

New Year's Resolutions

by David S. Medvidofsky, CPCU, CIC, AAI



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The beginning of a new year always provides an ideal time for reflection. In business, we measure our progress against annual goals, and we develop plans for the coming year. We build these short-term plans as a subset of our overall strategy. On a personal level, many of us do the same thing: we call them "New Year's resolutions."

Your Underwriting Section Committee meets twice yearly to establish goals and identify methods for adding value both to the profession, and to your membership. In addition to planning for the coming year, it has become habit to spend some time reflecting on past activities and asking ourselves: What worked well? What should we change for next time? This effort, while sometimes uncomfortable, is an important step in continuously improving our product.

The strategic goals of the Underwriting Section are to provide our membership:

1. timely information
2. educational materials
3. career development tools
4. networking tools

In support of this, our "resolutions" are to do the following in 2006:

- Continue to publish high-quality newsletters with high-quality technical content.
- Continuously update the web site to provide tools for our members.
- Conduct topical educational sessions at the Annual Meeting and Seminars.
- Host a "box lunch" at the Annual Meeting providing members the opportunity to network.

- Engage new designees in sections and Society membership.
- Provide ad-hoc technical resources to chapters, industry professionals, the media, and the general public.

How will we do on our "resolutions"? The external measurement is the Circle of Excellence Recognition Program, and we are targeting gold status for the third consecutive year. However, it is really up to you, as members, to decide.

We look forward to another excellent year of service. If there is more that we can do to increase the value of your membership, please let any Underwriting Section Committee member know or e-mail me at medvidod@msagroup.com

Happy New Year and best of luck on achieving both your business plans and your personal resolutions! ■

Thought to Ponder ...

"Leadership is more than a position or title."

—**anonymous**

"Your Price Is Too High"

by Tom Redmond, CPCU

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We've all heard this before and will continue to hear it. The good news is there are a lot of resources on this subject—here are some steps on handling this objection:

When the prospect says "You're price is too high":

- This is an objection, so the first thing to do is to simply acknowledge the objection—not agreeing with it, not disagreeing, not debating it, just acknowledging the prospect's point of view. Your quick response of lowering the price is usually the wrong approach—think about your own reaction when you are the buyer, and the seller lowers the price immediately—the seller's credibility and trust suffer.
- . . . and the dialogue begins: "Putting price aside for the moment, is there anything else in our proposal that needs further clarification?" A review of the benefits of your product/service may be in order—does the customer still see your value proposition?
- . . . and now to the client objectives: We find it very helpful to have a list of three or more client objectives—what does the client wish to accomplish with you? What are the problems to be solved? With a reduction in price, you can ask something like: "Which of these objectives might be less important? Perhaps we can eliminate one or two and reflect that change in the pricing."



- Offer an alternative—different terms could help—a different time frame, alternate personnel working on the project, some change in the product, and/or service mix may make sense.
- There are times when you need to walk away from this prospect. Too far apart, too unreasonable, etc. One of our reminders is that there is an unlimited supply of prospects—you can't get to them all anyway—so honorably move on to the next one.
- Of course, if the prospect is shocked by your price (or seems to be) something may be wrong with the qualification process. So a reminder of the qualification process—this is a guide, not a script:
 - Identify, quantify, and define the prospect's objectives.
 - Ask—If we achieve these objectives, do we have an order?
 - Ask—Who determines whether we have achieved these objectives?
 - Ask—Are there any other reasons why you could not do business with our company?
 - Ask—Are you psychologically prepared to fire your existing supplier?

- Gauge the enthusiasm of your prospect to hire you and set the strategy with your prospect to achieve the objectives!
- Describe the transition process where the prospect fires his or her current supplier, and hires you and your firm. ■

Liten Up

by B.D. Hicks

I want you to start working with our new underwriting tools.. even though you've done well with your lucky coin.

Casual
Fire
Ins. Inc.

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Ten Reasons Why Driver Monitoring Programs Fail and How You Can Guarantee Success

by Paul Farrell

Paul Farrell is CEO of SafetyFirst Systems, LLC. SafetyFirst is a team of experts from the transportation, insurance, and software industries that specialize in reducing commercial auto collisions through management information systems and programs, such as 24/7 call center and "Safety Is My Goal" decals for vehicles with phone number to call center encouraging motorists to report risk-taking behaviors by drivers. It provides solution in partnership with insurance carriers and transportation firms. More information can be found at www.safetyfirst.com.

