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The Honorable Steven T. Mnuchin
Secretary of the Treasury
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Dear Secretary Mnuchin**:**

The National Association of Mutual Insurance Companies (NAMIC) very much appreciates the opportunity to provide feedback in preparation for your upcoming report to the President on the extent to which the existing financial regulatory system for asset managers and insurance promotes the administration's "Core Principles" for financial regulation. The Core Principles include empowering Americans to make independent financial decisions, save for retirement, and build wealth; preventing taxpayer-funded bailouts; promoting American competitiveness both at home and abroad; and making regulation efficient, effective and appropriately tailored. NAMIC fully supports these principles and will work with the Treasury Department on keeping an appropriately tailored system of property/casualty insurance regulation in the United States.

NAMIC is the largest property/casualty insurance trade association in the country, with more than 1,400 member. NAMIC supports regional and local mutual insurance companies on main streets across America and many of the country's largest national insurers. NAMIC member companies serve more than 170 million policyholders and write more than $230 billion in annual premiums. Our members account for 54 percent of homeowners, 43 percent of automobile, and 32 percent of the business insurance markets.

The report "Report on Regulations Impacting Asset Management & Insurance Industries" will focus on the following 11 insurance topics:

- Role of State and Federal Regulation
- Systemic Risk (exclusive of FSOC designation)
- International Processes and Standard Setting Bodies
- Capital and Liquidity Standards
- Retail Investment Products, including the DOL Fiduciary Rule
- Institutional Investment Products
- Retirement Security

- Agents and Brokers Licensing
- Federal Insurance Programs, including TRIA and NFIP
- Reinsurance Marketplace
- Cyber and Data Security

Below you will find detailed comments on 7 of the 11 categories.

Role of State and Federal Regulation

Following the Supreme Court decision in United States v. South-Eastern Underwriters Association, 322 U.S. 533 (1944), that insurance was interstate commerce and subject to regulation by the federal government, Congress, in 1945, enacted the McCarran-Ferguson Act (15 USC 1011, et seq.). The McCarran-Ferguson Act recognizes the local nature of insurance and provides for the continued regulation of insurance by the states coupled with a narrow exemption from the federal antitrust laws for the business of insurance.

The state-based functional regulatory system and the corresponding application of the McCarran-Ferguson Act limited federal antitrust exemption have worked well for decades to promote and maintain a healthy, vibrant, and competitive insurance marketplace. There are nearly 6,000 insurers operating in the United States, the majority of which are relatively small. Virtually all studies done by academic and governmental entities have consistently concluded that the property/casualty insurance industry is very competitive under classic economic tests.

The national system of state regulation has for more than a century served consumer and insurer needs well.. The state-based insurance regulatory system has proven to be adaptable, accessible, and effective, with rare insolvencies and no taxpayer bailouts. Each state has adopted law and regulation tailored to the unique needs of its consumers yet all states have a common financial solvency system through uniform accreditation requirements. State regulators and legislators consider and respond to marketplace concerns ranging from risks related to weather, specific economic conditions, medical costs, building codes, and consumer preferences. In addition, state regulators respond and adapt to inconsistencies created by various state contract, tort, and reparation laws.

Property/casualty insurance is inherently local in nature. The United States has 54 well-defined jurisdictions, each with its own set of laws and courts. The U.S. system of contract law is deeply developed and, with respect to insurance policies, is based on more than a century of policy interpretations by state courts. The tort system, which governs many of the types of contingencies at the heart of insurance claims, particularly those covered by liability insurance, is also deeply based in state law including, for example, the law of defamation, professional malpractice, premises liability, state corporation law, and products liability. State and local laws determine coverage and other policy terms. Reparation laws affect claims. Local incidents of accident, weather, and theft impact pricing. Geographical and demographic differences among

states also have a significant impact on property/casualty coverages. Weather conditions – hurricanes, earthquakes, tornados, lightening, snow, ice, and hail, etc. – differ significantly from state to state.

With the ability to respond to unique local issues, the individual states serve as a laboratory for experimentation and a launch pad for reform. State-based regulators develop expertise on issues particularly relevant to their state. Insurance consumers directly benefit from state regulators' familiarity with the unique circumstances of their state and the development of consumer assistance programs tailored to local needs and concerns. State regulators, whether directly elected or appointed by elected officials, have a strong incentive to deal fairly and responsibly with consumers.

The most important insurance consumer protection is ensuring the ability of the carrier to provide the promised coverage at a future date. Thus, ensuring the solvency and financial integrity of the insurer is the fundamental consumer protection. In addition, states enforce a variety of other consumer protection laws and regulations designed to ensure disclosure, fairness, and competitive equity.

State insurance regulators actively supervise all aspects of the business of insurance, including review and regulation of solvency and financial condition to guard against market failure and minimize company failure. The laws for financial condition and solvency are significantly similar from state to state as a result of financial accreditation standards set forth by the NAIC. Public interest objectives are achieved through review of policy terms and market conduct examinations to ensure effective and appropriate provision of insurance coverages. Regulators also monitor insurers, agents, and brokers to prevent and punish activities prohibited by state antitrust and unfair trade practices laws and take appropriate enforcement action.

State insurance regulators also interact directly with consumers. As an example, nationwide, commissioners handle and respond to almost 2.3 million consumer inquiries and complaints in a single year. Inquiries range from general insurance information to content of policies to the treatment of consumers by insurance companies and agents. Most consumer inquiries are resolved successfully.

Another unique feature of insurance regulation in the United States is the state guaranty fund system. Unlike banking and pension interests, insurance products carry no federal guarantee, but are backed by other insurance companies through the guaranty fund system. This system aligns perfectly with the administration's core principle of ending taxpayer bailouts.

State guaranty associations provide a mechanism for the prompt payment of covered claims of insolvent insurers. All states and territories, with the exception of New York, have created post-

assessment guaranty associations. In the event of insurer insolvency, the guaranty associations assess other insurers to obtain funds necessary to pay the claims of the insolvent entity. In the case of New York, the New York Security Fund and certain funds that cover only workers' compensation utilize a pre-assessment mechanism.

Insurance companies writing property/casualty lines of business covered by a guaranty association are required to be a member of a guaranty association of a particular state as a condition of their authority to transact business in that state. Guaranty associations assess member insurers based upon their proportionate share of premiums written on covered lines of business in that state. Separate life and health insurance guaranty association systems also exist.

