



December 16, 2011

The Honorable Michael McRaith,  
Director, Federal Insurance Office  
United States Department of Treasury  
1500 Pennsylvania Avenue, NW  
Washington, DC 20220

RE: FR Docket No: 2011-26776  
Report to Congress on How to Modernize and Improve the  
System of Insurance Regulation in the United States

Dear Director McRaith:

The National Association of Mutual Insurance Companies ("NAMIC") appreciates the opportunity to comment on the Federal Insurance Office's ("FIO") report to Congress on how to modernize and improve the system of insurance regulation in the United States. NAMIC recognizes the importance of ensuring that the United States maintains an effective insurance regulatory system and appreciates the hard work being undertaken to make recommendations toward that goal.

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

The concept of mutuality is something that NAMIC members embrace as being of the utmost importance to their success. Mutual insurance companies serving Main Streets across the country have an entirely different mission and business model than Wall Street capital intermediaries. For one, a mutual company is operated solely for the benefit of its policyholders and issues no stock. Therefore, incentives and decisions are

not driven by earnings pressure from shareholders; rather, a long-term, conservative approach designed to build and maintain policyholder surplus to ensure adequate capital to pay claims is inherent in the mutual structure.

When crafting recommendations for the modernization of insurance regulation in the U.S. it is essential to consider what is the best structure for all constituents, including consumers, taxpayers, insurance companies, agents, and others affected by the insurance underwriting process. NAMIC is committed to identifying areas for improvement and coordination to strengthen the insurance regulatory system, increase competition, and protect the nation's policyholders.

Any discussion of insurance regulatory modernization must begin with the recognition that even in the tumultuous financial crisis, the current state-based system proved resilient and was effective for both solvency and consumer protections. Many financial and regulatory experts have concluded that it outperformed the other financial services regulatory frameworks in place at the federal level.

While the state-based regulatory system has allowed for a well-functioning and competitive insurance market, we are concerned with the lack of efficiency and uniformity in the states and believe that much can be done to modernize and streamline insurance regulation. Going forward, it is important that our insurance regulatory system direct its primary focus to ensuring that insurers have the capital strength necessary to continue to meet the promises they have made to their customers. This can be best accomplished if regulators encourage vigorous competition among insurers as opposed to pursuing policies such as price controls and the prevention of sound underwriting practices that will ultimately harm consumers by driving insurance capital out of the marketplace. It is our goal to help the FIO recommend actions that will promote as much efficiency in the state system as possible without jeopardizing its effectiveness.

To that end, NAMIC respectfully submits its views on the following topics identified in the Federal Register request for comment.

1. Systemic risk regulation with respect to insurance.

NAMIC continues to believe that traditional property/casualty insurers should not be subject to systemic risk regulation. The very nature of the industry's activities – and mutual companies in particular, specifically relating to conservative business strategies, incentives, and risk-taking – are not reflective of systemic risk.

The six primary factors that affect the probability that a financial institution will create or facilitate systemic risk are leverage, liquidity, correlation, concentration, sensitivities, and connectedness. An examination of these factors demonstrates that there is no

basis for regulating property/casualty insurance companies for systemic risk because, simply, they don't present such a risk.

### Leverage

Very few property/casualty insurers use commercial paper, short-term debt, or other instruments that may be used to leverage their capital structures, a fact that makes them less vulnerable than highly leveraged institutions when financial markets collapse. Because of their basic business model and strict capital requirements imposed by state regulators, property/casualty insurers are much more heavily capitalized in terms of their asset-to-liabilities ratios than banks and hedge funds. For these reasons alone, the banking system's perennial moral hazard of being "too big to fail" has no equivalent in the insurance industry. This, of course, is a completely different model than the banking world where leverage is a central component of the enterprise.

### Liquidity

Unlike most other types of financial institutions, the nature of the products that property/casualty insurers provide makes them inherently less vulnerable to disintermediation risk. While banks are exposed to the risk that customer withdrawals can exceed available liquidity, the risk of a liquidity shortfall is minimal for insurance companies. Insurance companies are financed by premiums paid in advance, and payments are subject to the occurrence of insured events. Insurance policies are also in force for a contracted period of time, the terms of which are agreed to by both parties. If an insurance customer cancels a policy before the end of the contract, the premium is refunded on a pro rata basis and coverage is canceled. Whereas bank liabilities are short-term and assets are long-term, insurance has liquid assets, but longer-term liabilities. Thus, for both business and regulatory reasons, property/casualty insurers carry a liquid investment portfolio. As long as the insurance company has built up reserves and its investments are calibrated to match the statistically anticipated claims payments, there is limited liquidity risk and no possibility of a "run-on-the-bank" scenario.

### Correlation

Property/casualty insurers use underwriting tools specifically designed to identify and control certain types of correlation, including market concentration, in order to control catastrophe and underwriting exposures. Identifying and managing risks are at the core of insurance and these tools allow insurers to accurately price and underwrite risk. The side benefit of rigorous underwriting is a reduction in systemic risk exposure. It is also important to note the difference between asset-backed securities and other derivative products, where the underlying risk is financial or market (such as credit, price, interest rate, or exchange rate), and property/casualty insurance, where the underlying risk is a more tangible event, such as an automobile accident, fire, or theft. While the former risks are likely to be correlated in that they will be affected by similar cyclical economic

or financial factors, the latter are largely individual, non-cyclical idiosyncratic risks. Banking risks are often highly correlated, particularly in economic downturns. Traditional insurance, in contrast, pools uncorrelated idiosyncratic risks, and is not subject to systemic crises in the same way as banks.

#### Connectedness/Sensitivities/Concentration

Property/casualty insurers manage concentrations of investments and have regulatory limitations on both the type and concentrations of the assets in which they invest. These realities have the effect of reducing the property/casualty insurance industry's connectedness and sensitivity to the actions and conditions of other sectors of the financial services industry.

Property/casualty insurers, like virtually all investors, suffered investment losses during the financial crisis. But, no contagion of losses was spread throughout the industry or from the industry to other financial markets. Even when a property/casualty insurer is part of a holding company that also holds other types of financial services companies, regulatory restrictions designed to protect policyholders operate to isolate the property/casualty insurer's capital and protect it from incursions caused by any problems of the other subsidiaries. Unlike the obligations of financial institutions such as investment banks and hedge funds, most of the obligations of property/casualty insurers are protected by the insurance guaranty fund system. This nationwide system, financed by the property/casualty insurers of each state, reduces the systemic impact of any failing property/casualty insurer by providing customers or claimants with assurance that most of the insurer's obligations will be satisfied on a timely basis.

