorists are now paying 10% of their policy premium to meet the cost of personal injury claim lawyers.

- **Spurious whiplash claims** - Another contributing factor to rising motor insurance premiums is the surge in whiplash claims, with 20% of every motor insurance premium spent on whiplash, drivers are paying a hefty slice of their premium on these claims. The incidence of whiplash is also increasing, with the number of claims rising by 25% in six years. This increase contrasts with the Government's road casualty statistics, which indicate that the number of ''slight'' injuries from road traffic collisions is falling.

- **Fraud** - Staged car accidents, in which fraudsters deliberately crash cars into innocent drivers to win thousands of pounds in compensation, are another reason causing insurance costs to increase. Some experts say about £44 from every policy goes to cover these claims.

- **Uninsured drivers** - About one out of every 20 motorists drives without cover, which costs every driver about £30 a year on their premium.

- **Young drivers** - Premiums for young drivers are increasing faster than for any other group, with AA figures estimating a rise of 51% in the past year, bringing the average premium up to £2,500 for a young man and £1,400 for a young woman. With 15% of drivers causing 30% of the accidents and 40% of all claims costs, insurance experts agree that schemes to educate new drivers can only help bring costs down, with significant evidence from programmes in other countries proving this.

Irish insurance market update

Rating agency Standard & Poor's has thrown doubt on the creditworthiness of at least five Irish insurers (Allianz plc, Allianz Worldwide Care Ltd, Aviva Insurance Europe SE, Irish Life Assurance plc, and RSA Insurance Ireland Ltd) due to the crisis in Ireland – the credit agency has already lowered the national sovereign ratings and placed them on credit watch with negative implications.

The formal sale of Quinn Insurance was thrown into confusion when a spokesperson for the Quinn family stated that "it is working with Anglo Irish Bank" to devise a plan for rescuing the troubled insurer. The company was placed in administration at the start of 2010 after it was discovered that subsidiaries of the company had made guarantees in relation to the group's assets which reduced them by €448 million in the wake of the financial crisis. Both administrators and Anglo Irish Bank, which is owed €2.8 billion by the Quinn family, dismissed talks of plans to "rescue" the company.

It was reported earlier in January that the sale was imminent after a short list of interested parties was announced. Zurich, Alllianz, Travelers and a joint effort by Anglo Irish bank and US insurance group Liberty Global (rather than the Quinn family) have been named as interested parties, with the likely preferred bidder to be announced at the end of January.

P&I Clubs

A report by Willis has suggested that protection and indemnity clubs have made a "spectacular comeback" after suffering one of the worst years on record in 2008/09. The Willis report suggests that, in contrast, 2009/10 will prove to be one of the best years ever for investment returns, with all-time record high levels of assets and free reserves for the International Group ("IG"). However, claims remain at a disturbingly high level, and only half of the IG clubs are achieving their goal of making a profit on pure underwriting. Nearly all the clubs are seeking a general increase in calls in the range 0% to 5% for 2011/12.

FRC highlights latest issues for audit committees and users of actuarial information

In November 2010 the Financial Reporting Council ("FRC") published two documents highlighting the latest challenges being faced by audit committees and users of actuarial information.

The current economic outlook appears to be less depressed than in previous years. However, with a Government programme to tackle public spending, significant economic and market risks remain and will present challenges for many during the 2010/11 reporting season. Past experience shows that insolvencies have increased after the technical end of recessions as companies run out of working capital. Companies with significant government business, especially where the spending is discretionary, are particularly exposed.

The "Update for Audit Committees" document produced by the FRC focuses upon risk identification and reporting. It also seeks to stimulate an appropriate environment for key estimates, assumptions and models produced by management to be challenged in a constructive way and for providing support for auditors carrying out their work with an appropriate degree of professional scepticism.

The "Update for users of actuarial information" document is particularly relevant to the governing bodies of insurers and pension schemes, but may also be useful for scheme sponsors, auditors and audit committees. The focus is on quality controls for actuarial work, understanding the business model and the way cash flows are projected and reported, and the way risks are assessed and managed.

Both reports are available at http://www.frc.org.uk/press/pub2442.html.

Making divorce pay through insurance

The road to marriage is full of rewards and fraught with perils, and with divorce rates as high as 50% in the United States, is divorce insurance the answer to mitigating these risks? According to John Logan, chairman and chief executive officer of Safeguard Guaranty in Kernersville, N.C. - and a handful of policyholders who have already signed on - the answer is yes.

Driven in part by his own marital breakdown, Mr. Logan launched WedLock Divorce Insurance in August 2010. The concept behind the insurance is fairly simple - the insurance is sold directly to consumers online in units, with each unit costing $15.99 per month in exchange for providing $1,250 of coverage. Policyholders can buy anywhere from one to 200 units, or up to $250,000 in initial coverage. Every year that the policyholder continues to renew beyond the 48-month waiting period, the policy increases in value by $250 per unit.

Policyholders must have an active policy for 48 consecutive months under WedLock's standard plan before they are eligible to make a claim. There is an option to reduce the time to 36 months by purchasing a rider, but it almost doubles the cost of the policy.

