



INSURANCE

The State of the Insurance Industry

Spring 2005

KPMG LLP

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Changes & Trends

Industry Overview

General Highlights

- Weiss Ratings reported that the number of insurance company failures declined in 2004, to 13 compared to 25 insurer insolvencies in 2003. Three life and health insurers and 10 property and casualty insurers failed in 2004, compared to 4 and 21 respective failures in 2003. HMO failures declined from three in 2003 to two in 2004. The banking industry, however, increased from three insolvencies to four during the same period. (*Weiss Ratings, Inc. Press Release, January 10, 2005*)
- According to Conning Research and Consulting, Inc., a redefinition of the roles of broker, agent, and insurer may be underway in the wake of investigations into broker practices in the commercial insurance industry. Conning's recently released study, "Prospects for Agents and Brokers: Producers, Consultants, or Distributors?" reviews the historical backdrop to the current industry structure and pricing practices, offers an overview of the investigations and regulatory initiatives underway, and provides a look ahead at likely changes and challenges to the commercial insurance industry in particular. The study also provides discussion of possible impact on personal lines, benefits, and life insurance distribution. (*Conning Press Release, February 14, 2005*)

Property & Casualty

- U.S. commercial property and casualty insurance accounts saw significant softening in pricing during the fourth quarter of 2004, according to The Council of Insurance Agents & Brokers' quarterly Commercial Market Index Survey, released in January 2005. More than 80 percent of small and large

commercial property/casualty accounts and 90 percent of medium accounts found their insurance premiums either stable or down by as much as 20 percent. The same trends in premiums were apparent in virtually all commercial lines, but commercial property premiums dropped the most. Broker errors and omission policies, commercial auto rates, workers' compensation and construction risks were the lines most likely to experience premium increases, although most hikes were modest, in the 1-10 percent range. (*The Council of Insurance Agents & Brokers Press Release, January 24, 2005*)

- In February, ISO's Property Claim Services unit reported that U.S. property and casualty insurers paid a record \$27.3 billion for insured property losses to homeowners and businesses from 22 catastrophic events in 2004 — surpassing losses from 2001 that included the September 11 attack. More than 80 percent of the insured losses were from the five hurricanes that made landfall in the U.S. along the Atlantic and Gulf coasts. Florida suffered the highest insured losses at \$18.8 billion in the third quarter from four of the hurricanes. Catastrophic activity was mild in the fourth quarter with insured losses of \$450 million from three events. (*ISO Press Release, February 9, 2005*)
- A Swiss Re sigma study, released in March 2005, revealed that more than 300,000 people lost their lives in approximately 330 natural and man-made catastrophes that occurred worldwide in 2004. The tsunami in the Indian Ocean alone left 280,000 dead or missing. The sigma study puts the total losses directly attributable to these catastrophes at \$123 billion — of this figure, \$49 billion was covered by property insurance. For property insurers, 2004 was a record year in terms of claims, mainly due to windstorms: hurricanes in the U.S. and

neighboring countries cost insurers around \$32 billion, typhoons in Japan and neighboring countries a further \$6 billion. These record figures were the result of both the unusually high number of storms — 13 hurricanes in the U.S. and 10 typhoons in Japan — and the increasing concentration of insured assets in highly exposed coastal regions. (*Swiss Re Press Release, March 1, 2005*)

- Tropical Storm Risk (TSR) reports a 76 percent probability of an above-normal Atlantic hurricane season. TSR is a consortium of experts on insurance, risk management, and seasonal climate forecasting led by the Benfield Hazard Research Center at University College London. TSR predicts 14 tropical storms for the Atlantic basin as a whole, with 8 of these being hurricanes and 4 intense hurricanes. Of these, TSR thinks four tropical storms will strike the U.S., two of which will be hurricanes. TSR anticipates weaker than normal trades and warmer than normal waters in 2005, conditions both favoring an above-average hurricane season. (*Benfield Press Release, February 16, 2005*)
- The Insurance Information Institute (III) reports that homeowners' insurance rates are expected to rise 2.5 percent in 2005, which would be the smallest increase seen in the last six years. In 2004, rates rose 3.8 percent and the average premium was \$660 — this is expected to rise to \$677 in 2005. The III's chief economist attributes the increase in rates in the past few years in part to the fact that lower interest rates have prompted people to move to bigger homes or make additions and improvements on their existing homes, and thus, these homes cost more to insure. In 2003, the most recent year for which annual figures were available, an estimated \$177 billion was spent on home improvements. (*Insurance Information Institute Press Release, March 1, 2005*)

- Estimated 2004 financial results for Canada's home, auto, and business insurance companies indicate that in 2004, the industry's 206 companies posted combined net earnings of CAD 4.2 billion, according to The Insurance Bureau of Canada (IBC). The industry also paid out CAD 20.6 billion in claims and contributed an estimated CAD 6 billion in taxes to governments. Shareholders' return on equity was 20.6 percent. According to the IBC, stronger financial results have permitted insurers to lower auto insurance premiums and have eased concerns about the industry's solvency. (*Insurance Bureau of Canada Press Release, February 18, 2005*)
- The fatal crash rate for 16-year-old drivers declined sharply after states began enacting graduated licensing laws in the 1990s, according to a study by the Insurance Institute of Highway Safety released in February 2005. A full graduated licensing law has three stages: supervised learner's period; intermediate license (after the driver's test is passed); and then a license with full privileges. Beginners must remain in each of the first two stages for minimum time periods. Fatal crash involvements based on the population of 16 year-olds decreased more than one-quarter from 1,084 in 1993 to 938 in 2003, while during the same period there was an 18 percent increase in the 16-year-old population. (*Insurance Institute for Highway Safety Press Release, February 24, 2005*)