In the aftermath of AIG's 2008 collapse and bailout, and the concurrent world financial crisis, tremendous attention has been paid to systemic risk regulation with respect to insurance.

Almost universally, those studying the issue have concluded that insurers engaged in traditional or "core" insurance activities, pose little if any systemic risk. Most recently, in November 2011, the International Association of Insurance Supervisors ("IAIS"), which represents insurance regulators and supervisors from approximately 190 jurisdictions, issued a comprehensive report on financial stability and insurance which concluded, among other things, that:

- The business model of insurers generally enabled them to withstand the financial crisis of 2008-2009 better than other financial institutions;
- The characteristics of the insurance business model including insurance techniques make it very unlikely for traditional insurance to be systemically relevant;
- The historical evidence of insurance runs is limited;

- In traditional insurance the risk of a liquidity shortage is small;
- Insurance markets tend to be competitive;
- For most lines of business there is little evidence of traditional insurance either generating or amplifying systemic risk within the financial system or in the real economy; and
- Insurers engaged in traditional insurance activities were largely not a concern from a systemic risk perspective.

These conclusions fully support the idea that the truest markers of systemic risk are unregulated interconnected activities that are highly leveraged, and subject to runs on the bank—and that none of these markers are present in connection with core/traditional insurance businesses.

The legislative history of the Dodd-Frank Wall Street Reform and Consumer Protection Act (“Dodd-Frank”) further suggests that lawmakers did not believe that the traditional business of insurance generally poses a systemic risk and there is currently no evidence that the property/casualty insurance industry contributes any substantial amount of systemic risk to the global financial system. In addition, in its latest proposed rulemaking on systemic risk, the Financial Stability Oversight Council (“FSOC”) also appears to have acknowledged the risk factors in screening nonbank financial companies for systemic risk by focusing on metrics indicative of heavy debt, high leverage, illiquidity, and interconnectedness (e.g., short-term debt and leverage ratios, loans and bonds outstanding, derivatives liabilities, and credit default swaps outstanding). Lawmakers and regulators agree that the best way to protect against a systemic risk to the economy is to protect the solvency of companies, which we believe the state system does well.

For all of these reasons, NAMIC believes that efforts toward modernization of insurance regulation should not focus on systemic risk regulation.

2. Capital standards and the relationship between capital allocation and liabilities, including standards relating to liquidity and duration risk.

NAMIC has long supported capital standards that capture the material risks of insurers’ activities and exposures. Adequate capital standards, along with other regulatory provisions and tools, help to establish the necessary environment in which insurers can provide products that consumers demand, and are therefore necessary for the competitive marketplace that U.S. consumers have long been afforded.

NAMIC believes that the National Association of Insurance Commissioner's ("NAIC") current risk-based capital formula is largely effective in capturing the material risks of property/casualty insurers, with only one exception. The NAIC's formula has never captured catastrophic risk, and therefore it is appropriate that the NAIC is currently in the process of developing a new charge for this risk. NAMIC supports the development of a charge in this area because it represents a potential material risk and also because advancements have been made by insurers in the identification and quantification of this risk.

However, NAMIC does not support the development of capital standards for property/casualty insurers in the area of liquidity risk and duration risk because these are generally not material risks for most NAMIC members. This is not to suggest that property/casualty insurers do not manage these risks nor is it to suggest that other regulatory tools are not appropriate. In fact, NAMIC supports the general direction of some of the NAIC's changes in terms of modernizing its system, provided such changes are carried out in a manner that is consistent with the way the insurer runs its business. For example, NAMIC supports the NAIC's risk-focused surveillance system and believes its recently developed Own Risk and Solvency Assessment ("ORSA") has the potential to improve regulation without the unnecessary costs that so many other jurisdictions have forced on insurers. In the long-run, we believe a system that is focused on understanding the risks of the business, such as liquidity and duration risk, but without stepping into the shoes of management, has the potential to increase the effectiveness of regulation without unnecessary regulatory burdens.

Finally, the enactment of Dodd-Frank is posing new challenges for insurers regarding capital allocation, reporting, and standards where an insurance holding company owns a thrift. Dodd-Frank was primarily designed to avert another financial crisis resulting from bank and bank-like activities of highly leveraged, illiquid, and interconnected financial firms. Unfortunately, insurers were swept up in many regulatory changes for financial firms that were focused on these banking types of activities.

For example, Dodd-Frank terminated the Office of Thrift Supervision, which regulated savings and loan holding companies ("SLHC"), and transferred its supervisory authorities to the Federal Reserve (the "Fed"). In assuming its new responsibilities, the Fed has pursued a default option of grafting its existing bank holding company regulatory structure upon SLHCs. While this may be understandable from the Fed's perspective as it attempts to achieve simplicity in its own operations and development of new rules under Dodd-Frank, the reality is that it creates a regulatory mismatch between what the Fed would like to accomplish and the real world business profiles of the new SLHCs placed under its authority. Specifically, unlike bank holding companies which typically involve entities engaged primarily in the business of banking, for many SLHCs, the banking component of the holding company system represents a relatively small part of the business. Consequently, attempting to apply a bank-centric capital regime or banking standards upon non-banking businesses simply may not work. This is especially true for insurance holding companies where capital allocation is based on

an entirely different business model than banks and such insurers also must comply with entirely different state laws governing their capital requirements.

Furthermore, in some instances Congress has mandated that the Fed use bank-centric standards that are essentially nonsensical when applied to insurers. The starkest example of this is the Collins Amendment (Section 171 of Dodd-Frank), which requires the Fed to establish minimum leverage and risk-based capital requirements on depository institution holding companies using a banking standard that bears no meaningful relationship to the allocation of capital and use of leverage in the insurance world.

As a result, insurers are confronting tremendous and needless added uncertainty concerning the rules of the road governing capital allocation and how capital should be deployed in the future.

It also should be noted that this uncertainty comes on top of Fed reporting requirements that could do away with an insurer's use of long-accepted Statutory Accounting Principles ("SAP") and mandating a costly transition to Generally Accepted Accounting Principles ("GAAP") for insurers not currently using GAAP. Moreover, this costly change could result in regulators receiving less relevant information about the financial strength of enterprises that are engaged predominately in the business of insurance.

3. Consumer protection for insurance products and practices, including gaps in state regulation and access by traditionally underserved communities and consumers, minorities, and low- and moderate-income persons to affordable insurance products.