Taking an example policy of 10 units at $159.90 a month, a person with a standard policy who decided to get divorced after year four would end up paying $7,680 in premiums for a claim payout out $12,500. Is it worth it? It may be worthwhile for people who cannot come up with lump sums of money to pay for things like an attorney's retainer fees. If a policyholder had a Legal Separation Agreement rider, they would receive half of the benefit when they legally separated (prior to the divorce), in order to provide cash to help pay the attorney up front.

So far, the response to divorce insurance has been encouraging to Mr. Logan who said that "We have a handful of policies sold, and we haven't done any advertising yet".

2. Claims and legal issues

Australia floods will be up to three cat events

It has been reported that the floods that have devastated Queensland could represent up to three events for the international (re)insurance community.

Insured loss estimates are trickling through, with AIR Worldwide pointing to an initial range of A$3 billion to A$6 billion for the floods in and around Brisbane and Rockhampton. These figures are based on projected growth of the number of claims reported to date, average claim size, and location, number and value of insured properties in AIR's industry exposure database for Australia - and not model output.

But with the high end of the range split between A$4 billion from last week's Brisbane deluge and A$2 billion for the central Queensland flooding from late December, attention is focusing on the number and timing of events. This issue is crucial for reinsurers. QBE and Insurance Australia Group ("IAG") - which have the second and third biggest market shares in the state - both renew programmes at 1 January 2011.

For insurers writing flood cover in the state, reinsurance contracts are thought typically to feature hours clauses allowing 168 hours or a week of flexibility for reinsureds to determine when loss events occurred and how they are split.

Aon Benfield, which placed the cat element of QBE's giant 1 January global programme, said: "For our clients with renewals at 1 January 2010, there is of course the possibility that this event may fall into either or both of their 2010 and 2011 reinsurance contract years. At an appropriate time, our clients will need to make this decision." One Bermudian reinsurer said: "The ability to carve up those losses will certainly affect reinsurers in terms of their loss potential".

Suncorp, with the biggest market share in Queensland, pointed to two insured events, and said its "comprehensive" reinsurance programme would limit the cost of claims to between A$70 million and A$90 million from the storm and flood damage in Brisbane and south-east Queensland since 8 January. It added that "the first weather system" that hit Queensland from Christmas Day is expected to cost between A$130 million and A$150 million pre-tax. Suncorp's programme is placed by Aon Benfield, and renews on 1 July at the start of its financial year.

Underwriting sources have suggested that the flooding may already represent three events.

The first is the flooding in December that was exacerbated by Tropical Cyclone Sasha and hit rural state areas, with a significant impact on miners in the Bowen Basin. This is expected to produce losses - potentially physical damage and business interruption - to the international (re)insurance and facultative market.

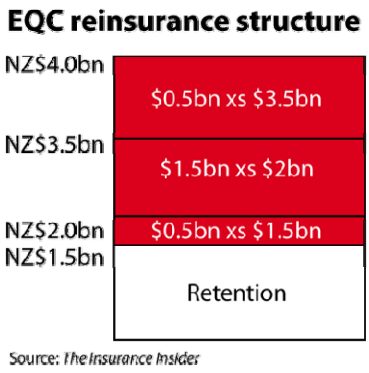
The second is the riverine floods that hit Rockhampton, rising to near record levels in the first week of January. These floods - which sources suggest are likely to lead to insured losses below A$500 million - could straddle the 2010-2011 years.

The third and most serious event appears to be the deluge of Brisbane, Ipswich and Toowoomba.

Commercial insurance cover for flash floods is more widely available than riverine floods in Queensland, with one underwriter putting an industry loss estimate at A$1.25 billion to A$1.75 billion.

New Zealand earthquake loss estimates rising

A succession of reinsurers (Amlin, Aspen, Catlin, Chaucer, Flagstone, Omega, Partner and Platinum) have revised upwards their initial estimates of insured losses from September's New Zealand earthquake, with some market commentators anticipating that other firms may have to follow suit and similarly rise their initial estimates. Earthquake losses are notoriously difficult to predict and on a number of occasions loss estimates have been continually revised up in the months after a catastrophe.



Most likely will be those markets on the NZ$1.5 billion in excess of NZ$2 billion layer on the EQC's reinsurance programme (see schematic). EQC is New Zealand's primary provider of natural disaster insurance to residential property owners and about 40 reinsurance companies are involved in its reinsurance programme.

If losses go past the NZ$3.5 billion mark then reinsurers on the highest excess layer of EQC's programme may also have to inflate their loss forecasts.

Mushrooming losses are not, however, confined to carriers that write the EQC programme. Reinsurers on the property treaties of IAG, Suncorp-Metway and AMI are also likely to be affected by the deteriorations.

AIG Workers' Compensation settlement

American International Group Inc. ("AIG") has tentatively agreed to pay $450 million to seven named insurance companies in order to settle a protracted federal civil lawsuit over alleged underreporting of workers' compensation premiums. However, Liberty Mutual subsidiaries Safeco Insurance and Ohio Casualty Insurance, who had filed the lawsuit in April 2009 on behalf of a pool of insurers, are not part of the settlement.

According to a source close to the matter, a high percentage of the pool, including yet-to-be-named companies, are willing to settle. The seven named companies were merely prepared to step in as a new class.