Life & Health

- A.M. Best Co.'s 2004 annual review of the financial strength and credit ratings of health insurers, released in March 2005, reported that the health insurance industry experienced improved operating earnings and balance sheet strength; Best's Rating upgrades outnumbering downgrades by almost two to one. Upgrades largely reflected improved earnings and increased organizational strength, built primarily through merger and acquisition activity. Downgrades were driven by poor operating performance caused by underwriting losses and substantial declines in capital. A.M. Best expects the sustainability of future earnings will be challenged by a number of factors including resistance from both employers and employees in accepting ongoing large premium rate hikes and likely regulatory intervention that will force not-for-profit insurers to keep prices down. These factors are not expected to adversely affect ratings in the near term. A.M. Best does believe, however, that the industry will be challenged over the longer term to maintain solid earnings and consistently accumulate capital — factors expected to pressure ratings over time. (*A.M. Best Co. Press Release, March 7, 2005*)
- With health benefit costs still rising at double-digit rates, more employers are adopting health management and consumer-directed health care programs to help control costs, according to a survey by Watson Wyatt and the National Business Group on Health. Survey findings indicated health care costs increased 10 percent this year, down from 12 percent last year. The report, released in March 2005, suggests that more employers are doing a better job budgeting for health costs. Nearly 4 of 10 employers reported that their costs were below budget last year, nearly double the 20 percent in 2003. Conversely, fewer than one in five respondents were over budget last year, down from 41 percent in 2003. Other findings indicate that employers that are doing the best job of controlling health care cost trends have a much greater focus on health management than those with higher cost increases. And finally, while a small number (8 percent) of employers now offer health savings accounts (HSAs), interest is growing in these accounts. HSAs allow enrollees to carry unused account balances forward from one year to the next and retain ownership of the funds after they leave the company. Eighteen percent of those surveyed plan to offer HSAs in 2006, and more than half of the respondents indicated they are considering the accounts. (*Watson Wyatt Press Release, March 17, 2005*)
- Genworth Financial released a study in March 2005 of major trends related to Alzheimer's disease. Among its policyholders, Genworth found that the cost of claims for the care of individuals suffering from the disease and other forms of dementia is nearly 40 cents of every dollar paid out to health care providers and caregivers. The findings in the report were drawn from data Genworth has collected over the past 30 years, as well as information released by third-party organizations including the Alzheimer's Association, the Alzheimer's Health Assistance Foundation and the National Institute on Aging. According to the Alzheimer's Association, an estimated 4.5 million Americans have the disease. Despite several promising advances, if there are no breakthrough treatments or new findings on preventative measures, Genworth warns that Alzheimer's disease threatens to bankrupt the health care system. (*Genworth Financial Press Release, March 10, 2005*)
- In a broad survey of American households, nearly half of the respondents said they believe they need more life insurance and more than one-quarter said they actually expect to purchase more in the coming year — a decision that would add trillions of dollars of coverage to the amount already in force. LIMRA International presented these findings from a 2004 survey of two groups of consumers, those who own life insurance and others who actually bought life insurance in 2003. Twenty-seven percent of households said they expect to buy life insurance in the coming year. Although no one can predict how many will actually buy, if all 27 percent did, it would increase total coverage by \$4.8 trillion and add an estimated \$9 billion to industry revenues, almost double the amount of new premiums now written each year. Sixty-six percent of those surveyed said replacing the lost income of a

deceased wage-earner was their reason for buying life insurance. The study found that consumers most likely to buy life insurance in the next 12 months are younger households (under age 45) and married households with children. (*LIMRA International Press Release, April 6, 2005*)

Reinsurance

- On December 8, 2004, Standard & Poor's Ratings Services announced that it has revised its outlook on the U.S. reinsurance industry to stable from negative because of recent improved market conditions in the sector. Despite moderate premium rate declines in both property and casualty lines in the previous few months, profitability margins in most lines of business are expected to remain reasonable in 2005, while the pace and magnitude of reserve additions are expected to slow substantially. Barring any major catastrophes, Standard & Poor's indicates that reinsurers are expected to report moderately improved operating performance in 2005. Standard & Poor's believes the U.S. reinsurance market is reaching a point of stabilization. The stable outlook signifies that Standard & Poor's expects fewer downgrades relative to upgrades in the U.S. market in 2005. (*Standard & Poor's Press Release, December 8, 2004*)
- Hedge funds, looking for new investment opportunities, are entering the reinsurance market to compete against traditional reinsurers, broker Jardine Lloyd Thompson (JLT) reported in its annual insurance market overview released in February 2005. The hard reinsurance market and the ease of entry via offshore vehicles have offered hedge funds with new opportunities to diversify their portfolios. The hedge funds, many of which have set up in offshore jurisdictions such as Bermuda, are participating in property catastrophe reinsurance programs. The estimated amount of capital invested during 2004 is no more than \$2 billion. JLT expects

the growth in hedge fund appetite to continue during 2005, fuelled by the desire for new investment opportunities at the same time as potential clients seek alternative capacity as a result of a dwindling number of traditional reinsurers. (*Jardine Lloyd Thompson Press Release, February 24, 2005*)

- Despite a second year of unprecedented catastrophe losses, increasing competition is already forcing underwriters to choose between sacrificing premiums, profit, or capital, according to a report on the 2004/5 reinsurance renewals prepared by Benfield. The report notes that there was ample capacity in most classes, with strong earnings and fewer reserve shortfalls easing pressure on balance sheets. Also, additional capital came from hedge funds to an already over-supplied market. In its 2005 renewal overview, Benfield's report indicates overall property rates softened further, except for those affected by hurricane losses. European and U.S. cedants saw property catastrophe prices drop by as much as 10 percent; in hurricane-affected areas, carriers with catastrophe losses saw rates jump as much as 20 percent. (*Benfield Press Release, January 19, 2005*)

Accounting Standards and Developments

Public Company Accounting Oversight Board (PCAOB) and Securities and Exchange Commission (SEC)

- **SEC Staff Guidance on Accounting for Share-Based Payment**
SEC Staff Accounting Bulletin No. 107, *Share-Based Payment*. SAB 107 permits registrants to choose from different valuation models to estimate the fair value of share options, and also provides guidance about developing assumptions used in valuing employee share options, related MD&A disclosures, and the interaction between FASB Statement No. 123 (revised 2004), *Share-Based Payment*,

and other SEC rules and regulations. The SAB does not modify the conclusions or requirements of Statement 123R, but rather, provides additional guidance that will be helpful when companies implement that Statement.