Background

While working as a safety consultant for the insurance industry, I heard all sorts of stories about 1-800-How's My Driving programs ("decal programs") that had disappointed management teams. I was concerned when, through a job change, I "inherited" the administration of this type of program. My boss made it clear that the program must be made to work, or I should appear to have "died trying to make it work." Over the next five years, I fired and replaced the vendor, ran educational meetings for staff and clients, held teleconferences with fleets using the program, wrote countless memos, and came to some amazing conclusions:

Conclusion #1—The program effectively, measurably reduced collisions.

Conclusion #2—The program worked so well that we needed to expand its use to any client that had commercial vehicles.

Conclusion #3—The program took too much effort to administer, and we needed to change the processes involved immediately.

We began to reengineer the program based on the results of a comprehensive actuarial study. During that time I became a passionate believer in the potential of

the program. In fact, my passion for the program ultimately led to a career move to focus on the program exclusively.

This article deals with the lessons learned from administering the program to over 300 clients and more than 45,000 vehicles while at the corporate office of that insurance carrier, and the countless clients that I've had the privilege to serve while working at SafetyFirst.

Reason #1—No Goals for the Program

The number-one reason most decal programs fail is that management sets no measurable mileposts or goals for the program. It is easy to understand why this happens—most managers are unfamiliar with the program at the outset and receive little counsel from their insurance provider or the service supplier. Without goals for the program, it will never be seen as a priority within the company, and there will be no sense of urgency associated with making it a success.

Solution—Work with your insurance provider and decal program supplier to understand the program's statistics, and set reasonable goals to measure:

1. Management use of the program reports.
2. Overall frequency of complaint reports—too many reports indicates a more serious, underlying problem with drivers and safety processes.
3. Report closeout rate (should be close to 100 percent—most target at least 80 percent)—this is a way to measure management involvement within your company and to document that reports are actively investigated.
4. Reduction in accidents as measured against the year(s) preceding the implementation of the program—this is the ultimate test of whether the program is producing results for your company.

5. Driver statistics including issues like turnover rate prior to and after adopting the program, driver OOS rate prior to and after adopting the program, etc.

6. Complaint report frequency for your company compared to similar companies in your industry (provided by your supplier).

Reason #2—Little or No Communication with Affected Employees

Most companies implement the program by instructing their maintenance department to install the decals on the vehicles as quickly as possible. This leaves drivers wondering why the program was put in place and how the program will affect them if a complaint is received. This fear builds into hostility, and hostility leads to defaced decals, confrontations with supervisors, and accusations of "crank calls." To some degree this is also an issue with "unionized" companies—misunderstandings about the point of the program, etc.

Solution—Early in the process, usually prior to installing decals, a letter is sent to all affected drivers explaining why the program is being set up and what they can expect if a complaint report is received. The letter may be followed by a meeting, teleconference, or additional memo(s) outlining relevant facts about the program such as 80 percent of all drivers will never get a complaint report, and those who do will be coached for improved safety results. Once drivers know what to expect, they will be more supportive of any safety program effort.

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Reason #3—Decals That Are Too Small or Not Noticeable

The marketing departments of many companies want to protect their “brand image” at all costs. This may lead to their suggestion that the decals be made to match company colors (making them virtually invisible) or made as small as possible. This will artificially cut down the number of calls from motorists and automatically defeat the purpose of starting the program. In this case, “no news is good news” does not apply.

Solution—Management teams that take a moment to test fit the largest possible decal to each vehicle type in their fleet are making a wise investment of time and energy. When possible, take photos of the sample decals in place on each vehicle type to train location managers on proper installation—especially where decals may be a tight fit or could interfere with trade marks, logos, or slogans. Decal colors are chosen to make them easy to read, easy to spot, and easy to remember. This helps motorists to make contact and file their report, which is the point of the program.

Reason #4—No Partnership with Supplier or Insurance Provider

Management teams that are uncomfortable sharing safety performance data with their insurance provider or even the program supplier typically end up with failed decal programs. They don’t want to highlight their “safety deficit” to outsiders or get “second guessed” on their safety efforts. As a result, they fail to take advantage of the insights developed by these team members. Without the accountability of the insurance provider or program supplier coaching the management team for results, the program fades into the background and dies.