Among the named group looking to settle with AIG is The Hartford Financial Services Group, Travelers Insurance Group and Ace INA Holdings. The insurance companies looking to end the suit said in court documents that they and Liberty Mutual's affiliates have "very different

business judgments about the wisdom of continued litigation as opposed to settlement". Liberty Mutual continues to seek class-action status in the case.

The case history goes back to 2007, when the National Council on Compensation Insurance ("NCCI") originally filed the suit on behalf of the pool, but the case was dismissed because NCCI lacked jurisdiction. Then Liberty Mutual took up the case and filed another lawsuit similarly alleging that AIG underreported workers' compensation premiums to residual insurer National Workers' Compensation Reinsurance Pool ("NWCRP").

AIG ended 2009 by agreeing with all 50 states and the District of Columbia to pay close to $150 million - $100 million in fines and $46.5 million in taxes - to settle allegations it underreported workers' compensation premiums over a 20-year period, ending all regulatory issues.

The $450 million settlement has the support of regulatory authorities, "whose involvement in settlement negotiations has been a central catalyst in achieving a resolution of these claims", according to court documents.

US firms sue Toyota for defects

Seven insurance firms in the US have filed lawsuits against Toyota, the Japan-based world's largest automaker, over payouts made after alleged car defects caused crashes.

The firms' move at Los Angeles County Superior Court follows Allstate Insurance Co suing Toyota last year after claims made when Toyota vehicles accelerated unintentionally. The National Highway Traffic Safety Administration, a US federal agency, is investigating up to 89 deaths since 2000 that may have links to faulty acceleration in Toyota-made vehicles. The government, however, has confirmed only five deaths from two crashes.

Hundreds of car-owners have already filed lawsuits against Toyota over the supposed defects, but insurance firms have far greater resources to see through litigation and retrieve losses. Allstate filed last October for $3 million for itself and its affiliates, and Toyota faces civil liability claims of up to $10 billion in US courts after claims of wrongful death, personal injury and consumer fraud were made against the company.

The seven insurance firms' lawsuits echo past complaints that Toyota ignored a defect that caused some of its engines to accelerate uncontrollably and failed to install a brake-override system that would have prevented accidents. Denying the allegations made last week, Toyota hit back hard, saying that such disputes with insurance firms are commonplace in the industry.

Toyota has said that unintended acceleration was caused by a mixture of driver error, faulty floor mats and sticky accelerator pedals and denies there is a design defect, as is alleged in some lawsuits.

Toyota admitted last week that it had paid $10 million to a Californian family to settle legal claims after four people were killed in a 2009 crash that prompted recalls of some of the automaker's cars. The firm has recalled more than 10 million vehicles since late 2009, 5.4

million of those in the US, and the US government has already fined Toyota $48.8 million for its handling of three recalls dating back to 2004.

Travelers must pay $500 million in asbestos claim

Travelers Companies must pay about $500 million to asbestos victims under a settlement made six years ago in the bankruptcy of Johns Manville Corp., a judge ruled.

U.S. Bankruptcy Judge Burton Lifland in New York said in an order that his ruling should resolve a dispute over whether a U.S. Supreme Court ruling reversed an earlier order over the settlements, involving Travelers Indemnity Co. and Travelers Casualty & Surety Co., for their work as insurers to Johns Manville. Johns Manville, once the nation's largest maker of asbestos, filed for bankruptcy in 1982.

In the latest legal tussle the counsel for the settlement and Travelers were disputing whether the Supreme Court decision in Travelers Indemnity Co v. Bailey (2009) or the judgment by the Second Circuit Court in Manville III (2010) should take precedent.

Port Authority settles Ground Zero workers' claims

Plaintiffs in the litigation arising from the debris clean-up at the World Trade Center site following the 11 September 2001 attacks have entered a settlement agreement with The Port Authority of New York and New Jersey, owner of the World Trade Center site.

Still subject to the approval of the Port Authority Board of Commissioners and the Governor's review, the Port Authority agreed to pay $47.5 million to settle claims of those plaintiffs who sued the Port Authority for injuries they sustained during the rescue, recovery and debris removal operations following the terrorist attacks of 9/11.

This compensation would be in addition to the compensation the plaintiffs are eligible to receive under the agreement their counsel reached with New York City and its contractors, worth up to $712.5 million.

While the Port Authority said it is not a party to the prior settlement that was reached between the City and its contractors, the Port Authority's settlement money will be allocated in accordance with the same objective diagnostic criteria and allocation process contained in that agreement. Judge Alvin K Hellerstein, of the U.S. Federal District Court for the Southern District of New York, who oversees these cases, has already declared that the allocation process is "fair and reasonable".

As with the City's settlement, the plaintiffs will be grouped into four tiers by the type and severity levels of their injuries. Tiers 1, 2 and 3 will receive fixed payments as follows: $2,000 for plaintiffs in Tier 1; $2,500 to plaintiffs in Tier 2; and $3,000 for plaintiffs in Tier 3. Plaintiffs in Tier 4 could receive tens of thousands of dollars in additional compensation.

3. Solvency II

The latter part of 2010 saw the continuation of the broad-fronted initiatives towards the implementation of Solvency II. Below is a summary of the recent main developments, with particular attention paid to areas of interest to general insurance actuaries.