Each guaranty association has established detailed procedures for handling of assets, filing of claims, and making assessments. The guaranty association laws of the states and territories are based on, and are similar in most respects to, the National Association of Insurance Commissioners (NAIC) Model Act. State legislators and regulators have crafted statutes and regulations regarding the creation and operation of the funds based on the specific needs of policyholders and in coordination with state laws. The funds operate to ensure payment of claims by other industry companies, rather than utilize state or federal financial backstops. The insurance guaranty system and the state regulatory and oversight structure function well for insurers and consumers. The current system avoids catastrophic financial loss to certain claimants and policyholders and maintains market stability, without governmental financial guarantees. As such, regulation and oversight of the guaranty fund system is appropriate at the state level and federal oversight is unnecessary in the context of the industry-funded state-based system.

The state insurance regulatory system, however, is not without its shortcomings. State insurance regulation receives justified criticism for overregulation of price and forms, lack of uniformity, and protracted speed-to-market issues. For example, only one state, Illinois, allows property/casualty insurers to set prices through what is known as "open competition." NAMIC believes that a reformed system of state-based insurance regulation is the best suited for the U.S. and we continue to work with state legislators and regulators to modernize the insurance regulatory system to meet the needs of a 21st century marketplace.

Federal Role

NAMIC continues to have significant concerns with the expansion of the federal role in insurance regulation. Any new federal regulatory authorities, whether designed to replace or duplicate the state system, would disrupt well-functioning markets, introduce competitive inequities, and generate confusion among consumers. We urge the administration to review all federal activity that touches on the property/casualty insurance industry with the goal of ensuring it is necessary, productive, "efficient, effective, and appropriately tailored." There are two

specific federal offices that have become increasingly involved in insurance since the passage of the Dodd Frank Wall Street Reform and Consumer Protection Act of 2010 (Dodd-Frank): the Federal Insurance Office and the Federal Reserve.

Federal Insurance Office

NAMIC suggests that you take a close look at the Federal Insurance Office (FIO), originally created by Dodd-Frank. Based on our experience with FIO, the office adds little value to the U.S. insurance system, policyholders, or taxpayers. We strongly urge you to consider including the FIO in your proposal to the Office of Management and Budget in response to Executive Order 13781. EO 13781 directs each agency "to improve the efficiency, effectiveness, and accountability of that agency." Specifically, the plan should:

(1) make "recommendations to eliminate unnecessary agencies;"
(2) consider "whether some or all of the functions of an agency, a component, or a program are appropriate for the Federal Government or would be better left to State or local governments;"
(3) consider "whether some or all of the functions of an agency, a component, or a program are redundant;"
(4) consider "whether certain administrative capabilities necessary for operating an agency, a component, or a program are redundant;" and
(5) consider "whether the costs of continuing to operate an agency, a component, or a program are justified by the public benefits it provides."

We can think of few offices more deserving of elimination than the FIO, based on these criteria. The FIO is "unnecessary," performs many "redundant" functions better left to the states, needlessly utilizes administrative capabilities, and does not provide public benefits that justify its cost. In addition to being unnecessary, in many cases, the office is actually creating duplicative burdens and negatively impacting the insurance industry.

The FIO is statutorily mandated to study the affordability and availability of insurance in traditionally underserved communities. The office has interpreted this mandate to mean it must attempt to objectively define a subjective concept, a project which will inevitably lead to problematic conclusions about the state of insurance markets without consideration of the actual costs of providing insurance products. State insurance commissioners across the country are committed daily to ensuring consumers in their state are protected. That should be the role of the regulators, not the FIO. Even conducting these studies has the negative effect of adding costs to insurers who must comply with annual data calls for these studies.

The FIO further encroached on the state regulators consumer protection function when it issued its November 2016 report on consumer protections. This study has a tenuous (at best)

relationship with its statutory mandates. This report – which was not mandated nor requested by the policymakers for whom the FIO serves as a resource – lacked substance and was thoroughly and one-sidedly political, throwing out alarmist conclusions and unnecessary proposals. It is not clear why we need a federal office for this.

Even in its chief role as an information resource the FIO has only added cost and duplication. The Terrorism Risk Insurance Act reauthorization bill passed in 2015 mandated that the FIO study the terrorism insurance marketplace and required data to be collected to do so. Before collecting any data, the FIO is required to work to obtain this information from relevant state, federal, or other public sources (31 U.S. Code § 313) before engaging in any mandatory data calls. The National Association of Insurance Commissioners has launched its own TRIA data collection process and yet the FIO basically refused to work with them on a common template that would allow for one data call. Companies writing TRIA-covered lines are now subject to duplicative data collection/reporting requirements to achieve very similar goals.

Even in the international arena, in which some claim the office has a necessary role to play, the FIO has not proven to be of value to the U.S. insurance industry. We will elaborate on some of these topics below, but in short, the FIO has not improved the results for the U.S. in the group capital debates at the International Association of Insurance Supervisors (IAIS); has voted against transparency (and state insurance regulators) at the IAIS in order to block due process; has not improved the Treasury Department's representation of insurance at the Financial Stability Board (FSB); and has advocated for compromise instead of flexibility in global insurance standards all without any clear policy objective supported by due process. The U.S. is already represented internationally by the Treasury Department, the Federal Reserve, the United States Trade Representative, and the functional state insurance regulators engaged in these discussions. It is unclear what the FIO adds that cannot be accomplished by the other U.S. participants.

Also internationally, the FIO led the effort to negotiate a "covered agreement" with the European Union on prudential matters relating to insurance. Overall, the deal was a bad one for 94 percent of the 3,200 U.S. property/casualty insurers, which do not have operations in Europe and which got nothing from the agreement but future regulatory uncertainty and the loss of reinsurance collateral. It is not clear that the FIO needed to use this authority in the first place, but we cannot think of another circumstance in which the mechanism of a covered agreement will be the necessary or appropriate solution.

In the end, the FIO is not needed to manage any particular program or fill any specific role. For example, the office is currently tasked with overseeing the TRIA program, but this is not a task requiring a stand-alone federal entity. TRIA was ably handled by the Treasury Department for a

decade prior to the FIO's creation. If the office were eliminated, it would simply revert to that system, which operated effectively.

Federal Reserve

One of the issues that arose from implementation of the Dodd-Frank Act on the regulatory side was the Federal Reserve's new authority to regulate both bank holding companies and savings and loan holding companies – which includes several insurance companies that own thrifts. Under Section 171 of the Dodd-Frank Act, known as the "Collins Amendment" for its author, Sen. Susan Collins, R-Maine, the Federal Reserve is required to impose minimum capital requirements for both bank holding companies and savings and loan holding companies.