Solution—Insurance providers and the program supplier only benefit (or prove their value) when collisions are

minimized. They may approach the program from a different perspective, but truly want to help make the program a success, and can provide insights from other clients and develop unique solutions to overcome unusual issues. A team approach brings multiple resources to bear on drivers who need help urgently.

Reason #5—No Training on How to Coach/Counsel Drivers

Most management teams receive “tips on how to coach drivers” from their supplier; however, these fact sheets often fail to translate into an organized training session. They usually get handed out and are never read. When a report does come across a manager’s desk, he or she does not have the benefit of these guidelines, and schedules a meeting that turns into a confrontation with a very defensive driver.

Solution—Management teams need to make the time (usually a half hour or less) to walk location supervisors through the coaching process steps. This will help make the coaching sessions productive and increase the likelihood that the program will reduce collisions. SafetyFirst makes coaching training available in a number of formats including PowerPoint presentations and Word documents. We even support teleconferences for larger clients who need additional help.

Reason #6—No Material Help for the Affected Driver

Programs that fail from frustration of managers and drivers are usually due to a lack of support tools that raise drivers’ safety awareness. The coaching sessions are conducted, but aside from discussing the report, there is no message of hope or corrective behaviors to change behavior.

Solution—Managers may be overwhelmed at the outset of the program with information and overlook tools that could help drivers. Taking time once a quarter

to check in with the program supplier (and your insurance provider) can yield a treasure of newly developed support tools. Collision countermeasures, safety bulletins, Training Topics, and other resources may be available from your supplier that were previously unknown or unpublished when you first started the program.

Reason #7—No Positive Component to Program

Some programs fail because there is no perceived “positive” side to the program. Although designed to highlight negative behaviors that should be modified, some programs fail to recognize the solid performance of the 80 percent of drivers who drive safely most of the time. This can lead to dissatisfaction among drivers and managers as they solely focus on negatives.

Solution—Fleets should celebrate complimentary reports when they are received, and offer driving training proactively to all drivers. In short, the decal program should be a part of the whole fleet safety program, not the only focus. When the program is blended with the other components and used to promote the best possible performance, it will be enthusiastically supported.

To further support this area, SafetyFirst has taken the step of offering training programs at no extra cost to participating fleet clients. The “Ten-Minute Training Topic” program is the first of its kind in the industry, and provides a positive message to all drivers on a monthly basis.

Reason #8—No Follow Up by Management on Activity

Programs that fail often do so from a lack of management support in the basic functions of the program. Reports are left uninvestigated, not closed out in the database, and monthly summary reports are not reviewed to note patterns in activity.

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by David S. Medvidofsky, CPCU, CIC, AAI

Solution—Managers need to be actively involved in the execution of the program. As a supplier, we do monitor our client's participation with the intent to provide coaching to the management team when we see a lack of activity. These report analysis calls can surface misunderstandings about report return processes and other areas of administration.

Reason #9—Replacement of Key Staff

Some programs fail when a key manager or staff member quits. The new hire is often unaware of his or her responsibilities for the program and may not know whom to contact at the supplier for assistance. This can lead to the "self-destruction" of the program within a matter of weeks.

Solution—Suppliers and fleets should try to keep in touch with human voices as much as possible (not relying exclusively on e-mails). If there is a staff change, it may not be immediately apparent to the supplier. Prompt notification of staff changes is vital to program success.

Reason #10—The Program Is Too Difficult To Administer

We acknowledge that there have been times when the program proved too difficult to administer from either a fleet or insurance carrier perspective. No one wants to do more work than is needed to get success from any safety program.

Solution—We have worked hard over the past several years to listen to our clients to streamline reports and re-engineer our web site to make it easier to use. We are open to suggestions and welcome constructive criticism. We may not be able to adopt all suggestions that we get, but we will try. ■

It has been said that working in insurance takes the fun out of everything. How many of us intuitively look for sprinklers and exits when we eat at a nice restaurant? How many of us have told our children that they cannot have a trampoline? I had one of these experiences recently that symbolized how far we have to go as a society in terms of privacy compliance.

Recently, my wife and I moved. As anyone that has moved knows, there is a seemingly endless list of tasks that need to be completed when joining a new community. One of our first activities was to open new bank accounts. On a busy Saturday morning, we went to the local bank where we were greeted by a wonderfully customer-focused representative. After leading us to her desk, she began the task of collecting the necessary account information. What my wife thought to be a very pleasant experience soon became one of those "insurance moments" for me.