■ PCAOB Proposes Standard on Reporting on the Elimination of a Material Weakness

The PCAOB proposed for public comment a standard that would apply when auditors report on the elimination of a material weakness in a company's internal control over financial reporting. The proposed standard would establish a stand-alone engagement that is voluntary, that is, performed only at the request of the company. The comment period ends May 16. Any final standard that the PCAOB adopts will be submitted to the SEC for approval.

Financial Accounting Standards Board (FASB)

■ FASB Plans to Examine Risk Transfer for Insurance and Reinsurance Contracts

FASB added a project to its agenda to examine risk transfer in insurance and reinsurance contracts. As part of this project, the FASB plans to define the terms *insurance contract* and *insurance risk*. The FASB also will consider whether risk and non-risk transferring provisions of contracts should be bifurcated and accounted for separately. This project is in part a response to issues being raised by regulators, including the SEC, New York Attorney General's Office, Department of Justice, National Association of Insurance Commissioners, and various state insurance departments into the use of insurance and reinsurance contracts.

NAIC / Regulatory

Developments at the Spring 2005 NAIC meeting

- **Finite Reinsurance**
The NAIC's Property and Casualty Reinsurance Study Group will propose industry-recommended additions to annual-statement disclosure

requirements about finite reinsurance and consider comments received from a 30-day comment period at an interim meeting next month. The Study Group also intends to reconsider the statutory accounting model for reinsurance and will receive proposed revisions from some of the Group's regulator members for consideration at the interim meeting.

Disclosure

The purpose of the disclosure proposal is to help regulators identify finite reinsurance contracts and understand their effects on the insurer's financial statements. Insurers would have to describe the reinsurance contract's terms and the principal objectives if it has specified features and meets a materiality threshold. Among the specified features are a noncancelable term longer than two years, aggregate stop loss coverage, and retroactive reinsurance (i.e., covering events that have occurred). The materiality threshold is yet to be determined, but the Chair suggested it should be based on percentages of premiums and surplus, with the percentage for surplus no less than 3 percent.

The proposed reinsurance interrogatories will also ask insurers to specify whether any reinsurance arrangement includes a written or oral side agreement that would reduce or limit the transfer of risk and whether they have completed a risk transfer analysis that is available for examination. During the meeting, a group of regulators said they plan to require the insurer's CEO to certify that its responses to the interrogatories on reinsurance are accurate. On March 29, 2005, the State of New York Insurance Department issued Circular Letter No. 8 (2005) to all authorized insurers requiring, as part of its examinations, the insurer's chief executive officer to attest that with respect to cessions under any reinsurance contract, that (i) there are no separate written or oral agreements that would under any circumstance, reduce, limit, mitigate or otherwise affect any actual or potential loss to

the parties under the reinsurance contract; and (ii) for each reinsurance contract the reporting entity has an underwriting file documenting the economic intent of the transaction and the risk transfer analysis evidencing the proper accounting treatment, which is available for review by regulators.

The Reinsurance Accounting Model

The Study Group plans to re-examine the statutory accounting model for reinsurance is in keeping with regulators' concerns. Some have questioned whether the current reinsurance accounting model consistently reflects the economics of reinsurance arrangements that contain a substantial financing element and believe the risk transfer rules are vague. Regulators from New York State plan to develop a proposed accounting model for discussion at an interim Study Group meeting, at which time they also plan to share with industry participants concerns about specific types of reinsurance contracts. The New York State regulators described a possible accounting model that would bifurcate the financing and reinsurance elements of certain reinsurance contracts and "put standards and boundaries around" risk transfer analysis. With respect to the boundaries, the Study Group Chair said in February that many regulators do not believe the so-called "10/10" rule (a ten-percent probability of a greater than ten-percent loss) identifies sufficient risk transfer.

■ **Incorporating Sarbanes-Oxley Type Provisions**

Potential provisions on internal control reporting moved ahead slowly during the meeting, but provisions on audit committees and auditor independence may be moved to a faster track. The NAIC/AICPA Working Group exposed its Title III subgroup's recommendations on audit committees at the meeting. Comments are due on April 29. The recommendations address the appropriate legal entity within a corporate structure for evaluating compliance with the rules

on audit committees, the definition of "financial expert," and independence requirements for audit committee members. The recommendations would allow each company to decide which corporate component evaluates compliance with the rules on audit committees and would base the proportion of audit committee members required to be independent on premium volume and on whether or not the company reports to the SEC. Comments will likely focus on industry's already expressed concerns, including the premium-volume thresholds and providing a "safe harbor" for financial experts.

Recommendations on auditor independence were re-exposed, with comments due by April 29. The recommendations include prohibited auditor services, audit partner rotation, and restrictions on auditors' employment with a client. The recommendations remain different in some respects from the rules on the same subjects already adopted in response to Sarbanes-Oxley requirements, which could increase the efforts companies have to devote to monitoring and compliance.

The Working Group's subgroup on Title IV is considering its original version of 404-like requirements for the insurance regulatory framework. The subgroup indicated it still might limit the requirements to management reporting on the effectiveness of internal control over financial reporting, excluding reporting by the external auditor. More broadly, the subgroup is considering whether to base the requirements on a framework other than the COSO control framework. These issues will be discussed at an interim meeting in early May. Industry leaders and representatives will then be able to propose specific ideas on scope exemptions and the level within an organization to which the requirements should apply.

No date was discussed for implementing the Sarbanes-Oxley-type provisions. Regulators are considering separately

adopting provisions on audit committees and auditor independence before completing work on reporting on internal control over financial reporting.