QIS 5 and the associated debates

As was reported in the last Current Issues Newsletter, QIS 5 continued through October for solo entities and November for groups with participating firms completing their work and making their submissions in those timeframes. In mid-December the Committee of European Insurance and Occupational Pensions Supervisors ("CEIOPS") declared phase one of the QIS 5 exercise complete. CEIOPS was also pleased to report a high participation rate of close to 70% of covered firms which was a large advance on the 33% QIS 4 participation rate.

With firms and industry commentators surveying the results of QIS 5, the last quarter of 2010 was punctuated by fierce debate about the outcome of the calculations. Nowhere was this more true than the non-life sector where areas such as the catastrophe modelling approach embodied in QIS 5 received much criticism. Many commentators were expecting the industry to display material reductions in solvency levels based on the exercise.

The industry's feedback on QIS 5 has been registering at European level and there are a number of processes now underway that could result in further amendment to the approach to the Standard Formula Solvency Capital Requirement ("SCR") as contained in QIS 5. In October CEIOPS announced the establishment of a working group involving, among others, Groupe Consultatif, the CEA, the Chief Risk Officers' ("CRO") Forum, the European Commission and itself to look specifically at the non-life SCR calibration. In support of its efforts it made a pan European data request to help it with its analysis. The working group is expected to report in mid-March 2011.

Further reinforcement of the presence of concerns at European level about the calibration of the non-life SCR came in November 2010 when the Director General of Internal Markets of the EC launched its public consultation, with responses due by 26 January 2011, on Solvency II Level 2 implementing measures. Although the consultation (which can be found at http://ec.europa.eu/internal_market/consultations/2010/solvency-2_en.html) focuses on all areas of the insurance industry, there is particular focus on areas specific to the non-life sector such as technical provisions and underwriting risk.

CEIOPS will begin the process of compiling QIS 5 results in January 2011 and is due to report on the impact on the industry to the European Commission ("EC") in March 2011. The report from CEIOPS on QIS 5, from the non-life working group and the public consultation, all promise to provide major guidance to the industry in respect of Pillar I requirements in 2011 and will be keenly watched.

EIOPA comes out of the shadows

From 1 January 2011, as embodied in the so-called Omnibus II Directive, the European Insurance and Occupational Pensions Authority ("EIOPA") comes into being, formally replacing CEIOPS as advisor to the European Union ("EU") on matters related to Solvency II implementation. EIOPA is part of a trio of new bodies that the EU is establishing to strengthen financial services regulation, the others being the European Banking Authority and the European Securities and Markets Authority. In this regard, EIOPA's powers go well beyond those of CEIOPS in that it adds formal regulation to its advisory capacity. EIOPA will, for example, have powers to intervene on matters specific to insurance regulation in the EU. Many in the industry see EIOPA as a new "super-regulator" at EU level.

On 6 December, EIOPA published details of its Solvency II related work priorities for 2011 and for firms engaged in preparation for Solvency II this represents interesting reading. The full paper can be found on EIOPA's website (https://eiopa.europa.eu/home/index.html). EIOPA priorities include:

- Completion of QIS 5
- Pre-consultation on Level 3 implementing measures
- Development of 16 binding technical standards by the end of 2011
- Consultation on reporting requirements under Solvency II
- Level 3 guidelines on internal models
- Level 3 guidelines on the system of governance and Own Risk and Solvency Assessment ("ORSA") process

The equivalence process moves up a gear

Following the publication at the end of August of CEIOPS final advice on equivalence criteria to the EC, the fourth quarter of 2010 saw the pace of the process of the granting of equivalence to a group of candidate countries move up a notch.

In its August work, CEIOPS had performed a benchmark analysis against Articles 172, 227 and 260 across a cohort of major insurance markets and determined that Switzerland and Bermuda were ready to be considered for Solvency II equivalence in the first wave. In its findings, CEIOPS explicitly excluded the United States ("US") on the grounds that regulation at national level in that country is weak with individual States playing the primary regulatory role. Stateside the National Association of Insurance Commissioners ("NAIC") had launched its "Solvency modernization initiative" which as a federal initiative implicitly recognises the need, in the wake of the financial crisis, for better co-ordinated regulation at national level. Notwithstanding the NAIC's position, CEIOPS' exclusion has caused much consternation in the industry given the importance of the US market and of US firms.

In the end, the EU has embarked upon an assessment of equivalence for three countries: Switzerland, Bermuda and Japan. On 1 December it issued its call for evidence on those countries' level of equivalence. The decision on this first wave of assessments will be made in September 2011.

News from the Internal Model Approval Process ('IMAP')

In its November 2010 newsletter to the general insurance industry (available at http://www.fsa.gov.uk/pubs/newsletters/gi_nov10.pdf), the Financial Services Authority ("FSA") indicated that some 25 UK firms had entered IMAP pre-application with almost 100 others stating an intention to do so.

4. Government and regulatory issues

EU move to end gender bias in insurance policies

The European Court of Justice ("ECJ") has edged closer to banning insurers from using gender to price insurance policies. An opinion statement made by advocate general Juliane Kokott at the ECJ, in October 2010, questioned whether the use of gender as a risk factor to rate policies was compatible with European human rights on gender discrimination. She pointed out that many other factors played an important role in the evaluation of insurance risks – for example, life expectancy was strongly influenced by the economic and social conditions for each individual.