We sat in an open area just off the teller line, and the customer service representative asked us a series of questions. As we provided responses, she input the information into her computer, which had a large flat screen in plain view designed for us to verify the information at each step of the process. She would verbally repeat each question and response before going to the next screen to assure information accuracy. Since we were opening multiple accounts, some of the information was redundant. To avoid repeating questions, she wrote common information such as our address, phone number, places of employment, previous accounts, dates of birth, and social security numbers on her desk blotter. Overall, this was a very pleasant experience compared with the rigid banking procedures of the past. I am sure their customer-focused practices developed from extensive focus group activity. Still, let me ask you the question: Does this experience raise any red flags?

The Financial Modernization Act of 1999, also known as the "Gramm-Leach-Bliley Act" (GLB), includes provisions to safeguard personal financial information held by financial institutions. The three principal parts of the privacy act are the Financial Privacy Rule, the Safeguards Rule, and Pretexting provisions. The Financial Privacy Rule governs the collection and disclosure of personal financial information. The Safeguards Rule requires adequate measures to protect the personal financial information of consumers. Pretexting relates to obtaining information under false pretenses. Banks and insurance companies are among the entities subject to the provisions of GLB under the definition of subject entities.

By now, each insurance company and agency should have established internal safeguards to assure GLB compliance. In light of efforts to reduce identity theft, legislators have been focused on other information safeguards—most recently data destruction.

Effective June 1, 2005, The Fair and Accurate Credit Transactions Act of 2003 (FACTA) has been expanded. The Federal Trade Commission (FTC) has issued the Disposal Rule published in the Federal Register on November 24, 2004 [69 Fed Reg 68690] requiring that all businesses take measures to dispose of sensitive information derived from consumer reports. Links to the rule and related documents are provided below.

The Disposal Rule applies to "any person who maintains or otherwise possesses consumer information for a business purpose." It goes on to require that "reasonable measures" be taken "to protect against unauthorized access to or use of the information in connection with its disposal."

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While not explicitly defined, examples of reasonable measures include:

1. Burn, pulverize, or shred papers containing consumer report information so that the information cannot be read or reconstructed.
2. Destroy or erase electronic files or media containing consumer report information so that the information cannot be read or reconstructed.
3. Conduct due diligence and hire a document destruction contractor to dispose of material specifically identified as consumer report information.

The FTC requires that financial institutions that are subject to both the Disposal Rule and the GLB Safeguards Rule incorporate practices dealing with disposal into their information security program (www.ftc.gov/privacy/privacyinitiatives/safeguards.htm).

Interestingly, the new FTC Disposal Rule does not **require** that you dispose of any information; it simply states that when information is destroyed, it must be done in a “reasonable and appropriate” manner.

So, what does this mean for insurance companies and agencies? Under the definitions of covered entities and data, we are subject to both GLB and the FTC Disposal Rule. Companies and agencies should review their existing procedures, and determine if updated procedures are required. Among the steps to consider as part of this review are:

1. Validate that GLB procedures are documented and are being followed. Periodic compliance reviews are one method to validate this. If procedures do not exist, establish compliant procedures ASAP. Information relative to GLB may be found at the Federal Trade Commission web site (www.ftc.gov).
2. Once it is determined that sufficient GLB procedures are in place, review the documented procedures as they relate to information disposal. It is

likely that a comprehensive GLB program already satisfies most of the requirements of the FTC Disposal Rule. Where disposal of hard and soft copy data is not explicitly addressed, document the required procedures.

3. To the extent there are gaps, revise the existing procedures and develop a comprehensive Information Security Manual that includes functional procedures for proper disposal of subject information. Areas to pay particular attention to beyond normal disposal procedures include:

- Mandate shredding of subject material and specifying the type of shredding to be used—cross-cut shredders yielding a paper fragment of 1mm by 5mm will comply with HIPAA requirements as well as the FTC rule.
- Assure “loose” information not kept within normal files (e.g., underwriting, claims, human resources, etc.) is shredded if it contains subject information.
- Document disposal procedures for paper files, archived systems data, tapes, disks, and other types of media.
- Develop due diligence procedures for third-party shredding vendors.
- Include privacy awareness as part of orientation and within your procedures manual.
- Require annual sign-offs by employees acknowledging privacy and disposal procedures.
- Adopt protective contractual language for third parties that have access to your information and incorporating into your nondisclosure agreements and contracts.
- Increase employee awareness via scheduled company-wide communications.