■ Reporting Control Deficiencies

The NAIC/AICPA Working Group discussed important follow up on a letter sent in early March to state insurance departments to help resolve the potential reporting problem created by different requirements for reporting on "significant deficiencies." The potential problem is confusion about which deficiencies must be reported to state regulators, given the assessments of controls performed to comply with section 404 of Sarbanes-Oxley. Should insurers report remediated as well as unremediated significant deficiencies? Insurers need to be clear on this question during the current reporting season.

The letter developed and sent by the NAIC/AICPA Working Group presents suggested guidance to state insurance departments on reporting significant deficiencies in internal control. If followed, the guidance would provide relief from reporting remediated significant deficiencies, but would not modify the insurance regulator's definition of "significant deficiency." Specifically, the letter recommends reporting significant deficiencies in internal control that existed at year end, but not reporting significant deficiencies that were remediated during the period. Unremediated deficiencies at year end would be assessed for materiality with respect to the individual company or reporting group that is required to produce audited statutory financial statements.

Insurers will need to learn and understand their domiciliary regulator's position, because each state and territorial regulator will determine for itself whether to accept the suggested guidance. An insurer domiciled in a state that does not adopt the suggested guidance would need to report both remediated and

unremediated significant deficiencies in internal control noted by the accountant during the audit.

Because it is essential for insurers to learn and understand their domiciliary regulator's position, an unofficial group of representatives from industry and accounting firms is following up on the letter and its suggested guidance. The group is taking steps to identify the positions of the individual state insurance departments and territories.

Other issues remain about reporting significant deficiencies to regulators, such as confidentiality and further analysis of the results of Sarbanes-Oxley internal control reporting.

■ Determining Impairment of Fixed Income Securities

The NAIC adopted as final an interpretation of its rules for determining whether a fixed income security is other-than-temporarily impaired that differs from U.S. GAAP accounting. Under the interpretation, which was effective upon adoption, an interest-rate-related impairment would be recognized at the reporting date if the insurer then intends "to sell" an investment before it recovers. The insurer should consider whether its cash or working capital requirements and contractual or regulatory obligations indicate that the investment may need to be sold before its forecasted recovery. This may lead companies to make system and process changes to identify an intent-to-sell category for securities that are in an unrealized loss position.

KPMG's Audit Committee Institute (ACI)

Recognizing the challenge that audit committees face in meeting their demanding responsibilities, KPMG created the Audit Committee Institute (ACI) in 1999 to serve as a resource for audit committee members and senior management. Our primary mission is to communicate with audit committee members and enhance their awareness, commitment, and ability to implement effective audit committee processes. ACI's initiatives include semiannual roundtables, publication of *Audit Committee Quarterly*, conference and board presentations, a toll-free hotline, periodic distribution of time-sensitive information, and our Web site. During the past five years, ACI has conducted active outreach

among thousands of audit committee members and we have sponsored hundreds of workshops, presentations, and issue-oriented meetings.

ACI's Web site address is <http://www.kpmg.com/aci/>. ACI can be reached toll-free at 877-576-4224 or via e-mail at auditcommittee@kpmg.com.

State Regulation

- On March 14, 2005, the NAIC Broker Activities Task Force held a second public hearing as part of the Spring 2005 National meeting in Salt Lake City, UT. The purpose of the hearing was to gain perspective from the insurance industry, the producer community, and community groups as to the adequacy of the protections put into place with the passing of Broker disclosures model act in December of 2004.

The format of the hearing consisted of three panels: a consumer panel, a producer panel, and an insurer panel. The consumer panel consisted of the Center for Economic Justice, and a few other consumer-oriented groups speaking out later on the meeting. The producer panel had wide representation including the American Bankers Insurance Association, the Council of Insurance Agents and Brokers, the Independent Insurance Agents and Brokers of America, the National Association of Insurance and Financial Advisors and Professional Insurance Agents. The insurers were represented by the American Council of Life Insurers, American Insurance Association, National Association of Health Underwriters, National Association of Mutual Insurance Companies, and Property Casualty Insurers Association of America.

The consumer panel asked the task force to focus on the broader issues regarding the overall producer compensation system to better serve all facets of the industry including insurers and insurance buyers, citing long-standing issues with the system as a strong cause of past issues in the life and annuity lines of churning and

replacement activities. The consumer representative alleged that the problem is not one of commercial lines and bid rigging only, but of a compensation system that may be an incentive for producers to be less loyal to the buying public than they could be.

The producer panel felt that the model was adequate as it was written and passed in December of 2004. They believed that the additional regulation would place an unfair burden on all parties to the transaction, including the consumer. The panel cited lack of complaints as evidence of the problem not being widespread and that there was no evidence that producers are putting their own financial interests ahead of the insurance buying public. The producer groups suggested that it is not compensation structure but conflicts of interest that create the issue and suggested that focusing on eliminating these conflicts would be a more prudent approach.

The insurer panel largely echoed the beliefs of the producer panel, reiterating that they too felt the model passed in December would be an effective way to address the conflict of interest issues. They further added that disclosing all quotes would be unreasonable and perhaps more confusing to the consumer than helpful, and like the producer groups, opposed additional legislation.

The Broker activities task force, which consists of 14 states, again gave the industry and all interested parties an additional opportunity to comment following the hearings. Any comments were to be in writing to the task force no later than March 22, 2005.

- The Health Insurance and Managed Care (B) Committee met to hear reports and pass model laws from several subcommittees including the ERISA work group, the Senior Issues Task Force, the Regulatory Framework Task Force, and the Subgroup on Health Discount Plans.