The EU gender directive, published on 13 December 2004, provides for the equal treatment of men and women in the access and supply of goods and services. A derogating provision exists such that countries can opt out of the directive for insurance where using gender is based on actuarial and statistical data. But this latest opinion suggests the ability for countries to opt out may be removed.

Advocate general Juliane Kokott's opinion stated that life insurance discrimination might be permissible under the law if women live longer because they are women, if there is something innate and biological about the female sex that causes longevity. But, she argued, important causes of longevity are behavioural - eating habits, smoking and drinking, sports, work environments, drug use. That women have, on average, behaved differently than men doesn't necessarily mean any one woman's femaleness is the reason why. Differences in longevity "merely come to light statistically," Ms. Kokott wrote, and sex is thus just shorthand for whatever is causing those differences. And, she said, "the use of a person's sex as a kind of substitute criterion for other distinguishing features is incompatible with the equal treatment of men and women". That it is easier for insurance companies to record a person's sex than his or her behavioral habits when building actuarial models, Ms. Kokott writes, doesn't overcome the prohibition of discrimination.

Juliane Kokott concluded that the use of risk factors based on sex in insurance products was incompatible with the EU's principle of equal treatment for men and women and advised the full court to declare the derogating provision to be invalid. An advocate general's opinion is not binding on the full court, which will make its decision in the coming months. However, opinions are followed in about 70% of cases.

In addition, in September, the ABI published a research paper that analyses the impact of a potential ban on the use of gender in insurance policies. An ABI spokesman stated "It is right for insurers in the UK to use gender. If you take away the ability of insurers to take gender into account, that is going to be bad news for customers and could lead to an impact on premiums". The ABI's paper is available at http://www.abi.org.uk/Publications/51810.pdf.

Stress testing exercise

The FSA views stress testing as an invaluable risk management tool that allows management to better understand the risks it faces and supports strategic decision-making. When modelling capital requirements, the accessibility of stress testing can be useful in engaging more widely with different parts of the business, drawing in expertise and knowledge, and helping arrive at a shared understanding of risk exposures for capital modelling. The FSA has stated that firms' ICA submissions should include analysis of their stress testing, and the FSA's Policy Statement on Stress Testing (PS09/20) further strengthened the stress testing regime - requiring firms to improve capability, enhance capital planning stress testing and introduced reverse stress testing.

During the summer of 2010, the FSA conducted a stress testing exercise across a range of 19 larger retail and wholesale general insurers. This provides some of the wider findings arising from the analysis, which may be of assistance when firms consider their own stress testing exercises. The exercise asked firms to consider up to 17 scenarios, depending upon their applicability to the firm (including : the Weak UK Growth scenario described in the FSA's Financial Risk Outlook; Major man-made and natural catastrophes; Operational risk; and Scenarios of the firms' own choice).

Examples of good practice within the submissions included firms providing responses that:

- Drew on previously run internal realistic disaster scenario, or similar exercises;
- Used their own-choice scenarios to recognise key concentration risks pertinent to their portfolios outside the well recognised industry-wide catastrophe scenarios (also including economic downturn risk);
- Included consideration of secondary risks attached to the detailed scenarios; and
- Demonstrated that they were engaging internally with a variety of internal experts, identifying credible management actions.

As expected, firms relied heavily on their catastrophe models, sometimes simply reading results from these, with little further analysis. Areas where firms might improve robustness of their approach include consideration of:

- Information and analysis of scenarios, over and above simply using a catastrophe model output;
- Un-modelled exposures;
- Modelling and parameter error; and
- Monitoring and managing data quality.

The FSA's view is that stress testing can also assist firms in analysing exposures should unexpected events materialise. One risk included in the exercise, which was designed particularly to encourage this (a UK earthquake), received considerable feedback (to the extent

that some considered this scenario to be a one in 10,000 year event – with which the FSA disagrees). Co-incidentally, the British Geological Survey has more recently published comments suggesting it believes the UK is more exposed to earthquakes than many people recognise. Responses to the earthquake scenario in the 2010 FSA exercise ranged widely from firms' disappointing total reliance upon catastrophe models to better responses that attempted to understand underlying exposures, or in one case, their own modelling.

Given the importance the FSA attaches to stress-testing and the varied practices and standards observed within firms, it intends to carry out a further stress-testing exercise in the summer of 2011.

BAS update

Standard on Insurance published

In November, the Board for Actuarial Standards ("BAS") published its standard for insurance work, building on the foundation laid by its standards on Reporting, Data and Modelling. The aim of the new standard is to help ensure that managers and directors of insurance companies can rely on the actuarial information supplied by their actuaries, and understand its implications for their decisions. It requires actuaries to justify their assumptions and explain the uncertainty around any results and projected cash flows.

Commenting on the new standard, Jim Sutcliffe, Chairman of the BAS, said: "Actuarial work has often been seen as a "black box". Decisions taken by those responsible for insurance companies are heavily dependent on actuarial work and we have laid out principles that we believe will help ensure that the work is not only of a high quality, but also comprehensible. Actuaries cannot predict the future, but they can provide useful insights into a world where continuing financial uncertainty, changes to capital requirements and potential changes in financial reporting pose many diverse challenges to managers and directors of insurance companies. The insurance standard sets a new benchmark in ensuring that users receive the actuarial information they need to make the best decisions."