We suggest re-examining the duplicative oversight of the Federal Reserve of the depository institution holding companies that are supervised by insurance regulators. The task for the Federal Reserve has been challenging as they regulate an asset-focused industry while property/casualty insurers are a liability-focused industry. Managing the liability side of the balance sheet is where the property/casualty insurance groups succeed or fail. Banks are focused on their asset risks. Consequently, the Federal Reserve has always focused its supervision on protecting assets, testing capital requirements, determining how organizations will react to market disruption, etc. The insurance holding companies managing depository institutions face far different risks. Their solvency is better regulated by state regulators providing hands-on oversight of the risk management of liabilities, accuracy of reserving practices, and the stability of insurance financial practices.

Of course the Federal Reserve should remain engaged with the depository institutions under these insurance companies, but the supervision of the holding company by state insurance regulators does not need to be duplicated. In recognition of this duplication of effort, the NAIC and the Federal Reserve are currently trying to work together to achieve the common goal of group supervision for the handful of insurance groups that also have depository institutions. Ultimately, the Federal Reserve does not need to be duplicating the states' work when coordination can be much more effective and efficient.

Systemic Risk

NAMIC supports regulatory measures designed to prevent future financial crises. However, we would argue that the property/casualty insurance industry is highly competitive, well capitalized, and poses no systemic risk. This has been documented in studies conducted by authorities around the world – there is little dispute on this point. However, property/casualty insurers will be dramatically affected by the systemic risk regulation that is being contemplated by the actions of the G20, the Financial Stability Board, the International Accounting Standards Board, and the International Association of Insurance Supervisors. The property/casualty insurance industry would be subject to significant disruption and costly, ill-suited requirements if all of the initiatives coming from these global standard setters are allowed to be adopted in the U.S. Even

the support by the U.S. at the G20 or the FSB could have critical impacts on the U.S. property/casualty industry. Property/casualty is unique within the insurance sector for a number of reasons: 1) property/casualty risks are not at all correlated with the market. When the market falls there will not be more auto accidents or more homes catching fire, and importantly once policyholders cancel their policies there are no new liabilities for claims; 2) the industry has low leverage ratios and relatively liquid assets; and 3) the property-casualty market is very competitive, substitutable, and has low concentrations in the marketplace.

Systemic Risk in the Insurance Industry

There are six primary factors that affect the probability that a financial institution will create or facilitate systemic risk: leverage, liquidity, correlation, concentration, sensitivities, and connectedness. An examination of these factors will demonstrate that there is no basis for regulating property/casualty insurance companies, with the possible exception of financial guaranty insurers, for systemic risk because they do not present such a risk. This analysis addresses only property/casualty insurance products, which are far different, in particular, from life insurance products that may offer investment features similar to bank and securities products and, as such, may warrant a different regulatory structure.

Leverage

Very few property/casualty insurers use commercial paper, short-term debt or other leverage instruments in 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 the 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 example, at the time that the recent financial crisis began to unfold, many large commercial and investment banks were operating at very high leverage ratios, often borrowing $15 to $25 for every $1 in capital they held. When the crisis struck, pools of available credit dried up and the cost of borrowing soared, destroying or severely impairing these firms' operating models. By contrast, property/casualty insurers neither borrow to make investments, nor borrow to pay claims. Thus, even when some of their investments perform poorly, the effect on property/casualty insurers is not transmitted to other financial institutions, and does not impact the economy as occurs in highly leveraged industries. This explains why the property/casualty insurance industry did not suffer from a credit or liquidity crisis.

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 property/casualty insurance companies. A high level of liquid assets is a critical part of the basic property/casualty insurance business model which is

reinforced by regulatory oversight of the levels of liquidity. Our 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 a property/casualty 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, the converse is true of property/casualty insurance, which has liquid assets but longer-term liabilities. It is for both business and regulatory reasons property/casualty insurers carry a liquid investment portfolio. As long as the insurance company has sufficient reserves for incurred claims and adequate policyholder surplus for future claims , there is no liquidity risk. Another self-limiting aspect is that claims can only arise when unexpected adversity occurs. Policyholders cannot choose when claims occur so there is no possibility of a "run on the bank" scenario.

Correlation

Correlation can arise in a number of ways and none of them affect property/casualty insurers. First, property/casualty insurance risks are completely uncorrelated with the movement of the markets. Note the difference between asset-backed securities and other derivative products, and property/casualty insurance. In the former, the underlying risk is a financial or market based risk (such as credit, price, interest rate, or exchange rate), whereas in property/casualty insurance, the underlying risk is a real event, such as an automobile accident, fire, or theft. While the financial 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 property/casualty insurance, in contrast, pools uncorrelated, idiosyncratic risks, and is not subject to systemic crises in the same way as banks.

Second, property/casualty insurers have strict regulatory limitations on their investments assuring that they are not engaged in risky ventures that might transmit systemic risk. In fact, investment restrictions ensure that property/casualty insurers do not include many risky assets in their portfolios.

Concentration/Sensitivities/Connectedness

Concentration risk within a property/casualty company is carefully monitored and managed as part of the traditional risk management efforts that are customary in the insurance industry. Property/casualty insurers use underwriting tools specifically designed to identify and control certain risks, including market concentration, to control excessive catastrophe and underwriting exposures. Total Insured Value (TIV) and probable maximum loss (PML) examined by geographic territory are standard measures used by companies to assure they are not overexposed in any catastrophe-prone geographic area. Identifying and managing risks are at the core of

insurance; these tools allow insurers to accurately price and underwrite risk. The side benefit of rigorous underwriting and risk management is a reduction in systemic risk exposure.

Concentration risk within the property/casualty industry is extremely low. It is a highly competitive industry where small, medium and large companies can excel. In the largest lines of insurance like auto, homeowners, general liability, workers' compensation, no company holds 25% of the market, and there are thousands of companies ready to write any business if a company, even a large one, is to fail.

Asset concentration risk is also highly regulated and managed. Traditional 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 limitations 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. While property/casualty insurers, like virtually all investors, suffered investment losses during the financial crisis, no financial contagion spread throughout the industry or to other financial markets. Even where a property/casualty insurer is held by a holding company that also holds other types of financial services companies, regulatory restrictions designed to protect policyholders operate to "ring-fence" the property/casualty insurer's capital and protect it from incursions caused by any problems of the other subsidiaries.

Unlike 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, which is financed by the property/casualty insurers of each state, reduces the systemic impact of any failing property/casualty insurer by providing claimants assurance that the insurer's obligations will be satisfied on a timely basis.