- The ERISA working group held an informational public hearing on the discussion draft, *Prevention of Illegal Multiple Welfare Employer Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation*. The purpose of the hearing was to hear comments on the draft and also to obtain specific information from the persons and licensees who will be impacted by the regulation.
- The Senior Issues Task Force reported on long-term care issues, among others, beginning important discussions of downgrades of coverage at the option of the policyholder. Presently, under the model, the companies are only required to provide downgrades upon a substantial rate increase.
- The Regulatory Framework Task Force adopted revisions to the Group Health Insurance Mandatory Conversion Privilege Model and the Model Newborn Children Bill. The revisions make the models consistent with requirements of HIPAA.
- The Subgroup on Health Discount Plans reported that it has begun receiving comments on a proposed model — the Medical Discount Organization Model Act. In the results of a study at the Health Policy Institute, Georgetown University found serious problems with how some of the discount cards are being marketed and sold to consumers. The study urges the states to intervene to more aggressively protect consumers.
- Lastly, the Committee heard a request from several groups, including industry, to attack the issue of the uninsured and underinsured. The Committee agreed to take this on, working as necessary with the federal government to find a reasonable solution for all parties.

(NAIC Spring National Meeting, March 12-15, 2005)

Federal Regulation and Legislation

■ Joint Forum Releases Report on Outsourcing in Financial Services

On February 15, the Joint Forum released a report examining the trends in outsourcing in the financial services sector. The report recognizes the potential risks and benefits made available by outsourcing, and provides a set of principles outlining issues that should be taken into account as part of the decision to enter into an outsourcing agreement. The principles are designed to apply whether or not the service provider is regulated. The report also contains broad principles to help supervisors take outsourcing into account in their regulatory risk reviews.

The principles are broad and apply across the banking, insurance, and securities sectors. However, the international committees involved with each sector (the Basel Committee on Banking Supervision, the International Organization of Securities Commissions (IOSCO), and the International Association of Insurance Supervisors) are encouraged to build on the principles to offer more specific and focused guidance. In fact, the IOSCO released a paper on outsourcing the same day the Joint Forum paper was released. An earlier version of the Joint Forum report, "Outsourcing in Financial Services," was released in August 2004.

The Joint Forum was established under the aegis of the Basel Committee on Banking Supervision, the IOSCO, and the International Association of Insurance Supervisors to study issues related to the financial, securities, and insurance sectors. The report is available on the Web site of the Bank for International Settlements (www.bis.org). (KPMG's *The Washington Report*, February 21, 2005)

■ Agencies Release Interagency Statement on Purchase and Risk Management of Bank-Owned Life Insurance

On December 7, the Federal Reserve Board, the Federal Deposit Insurance Corporation, the Office of the Comptroller of the Currency, and Office of Thrift Supervision (collectively, the Agencies) jointly issued an *Interagency Statement on the Purchase and Risk Management of Life Insurance*. This guidance discusses the safety and soundness and risk management implications of purchases and holdings of life insurance by banks and savings associations ("institutions").

Institutions may purchase life insurance on their employees or others for several appropriate business purposes, the most common of which are to recover the cost of providing pre- and post-retirement employee benefits, to recover losses associated with the death of a key person, and to obtain insurance on borrowers.

The Agencies have noted that purchases of bank-owned life insurance (BOLI) have increased steadily and significantly. The Agencies are concerned that some institutions may not have an adequate understanding of the full array of risks posed by BOLI, including liquidity, operational, reputational and compliance/legal risks. The Agencies also are concerned that some institutions may have committed a significant amount of capital to BOLI holdings without properly assessing the associated risks.

Such developments have highlighted the need for the Agencies to enhance and harmonize their supervisory guidance on BOLI. The Interagency Statement is intended to help institutions and examiners ensure that risk management practices for BOLI are consistent with safe and sound banking practices. The guidance addresses the need for both a comprehensive pre- and post-purchase analysis of BOLI risks and rewards, as well as its unique characteristics. The Agencies expect institutions to have comprehensive risk management processes applicable to their BOLI purchases and holdings, including:

- Effective senior management and board oversight;
- Comprehensive policies and procedures, including appropriate limits regarding purchases; and
- An effective ongoing system of risk assessment, management, monitoring and internal control processes, including appropriate internal audit and compliance frameworks.

The Interagency Statement is available on the Web sites of each of the issuing Agencies (www.federalreserve.gov, www.fdic.gov, www.occ.treas.gov) (KPMG's *The Washington Report*, December 13, 2004)

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Taxation

■ Final Regulations on Diversification Requirements for Variable Annuity, Endowment, and Life Insurance Contracts

Under Section 817(h),¹ a variable contract based on a segregated asset account is not treated as an annuity, endowment, or life insurance contract unless the segregated asset account is adequately diversified. The Treasury Department and IRS issued final regulations (T.D. 9185) removing provisions from Treas. Reg. Sec. 1.817-5(f)(2)(ii) that apply a look-through rule to assets of a nonregistered partnership for purposes of satisfying the diversification requirements of Section 817(h). The application of section 1.817-5(f)(2)(i) to interests in nonregistered partnerships will be unchanged by the removal of section 1.817-5(f)(2)(ii). Thus, look-through treatment will be

available for interests in a nonregistered partnership if all the beneficial interests in the partnership are held by one or more segregated asset accounts of one or more insurance companies and public access to the partnership is available exclusively (except as otherwise permitted by section 1.817-5(f)(3)) through the purchase of a variable contract.

These final regulations are effective as of March 1, 2005. However, arrangements in existence on March 1, 2005 will be considered to be adequately diversified if:

- those arrangements were adequately diversified within the meaning of section 817(h) prior to March 1, 2005, and
- by December 31, 2005, the arrangements are brought into compliance with the final regulations.

■ Revenue Ruling Addresses Look-Through Rules for Assets Held Through Certain Investment Companies, Partnerships, or Trusts

Rev. Rul. 2005-7 addresses whether a segregated asset account held by an insurance company is adequately diversified under Section 817(h)(4), when the segregated asset account invests in a regulated investment company, which in turn, holds an interest in another regulated investment company. The IRS held that the segregated account may look through to the individual assets of both regulated investment companies for purposes of testing adequate diversification, if all beneficial interests in the funds are held by segregated asset accounts and public access to the funds is only available through the purchase of a variable contract.