Copies of the insurance standard can be downloaded from the BAS's website at http://www.frc.org.uk/bas/publications/pub2438.html.

Standard on Transformations published

The following month saw the BAS publish its standard for actuarial work concerning pension and insurance transformations. Within general insurance, transformations may occur, for example, where there is a transfer of a book of insurance business between insurers. In making a transformation, an insurer seeks to change the benefits of insurance policyholders without having to obtain their consent. There is often a separate body – such as a court – with a role in determining whether or not the transformation may proceed. The new standard will help to ensure that those making decisions about transformations can rely on actuarial information to help them understand the potential effects on beneficiaries. It requires actuaries to analyse the impact of the proposed transformation by adopting assumptions which place proper emphasis on the interests of all parties, and to indicate how that impact might change under different scenarios.

Commenting on the new standard, Jim Sutcliffe, Chairman of the BAS, said: “Legislation places an important responsibility on trustees and courts to consider how proposed transformations might affect a wide range of beneficiaries. The complexity of the analysis required means that they will rely heavily on actuarial work. We have laid out principles that we believe will help ensure that the work is not only of a high quality, but conveys clearly the uncertainties and risks associated with the proposed transformation. The transformations standard sets a new benchmark in ensuring that users receive the actuarial information they need to make the best decisions.”

Copies of the transformations standard can be downloaded from the BAS’s website at http://www.frc.org.uk/bas/publications/pub2467.html.

5. International

Europe

Russian government mulls mandatory insurance for all types of vehicles

The Russian government is considering introducing mandatory insurance for all types of passenger vehicles, Prime Minister Vladimir Putin has said. Mandatory insurance is expected to be applied to railways, ships, buses, rapid transit, and other types of transport. Currently, mandatory insurance only applies to cars and trucks.

Italy - Motor insurance

Italy's insurance regulator wants average auto premiums cut by 15% to 18% via actions to curb fraudulent and accidental injury claims in one of Europe's most expensive markets for auto liability cover. In a statement, regulator ISVAP said the cuts will be achieved if parliament and government back its proposals, adding its estimate is prudent and takes account of an examination by insurance association ANIA. The proposals include setting up an anti-fraud unit to cooperate with police. For minor injuries, it wants to find a way to deal with improper medical opinions. The aim is to introduce the proposed measures over a three-year period.

USA

National Flood Insurance Program

On 23 September 2010, Congress passed legislation extending the National Flood Insurance Program ("NFIP") until 30 September 2011. The one-year extension meant that Congress averted another lapse in the flood insurance program. The NFIP has become a political football because it is more than $18 billion in debt. There were four program lapses in the past year as Congress approved extensions of only months or weeks and then failed repeatedly to act in time to avert interruptions in the program.

It is generally agreed that reform of the NFIP is necessary, but there is disagreement over how far reforms should go, including the phasing in of market-based rates and whether wind coverage should be added to the flood program.

Privatization proposals have been floating around. The Reinsurance Association of America and the Association of Bermuda Insurers and Reinsurers discussed privatization concepts at a November forum sponsored by the Federal Emergency Management Agency, which manages the NFIP. Options include having the private insurance and reinsurance sector assume flood risk over time and eliminating or greatly reducing the federal role for providing insurance. This option is feasible if insurers could be encouraged to underwrite flood policies as part of standard homeowners policies with actuarially sound, risk-based rates that reflect the true cost of capital. They also suggested that insurers should be provided incentives to assume NFIP policies and that private sector flood coverage should be exempt from state rate regulation, or alternatively,

federal law should authorize competitive use-and-file rating rules for federally determined flood risk coverage.

Dodd-Frank Wall Street Reform and Consumer Protection Act

In 2010, comprehensive financial services reform legislation was passed that for the first time gives the federal government some voice in regulating the property and casualty insurance industry. The Dodd-Frank Wall Street Reform and Consumer Protection Act generally retains state regulation of insurance. It does, however, give federal financial regulators authority to prevent future market meltdowns by forcing prompt corrective action and, in a pinch, a federal takeover of a failing institutions - including an insurer - deemed to constitute a potential systemic risk. It also triggers potentially significant improvements for surplus lines reinsurers.

The Act has set in motion an intense effort by the insurance industry to shape the regulations and government bodies that will implement the legislation. In recent comments to the Casualty Actuarial Society at the group's annual meeting in November, Steve Broadie said that insurers were unlikely to be subjected to systemic risk regulations or liquidation provisions contained in the law. "Our sense is that the impact of the Dodd-Frank Act on most insurers will be limited" he said. However, given the establishment of the Federal Insurance Office ("FIO"), "we are sailing into uncharted waters" in terms of insurance regulation, Mr Broadie noted.

The main areas expected to impact the insurance industry are the establishment of the FIO and the changes for non-admitted insurance.

Functions of the FIO include:

- Data collection and analysis
- Systemic risk monitoring
- Advising on the Terrorism Risk and Insurance Act
- Monitoring the affordability and availability of insurance in under-served areas
- Recommending insurers for systemic risk supervision
- Advising on insurance policy issues and coordinating the development of federal policy on international prudential insurance issues

The FIO has very limited authority to enter into international agreements and pre-empt state law. However, US Deputy Treasury Secretary Neal Wolin has raised the possibility that increased federal powers in the insurance sector might make it easier to resolve some of the issues between US and European insurers and regulators. Speaking at the London Stock Exchange, he said the Treasury Secretary and the US Trade Representative are now "empowered to negotiate certain international agreements regarding prudential insurance measures". "We anticipate that the Federal Insurance Office will be actively involved, for example, in working with the representatives of other countries on reinsurance collateral and US equivalence under Solvency II" he said.