The state-based system of insurance regulation provides a robust system of consumer protections. The ultimate consumer protection is, of course, ensuring the solvency of companies – and the current system's ability to do this was highlighted in the recent financial crisis. The state system of solvency is well developed and involves financial reporting, financial analysis, financial examination, and corrective action. State regulators utilize SAP which primarily focus on the needs of regulators to assure solvency. In the most simplistic terms, SAP differs from GAAP in that it recognizes liabilities earlier and/or at a higher value and recognizes assets later and/or at a lower value. As a result, insurers will generally show lower surplus and earnings under SAP, presenting a more conservative financial picture of the company. The Annual Statement filed by each company also provides extensive information, including in addition to a balance sheet, income statement and cash flow statement, an extensive schedule showing the history of how loss reserve estimates have developed over time, and another schedule that contains separately-reported data on each security that the company owns. Nearly all property/casualty insurers must include an actuarial opinion with the Annual Statement as to whether the company's loss and loss adjustment

expense reserves make a “reasonable provision” for the company’s future claim and expense liabilities.

Regulators also utilize the Insurance Regulatory Information System (“IRIS”), which is part of the NAIC’s Financial Solvency Tools (“FAST”). For property/casualty insurers, IRIS consists of a series of 12 financial ratios, aimed at key financial indicators, including capital adequacy, changes in business patterns, underwriting results, reserve adequacy and asset liquidity. The FAST system also includes other ratios focusing on profitability, asset quality, investment yield, affiliate investments, reserves, reinsurance, liquidity, cash flows and leverage. In addition, insurers are subject to stringent capital and surplus requirements. Risk-based capital (“RBC”) formulas for life, property/casualty and health insurers apply separate RBC charges for an insurer’s business and underwriting risk, asset risk in affiliates, asset risk in other investments, and credit risk. The NAIC’s Model Law on Examinations requires each state to conduct an on-site examination of each domiciled insurer at specified intervals. These examinations, conducted according to the NAIC’s Financial Condition Examiners Handbook, include an extensive compilation of schedules, procedures, outlines and other guidance. If a state regulator determines that a company’s financial condition is endangered, state statutes provide broad authority to require companies to take corrective action. In sum, this extensive system of financial supervision, examination, and correction provides the most essential consumer protection – ensuring that the promise of financial protection is fulfilled.

Over and above its financial supervision activities, the states handle millions of consumer inquiries per year, many involving highly fact-specific situations and varied local conditions, laws and regulations. Prompt payment statutes ensure timely payment of claims and market conduct examinations conducted by many state departments monitor insurer compliance with consumer protections standards. State insurance departments are accessible and accountable to insurance consumers and consumer protection is an area in which the state system does exceedingly well.

There is little evidence of underserved populations with respect to personal lines insurance. The personal lines property/casualty marketplace is competitive and coverage is widely available. An exception is the homeowner insurance market in certain catastrophe-prone states, most notably Florida, where the combination of government rate suppression and state-run insurance mechanisms have driven property insurers from the marketplace. One need only note the large number of television and radio ads for automobile and homeowners insurance, the aggressive marketing campaigns by the nation’s insurance carriers, and the tens of thousands of insurance agents to understand the competitive nature of the market. As the FIO evaluates the availability of insurance it should evaluate the number of companies writing in an individual area and market concentration. We believe that it will find that multiple companies are actively competing for business and markets are competitive as indicated by objective measures such as the Herfindahl-Hirschman Index.

With respect to affordability, it is important to bear in mind that the cost of insurance coverage must be directly correlated to the underlying risk. Automobiles, homes or other covered assets more prone to loss or more expensive losses must necessarily bear a higher cost. The cost of insurance is tied to the cost of the covered asset, loss experience of the policyholder, replacement costs, likelihood of loss and other relevant underwriting factors, not to the financial position of the insured. Delinking the cost of the insurance from the underwriting factors undermines the financial stability of the transaction and/or inappropriately shifts the cost of the insurance to other policyholders. To maintain well-functioning insurance markets, prices must not be excessive or discriminatory, but neither can they be inadequate. Charging too little for coverage is just as damaging to policyholders as excessive or discriminatory rates. Rates that adequately reflect the cost of the underlying risk are essential to maintain healthy markets. The National Flood Insurance Program provides an excellent example of the folly of maintaining artificially low rates. Inadequate rates and repeated loss properties have threatened the financial viability of the program and distorted market signals regarding land use and building standards.

When assessing affordability, FIO must consider the cost of the insurance product in relation to the underlying risk. In other words, the insurance mechanism can only work when insurers are permitted to match the price of the product to the underlying risk. Premiums that adequately reflect the risk should not be deemed excessive or “unaffordable.” Given the pervasiveness of state consumer protection rules and prohibitions on excessive, inadequate or discriminatory rates, we do not believe any crisis of availability or affordability exists.

In addition to the protections inherent in the state-regulatory system, each state has well developed residual market mechanisms. Consumers who are unable to purchase insurance in the standard market are able to obtain automobile insurance through “assigned risk” pools and purchase property insurance through Fair Access to Insurance Requirements (FAIR) plans. These plans are specifically designed to provide coverage for individuals who would otherwise be uninsurable under standard underwriting criteria. Drivers with poor records or accidents and homeowners with repeated claims or problematic properties are eligible to participate in residual market plans to provide necessary coverage. While these residual market plans serve as the market of last resort, it is worth noting that, in general, residual market plan participation has declined in recent years in jurisdictions that have resisted artificial price suppression and allowed standard insurers to more aggressively compete for business on a market-oriented basis. As part of its analysis, we encourage FIO to study recent patterns in residual markets.

- 4.** The degree of national uniformity of State insurance regulation, including the identification of, and methods for assessing, excessive, duplicative or outdated insurance regulation or regulatory licensing process.

State insurance regulation has come a long way in the past 20 years. In part, the improvements have been aided by new technologies and, in part, they have been helped along by other forces. The adoption, by NAIC members, of standards and a formal certification program for financial regulation in 1989-90 has brought significant uniformity to the financial side of regulation. Fifty-one jurisdictions are accredited under the NAIC financial accreditation system.

Likewise, since the enactment of the Gramm-Leach-Bliley Act in 1999, reciprocity and uniformity across states in producer licensing have increased as well. Most states have passed the NAIC's Producer Licensing Model Act; and the development and expansion of the National Insurance Producer Registry ("NIPR") since 1996 has enhanced producer licensing in all states. While nearly all states have been designated as "reciprocal states" for purposes of uniformity, some state-specific differences remain and several producer licensing challenges remain.

Business entity licensing requirements are less than uniform and continue to cause problems for the many producers who do business in multiple jurisdictions. During the NAIC's recent Fall National Meeting, the Producer Licensing (EX) Task Force adopted five new licensing standards aimed at business entity licensing – three more controversial ones, including those addressing business entity licensing by line of business, designated responsible producers, and appointments, were not approved. The new standards may help alleviate some of the business entity licensing issues, but many states seem reluctant to give up their particular licensing practices in this area, especially if revenue considerations are relevant.