■ Revenue Ruling Addresses Definition of Life Insurance Contract

Rev. Rul. 2005-6 provides that charges for qualified additional benefits (QABs) should be taken into account under the expense charge rule of section 7702(c)(3)(B)(ii) (and not under the

¹ All Section references are to the Internal Revenue Code of 1986, as amended.

mortality charge rule of section 7702(c)(3)(B)(ii) for purposes of determining whether a contract qualifies as a life insurance contract under section 7702 or as a modified endowment contract (MEC) under section 7702A, vis-à-vis the guideline premium test.

In the ruling, a life insurance company issues a policy with a rider that provides term life insurance coverage on the life of a family member of the individual insured by the policy. The policy is a life insurance contract under state law and is designed to qualify as a life insurance contract under Section 7702 by meeting the guideline premium requirements of Section 7702(c) and falling within the cash value corridor as defined by Section 7702(d). The insurer imposes a charge for the mortality risk that it assumes under the rider and subtracts this charge monthly from the policy's cash value.

Section 7702(f)(5)(A)(iii) characterizes family term riders as QABs.

Section 7702 is silent on the treatment of charges for QABs for purposes of determining whether a contract satisfies the guideline premium requirements. Under section 7702(b)(2)(B), however, charges for QABs are subject to the expense charge rule of section 7702(c)(3)(B)(ii) for purposes of determining whether a contract satisfies the cash value accumulation test. The same rule applies under section 7702A(c)(1) for purposes of determining whether a contract satisfies the 7-pay test and therefore is not a MEC. The IRS observed that there is no indication that Congress intended charges for QABs to be accounted for under one rule for purposes of the cash value accumulation test of section 7702(b) and the 7-pay test of section 7702A(b), and under a different rule for purposes of the guideline premium requirements of section 7702(c). Moreover, the IRS further observed that there is no indication that Congress intended to

take into account charges with respect to QABs that exceed amounts reasonably expected to be actually paid. Accordingly, the IRS reasoned that charges taken into account with respect to QABs are subject to the expense charge rule of section 7702(c)(3)(B)(ii) for purposes of the guideline premium requirements.

■ **IRS Publishes Differential Earnings Rate for 2004 for Use by Mutual Life Insurance Companies**

The IRS released Notice 2005-18, providing a tentative determination under section 809 of the differential earnings rate for 2004.

The Job Creation and Worker Assistance Act of 2002, Pub. L. 107-147, section 611, amended Section 809 by adding new paragraph (j). As amended, Section 809(j) provides that the differential earnings rate shall be treated as zero for purposes of computing both the differential earnings amount and the recomputed differential earnings amount for a mutual life insurance company's taxable years beginning in 2001, 2002, or 2003. See Notice 2002-33, 2002-1 C.B. 989. Because of section 809(j), there is no need to determine a tentative recomputed differential earnings rate for 2003.

The final recomputed differential earnings rate for 2003 is already determined to be zero. Subsequently, the Pension Funding Equity Act of 2004, Pub. L. 108-218, section 205, repealed Section 809 of the Code for taxable years beginning after December 31, 2004. Therefore, the IRS is still required to determine a tentative differential earnings rate for 2004.

Source: IRS; Court rulings; Legislative materials

Market Forces

Consolidation and Convergence

- On March 21, ING Group announced that it had signed an agreement to sell ING Chile's property and casualty insurance operation, ING Seguros Generales, to Boston-based Liberty Mutual Group. Financial details of the transaction, which was closed on April 13, were not disclosed. In another announcement on March 30, ING Group said that it had closed its transaction to transfer all outstanding life insurance policies and other assets of its Argentine life insurance subsidiary, ING Insurance Argentina, to Zurich Financial Services. (*ING Group Press Releases, March 21, 30, and April 13, 2005*)
- On April 18, Fortis announced the tie-up of Fortis AG and FB Insurance as part of Fortis' new strategy. The tie-up will create Fortis Insurance Belgium, which, according to the announcement, will become Belgium's largest insurer. Fortis sells its insurance products through independent intermediaries, Fortis AG and Fortis Bank (FB Insurance). This dedicated approach will be retained and Fortis Insurance Belgium will continue to serve customers through these two distinct channels. (*Fortis Press Release, April 18, 2005*)
- Aon Corporation announced on February 9 that it has entered into an agreement with Le Foyer and Kredietbank to transfer the business of Gecalux S.A. Luxembourg, Gecalux Switzerland A.G. and Gecasuisse A.G. The Gecalux business represents in excess of 40 captive clients. (*Aon Press Release, February 9, 2005*)
- Aetna has announced that the completion of its acquisition of Strategic Resource Company (SRC), a privately held administrator of group benefit products for part-time and hourly workers, headquartered in Columbia, S.C. Aetna in August announced its intention to acquire 100 percent of the

stock of SRC as well as the insurance contracts administered by SRC for approximately \$250 million. The transaction was financed from available cash. The company will be known as "SRC, an Aetna company." (*Aetna Press Release, January 6, 2005*)

Risk Management

- Insurers worldwide are making progress in their efforts to implement enterprise risk management (ERM), and 85 percent of survey respondents say ERM is more of a priority today than it was a year ago. However, insurers' success with ERM strategies depends on companies' adoption of economic capital concepts, says a study conducted by the Tillinghast business of Towers Perrin, released in February 2005. The survey identified a major shift in the positioning of the risk management function within insurance organizations, with 39 percent noting that chief risk officers have primary responsibility for risk management. Some key findings from the study include:
 - Gaps between ERM objectives and current efforts — insurers want to use ERM to build shareholder value, but current efforts still focus on the fundamentals.
 - ERM is already making a difference — insurers report that improved risk and capital management considerations have caused them to change business decisions in many areas.
 - Low confidence about operations risk — respondents expressed low satisfaction with the tools and techniques to manage operations risks, as well as their overall capability to measure them.
 - Economic capital (EC) is critical to ERM — An overwhelming majority of respondents say they use, or plan to use, EC concepts to improve risk-based decision making. However,

regional differences surface in the way that EC is put into action. North American respondents tend to have a more regulatory view of EC.