- Document procedures for internal and external compliance controls.

If your business completed a comprehensive GLB assessment several years ago, chances are that compliance with the new FTC Disposal Rule will require minimal effort. An assessment of current practices represents an excellent opportunity to develop, review, and/or validate your internal procedures.

It is clear that privacy, to include protecting consumers from identity theft, is becoming an area of increased regulatory and legislative importance. That being the case, being proactive in developing and implementing sound procedures not only benefits your customers, but also affords the opportunity to practice sound risk management. ■

For Additional Information

References and Source Materials

- www.ftc.gov/bcp/conline/pubs/alerts/disposalalrt.htm
- www.ftc.gov/opa/2005/06/disposal.htm
- www.ftc.gov/privacy/privacyinitiatives/safeguards.html
- www.ftc.gov/privacy/privacyinitiatives/glbact.html
- www.ftc.gov/os/2004/11/041118disposalfrn.pdf

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NAIC Adopts Enhanced Disclosure and Attestation Requirements for Finite Reinsurance Contracts

by Thomas R. Hrdlick



Thomas R. Hrdlick is a partner with Foley & Lardner LLP, resident in the firm's Milwaukee office. He is a member of the Insurance Industry Group in the Regulatory Department. Hrdlick's practice is concentrated in the fields of corporate and regulatory insurance law, with a particular emphasis on transactional work within the insurance industry. He has represented insurance companies and other insurance-related entities in a variety of transactions and corporate restructurings, including reinsurance affiliations, mergers, stock acquisitions, initial and secondary public offerings, demutualizations and mutual holding company conversions. Hrdlick has also counseled such entities with respect to their regulatory affairs, including their dealings with state insurance departments and matters involving federal agencies such as the SEC, FTC, Treasury, and OFAC.

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The National Association of Insurance Commissioners (NAIC) recently approved enhanced disclosure and attestation requirements obligating property and casualty (P&C) insurers to regularly disclose and attest to their use of nontraditional reinsurance contracts generally known as "finite reinsurance."

What Is "Finite Reinsurance"?

Finite reinsurance is not easily susceptible to a single definition or description. Overly simplified, the defining characteristic of finite reinsurance is that—unlike traditional reinsurance—it involves little or no actual risk transfer from ceding company to assuming company; rather, the parties generally know at the outset what the financial outcome of their reinsurance transaction will be, or have created mechanisms within or outside the contract that ensure the financial outcome will not exceed certain parameters.

The relative lack of risk transfer often leaves finite reinsurance transactions open to the charge that they should be accounted for as loan facilities using deposit accounting rather than reinsurance transactions using reinsurance accounting in accordance with *Statutory Statement of Accounting Principle (SSAP) No. 62—Property and Casualty Reinsurance*. Under reinsurance accounting, the ceding company effectively removes the "ceded" liabilities from its balance sheet on the premise that these risks have been transferred to the assuming reinsurer; under deposit accounting, there is no recognition of risks being transferred between the parties, and the ceding company effectively retains the "ceded" liabilities on its balance sheet.¹ Thus, when accounted for as a reinsurance transaction, finite reinsurance can have the effect of boosting the ceding company's balance sheet and the calculation of its statutory capital, with

the corresponding risk that the insurer appears more financially sound than it truly is.

The Spitzer Investigations and Related Regulatory Initiatives

The use of "finite reinsurance" products has attracted increased regulatory scrutiny recently as a result of New York Attorney General Eliot Spitzer's high-profile investigations into the use of such products by American International Group, Inc. (AIG) and other industry heavyweights. These investigations pursued suspicions that AIG and others engaged in finite reinsurance transactions as a means to inflate their balance sheets or smooth out their income statements, with little intended or actual risk transfer taking place. To the extent AIG and others utilized reinsurance accounting for such transactions, Spitzer claimed that they were misrepresenting their financial condition in their publicly filed and/or available financial statements. In the case of AIG, these claims led to, among other things, the abrupt retirement of AIG's famous Chairman Maurice "Hank" Greenberg and multiple restatements of AIG's 2004 financials involving hundreds of millions of dollars in reserve increases.²

Following Spitzer's lead, many states issued subpoenas or other formal information requests to their respective domestic insurers seeking information regarding their potential use of finite reinsurance products. Generally speaking, these requests were not coordinated, and each state's approach was unique to some degree. Recognizing the need for a more regular and uniform approach to such requests, the NAIC recently adopted amendments to its own Property and Casualty Annual Statement Blank and Annual Statement Instructions that will take the place of independent inquiries by

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the various states. These amendments are effective for the upcoming 2005 annual statements of all P&C insurers.