Another area of issue in producer licensing is limited lines licensing and, again, this area would benefit from increased uniformity that would alleviate problems for multi-state or national producers. The issues surrounding limited lines licensing continue to be debated.

Product approval has become more streamlined over the past 10 years, particularly since the development of the NAIC's System for Electronic Rate and Form Filing ("SERFF"). However, while SERFF has provided for faster review of company rate and form submissions, it has not served to increase uniformity and reciprocity in product approval. One vehicle that does seem to be making a difference in that regard is the Interstate Insurance Compact ("Compact"), as managed by the Interstate Insurance Product Regulation Commission ("IIPRC"). The Compact provides for adoption of uniform standards for life and annuity products and for filing and approval of life and annuity products through the IIPRC. Currently 41 jurisdictions have enacted legislation providing for their membership in the Compact and more members are anticipated.

There has been progress in the states, although significant challenges remain. For example, while SERFF provides better turn-around time for company filings, it has had little impact on uniformity. Another area of state insurance regulation that is in need of movement toward uniformity and efficiency is market conduct regulation. Because of

unwillingness to recognize domestic deference in market regulation, there has been no development of binding standards for regulators for market conduct surveillance. Such standards might be included in an accreditation program for market conduct regulation, similar to the program that has been so successful on the financial side, and NAMIC believes that the NAIC should redouble its efforts to develop and institute such a certification program. Currently, however, market regulation is conducted on a state-specific basis, with each jurisdiction operating on its own, usually without regard to actions taken by other states and without coordinating with other states that might have an interest in a particular company or group.

At the same time, there have been some developments in market regulation. The introduction of the concept of “market analysis” ten or so years ago was thought by many to herald the beginning of a whole new era in regulation. The theory was that regulators would be able to gather data about their state insurance marketplace, to enable them to determine marketplace norms. Then, using the same data to find the “outliers,” they could deal with those companies in targeted and specific ways and thus streamline and focus market conduct examinations. However, over the years market analysis procedures aimed at generating the required data, such as the Market Conduct Annual Statement (“MCAS”), have been adopted in addition to, rather than in place of, other tools and procedures that have always been used in market conduct surveillance. The new tools have not replaced the older system, but rather have been added unnecessarily to the cumulative burden of regulations.

NAMIC member companies continue to share their issues related to market conduct problems. Some examples include:

- Companies have had successions of teams of market conduct examiners on site at their company headquarters to perform targeted examinations, often with one state’s team arriving just as another is leaving.
- An NAIC working group is currently considering adding a data element to MCAS, over strong objections from the industry and without any cost-benefit analysis, in an attempt to collect data that companies do not keep in the normal course of business and which will cost companies millions of dollars to retrieve if the proposal is adopted.
- A company in an east coast state complains that its domiciliary regulator posts company complaint ratios on its website for public viewing, but that the state insurance department has no complaint reconciliation process and the complaint data posted by the insurance department does not match the complaint data maintained by the company.
- Other insurers report problems with detail on the costs of market conduct examinations performed by contract examiners since the billing often do not provide any cost breakdown.

To quantify concerns with market conduct examinations, NAMIC, in a cooperative effort with the American Council of Life Insurers (“ACLI”), recently surveyed its 25 largest member companies/company groups. The survey questions used were identical to those used by ACLI (with the exception of one question) and the time period at issue was the same. Twenty-four companies responded to the 12-question survey.

Based on the responses, on average, over the past 18 months, each company responded to 42 market conduct actions of various kinds. An average of eight of those actions were reported as being ongoing in nature. Ten companies specifically reported MCAS filings and, on average, reported 37 such filings during the period in question. The responding companies reported an average of four comprehensive market conduct examinations and six targeted market conduct examinations during the reporting period. For all market conduct actions reported, the average largest number of days an investigation was open was 618 and 82 percent of those long-term actions were ongoing. Only one company reported a multi-state action and, in that case, the total number of states participating was not known.

For all market conduct actions, the survey respondents reported an average of three that were conducted by third party contractors. For the actions involving those contractors, companies reported an average for fees and expenses of \$115,658 while fees and expenses for state DOI staff averaged \$143,431. These fees are average costs for each exam and respondents had an average of four comprehensive and six targeted exams in the reporting period, resulting in average market conduct examination costs topping \$1 million.

As noted, the numbers provided above reflect average results. Five of our member companies had to respond to more than 75 market conduct actions during this period and two companies reported on-going investigations lasting over 5 years. The volume of market conduct actions reflected in this survey clearly demonstrates that regulators continue to lean too heavily on market conduct examinations and not heavily enough on the market analysis process. The level of coordination in terms of multi-state exams is also lacking. For the sake of efficiency, we believe that regulators must move toward the analysis process and away from the older exam based system. Ultimately, costs of these actions are borne by consumers and some kind of cost-benefit analysis has to be part of the process.

NAMIC has several recommendations for action that would stimulate improvement in this area of insurance regulation. First, a systematic and comprehensive survey of insurers would go a long way to define and understand the true state of market regulation today. This industry survey should be coupled with a survey or audit of state insurance departments targeted at market regulation practices and procedures in order to gain the entire picture.

Based on prior NAMIC sample surveys and anecdotal information, along with studies such as GAO-09-372 Insurance Reciprocity and Uniformity (April 2009), we would recommend, among other things:

- reduction or elimination of regulatory redundancies.
- increased interstate collaboration and cooperation among regulators;
- deference to the domestic regulator in market conduct matters;
- implementation of systematic procedures for adding or changing market analysis tools or procedures; and
- increased oversight and training of, and accountability by, contract examiners.

The question is how to induce state insurance regulators to make the changes necessary to improve the system. NAMIC believes that the federal government could play a limited role in achieving some of these specific targeted reforms to achieve national uniformity and consistency. For example, adopting national standards and encouraging the development and adoption of state compacts and model laws would be beneficial. An approach such as “The Nonadmitted and Reinsurance Reform Act” that was recently passed in the Dodd-Frank Act, or the “National Association of Registered Agents and Brokers Reform Act (“NARAB II”) provide models to consider and build upon. That said, any action taken must be carefully crafted to provide state regulators the right incentives and accountability mechanisms in order to make those changes occur.

Market conduct regulation lags behind the process of bringing uniformity and efficiency to the state system, much to the detriment of the insurance industry and its customers. However, state-based insurance regulation has worked and can continue to work and any modernization should carefully avoid up-ending a system that has served the interests of policyholders and companies for decades.