Globally, European businesses are leading in many areas in the use of integrated risk and capital management approaches to drive business decisions. Sixty-nine percent of European companies surveyed already have cross-functional risk management committees compared with 63 percent globally. Nearly half of European insurers cite compliance with regulatory changes as a key objective for improving risk management. In addition to Europe, according to a Towers Perrin spokesperson, Asia and Canada are well-advanced in the integration of risk to improve the understanding and communication of risk management through their organizations. (*Tillinghast Towers Perrin Press Releases, February 8, 2005*)

- In February, Aon's trade credit and political risk experts presented their annual analysis of the world's trade credit and political risk hotspots as illustrated in the 2005 Political and Economic Risk Map. Each year, Aon presents its Map to rate the economic, currency, and political risks of doing business in more than 200 territories worldwide. This year, Aon's trade credit experts have developed a new Supply Chain Risk Index measuring a company's vulnerability to key threats to their global supply chains. According to the new Index, released in February 2005, of the more than half a trillion dollars worth of goods and services the U.S. imported from 50 countries in 2004, close to \$312 billion is at risk because of political and economic instability. This estimate is likely to grow in 2005 as firms continue to integrate and consolidate their supply chains. Aon's Index also ranks the top 50 countries at risk for supply chain disruptions. While the U.S. received a "low" risk ranking, the ongoing threat of

terrorism and its potential impact on trade flows or a repeat of labor strikes at California's ports indicate ongoing concerns that should not be overlooked. *(Aon Corporation Press Release, February 1, 2005)*

International Focus and Globalization

- Prudential plc announced on March 15, 2005 that its life insurance joint venture, CITIC Prudential has been awarded a life insurance license for Wuhan, in the Hubei province of Central China. Earlier this year in February, CITIC Prudential received life insurance licenses for Dongguan and Foshan, two large cities in China's Guangdong province, and in January, a group life insurance license. The company was granted a license for Shanghai in November 2004 and plans to open an office there in May 2005. The Wuhan branch is expected to open in the third quarter of 2005. *(Prudential Press Releases, March 15, February 16, and January 31, 2005)*
- In January, Manulife Financial announced that Manulife-Sinochem Life Insurance Co. Ltd., a subsidiary of Canadian-based Manulife Financial, received approval from the China Insurance Regulatory Commission (CIRC) to convert its Guangzhou Branch license into a province-wide license for Guangdong, excluding Shenzhen. Additionally, in April, it was announced that Manulife-Sinochem began business in the city of Ningbo, Zhejiang province, site of the company's third branch office in China. In September 2004, Manulife-Sinochem received the first license granted in Zhejiang province to a foreign-invested joint venture life insurance company by the CIRC, according to Manulife. *(Manulife Financial Press Releases, January 18 and April 9, 2005)*
- CIRC has licensed China Re Asset Management Company Limited (CRAMC), based in Beijing, as the country's first insurance asset manager with a foreign shareholder, Swiss Re Asset Management Asia Ltd. Based in Beijing, CRAMC was founded by six companies: China Re Group, China P&C Re, China Life Re, China Continent P&C, Swiss Re Asset Management Asia Ltd., and Fuxi Investment. CRAMC will initially focus on managing the capital assets of China Re, and plans to expand to serve both life and non-life insurance companies in China. *(Swiss Re Press Release, February 18, 2005)*
- In January, AEGON N.V. announced that Transamerica Occidental Life Insurance Company (Transamerica), a subsidiary of the AEGON Group, received a license from the Monetary Authority of Singapore to operate as a direct life insurer. *(AEGON NV Press Release, January 26, 2005)*
- According to a survey by Watson Wyatt released in March, sales of impaired life annuities were 44 percent higher in the fourth quarter of 2004 compared with the first quarter of 2004 and comprised 19 percent of all annuities sold in the open market in the U.K. Volumes of enhanced annuities sold were GBP 120 million in the first quarter, growing to GBP 173 million in the fourth quarter, its highest level for nearly two years. Watson Wyatt believes that this growth in the number of people taking out impaired life or enhanced annuities, which includes annuities enhanced for serious medical conditions as a result of lifestyle factors such as weight, smoking, occupation, and geographical location, is set to continue. *(Watson Wyatt, March 30, 2005)*
- The ACE Group of Companies announced that it has received regulatory approvals to commence property and casualty insurance operations in Poland and Russia. The Financial Services Authority (U.K.) has authorized the opening of an ACE European Group Limited branch in Poland under the European Union Freedom of Establishment Directive. In addition, CSJC ACE Insurance Company, ACE's newly created insurance subsidiary in Russia, has received a license to begin operations from the Department for Insurance Supervision of the Russian Federation. *(ACE Group Press Release, March 24, 2005)*

e-Business and Technology

- A recent Celent survey of insurer business and IT executives, released in March 2005, reveals several important disconnects between what buyers value in the sales process and what their general experiences are. For final decision-makers, the areas of greatest disconnect were knowledge-related, with "knowledge of their IT environment and how the solution would be integrated" topping the list. Knowledge-related issues were high on the list for lower-level decision makers as well, but nearly as important were two key communications areas: willingness to discuss pricing in simple terms, and ability to assist in internal communication. *(Celent Press Release, March 11, 2005)*
- New challenges in the U.S. insurance industry are creating one of its most difficult operating environments in recent memory. In the context of such divergent issues as terrorist threats, state and federal regulatory activity, competition from other financial services players, and tight global economic conditions, TowerGroup forecasts a cautious approach to IT investments in 2005. According to a study conducted by TowerGroup released in February 2005, technology spending is expected to remain relatively flat in 2005, at \$36.4 billion compared to \$35.3 billion last year. Most of the IT spending action in 2005 will be found in the property and casualty sector. For most property and casualty carriers, TowerGroup projects an IT spending increase in 2005 from 2.5 percent to 10 percent over 2004 spending estimates. Investments primarily will be for operations, profitability and distribution, TowerGroup says. Life and annuity IT spending is expected to remain flat, with legacy systems being identified as one of the biggest challenges facing life and annuity insurers in their IT environments. *(TowerGroup Press Release, February 7, 2005)*

KPMG *Insurance Insider*

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Analysis and Commentary

In this section, we offer KPMG's analysis and commentary reprinted from KPMG *Insurance Insider*.