International Processes and Standard Setting Bodies

Over the last several years, the Financial Stability Board (FSB) has become an increasingly important and influential regulatory organization for the global financial services sector. Re-established in 2009 in the wake of the financial crisis, the FSB's core mission is to promote regulatory standards that ensure the stability and soundness of the world's financial system. Pre-crisis, the precursor organization the Financial Stability Forum had a role of monitoring, coordinating, and communicating between regulatory jurisdictions. However, the mandates provided in the FSB's charter go well beyond generally-expressed objectives and require that the FSB assume a direct role in monitoring how various countries implement global rules at home.

Beyond the overreach of a group of mostly foreign policymakers exerting their vision of regulation on our banking system, it is particularly troubling for the U.S. property/casualty insurance industry. During a Senate Banking Committee hearing in July of 2015, Dr. Adam

Posen – testifying in support of many of the FSB's activities and decisions – said, "Where the FSB at present is getting things wrong, in my opinion, largely has to do with its approaches to coordinating regulation of the non-bank parts of the financial system." NAMIC wholeheartedly agrees.

Multilateral organizations like the FSB have always been intended to promote and foster economic growth while maintaining financial stability, not to regulate financial services markets everywhere in the world. Over the last decade, the movement toward more formulaic, prescriptive and intrusive standard development seems to be accelerating. The FSB decisions are especially impaired in the insurance arena as its membership does not include U.S. representatives with insurance expertise and it is not transparent in its deliberations. If U.S. property/casualty insurers are not represented and not allowed to speak on their own behalf the FSB is bound to adopt ill-informed concepts and push global standards that do not recognize the differences in our business model. One-size-fits all regulation does not work within the insurance industry and certainly creates challenges when it is applied to all financial institutions.

Problematic examples of the FSB behaviors include strong pressure for global adoption of international accounting standards without understanding the shortcomings (e.g. IFRS 17); development of Key Attributes and Critical Functions for insurance without coordination with the IAIS; and attempting to define sound compensation practices for all financial companies.

The FSB has been applying pressure on international standard setters to adopt the international accounting standards of the IFRS system. The International Accounting Standards Board developed the Insurance Contracts standard, IFRS 17 with no recognition of the significant issues raised by U.S. property/casualty companies. IFRS has many weaknesses observed specifically in IFRS 17, the recently adopted Insurance Contracts standard. The U.S. GAAP standard setting body the Financial Accounting Standards Board clearly evaluated the IASB approach to Insurance Contract Accounting and rejected it out of hand. That decision was applauded by investors, preparers, and insurance regulators in the U.S. The one-size-fits-all approach of the IASB certainly doesn't work for U.S. property/casualty insurance contracts, and we encourage U.S. authorities engaged at the FSB to bring these issues to the debate around global standards.

Recently we were surprised to see the FSB delve into the compensation practices of firms including when compensation should be used to punish behavior. This was surprisingly deep into the management function of the company and seemed to extend well beyond the FSB's scope of managing financial stability.

NAMIC also has significant concerns with the FSB's review and guidance of the policy development work of international standard setting bodies, specifically the International Association of Insurance Supervisors (IAIS).

Following the financial crisis, the IAIS was directed to begin work on a Common Framework for the Supervision of Internationally Active Insurance Groups (IAIGs), also known as ComFrame. The IAIGs are defined only in ComFrame; this category of company was never contemplated nor defined in the Dodd-Frank Act, nor any U.S. government regulatory regime. This new framework, which started as new standards for cooperation and coordination among insurance supervisors, quickly became a series of new requirements for a segment of insurers.

As an example, in 2013 without warning or clear reasons, the FSB met with IAIS leadership and informed them that these IAIGs should also adhere to a global consolidated capital requirement similar to the Basel II and III requirements for banks. The IAIS was ordered to design, field test and adopt such global capital requirements for the IAIGs by 2016. The pace of this edict was unreasonable and unworkable, but IAIS leaders indicated they had no choice but to comply.

Since the FSB's mandate, the IAIS Executive Committee has made numerous decisions regarding the structure and design of the International Capital Standard (ICS) for the IAIGs without actually stating the problem the FSB was trying to solve, and without explaining why the decisions were made. The most troublesome of these decisions include:

- the insistence on a highly detailed, prescriptive formula for the ICS that would be applied to all countries;
- the requirement that all countries use the same valuation/balance sheet without regard to the costs and implications; and
- the insistence that the capital resources that companies use to meet the obligation be identical even when the capital instruments available to companies vary across countries.

Despite the goal of the IAIS to achieve a comparable ICS for all IAIGs around the globe, the application of the same capital standard to unique companies that come from very different regulatory environments with very different economic and political objectives will not produce comparable indicators of capital adequacy or solvency. Every country has a unique regulatory system with features that influence the solvency of the companies doing business in that regulatory environment. Similarly, every insurance group has unique characteristics that cannot be fully captured by a single, one-size-fits-all formula. In their zeal to achieve comparability, the FSB – through the IAIS – will succeed only in generating unnecessary costs to governments and insurers.

NAMIC believes that a successful global effort should not create unnecessary competitive asymmetries between companies domiciled in different, but equally well-supervised, jurisdictions. Instead, what is needed is a flexible and dynamic capital assessment that would recognize and improve understanding of diverse, successful approaches to solvency regulation. Such an approach would be principle-based and outcomes-focused. Under this approach, supervisors could achieve the desired goals of policyholder protection and insurer solvency without the costs of implementing new global systems in nearly every country in the world.

To be clear, NAMIC believes that American insurers should be positioned to compete in the international insurance market. That means participating in international discussions on insurance and insurance regulation – we support communication and coordination between international regulatory authorities. Working together will improve understanding of differing regulatory systems and may well result in shared best practices. However, while cooperation and coordination on the regulatory front is a positive thing, it should not result in abdication of regulatory authority to foreign jurisdictions or quasi-governmental bodies. Ultimately, U.S. representatives at international fora should advance policy positions that represent the best interests of U.S. insurance consumers, the insurance markets, the insurance regulators, and the U.S. economy in general.