As they pertain to finite reinsurance, the amendments adopted by the NAIC impose three new requirements on P&C insurers:

- P&C insurers must answer several new general interrogatories in their annual statements related to the use of finite reinsurance.
- To the extent that a P&C insurer answers any of these new interrogatories in the affirmative, the insurer must submit a new Reinsurance Summary Supplemental Filing for General Interrogatory 9 (Part 2) along with its annual statement.
- All P&C insurers must include with their annual statements a Reinsurance Attestation Supplement regarding their reinsurance agreements, signed by their chief executive officer (CEO) and chief financial officer (CFO).

The New General Interrogatories

There are several new interrogatories in the P&C Annual Statement Blank addressing finite reinsurance issues. For example, P&C insurers previously had to answer an interrogatory asking if they reinsure any risk under a quota share contract that effectively reduces or limits the reinsurer's losses below the stated quota share percentage (e.g., through features such as deductibles, loss ratio corridors, loss caps, aggregate limits, etc.³). Under the revised interrogatories, if an insurer answers that question in the affirmative, it must further disclose whether the amount of reinsurance credit it takes with respect to that contract reflects the reduction in quota share coverage driven by these contractual features.⁴

P&C insurers must answer a new Interrogatory 9.1 inquiring as to whether they ceded risk under any reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates)

for which during the period covered by the statement: (i) the insurer recorded a positive or negative underwriting result greater than 3 percent of its prior year-end surplus, or reported calendar-year written premium ceded or year-end loss and loss expense reserves ceded greater than 3 percent of its prior year-end surplus; (ii) the insurer accounted for the contract under reinsurance accounting rather than deposit accounting; and (iii) the contract contains one or more of the following features or other features with similar results:

- a noncancellable contract term longer than two years
- a limited or conditional cancellation provision requiring the reporting entity to enter into a new reinsurance contract with the reinsurer in the event of cancellation
- aggregate stop loss reinsurance coverage
- an unconditional or unilateral right by either party to commute the reinsurance contract except where the same is triggered by a decline in the credit status of either party
- a provision permitting the reporting or payment of losses less frequently than on a quarterly basis (except where there is no activity during the period)
- a payment schedule, accumulating retentions from multiple years or any features inherently designed to delay the timing of reimbursement to the ceding company⁵

P&C insurers must also answer a new Interrogatory 9.2 inquiring as to whether they ceded risk under any reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates) during the period covered by the statement where either (i) the written premium ceded to the reinsurer by the reporting entity or its affiliates represents 50 percent or more of the entire direct and assumed premium written by the reinsurer; or (ii) 25 percent or more

of the written premium ceded to the reinsurer has been retroceded back to the reporting entity or its affiliates.⁶

Finally, P&C insurers must answer a new Interrogatory 9.4 inquiring as to whether they ceded any risk under any reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates) during the period covered by the statement and accounted for the transaction one way for GAAP purposes (reinsurance versus deposit accounting) and the opposite way for statutory accounting or SAP purposes.⁷

A copy of the pertinent sections of the P&C Annual Statement Blank showing these latest revisions to the General Interrogatories can be downloaded at www.naic.org.

The New Reinsurance Summary Supplemental Filing for General Interrogatory 9 (Part 2)

If a P&C insurer answers any of the new Interrogatories 9.1, 9.2, or 9.4 in the affirmative, it must file the new Reinsurance Summary Supplemental Filing for General Interrogatory 9 (Part 2) (Reinsurance Supplemental Form) along with its annual statement.⁸

In the case of affirmative answers to Interrogatories 9.1 or 9.2, the insurer must include the following information in the Reinsurance Supplemental Form: (i) the aggregate impact of the suspect reinsurance contract(s) on the reporting entity's financial statement gross of all such ceded contracts on the balance sheet and statement of income; (ii) a summary of the terms of the suspect reinsurance contract(s); and (iii) a brief discussion of management's principal objectives in entering into the suspect reinsurance contract(s), including the economic purpose to be achieved.⁹

In the case of an affirmative answer to Interrogatory 9.4, the insurer must include in the Reinsurance Supplemental Form an explanation as to why the suspect reinsurance contract(s) are treated differently for GAAP and SAP purposes.¹⁰

The Reinsurance Supplemental Form can be downloaded at www.naic.org.