It may be years before the full impact of the Dodd-Frank financial services reform bill becomes known, but participants of the non-admitted insurance, or excess and surplus lines ("E&S"), market appear to be clear upfront victors provided the states implement the surplus lines reforms as intended.

The law establishes that only one state - the home state of the insured - can regulate a multistate surplus lines transaction. It also creates national eligibility standards for surplus lines insurers and streamlines access to the E&S market for large commercial insurance buyers. In addition, there is a provision of the law which says that "Congress intends for each state to adopt nationwide uniform requirements, forms, and procedures, such as an interstate compact, that provide for the reporting, collection and allocation of premium taxes for non-admitted insurance".

States are required to act to implement the E&S provisions of the federal law, formerly known as the Non-admitted and Reinsurance Reform Act, by July 2011. Regulators on the NAIC's Surplus Lines Implementation Task Force decided in late October that their proposal for implementing E&S reforms will be a minimal plan addressing the collection and allocation of surplus lines premium taxes (the Nonadmitted Insurance Multi-State Agreement or NIMA), but not uniformity of regulation between the states.

Separately, three groups representing state governors and legislators, the National Conference of Insurance Legislators, the Council of State Governments and the National Conference of State Legislatures have adopted resolutions in November and December supporting an alternative approach, known as SLIMPACT, or Surplus Lines Insurance Multi-State Compliance compact.

The concern now is that duelling proposed compacts creates potential for the "worst of all possible worlds", which would be that some states adopt SLIMPACT and other states adopt NIMA. If that is what happens, NAIC and state insurance legislators agree that Congress is likely to step in.

Federal license for reinsurers?

Dennis Moore (a Democratic member of the US House of Representatives representing the 3rd Congressional District of Kansas since 1999) has introduced legislation in Congress with strong support from the reinsurance industry that would create a federal license for reinsurers, with a bill which is titled the "Federal License for Reinsurers Act". The bill would create a federal license for national reinsurers that would be administered by the director of the new Federal Insurance Office created by the Dodd-Frank Wall Street Reform and Consumer Protection Act.

New York - Pay-as-you-drive motor insurance

Progressive has become the first insurance company to receive approval from New York's state regulators to offer usage-based motor insurance. With the so-called "pay as you drive" insurance, motorists agree to install a device in their cars that monitors their mileage and driving habits in order to set rates.

California - Supreme Court expands the potential obligations of insurers to defend

The California Supreme Court has issued a landmark decision that provides a new standard in analyzing whether an insurer's duty to defend is triggered under a policy of insurance whereby the term "suit" is not defined. In the process, it has expanded insurers' potential defense obligation.

Prior to the Ameron case (Ameron International Corp. v. Insurance Company of the State of Pennsylvania et al., Case No. S153852) the rule was that the undefined term "suit" was strictly read to mean an action in a court of law. This meant that insurers for policies that do not have an express definition of the term "suit" could decline to defend an insured against administrative proceedings, quasi-judicial adjudicative proceedings, or other proceedings that were not being litigated in a traditional court of law.

The Ameron case expands the potential obligations of insurers concerning the duty to defend and/or duty to indemnify. Insurers' obligations may also now be triggered when the claim against the insured is pending before an administrative agency that is sufficiently adjudicative such that the proceedings look like traditional court litigation, except for the forum in which the matter is being litigated.

The Ameron case related to an Interior's Board of Contract Appeals (“IBCA”) proceeding which operated in a very similar manner to litigation in a court of law. In particular, IBCA proceedings are consistent with, and meet the standards of, California's Code of Civil Procedure. Insurers now face a more challenging determination regarding defense and indemnity as to cases involving other quasi-judicial or administrative proceedings that, while contentious, may not necessarily operate like a traditional trial in a court of law, or that do not have the same "complaint" requirements similar to California's Code of Civil Procedure. In such circumstances, insurers may have to consider how similar such proceedings are to civil litigation and, if there are apparent parallels, may consider providing at least a defense to an insured under a reservation of rights.

New Jersey - Court panel to study mandatory malpractice insurance for lawyers

The state Supreme Court in New Jersey has formed a committee to weigh the benefits and burdens of mandatory malpractice insurance and a requirement that lawyers disclose whether they have such coverage. The Ad Hoc Committee on Attorney Malpractice Insurance came into being on 29 September and the panel will include representatives from the bar, professional liability insurance industry and other affected groups.

Lawyers in the state who practice in a professional corporation, limited liability company or limited liability partnership must have at least $100,000 of coverage, but there is no requirement for solo practitioners or small firms to have malpractice insurance.

As at November, 18 US states required attorneys to disclose on registration documents whether they had malpractice insurance, while seven others required disclosure to clients. Four other states were considering a disclosure rule and four others decided against enacting one. Only one state, Oregon, requires lawyers to have malpractice insurance.