Capital and Liquidity Standards

For more than 15 years the NAIC has enforced risk-based capital requirements for insurance companies including factor-based requirements for five to ten categories of risk. The categories focus on asset risk, underwriting risk, and other risk (including for 2017 affiliate risk, credit risk and catastrophe risk). The RBC regime was created to replace less sensitive methods for capital adequacy and to provide a uniform safety net that included regulatory authority for timely action. The model law provided the authority and the risk-based capital formula included a minimum capital requirement that is compared to the actual capital level of a company to result in a ratio: actual capital to required capital. The large majority of insurance companies operate at 400%-600% of the minimum RBC requirement. The ladders of regulatory intervention vary under the law depending of the level of impairment and include company action level, regulatory action level, and mandatory action level. This RBC system has worked well to maintain a healthy insurance industry since its inception.

This system has maintained close attention to each and every legal entity selling insurance products and has provided necessary oversight to prevent insurance company insolvencies. Insurance capital requirements should be used for this limited “safety net” purpose, not as the ultimate proof of solvency. There are many better tools to supervise companies to avoid insolvency than capital – in the insurance industry capital is at best a poor tool to protect against insolvency. Low capital levels are more similar to the canary in the coal mine—just an indicator of much more serious problems.

Since the financial crisis – and without a serious and substantial debate as to the merits – it has been determined by the FSB, the IAIS, the Federal Reserve, and even the NAIC that capital requirements are needed at the group level even though every insurance policy that is sold is backed by an insurance legal entity, not by an insurance group.

The IAIS was the first to pursue the requirement, as noted above, at the behest of the FSB in 2013. There are a number of concerns with the direction of this standard.

- The insurance capital standard (ICS) IAIS is creating began with a required "consolidated" group capital standard and a complex formula. In the U.S. mutual companies, who only file under the NAIC statutory accounting and not GAAP, cannot provide information on a "consolidated" basis without costly changes to their accounting system. We can only provide an aggregated group approach.
- Under the ICS the capital resources within the insurance group that can be applied to meet the capital requirement are tiered and significant differences exist between the sources of capital to meet Tier 1 requirements and those that apply in the U.S. to admitted capital.
- In addition, the standard requirement will result in regulatory action if insurance groups do not mean the 99.5% VaR. We have no specific parallel comparisons but is seems most U.S. RBC requirements are at minimal levels of 88% to 92% VaR. Holding insurers to a near 100% capital requirement under the standard formula leaves little room for error and will tie up significant capital in non-productive assets that could result in hard markets and high prices for many years to come, until the error is recognized. At that point it may be too late as we may be in the midst of another crisis in which capital serves no real purpose.

The Federal Reserve's Building Block Approach and the NAIC's Group Capital Calculation are the U.S. systems in progress to create an insurance group capital formula. They are similar at this stage in that they are both based on an aggregated system of group capital. Both the NAIC and the Federal Reserve have also started with a valuation approach based on NAIC statutory accounting, recognizing that this is the only system that all insurers in the U.S. apply. The development of these two systems are both in flux. We are continuing to work with both organizations to derive a simple means to measure group capital for the insurance and financial entities within the insurance group with the goal to treat all entities equally, eliminate duplications, and use NAIC RBC formulas as the basis for the calculation. While it is not clear exactly why it is necessary to measure group capital within a legal entity system of regulation, we believe the aggregated approach will produce the best result for U.S. insurance companies and policyholders.

Agents and Brokers Licensing

NAMIC supports a streamlined, uniform system for insurance agent and broker licensing in the United States. To that end, we supported the passage of the National Association of Registered Agents and Brokers Reform Act (NARAB) which became law in 2015. The legislation establishes an independent body that agents who sell insurance in multiple states could join and be authorized to sell, solicit, or negotiate insurance and perform related activities in any state where the producer seeks to operate, if the member pays the requisite state-established licensing fees. This would allow an insurance producer to utilize NARAB to obtain the regulatory authority needed to operate in any state in an efficient and expedited manner.

The law required that NARAB be up and running within two years following enactment which was January 12, 2015. Obviously, this deadline has been missed and NAMIC strongly encourages the administration to expeditiously take action to get the system up and running. The next step is for the president to appoint a board of directors consisting of 13 people to be approved by the Senate. The board is to be comprised of eight state insurance commissioners, three individuals with "demonstrated expertise and experience with property and casualty insurance producer licensing", and two individuals with similar expertise and experience in the life or health insurance arena.

NAMIC would urge the Administration to submit nominations for the board of directors and has a list of potential names for consideration.

Federal Insurance Programs, including TRIA and NFIP

Terrorism Risk Insurance Program

Since the events of September 11, 2001, the federal government has developed a robust and sophisticated counter-terrorism apparatus that has thus far succeeded in preventing large-scale terrorist attacks on the U.S. homeland. That said, the threat of terrorism is continuing to evolve amid a changing, unstable and dangerous international environment. Attacks such as the Boston Marathon bombings were a stark and painful reminder that the United States must remain vigilant. However unfortunate, it will likely never simply be about prevention – response and recovery are also integral pieces of national security apparatus. It is vital that we protect the U.S. economy from financial devastation and help get it back on its feet after an attack.

Before the events of 9/11, the abstract possibility of a major terrorist attack on the U.S. was known, but largely dismissed by most people. At the time, terrorism was typically included in "all-risk" policies because the risk was deemed so small as to be incalculable. In one morning, the 9/11 attacks caused roughly $40 billion in insured losses.

Soon after the events, reinsurers and then insurers moved to exclude terrorism coverage from their new and renewing policies as this was a poorly understood risk that could potentially produce unimaginable losses. Consequently, the ability of commercial policyholders to purchase

adequate coverage at affordable prices was severely constrained. As a result, many were forced to go without coverage or only partly insure their assets. In states which prohibited carriers from excluding coverage for terrorism and with reinsurance companies universally excluding terrorist acts in property/casualty treaties, most carriers' only alternative was to offer less coverage or not write the business at all.

The lack of adequate insurance capacity and significant increases in pricing of commercial multi-peril business resulted in the postponement of many construction projects. It was estimated at the time to have delayed or cancelled $15.5 billion in real estate transactions and cost 300,000 construction workers their jobs. Given the economic uncertainty that was created and the insurance industry's serious concern about properly managing this risk, Congress passed and President George W. Bush signed into law the Terrorism Risk Insurance Act of 2002. It was quickly realized that without the program American businesses would be hard pressed to find or afford the coverage they needed and so the TRIA program has been extended three times.

It is our firm belief that in the absence of a terrorism loss management plan such as TRIA, no self-sustaining private market for terrorism risk coverage is likely to develop. However, the existence of TRIA allows a viable private market to function for a difficult peril which involves strategic human behavior and represents a dynamic threat that is intentional, responsive to countermeasures, and purposefully unpredictable. The TRIA program is a highly innovative and well-designed mechanism to encourage the private sector to put its capital at risk for losses that result from what amount to acts of war – which have always been considered uninsurable events.