#### 5. The regulation of insurance companies and affiliates on a consolidated basis.

As discussed in the response to question three, NAMIC believes that, with the exception of the existing requirements on legal entity insurers, regulators’ processes should be focused on understanding the risks of the business. One of the reasons NAMIC supports the NAIC’s risk-focused surveillance system and aspects of its recently developed ORSA is because both are centered around understanding the risks of the insurance group from the perspective of how the insurance group identifies and manages its risk.

Unfortunately, there is currently a tremendous lack of clarity about the content and meaning of “group” or “consolidated” regulation, especially to the extent that these terms may be imported from non-US regulators. Consequently, NAMIC believes that at a minimum, some clear basic principles should be established from the outset:

1. The separate management, identity and regulation of legal entities must be adhered to, where each policyholder is entitled to look to his or her own insurance company for the satisfaction of the promises made in the policy.

This principle means that the solvency of each company is paramount, whether or not it belongs to a group of companies. This principle further implies that no member of a group of companies should be held responsible for the obligations of another except as established by contract, reported in the Annual Statement, and approved by the regulator pursuant to the applicable Holding Company Act. Indeed, this principle that companies are to be managed so as to assure their separate operating identity is explicit in the Model Act. Adherence to this principle has led to the success of American solvency regulation.

2. “Group” or “consolidated” regulation must never involve taking the surplus of one company to relieve the surplus needs of another in order to benefit the regulatory shortcomings of the jurisdiction seeking to exploit the strength of the group.

NAMIC appreciates that the troubles of one entity in a group of companies could theoretically infect another company in the same group, providing a rationale for “group” or “consolidated” regulation. However, such group regulation also entails a potentially larger risk that a regulator in a particular jurisdiction could misuse the strength of a broader group in order to suppress rates for a group member operating within its own borders—an act that is detrimental not only to the group, but other jurisdictions as well. Although much of this concern would be mitigated by adhering to the first principle of regulation on an entity-by-entity basis, understanding the potential vulnerabilities such regulatory gamesmanship and preventing it is a key prerequisite to any efficient group supervisory model.

3. The parameters and broader regulatory implications of any group supervision should be well delineated and clearly defined.

While the principles above go to the heart of solvency regulation, there needs to be far more discussion of what group supervision means in practice and how it would be implemented – both on a regulatory basis and potentially through the courts. For example, to what extent could discipline, fines, or enforcement activity be imposed on the group for problems in one entity? Moreover, how much does a group supervisory approach provide an open invitation to courts to “pierce the corporate veil?” If regulatory and judicial actions are allowed to redress problems in one company by imposing solutions on the group, the very foundation of the “legal entity” approach to insurance could be shaken to its core – to the detriment of companies and consumers alike.

## 6. International coordination of insurance regulation.

NAMIC's position on international coordination of insurance regulation matches our views on the NAIC's risk-focused surveillance process and their proposed ORSA. As with both of those processes, we believe the international coordination of insurance regulation should be centered on understanding the risks of the insurance group from the perspective of how the insurance group identifies and manages its risk.

Specifically, the IAIS has supported the use of supervisory colleges as a means for international regulators to convene and discuss a particular insurance group. We agree with the use of supervisory colleges, particularly when the discussions are focused on the current activities and issues being dealt with by the insurance group itself. We believe the IAIS's use of supervisory colleges is largely consistent with the NAIC's lead state concept, in which the states have held periodic regulator-to-regulator conference calls to discuss issues related to a particular insurance group. We believe such forums are particularly beneficial when they are developed around management's discussion of the insurance group with the most impacted supervisors. We believe this type of communication is the foundation on which international coordination of insurance regulation should be developed.

Although there is some value in the development of international requirements, such as the IAIS's Insurance Core Principles ("ICPs"), NAMIC believes the IAIS has become far too prescriptive in these requirements and we are concerned that such principles, if forced onto the U.S. system, could weaken the U.S. regulatory system as opposed to strengthen it. We appreciate that U.S. regulators recognize the uniqueness of our system and have made statements to the effect that they will only accept the international best practices where they make sense for the U.S.

## 7. The costs and benefits of potential Federal regulation of insurance across various lines of insurance (except health insurance).

Proponents of federal regulation argue that consolidated regulation would streamline regulation of multi-state insurers and promote competition between federal and state regulators. Although federal regulation of property/casualty lines could potentially reduce operating costs for some multi-state and national carriers, such cost savings would not be realized by the majority of insurers who write in a limited number of states or a single state. The competitive inequities inherent in a two-tiered system of regulation would also impose costly economic consequences on the property/casualty insurance marketplace. It is reasonably certain that federal regulation would create an uneven playing field for large multi-state insurers and small insurers. Despite assurances that all players could choose the regulatory system best matching their business model and consumer needs, the reality is that transaction costs, as well as retooling and retraining expenses, would effectively lock small and mid-sized insurers into their original choice of regulator.

In evaluating potential “costs” one must account for the unintended consequences that would ensue from any design of a federal regulatory regime, to say nothing of the creation of an entirely new federal bureaucracy. While it is not possible to identify and measure these costs in advance, recent experience with ambitious new regulatory regimes such as the Patient Protection and Affordable Care Act (“PPACA”) and the Dodd-Frank Act confirm the inevitability of hidden or unanticipated costs. The PPACA and Dodd-Frank have generated hundreds of new federal regulations. Large insurers with depository institutions have already experienced increased costs associated with federal regulation under Dodd-Frank. Under the PPACA, the Department of Health and Human Services is considering imposing extensive and costly transaction and operating standards on all automobile and workers’ compensation transactions. A federal insurance regulatory regime is likely to result in similar unintended costs.

A federal regulatory system that results in overlapping or dual regulation would significantly increase the cost of doing business for insurers, a cost that will ultimately be borne by the policyholders. Financial or market conduct oversight at both the federal and state levels would needlessly drive up operating costs, and insurer solvency could be jeopardized. In addition, any system that attempts to divorce consumer protection and product design from solvency would be disastrous for policyholders and claimants. Likewise, any system that establishes a national solvency fund for federally chartered companies could impair the financial capacity of state guaranty funds, again, the ultimate loser in such a system being the consumer.

Although the price of federal regulation could be high, there is no evidence that it would provide a significant benefit. For example, federal regulation has not proven better than state regulation in addressing market failures or protecting consumer interests. Unlike state regulatory failures, federal regulatory mistakes can have disastrous economy-wide consequences – as evidenced in the recent financial crisis. Furthermore, it is likely that insurers would find themselves subject to myriad new federal rules and regulations once that door had been opened.

The presence of a federal regulator also raises concerns regarding accessibility and accountability for both consumers and market participants. The likelihood that a federal regulator could provide the same level of response to consumer inquiries and complaints that the states currently provide is not high.