South America

Brazil

Brazilian insurance regulator Susep has published a series of year-end updates to the country's regulation, this time revising the rules that govern its own operations and refining its objectives. These include new changes to the local reinsurance market.

Susep said in a filing that local reinsurers - those under the strictest regulatory regime and with the greatest ability to sell reinsurance in Brazil - would have to review the criteria by which they record their premiums and perhaps change the way they set aside capital accordingly.

The move follows more controversial ones in the segment, whereby local insurance companies will be required to cede 40% of all reinsured risks to local reinsurers from 31 March 2011 and will have to accept whatever rates and conditions are offered locally, whether or not foreign reinsurers are willing to offer more attractive terms.

In addition, from 31 January 2011, neither insurers nor reinsurers will be allowed to (retro)cede risks directly to their reinsurance affiliates based abroad.

Previously, state reinsurer IRB-Brasil Re had a monopoly on reinsurance, but the market began a process of liberalisation in 2008.

Latin America

Flood risk models for key cities in Latin America

Willis Re has released flood risk models that include detailed risk estimates and large event scenarios for key cities in Latin America, including Sao Paulo, Santiago and Bogota.

Costa Rica

The Costa Rican insurance industry opened up to private sector competition in 2010. Costa Rica's obligatory vehicle insurance and workers' compensation insurance are both set to open to private sector competition starting in January 2011, the final stage of insurance market liberalization.

So far, not much has happened to rearrange the market fundamentally. While nine new insurers backed by foreign capital are now either registered or on the way to being registered in Costa Rica, their actual market participation remains negligible. The market continues to be dominated by the state insurer, and former monopoly holder, Instituto Nacional de Seguros ("INS"). According to the latest numbers from regulator Sugese, insurers wrote 294 billion colones ($579 million) worth of premiums during the first 10 months of the year, of which 99.4% was written by INS.

It appears to be difficult for the new foreign-backed private sector players to get regulatory approval for their products. Through the end of October 2010, Sugese had registered only 40 policy types from the four foreign-backed private sector insurers: two for Mapfre, two for ALICO,

two for Pan American Life and the rest for ASSA. By comparison, INS registered an additional 97 new policies to bring its total number of policies to 158.

Caribbean

Regulatory change

Authorities across the Caribbean are in the process of upgrading their regulatory insurance frameworks to make them more focused on risk, capital and corporate governance. The reforms may lead to mergers and acquisitions as some local insurers may not be able or willing to come up with the additional capital that the new rules may require.

Jamaica

The Government of Jamaica has decided to extend its coverage under the Caribbean Catastrophe Risk Insurance Facility ("CCRIF") to include damage caused by flooding and periods of unusual rainfall, following discussions with the World Bank. Finance minister Audley Shaw said that the decision was partly influenced by the considerable damage suffered in 2008 during tropical storm Gustav and tropical Storm Nicole in late-September 2010. The minister said he expects that the extended facility should come into effect by the end of January 2011. Prior to the extension, Jamaica has only had earthquake and hurricane coverage under CCRIF.

CCRIF, which is managed by AJG affiliate CaribRM with support from Sagicor and Aon Benfield, is also working on an excess rainfall product.

Australasia

Australia - Motor insurance

In New South Wales ("NSW"), the Government's attempts to crack down on car rebirthing are expected to result in significantly higher motor insurance premiums. Cars previously classified as "repairable write-offs"' will be prevented from being re-registered in NSW. Previously, insurance companies had paid out to owners when the cost of repairing a damaged vehicle was more than it was insured for. The insurer would sell the damaged car and, after repairs, a new owner could apply for re-registration. But the Government said thieves were buying "repairable write-offs"' at auction and using stolen parts to rebirth and re-register the vehicles.

Asia

China - Work-related injuries

China has raised the compensation to be paid for work-related injuries. The compensation paid to the families of those who die from work-related injuries has been raised to 20 times the per capita disposable annual income in urban areas. For work-related disability, the compensation has risen by one to three months' salary for insured employees.

The revision has also widened the application of the regulation. Previously, only enterprises and small business employers were obliged to pay for work related injury insurance, but now public institutions, social groups, non-profit grass-root organizations, foundations, law firms and accounting firms will also need to purchase insurance for their employees.

India - It takes five years to settle motor third party claims

A study by the insurance regulator in India has shown that justice is greatly delayed for road accident victims who have to on average wait for five years before receiving compensation. The delay is because compensation involves a complex process of claims filing which needs to be routed through the judicial system and it involves different parties. Each case takes at least three to four hearings to complete and the gap between each hearing is generally about a month.

According to a study on motor third party claims, conducted by the Insurance Regulatory Development Authority ("IRDA") over the past five years, it took five years for accident victims to receive payment from the time of accident in as many as 85% of the cases.

Insurers say most cases end up in tribunals because ambulance chasing lawyers reach the accident victim before the insurance company can and encourage them to go for litigation promising better compensation.

Interestingly, it takes at least two years for a majority of accidents to be reported to the tribunal. In the case of death due to a vehicle accident, this time increases to three years, the IRDA data indicated. The official added: "There is no time frame for filing a claim for such third party claims. One can file a claim with the courts even three years after an accident. In certain cases, victims realise that they can file a case after a couple of years only after such time they contact a lawyer and proceed to filing a claim."