Managing terrorism risk defies the normal underwriting practices of insurers. Immediately following 9/11, there was hope that, given time, more accurate modeling could be developed and utilized to help insurers manage the terror risk. And indeed, much has been done to develop tools to manage aggregate loss exposures that are based on a predetermined event of a certain magnitude in a given area. That said, the underwriting challenges that remain are numerous and profound:

- **Identical to Acts of War** – Acts of war have always been considered uninsurable events with either an implicit or explicit expectation that financial responsibility resided with the governments involved. War-related damage has never been covered by insurers and no one has suggested that something must be done to maximize private sector capital to be used to provide such coverage. Simply because stateless, transnational groups are perpetrating these acts of terror does not categorically change them.

- **Absence of Meaningful Actuarial** Data – The data that insurers normally rely on when considering whether coverage can be offered and, if so, at what price, either does not exist or is not available. In the case of natural catastrophe risk, a company can rely on

decades of relevant event data that can be plugged into mathematical models to quantify risk – there is no comparable historical record on which to draw for large-scale terrorist events. Further, much of the relevant data that might be used by an insurance company is appropriately kept secret by the federal government for national security reasons. Without access to this type of information insurers cannot meaningfully calculate the likelihood, nature, or extent of a potential event, making pricing and reserving virtually impossible. Although in theory access to classified information might paint a more accurate picture of the threat matrix facing targets in the U.S., insurers should not – and are not asking to – be given state secrets in order to write terrorism coverage.

- **Intentional Acts** – A related point is that terrorist acts are caused deliberately and do not occur randomly. Because of this, there is no way to determine the probability that a particular property or asset will experience a terrorism-related loss. Part of the difficulty in assessing terrorism risk stems from the fact that, because of response measures taken in the wake of an attack, the next event is unlikely to follow a similar pattern. Unlike criminal acts such as robbery where the goals are predictably targeted, the goal of maximizing death and destruction can be accomplished in countless ways, anywhere, and at any time. Terrorism is not comparable to a random event – a hurricane cannot study wind-damage mitigation efforts and then think up new ways to get around them. The only truly effective mitigation tools – if there are any -- reside within the government's national security apparatus, and as noted above, these are understandably kept secret.

- **Risk Concentration** – Terrorism risk is highly concentrated and incredibly difficult to effectively pool across geographical locations and policyholder type, particularly in an age of mass-casualty terror. Acts of terrorism on the scale of 9/11 are what are known as a "clash events" meaning they cause significant losses across multiple lines of insurance. These types of events directly threaten the solvency of both insurers and reinsurers and are not typically covered risks. In a fully free market, it would likely be the case that highly concentrated urban areas in particular would find it difficult to find or afford coverage for terrorism.

- **Interdependencies** – At the very highest level, the nation's foreign policy decisions and the effectiveness of its homeland defense have a direct impact on the likelihood and success of an attack. At the policyholder level, the vulnerability of one organization is not simply dependent on its own security decisions, but also on the decisions of other organizations and agents beyond its control.

In order to deal with these underwriting challenges, TRIA essentially places a ceiling on individual company terrorism losses, which permits them to quantify their terrorism exposure

and make the coverage available. The program was purposefully designed to force insurers back into a market, with the benefit of knowing their exposure.

Specifically, the program is a federal backstop for commercial property/casualty insurance that acts to spread losses in the event of a certified terrorist event. A private insurance company pays for losses up to 20 percent of the prior year's direct earned premium on all lines of business covered in the TRIA program, which for the largest companies is several billion dollars, and then a (soon-to-be) 20 percent co-pay up to a program cap of $100 billion. After $100 billion, neither the government nor the company is required to pay for excess losses.

Further, the program has a recoupment mechanism which ensures that taxpayers are completely protected under TRIA – the federal government has the ability to recoup *any* money that is spent through the program. By law the federal government must recoup the difference between insurers' total costs and the industry aggregate retention (the aggregate of all TRIA-eligible companies' individual retentions) over time through surcharges on every policy covered by TRIA. Since 2007, the government must actually recoup 133 percent of this mandatory recoupment. In the event the insurers' total costs exceed the industry aggregate retention level then the government can still recoup whatever money it pays out, but this is at the discretion of the Treasury Secretary.

In this way, the federal government can be thought of as a post-funded reinsurer for the catastrophic tail coverage of terrorism risks. This coverage is valuable, but not priced explicitly nor paid for upfront – it is paid for in the event it is used and in effect, pricing is determined after any event. It is common for risks that are more difficult to quantify and where there is great uncertainty as to the range of possible outcomes for benefits and policy limits to be determined up front and premiums after the policy period based on actual experience (nuclear power plant disasters are one example).

In fact, it is the unique structure of the program's recoupment mechanism that takes losses that could render a single company insolvent and spreads them throughout the private sector and over time. This mechanism allows for a large and temporal transfer of risk that would not occur in a fully private market. TRIA acts as a shock-absorber for the U.S. economy to reduce the financial impact of a jarring terrorism event.

The current TRIA program has created space for a private market to operate under the umbrella of federal participation. The private sector involvement reduces the unaddressed needs of victims which in turn reduces the necessity of government intervention – thus taxpayer exposure – post attack. It is important to remember that the response of the federal government to a large-scale terrorist attack – particularly in the absence of the risk-sharing mechanism – will not be inaction. Importantly, what TRIA does is define the government's role in advance of a

catastrophe rather than relying on ad-hoc authorizations after the fact, thus allowing all parties to efficiently plan.

The TRIA program will be up for reauthorization again in 2020 and there will inevitably be calls to reform or change it. Throughout these discussions it is crucial that we appropriately keep the focus on the individual company. The program recognizes the fact that losses are not likely to be spread evenly among a large number of insurers even in a catastrophic event, so insurance companies may either suffer no losses or they could suffer losses sufficient to threaten their very existence. The TRIA program allows this "bet the company" risk to be spread throughout the private sector and over time in a manner that cannot be duplicated by the private sector.