Finally, in contrast to other insurance products, the property/casualty business is highly dependent on state and regional differences. Insurance is subject to state and regional differences in legal systems and reparation laws; geographical differences impacting weather patterns and catastrophes; differences in demographics affecting population concentration, driving patterns, and land use; and state and local laws establishing driving rules, building codes, and other local matters. These differences are particularly critical for personal lines property and casualty coverages (auto, homeowners, personal liability) making “national” products and regulation difficult.

For these reasons, NAMIC supports a reformed state-based insurance regulatory system with an appropriate role for limited federal intervention. For example, federal legislation could be enacted that would:

- Prohibit states from limiting property/casualty insurers' ability to set prices for insurance products, except where the insurance commissioner can provide credible evidence that a rate would be inadequate to protect against insolvency; and
  - Prohibit states from limiting or restricting the use of underwriting variables and techniques, except where the insurance commissioner can provide credible evidence that a challenged variable or technique bears no relationship to the risk of future loss.
8. The feasibility of regulating only certain lines of insurance at the Federal level, while leaving other lines of insurance to be regulated at the State level.

As previously noted, federal regulation of property/casualty insurance is problematic. Geographic and demographic differences and variances in state legal systems and reparation laws make national regulation of products inherently difficult. Insurance regulatory reform is highly complex and the industry is extremely diverse. Any attempt to identify and regulate specific lines of insurance at the federal level would create winners and losers within the property/casualty insurance industry with adverse effects on market conditions and consumer choice. Bifurcation of property/casualty insurance regulatory authority would also generate significant confusion among consumers and complicate settlement of claims that involve multiple lines of insurance. In the case of complex insurance claims involving multiple carriers and crossing product lines, the presence of multiple regulators would introduce unnecessary regulatory complications and consumer confusion and could ultimately lead to regulatory gaps or lessened consumer protection. Regulation of specific lines at the federal level, while other lines are regulated at the state level, would also needlessly complicate solvency regulation if regulators impose different - or even conflicting - capital and investment standards.

Lastly a dual regulatory system could undermine the functioning of the state guaranty fund system (discussed in detail below.) Either removing certain lines from the guaranty fund system or including companies in the same system with different regulatory standards would create an un-level playing field and ultimately reduce the effectiveness and efficiency of the well-functioning resolution system.

9. The ability of any potential Federal regulation or Federal regulators to eliminate or minimize regulatory arbitrage.

With respect to insurance regulation, the existing state-based regulatory system provides little opportunity to engage in regulatory arbitrage – the strategy of identifying and exploiting loopholes in the regulatory apparatus, or choosing to be regulated by a relatively lax regulatory regime. There is ample reason to believe, however, that such opportunities would likely become available under federal regulation. More generally, the long history of regulatory arbitrage practiced by federally-regulated financial institutions does not inspire confidence in the ability of federal regulators to “eliminate or minimize” regulatory arbitrage. Although the Dodd-Frank Act was crafted in part to achieve this objective, recent events such as the collapse of MF Global suggest that opportunities for regulatory arbitrage remain.

Section 111 of the Dodd-Frank Act established the FSOC, which is tasked with identifying risks to the financial stability of the United States that could arise from the material financial distress or failure, or ongoing activities, of nonbank financial companies, as well as large, interconnected bank holding companies and to make recommendations concerning the establishment of heightened prudential standards for risk-based capital, leverage, liquidity, contingent capital, resolution plans and credit exposure reports, concentration limits, enhanced public disclosures, and overall risk management of such institutions. The FSOC is further directed to require supervision by the Board of Governors of the Federal Reserve for nonbank financial companies that may pose risks to the financial stability of the United States in the event of their material financial distress or failure.

A fundamental feature of the FSOC is to enable information exchange among state and federal financial regulators. The Council includes voting representatives of all the federal financial regulators, as well as non-voting representatives of state insurance and banking regulators. The ability of regulators to effectively supervise entities under their control is directly related to the quality of information regarding the business structure and operation of the entities, including the parent and subsidiary enterprises. To the extent that regulators working collaboratively can obtain a full 360-degree picture of financial condition, operating structure, product offerings and business practices, regulatory arbitrage or supervisory gaps are less likely to occur. NAMIC believes that the FSOC’s highest and best use is to facilitate this information sharing and identification of regulatory gaps.

In addition, implicit regulatory arbitrage could occur if the federal government chooses to designate specific companies as systemically significant or “too-big-to-fail.” A federally-regulated insurer designated as a Systemically Important Financial Institution might overtly or unconsciously take advantage of the implicit guarantee of a government bailout and engage in riskier (but potentially more profitable) underwriting or investment practices. Such actions would act to the ultimate detriment of not only the company, but the entire industry. Rather than discourage such regulatory arbitrage, federal

designation could, in fact, enhance the likelihood of its occurrence. The federal government should utilize its authority and power through the Council to coordinate, rather than supplant, state regulatory oversight of insurance companies and encourage joint – not duplicate – regulation of those companies subject to federal supervision as savings and loan holding companies.

**10. The impact that developments in the regulation of insurance in foreign jurisdictions might have on the potential Federal regulation of insurance.**

The development of new, untested solvency regulation in foreign jurisdictions raises serious concerns for NAMIC members. Clearly, these developments are already having a tremendous impact on the U.S. regulatory system as the NAIC considers its Solvency Modernization Initiative (“SMI”). We generally agree with the approach the NAIC has taken with respect to SMI. Specifically, we agree with the comments that have been made by regulators to the effect that they intend to take best practices from other countries, but only adopt what is appropriate for the U.S. system. So far, this has largely been the case, although we have never favored the reduction of reinsurance collateral as we believe that has the potential to weaken the U.S. system. However, we believe the NAIC has exercised appropriate discretion with respect to its approach to risk-based capital, group capital, and the Own Risk and Solvency Assessment in general.

We have concerns regarding the potential changes that could come in the form of additional governance requirements as well as the potential change in existing accounting requirements that have been tried and tested, and supported by virtually all users of non-life insurers’ financial statements. Despite those concerns, and as we have alluded to previously, we believe the NAIC and the states have developed a regulatory approach that is much better than the untested Solvency II system, and other related systems. We believe it’s important that regulators of different jurisdictions retain their authority for establishing their own solvency systems since they understand the needs of their market. As previously indicated, we support the use of supervisory colleges as a means to improve the coordination of group supervision. We urge the FIO to approach international issues with these basic principles in mind and to assist Congress and others in the federal government in gaining an understanding and appreciation of our industry. We also believe that the U.S. insurance sector should not be viewed unfavorably if it obtains partially observed scores on many of its Insurance Core Principles in its next Financial Sector Assessment Program.