The New Reinsurance Attestation Supplement

In conjunction with the filing of their annual statements, all P&C insurers are now required to file an annual Reinsurance Attestation Supplement signed by its CEO and CFO. By signing and filing this Attestation, the CEO and CFO are attesting, under penalty of perjury, with respect to all reinsurance contracts for which the insurer is taking credit on its current financial statement, that to the best of their knowledge and belief after diligent inquiry:

- Consistent with SSAP No. 62, there are no separate written or oral agreements between the insurer (or its affiliates) and the assuming reinsurer that would under any circumstances reduce, limit, mitigate, or otherwise affect any actual or potential loss to the parties under the reinsurance contract, other than inuring contracts that are explicitly defined in the reinsurance contract (except as disclosed in the Attestation).
- For each reinsurance contract entered into, renewed, or amended on or after January 1, 1994, for which risk transfer is not reasonably considered to be self-evident, documentation concerning the economic intent of the transaction and the risk transfer analysis evidencing the proper accounting treatment, as required by SSAP No. 62, is available for review.
- The insurer complies with all requirements of SSAP No. 62.
- The insurer has appropriate controls in place to monitor the use of reinsurance and adhere to the provisions of SSAP No. 62.¹¹

Note that the Reinsurance Attestation Supplement only applies to a P&C

insurer's **ceded** reinsurance program and not to any **assumed** reinsurance.

Note also that the terms of the Reinsurance Attestation Supplement effectively create certain "safe harbors" through which some reinsurance contracts will be excluded from the scope of the Attestation. For example: (i) the Attestation only applies to contracts "for which the reporting entity is taking credit on its current financial statement"; (ii) the component of the Attestation requiring documentation of a contract's risk transfer analysis only applies to contracts "entered into, renewed or amended on or after January 1, 1994"; and (iii) the component of the Attestation requiring documentation of a contract's risk transfer analysis only applies to post-1/1/94 contracts for which risk transfer is not "reasonably considered to be self-evident."¹²

The Reinsurance Attestation Supplement can be downloaded at www.naic.org.

Compliance with the Enhanced Disclosure and Attestation Requirements

For many P&C insurers, compliance with these enhanced disclosure and attestation requirements will be a complex task requiring a great deal of time and effort, both internally and in connection with the insurers' professional advisors and consultants. This is particularly the case with respect to the initial round of disclosures and attestations for the 2005 annual statement, as many insurers will likely be conducting a comprehensive review of their ceded reinsurance activities for the first time. This review must be completed and the enhanced disclosures and attestations submitted to each insurer's domestic regulator by March 1, 2006.

Insurers are well advised to begin their compliance effort now in order to ensure that they are able to comply with this initial deadline. Typical tasks may include, among others:

- A broad internal review of the insurer's operations to identify and produce documentation for all of the

insurer's active ceded reinsurance contracts, including any side agreements relating to the same.

- The preparation of contract summaries for all of the foregoing reinsurance arrangements.
- The identification of those contracts (if any) within the foregoing contracts that require disclosure in connection with the insurer's answers to Interrogatories 9.1, 9.2, or 9.4, and/or for which risk transfer is not reasonably self-evident and that have been accounted for under reinsurance accounting.
- For those contracts identified above for which risk transfer is not reasonably self-evident and that have been accounted for under reinsurance accounting, the preservation or creation of documents concerning the economic intent of the transaction and the risk transfer analysis supporting such accounting as of the contract's inception.
- The preparation and execution of appropriate sub-certifications from relevant staff members in support of the Reinsurance Attestation Supplement and, if necessary, the Reinsurance Supplemental Form.
- The preparation and execution of the Reinsurance Attestation Supplement and, if necessary, the Reinsurance Supplemental Form.
- The development of formal procedures going forward to facilitate and ensure continued compliance with SSAP No. 62 and the enhanced disclosure and attestation requirements.