Ultimately, an effective terrorism loss management plan depends on participation by insurers of all sizes and structures and so any proposed changes should take care not to adversely impact small and medium-sized companies. Specifically, raising the trigger level again from its eventual $200 million level will not necessarily impact initial government outlays, depending on the specific insurers and losses involved in an attack. Consider a scenario with $250 million in losses involving five insurers, each with a deductible of $300 million or higher. Under current law, the TRIA program will have been "triggered" at $200 million in losses, but because of the deductibles there will be no government outlays at all. It would make no difference in this scenario if the trigger had been $250 million or if there had been no "trigger" level at all. That said, the only impact of raising the trigger would be on smaller, regional, and niche insurers whose deductible – and even total exposure – is less than the amount of an elevated trigger level that has been set too high. This situation would reintroduce the "bet the company" risk for these companies and would likely force them to limit coverage or leave certain markets entirely. Because it is not at all clear that remaining companies could or would provide this missing coverage, a higher trigger could have the unintended effect of reducing the total amount of private capital allocated to terrorism risk.

In short, raising the trigger does nothing to reduce taxpayer exposure while simultaneously having the potential to drive private capital from the market.

In the end, the purpose of the program is not to protect insurers, but to make sure that the economy can recover in as orderly a fashion as possible from a terrorist event. In order to encourage private sector involvement in the terrorism insurance marketplace – and thereby protect and promote our nation's finances, security, and economic strength – we should maintain long-term a terrorism loss management plan on the model of TRIA.

Section 111 Reporting

Section 111 of the Terrorism Risk Insurance Program Reauthorization Act of 2015 requires the Secretary to submit reports to the Committee on Financial Services of the House of

Representatives and the Committee on Banking, Housing, and Urban Affairs of the Senate on, among other things, the impact and effectiveness of the TRIA program. In 2016, the FIO conducted a voluntary data call for its first report, and in 2017 the office launched a mandatory data call for most insurers offering TRIA-eligible lines of insurance.

NAMIC recommended throughout the data call development process that the FIO should work directly with state insurance regulators who were simultaneously developing their own TRIA-related data collection effort. Ultimately, Treasury determined that "the needed information will not be available in a timely or meaningful manner from other sources" and went ahead with its own reporting requirements. We have previously expressed our dismay at the apparent inability of Treasury and state insurance regulators to collaboratively develop a single data call that could be used by both federal and state entities, to avoid the present situation in which insurers must respond to two separate data calls administered at different times of the year. We fervently hope that with new leadership at Treasury and the FIO, you can find a way to cooperate with state insurance regulators on future efforts to collect terrorism insurance data.

National Flood Insurance Program

Prior to the creation of the NFIP, flood losses were dealt with in a simple and direct fashion by the federal government. As noted in a 2002 report by the Federal Emergency Management Agency, "major riverine flood disasters of the 1920's and 1930's led to considerable Federal involvement in protecting life and property from flooding through the use of structural flood-control projects, such as dams and levees, with the passage of the Flood Control Act of 1936." These projects proved to be a costly and generally ineffective solution. Despite billions spent by the federal government on flood control projects during that time the report noted that "the losses to life and property and the amount of assistance to disaster victims from floods continued to increase." Furthermore, the only assistance available to flood victims at that time was direct federal disaster aid, which also contributed to the high costs of a major flood catastrophe. Congress began considering the potential for a national flood insurance mechanism as early as the 1950s, but quickly realized that the private market simply could not underwrite the highly concentrated and correlated risk of massive floods.

In order for insurance markets to function properly, certain conditions must be met. For example, individual exposures should be independent of each other (i.e., not correlated) and there should be a large number of individual risk exposures to allow the use of statistical predictions of future losses. Losses should be accidental or unintentional in nature and should be generally predictable, allowing insurers to set premiums properly. Insurers must be able to spread risk over a large enough pool and each insured must pay the cost of adding to the risk pool.

For some risks, however, private insurance markets are unable to provide sufficient coverage. Certain risks are more difficult to insure because they defy the conditions private markets require for operation. Flood risks are one of those. Adverse selection prompts only those who believe they are at risk of flooding to purchase insurance, which limits insurers' ability to properly pool risk. Properly priced insurance (which takes into account the amount of surplus needed to pay claims in high-loss years) would be regarded by most potential purchasers as a "bad buy" – property owners who perceive that there is little likelihood they will experience loss due to flooding will conclude that the cost of purchasing insurance is not worth it. Flooding is extremely devastating and markets face serious problems providing coverage for these truly large and costly events. The fact that flooding involves a risk that is highly concentrated and correlated makes flood loss especially difficult to insure. In most lines of insurance (e.g., life, auto, fire insurance), the total amount in premiums collected and the total amount paid in claims are almost continuously in balance because claim costs for any given year are relatively predictable. This is not the case with flood risk, which by nature tends to result in losses that are very low in some years and extremely high in other years. Additionally, unlike other traditional threats to property, flooding has historically been spatially confined and generally limited to specific geographic locations, complicating an insurer's ability to widely spread the risk. Compensating for these challenges would require insurers to charge high premiums to cover the sizable cost of capital that they must hold in reserve to ensure they are able to pay all the claims that will be filed in high-loss years.

With no private market for flood coverage, the federal government stepped in to create the NFIP in 1968 to mitigate the exposure both to taxpayers as well as citizens in flood-prone areas. Congress sought to address the increasing costs of taxpayer-funded disaster relief by using premium dollars taken in every year to pay out any flood losses incurred by policyholders for the same year.

Originally, the only way property owners could purchase NFIP coverage was through specialized insurance agents. To increase take-up rates and streamline the claim handling process, the NFIP in 1983 created a "public-private" partnership with private insurers known as the Write-Your-Own (WYO) program. The program utilizes private insurers to market, sell, and administer the Standard Flood Insurance Policy. These companies – WYO carriers – use their own agents and letterhead and deal directly with the policyholders while the federal government retains responsibility for underwriting losses. The partnership has proven successful in facilitating the prompt settlement of claims, even when faced with a very large volume of claims following extreme flooding events.

Over the last 50 years, the NFIP has allowed millions of Americans to avoid serious financial losses brought about by disastrous flooding. However, the NFIP has many flaws in its design and execution and is need of serious reform in order to maintain a sound financial footing and

better protect the American taxpayer. Subsidized premiums have been charged on a non-actuarial basis; development has increased the amount and value of property exposed to flood risk; take-up rates for those in need of coverage remain extremely low; and the recent severity of flood losses has demonstrated that the NFIP is not constructed to handle major catastrophic events. The program is currently almost $24 billion in debt.