**11. The ability of any potential Federal regulation or Federal regulator to provide robust consumer protection for policyholders.**

Consumer protection and ensuring that insurance companies can pay their claims to consumers is the *raison d’être* of insurance regulation – and there is no better protection for consumers than effective solvency regulation. In addition, the state-based insurance

regulatory system includes protections covering virtually every aspect of the insurance enterprise. States impose licensing requirements, including background checks and education and continuing education requirements for most insurance company employees and agents. Fair claims settlement regulations govern insurance company practices, and rigorous comprehensive examinations cover insurance company operations and management, complaint handling, marketing and sales, producer licensing, policyholder services, underwriting and rating, and claims practices. Insurers are also subject to state unfair trade practice and anti-trust laws. State insurance regulators and state attorneys general play complementary and mutually supportive roles to vigorously enforce these laws.

In sum, the current regulatory structure works well to address consumer protection issues. State regulators are keenly attuned to the needs of their residents, and are accountable and accessible, both geographically and politically, to their consumers. The states collectively employ more than 1,600 consumer service personnel to respond to millions of consumer inquiries annually, ranging from simple questions to formal consumer complaints. For example, in 2010, state insurance departments received 2.1 million insurance inquiries.

Federal lawmakers recognized the quality of the state insurance consumer protection programs and properly excluded insurance services and products from the Consumer Financial Protection Bureau ("CFPB"). Congress acknowledged that a federal agency was unlikely to provide better consumer protection, more efficiently or more cost effectively. Given the unique differences in state liability and reparation laws, a one-size-fits-all federal approach to consumer protection would not better safeguard the interests of America's insurance policyholders and claimants. As such, NAMIC is pleased the newly operational CFPB complaint database properly directs individuals to the appropriate state insurance department for inquiries related to insurance products and services. We believe this approach properly fulfills a needed role in providing consumer information and facilitating consumer contact directly with their state insurance department. To the extent the federal government seeks to enhance its role in insurance consumer protection, we believe it should be confined to the facilitation of information sharing and consumer information.

The statutory language and the legislative history of Dodd-Frank are unequivocal in the exclusion of insurance from the purview of the CFPB. In testimony before the House Financial Services Committee, Elizabeth Warren, in her capacity standing up the bureau, acknowledged that insurance complaints would be outside the scope of the bureau and emphasized to lawmakers that the CFPB would respect the statutory limitations placed on its authority. However, we are concerned that this position may not be fully communicated throughout the bureau. In the context of holding company structures, we are concerned that the CFPB properly respect its limitations and refrain from inquiries into insurance company affiliate operations. The statutory prohibition on involvement in the business of insurance is clear and the CFPB should comply with that prohibition in all respects. We encourage the FIO to work closely with the CFPB and

carefully monitor the work of the bureau to ensure that the statutory exclusion of insurance is respected.

12. The potential consequences of subjecting insurance companies to a Federal resolution authority, including the effects of any Federal resolution authority.

The state-based resolution authority for insolvent property/casualty insurers is a thoughtful, methodical process with a superb track record of protecting insurance claimants and policyholders. The first step in the process is often an order of rehabilitation for a troubled insurance company. The rehabilitation order is sought and obtained by the insurance department as part of the agency's supervisory role. A rehabilitator is appointed to take over the operations of the insurance company. When the rehabilitator and the state insurance department determine that a company's surplus is impaired and it is unable to pay its obligations, the insurance department in the state of domicile of the insurance company will obtain a court order for liquidation. Upon a determination of insolvency, the court will issue an order directing the insurance department to marshal the assets of the insurance company and to determine its liabilities. During this period, payments will be halted and typically all existing contracts will be terminated and the company will be barred from writing new business. Assets will also be liquidated. When all claims are valued and assets liquidated, the percentage of each claim that can be paid from the insurance company will be determined.

State guaranty funds cover claims by or against residents of its state. Payments are made according to state law priority, and policyholder claims receive priority over general creditor claims. In addition, upon entry of the liquidation order, the state guaranty fund becomes obligated to begin paying covered claims to or on behalf of the residents in its state who were insured by the insolvent insurer. The guaranty fund works with the liquidator to determine to what extent the claims constitute "covered claims." That determination requires specific knowledge and experience with insurance policy provisions and state law. Once the claim is determined to be a covered claim the guaranty fund will adjust and settle the claim, subject to state maximum limits. In most cases, policyholders are paid in full through the guaranty fund process.

Adjusting and settling claims again requires specific detailed knowledge and expertise in state insurance laws with respect to adjustment of property claims, workers' compensation laws and procedures, and state tort laws. Additionally, knowledge of state and local court procedures and familiarity with licensed attorneys capable of defending claims are essential to the orderly settlement of claims. State guaranty funds assess member insurers to obtain funds sufficient to pay obligations related to the insolvency. Assessments typically are prorated among member insurers based on the written premiums that each insurer wrote in that state during the previous calendar year for the specific line of insurance and are generally limited to one or two percent of the insurer's total written premium for the specified lines of insurance. Guaranty funds have

the ability to make repeated assessments and to engage in short term borrowing and other financing mechanisms to meet their obligations to insurance consumers.

Subjecting insurance companies to a federal resolution would disrupt this well-functioning system. Overlaying a federal resolution would needlessly complicate the process and likely disadvantage policyholders and claimants. Replacing the state-based system with a federal system would likely be much less efficient in resolving claims inherently dependent on state law.

*i. On the operation of State insurance guaranty fund systems, including the loss of guaranty fund coverage if an insurance company is subject to a Federal resolution authority.*

All states have property/casualty insurance guaranty funds that safeguard their residents against the insolvency of a property/casualty insurer doing business in the state. The state guaranty system continues to work well to protect consumers without taxpayer bailouts. An established national solvency fund for federally chartered companies could raise significant questions regarding the operation, stability, and viability of the financial backstop for policyholders and claimants. Although there are over 3,000 property/casualty insurers licensed in the United States, premium volume is concentrated in a smaller number of companies. If a significant number of these companies were subject to federal resolution authority and removed from the state guaranty fund system it could imperil the functioning of the state-based resolution system. Separate funds would leave each with less premium base for assessment, potentially weakening both systems. Likewise, if companies were subject to a federal resolution regime, but remain covered by the state guaranty fund system, it could threaten the operation of the state-based system. Federal resolution authority for insurers is further complicated by the fact that the U.S. Constitution leaves it to the states to enact laws related to liability, and these state tort laws, compensation systems and attendant legal procedures do not permit uniform claims treatment. Last, but not least, unlike federal resolutions of banking interests, insurance company resolutions require adjustment of property/casualty insurance claims, which are dependent on state law and require detailed and specialized knowledge.