Foley's Insurance Industry Team has helped several clients address these and other complicated disclosure and analytical issues related to their potential use of finite reinsurance products. Should you have any questions relating to the NAIC's enhanced disclosure and attestation requirements, or require assistance in your compliance efforts, contact Tom Hrdlick at (414) 297-5812 or thrdlick@foley.com; Ethan Lenz at (414) 297-5835 or elenz@foley.com; or Kevin Fitzgerald at (414) 297-5841 or kfitzgerald@foley.com.

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NAIC Adopts Enhanced Disclosure and Attestation Requirements for Finite Reinsurance Contracts

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Endnotes

1. See SSAP No. 62—*Property and Casualty Reinsurance* at ¶¶ 17-34.
2. See generally, *Finite Reinsurance: Is It Finished?*, *Captive and ART Review* (posted 1/8/2005); see also, Gilbert, Spitzer Crusade Grabs Greenberg, Bypasses Buffet, Bloomberg.com (posted 4/13/05).
3. See *Property and Casualty Annual Statement Blank for the Year 2005*, General Interrogatories, Part 2, #7.1 (NAIC 2005).
4. See id. at #7.3.
5. See id. at #9.1.
6. See id. at #9.2. This disclosure excludes cessions to approved pooling arrangements or captive insurance companies that are affiliated with (i) unaffiliated policyholders of the reporting entity; or (ii) an association of which one or more unaffiliated policyholders of the reporting entity is a member. See id.
7. See id. at #9.4. This disclosure excludes transaction meeting the requirements of paragraph 30 of SSAP No. 62—*Property and Casualty Reinsurance*. See id.
8. See id. at #9.3 and 9.5.
9. See id. at #9.3.
10. See id. at #9.5.
11. See 2005 NAIC Annual Statement Instructions—*Property/Casualty, Supp 20-1*. Any exceptions to the Attestation statements must be disclosed in the Attestation and an explanation of the exceptions must be attached thereto. See id.
12. See, *American Academy of Actuaries—Committee on Property and Liability Financial Reporting, Reinsurance Attestation Supplement 20-1: Risk Transfer Testing Practice Note* at 9-10 (Nov. 2005). Unfortunately, the NAIC does not provide further guidance as to when risk transfer is “reasonably . . . self-evident.” The same is a principles-based standard, however, requiring application of the P&C insurer’s judgment. See id.

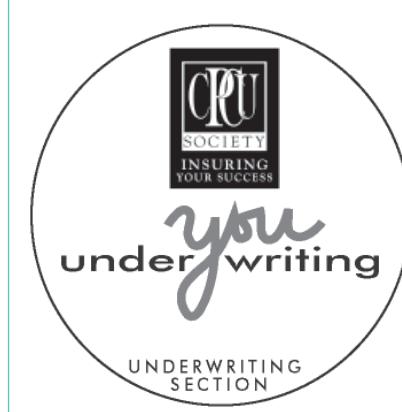
Underwriting Section Committee Member Spotlight

Anne Crabbs, CPCU, CIC, is a commercial specialist II for State Auto Insurance Companies in Columbus, Ohio. She began her career as an executive secretary in 1973, moving into the underwriting area shortly thereafter.

Crabbs earned her CPCU designation in 1993, and immediately became involved with the CPCU Society. In 1994, she became treasurer of the Mid-Ohio Chapter, then president in 1995. After moving to Columbus, OH, in 1997, she became active in the Columbus Chapter, moving through the chairs and eventually becoming president in 2002. She has also been involved in national CPCU Society service, including the Continuing Education Committee, and now in her

third year on the Underwriting Section Committee. She is proud to be a CPCU and finds the Society is an excellent way to give back to the profession and make friends for life. Crabbs is an example of what it means to get involved . . . serving as president of two different CPCU Society chapters, and serving nationally for nearly a decade! She encourages all CPCUs to seek out volunteer opportunities at either the local or national level.

Crabbs and her husband, Jim, spend their spare time with their children and grandchildren. She is accomplished at her hobbies of quilting, crocheting, knitting, and caning chairs. ■



The Underwriting Section Committee

We put the YOU in underwriting. The importance of this slogan is that insurance is still a people and relationship business. People make the difference.

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Retired FDNY Battalion Commander Richard Picciotto will speak at the CPCU Society's Annual Meeting on September 10, one day before the fifth anniversary of 9/11.



Photo courtesy of Nashville CVB and Heavenly Perspectives.

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