Clearly the status quo is unacceptable. Nothing about the realities of flood risk has fundamentally changed. Primary insurers are still unable to offer this coverage as the continuance of the NFIP offering subsidized rates prevents companies from offering policies at rates that are simultaneously risk-based and competitive with NFIP subsidized rates. As actuarial risk-based NFIP rates began to be implemented in accordance with the Biggert-Waters Flood Insurance Reform Act of 2012, a few private sector companies began to offer policies. Many WYO Companies also began to research and prepare to potentially offer private sector policies. However, when members of Congress passed the Homeowners Flood Insurance Affordability Act of 2014, which delayed and repealed the movement towards actuarial rates, private sector development halted. That repeal, coupled with potential rate restrictions at the state level, continues to prevent the development of a private marketplace for flood insurance.

Inadequate rates that do not reflect the actual costs of living in a flood-prone area are the source of many of the NFIP's problems. In the original NFIP legislation, Congress tasked FEMA with setting rates to meet the "objective of making flood insurance available where necessary at reasonable rates so as to encourage prospective insureds to purchase such insurance." The program was structured to subsidize the cost of flood insurance for existing homes, while charging actuarially sound rates for newly constructed properties built after the introduction of flood insurance rate maps.

Just as inadequate rates fail to reflect the true cost of providing coverage, they also fail to reflect the actual risks of living in a flood-prone area. This has the effect of encouraging poor land use and development in high-risk areas, thereby increasing the total potential losses that will be incurred in the event of a flood. During the almost 50 years that the NFIP has been in place, there has been a large population increase in flood-prone coastal states, which now account for a very large portion of the NFIP portfolio. In Florida, for example, the population has increased from 6.8 million in 1970 to nearly 18.5 million in 2009. During the same period, there was a seven-fold increase in the number of NFIP flood policies in force and now more than two-thirds of NFIP policies are located in just five coastal states.

The NFIP must begin charging risk-based rates if it is to have any chance of being a solvent program. Moreover, the implementation of risk-based NFIP rates is a prerequisite for private insurers to be able to offer private sector flood policies. The move to actuarially sound rates is likely to be painful due to the higher premiums that will have to be charged in many instances.

Any subsidies that the government believes are necessary must be independent of the NFIP and fully transparent. Subsidies cannot continue to be hidden within the insurance mechanism, and homeowners should be fully aware of the real risks of where they live. The Administration should work with Congress on other ways to address the problems of affordability caused by the onset of sudden, substantial rate increases.

The Administration and Congress should also work on to encourage and facilitate property owners' investment in mitigation. Mitigation measures, such as elevating structures, have been proven to protect properties from damage caused by flooding. Mitigation tools are a much better method of assisting homeowners who live in flood prone areas. Not only does every $1 spent on mitigation save $4 in the long run, but it forces homeowners to confront reality in understanding the risks they face.

The NFIP needs significant reform in order to continue providing flood protection to those who need it. As a practical matter, there is no substantial private residential market for flood insurance and efforts to create one will continue to be frustrated by rate regulation, adverse selection, and capital constraints. However, other proposals that seek to explore a risk-bearing role for the private sector in the NFIP may have merit and should be given due consideration. For example, the Administration could take steps to do three fundamental things. First, FEMA should eliminate the non-compete clause from its WYO contracts. Second, clarification should be issued allowing the holders of mortgages to accept private sector flood coverage for purposes of the mandatory purchase requirements. Finally, FEMA should be directed to figure out a way to share its historical loss-cost data with the private sector.

Cyber and Data Security

The property/casualty insurance industry is at the forefront of efforts to protect the security and integrity of sensitive personal information and reduce fraud. Insurers, like other financial institutions, comply with federal and state laws, employ a high degree of internal controls, and are regularly examined by regulators to ensure the safeguarding of personal information, which includes sensitive information, such as social security numbers, financial information and medical information.

The collection and use of personal information goes to the very heart of the business of property/casualty insurance. Information – including personal characteristics and experience information – that in the context of many businesses would seem intrusive is essential to the provision of property/casualty insurance.

For example, property/casualty insurers collect and verify drivers' license numbers to underwrite claims and verify required coverage mandates. Social security numbers are collected and shared in certain specified instances to comply with federal Medicare secondary payer reporting obligations and federal and state tax reporting obligations. Medical information is needed to

process claims for personal injuries under automobile, homeowners, business liability, workers' compensation and other insurance coverages, and to coordinate with other providers of benefits. Credit card or bank account information is collected to facilitate policyholder payments. Personal information is also used to fight fraud, including verifying eligibility for benefits and identification of suspicious activities. This information is collected for both transactional and operational purposes. Additional hurdles or roadblocks to the collection of this information would unduly burden insurance operations and lead to higher consumer costs and less efficient service.

Insurers collect this information in a variety of methods, including over the internet, over the phone, or via an agent or third party. Insurers comply with the privacy notice requirements of the Gramm-Leach-Bliley Act and notice requirements under the Fair Credit Reporting Act as well as numerous other federal and state law requirements.

Because personal records including financial records and government documents cross state boundaries, and the insurance industry and broader business community, has consistently argued the merits of a single consistent national standard for data security as well as data breach notification. However, inappropriate, overly restrictive, overlapping, and potentially inconsistent state specific standards present significant obstacles for insurers in meeting policyholder needs. NAMIC supports legislative efforts to pursue uniformity and establish a national standard that appropriately precludes private rights of action. Rather than layering new federal standards upon a multitude of often inconsistent state standards on what constitutes breach and appropriate reporting obligations, NAMIC supports preemption and the establishment of a national standard while leaving the enforcement of such a standard to the state insurance commissioners.

The NAIC has enhanced its focus on cybersecurity issues, starting with the establishment of a Cybersecurity Task Force in 2014 that worked with industry, including property/casualty insurers, to develop a set of regulatory principles for effective cybersecurity regulation and a plan for developing consumer protections. The NAIC has also enhanced information technology review in financial examinations of insurers and has worked on the development of a model law to establish data security requirements for regulated entities. NAMIC has consistently advocated that state regulators maintain a risk-based and flexible approach to regulation of insurers to recognize the constantly evolving nature of cyber risk.

New York's Department of Financial Services has also been active regarding cybersecurity matters, issuing a comprehensive regulation applicable to all financial services entities doing business in the state. Some have suggested the New York regulation could serve as a model for other states to follow and elements of it have been incorporated into the most recent draft of the NAIC data security model law.

NAMIC will continue to work with the administration, the NAIC, and Congress on solutions that recognize the information needs of the nation's property/casualty insurance industry and the importance of seeking balance in the protection of customer non-public personal and sensitive information.

We hope you find these comments useful, and we look forward to continuing to be a resource to the Treasury Department. Should you have any questions, please do not hesitate to contact me.

Respectfully submitted,

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