*ii. On policyholder protection, including the loss of the priority status of policyholder claims over other unsecured general creditor claims.*

The state-based guaranty fund system is designed first and foremost to protect policyholder and third-party claimant interests. Each state provides for priority of these claims over other unsecured general creditor claims. The guaranty fund system has a proven track record of policyholder protection. Any federal resolution system is unlikely to prove as efficient and effective in protecting policyholder interests. Protection of policyholder interests includes not only prompt payment of claims, but appropriate and accurate adjustment of these claims, including application of applicable state law and

competent defense of third-party claims. Adjustment and adjudication of these claims is at the heart of policyholder protection and requires state-specific knowledge and skills which are effectively embraced by the state guaranty fund system. Given the dependence on claims adjustment, it is unlikely that a single federal resolution system would as efficiently or cost-effectively serve this function as well as protect policyholder interests.

*iii. In the case of life insurance companies, on the loss of the special status of separate account assets and separate account liabilities*

*iv. On the international competitiveness of insurance companies.*

The state-based guaranty fund system does not impair the international competitiveness of insurance companies. Companies are subject to the jurisdiction of the guaranty funds in the states in which they do business and are subject to assessment in proportion to their premium volume. Overlaying a federal resolution system would needlessly complicate the orderly dissolution of an insolvent insurer.

### **13. Additional comments on U.S. natural catastrophe preparedness**

The question of how the United States should prepare for and respond to natural disasters in the future is a complex and difficult one to answer. We would note that even six years after the devastating storm season of 2005, it is not clear that, as a nation, we have taken comprehensive action to better prepare for such a season. The continuing concentration of the country's population in areas vulnerable to natural disasters pose significant challenges for government policymakers, insurers, realtors, home builders, mortgage lenders, and property owners.

It is clear that the answer to the broad problem of natural disasters will involve a varied and extensive response. Flood is a prime example – the inability of the private insurance market to underwrite the adversely selected and highly concentrated risk of flood led to the necessity of the National Flood Insurance Program. While that program is in need of reform in order to be fiscally sustainable, it represents needed government action that works in conjunction with the private insurance markets to protect individuals and businesses from disaster losses. Similarly, the government and the private sector can and should work together to address problems of insurance availability and affordability in high risk areas, but the economic principles affecting the complex relationship between supply, demand, and price cannot simply be ignored or erased by regulation and programs.

NAMIC has adopted four core principles that we believe represent the right approach to meet the challenges of natural disasters:

- Market freedom and competitive pricing will lead to innovation in developing solutions to problems relating to disaster insurance and mitigation.
- Competitive pricing and risk-based underwriting are essential to developing and maintaining a viable disaster insurance market.
- Mitigation must be an indispensable aspect of any disaster risk management and insurance initiatives.
- The National Flood Insurance Program should be maintained, but must be reformed.

As these are broad principles, we remain open to a discussion of many different approaches – indeed there will be multiple pieces to a comprehensive solution. NAMIC would like to take this opportunity to highlight a major piece of that solution that we feel has been overlooked and underestimated and addresses our third core principle: the importance and value of pre-disaster mitigation.

Planning and preparation must be a significant part of the equation and specifically, NAMIC supports the adoption of strong building codes. Overwhelming evidence exists to demonstrate the adoption and enforcement of statewide building codes greatly reduce property damage and personal injury resulting from disasters. Building codes govern all aspects of construction and help to protect single-family dwellings and commercial buildings from disasters such as hurricanes, tornadoes, earthquakes, and other natural catastrophes. According to a National Institute of Building Sciences study, for every \$1 spent to make buildings stronger, the American taxpayer saves \$4 in federal disaster assistance.

Despite this correlation, most states have not enacted statewide building codes and related inspection and enforcement measures. State standards for construction, code-related inspection and enforcement vary widely across the country. Where statewide codes exist, it is not uncommon to allow individual jurisdictions (e.g., cities of a particular class, or counties) to deviate from the state standards, occasionally resulting in a weakening of the model minimum standards. The federal government and the private sector pay billions for disaster relief and rebuilding of communities. In the aftermath of the 2004 and 2005 hurricanes, studies examining property damages illustrate that the damages associated with high winds could have been avoided or minimized by adoption of stronger nationally recognized building codes in the Gulf States. For example, the Louisiana State University Hurricane Center estimated that of the \$10 billion in wind damage to homes in Louisiana as a result of Hurricane Katrina, modern building codes would have prevented 80 percent of the damage.

FEMA's stated mission of leading "America to prepare for, prevent, respond to and recover from disasters" is well embodied in the pre and post mitigation programs

available to states under the Stafford Act and the Disaster Mitigation Act of 2000. These programs help states assess how to alleviate or eliminate long-term risks affecting people, property, the environment, and ultimately the economy. Under the Hazard Mitigation Grant Program (HMGP), states are required to submit a Standard Mitigation Plan for approval by FEMA as a condition to receive monetary disaster assistance. According to the HMGP, one of the permissible uses of funding includes projects associated with “post-disaster building code related activities that support building code officials during the reconstruction process.”

Further, a state may elect to prepare a more comprehensive plan (Enhanced Mitigation Plan) which would qualify the state for additional funding up to 20 percent of the estimated aggregate amount of grants to be awarded. One example of projects a state could consider to demonstrate its commitment to having a strong mitigation program implemented is as follows: “To the extent allowed by State law, the State requires or encourages local governments to use a current version of a nationally applicable model building code or standard that addresses natural hazards as a basis for design and construction of State sponsored mitigation projects.”

NAMIC believes that additional post-disaster funding for states which enact a statewide building code and provide mechanisms for active enforcement would serve as an appropriate federal incentive. To that end, NAMIC helped organize the Build Strong Coalition to advocate for the development of federal programs that provide economic incentives to encourage the adoption of statewide building codes, specifically, the Safe Building Code Incentive Act (H.R. 2069). Under the proposed law, states that adopt and enforce recognized model building codes for residential and commercial structures would qualify for an additional 4-percent of funding available for post-disaster grants. The program would be administered by the Federal Emergency Management Agency.

Stronger homes and businesses will save private property, federal funds, environmental damage and insurance claims paid. Most importantly, stronger homes and businesses save lives. The Safe Building Code Incentive Act provides the right light-touch, federal incentive to states to take the common sense approach and adopt statewide, enforceable building codes. The bill is a fiscally responsible, mitigation-focused legislative proposal and would be a strong signal that the federal government is serious about preparing our nation’s infrastructure for the threat of natural catastrophes.