State Opposition, Other Issues Bury Federal Charter Efforts

**By Jacqueline S. Gold, Managing
Editor, *Insurance Insider***

March 25, 2005

Although three major proposals to revamp insurance regulation are before legislators in some form, it appears that the industry's ultimate goal of optional federal charters is nowhere close to fruition.

Only the National Association of Insurance Commissioners' (NAIC) interstate compact is likely to muster passage, while the other two proposals, currently floating in Congress, appear to be long shots. But the NAIC proposal doesn't address federal charters.

The key issues for insurers are increasing speed to market, conduct exam reform, and uniform producer licensing requirements. The industry has long called for a streamlined process to reduce repetitive and costly bureaucratic compliance requirements in each state.

The NAIC interstate compact tries to deal with some of these issues while remaining rooted in the traditional state-based insurance regulatory system. In addition, it only affects life insurance, annuities, disability income insurance, and long-term care insurance in the states that sign on.

Once the compact is passed by at least 26 state legislatures or 40 percent of the market — 10 states have given it the nod so far and another 19 are considering it — it would provide uniform standards for product approval, helping speed new product introduction, at least in the states that opt in.

But for many in the insurance business, that won't be enough. The current, state-by-state approval process costs large carriers millions of dollars annually in regulatory compliance, according to Lisa Stimson, a senior manager in KPMG's risk advisory services.

The time-consuming approval process also stifles product introduction:

"What good does it do you if you see a need in the marketplace and it takes two years to get a product out there?" Stimson asks.

The movement for insurance reform gained new life after the passage of the Gramm-Leach-Bliley Act (GLB) in 1999. That financial services modernization bill allowed banks to merge with brokerage companies for the first time since the 1930s, and it opened the door for banks and brokerages to own insurance companies.

In the wake of GLB, carriers feared that they could not withstand the onslaught of banks and brokerages selling insurance, and argued for lighter regulation to help them compete. Insurers said that an optional federal charter would give them the same regulatory choice (state or federal) as banks.

"The optional federal charter is a very comprehensive approach," says Gary Hughes, executive vice president and general counsel of the American Council of Life Insurers (ACLI). "Ideally, we would like to see a dual chartering system where you could pick the one that best suits your circumstances."

The American Insurance Association, which represents property/casualty companies, also supports the optional federal charter idea. Julie Rochman, senior vice president of public affairs at the AIA, says it would allow states to maintain many prerogatives, but also give insurers that market products nationally oversight at the federal level.

Insurance associations and others soft-pedal the fact that a federal charter would likely eviscerate the current state regulatory system, which has led to huge opposition from state insurance regulators. Regulators argue that an optional federal charter would pit the states against the federal government, and that oversight would decline as a result.

"The states are closer to the consumer and they can handle the day-to-day problems," says Oregon insurance administrator Joel Ario. "The federal government does not have the wherewithal to handle half a million consumer complaints each year."

But perhaps the biggest obstacle is that the dire threat to the insurance industry from banks and brokerages has yet to materialize. The European model of bancassurance — banks owning insurance companies — has not caught on in the United States.

In spite of the roadblocks, several of the national insurance trade organizations are looking for a Senator to sponsor an optional federal charter bill. The effort has gone nowhere to date, with Terrorism Risk Insurance Act renewal taking much higher priority.

In addition, N.Y. Attorney General Eliot Spitzer's investigations have roiled the insurance world, making Congressional action on federal regulation extremely unlikely. "It's not going to be an easy sell," admits the ACLI's Hughes.

Meanwhile, in the House of Representatives, Michael Oxley, R-Ohio, and Richard Baker, R-LA., have been pushing the State Modernization and Regulatory Transparency Act. The so-called Smart Act would deregulate insurance rate structures and policy forms, while leaving enforcement and oversight with state regulators.

But neither insurers nor state regulators like the Smart Act. Carriers feel they'd be held to a mishmash of state and federal regulation, and state commissioners feel the legislation would usurp their power.

Birny Birnbaum, executive director of the Center for Economic Justice, a group that represents consumers, says that the Smart Act would make it difficult for state regulators to do their jobs.

"The premise is that the feds will set standards and the states will implement them," he says. "But it's really like a massive unfunded mandate that won't let the states protect consumers."

Insurance commissioners aren't against all federal involvement in insurance. States want TRIA extended past this year, and they would also like more information sharing between the federal government and state insurance departments.

In particular, commissioners want access to the Federal Bureau of Investigations' criminal data base, in order to screen agents who are applying for licenses. Providing health insurance is another area where the federal government could play a positive role, commissioners say.

But "the overall regulatory framework is best served at the state level," says Alessandro Iuppa, Maine Superintendent of Insurance and president-elect of the NAIC. "I have yet to meet a person who would like to deal with an insurance problem by calling Washington."

Private Retirement Accounts: a Boon for Annuity Providers?
By Jacqueline S. Gold, Managing Editor, *Insurance Insider*
March 7, 2004

Insurance companies that sell annuities and operate mutual funds could be the biggest winners in President Bush's proposal to create private retirement accounts as part of changes to the nation's Social Security system.

Although observers predict financial services firms with market-index mutual funds will benefit from private accounts, insurance carriers could gain the most, selling products at every step of the process.

"It would be a front-to-back situation," says Bob Swanton, team leader for the life and health group in North America at rating agency Standard & Poor's. "The insurers would have their mutual funds [operations] manage the money while people were still working, and then they'd make the payout through an annuity when these workers retire."

The allure is so great that insurance companies currently without mutual fund subsidiaries are expected to buy fund companies if private accounts move toward approval — certainly not a sure thing.

"You can be sure that insurance fund companies will try to steal market share from mutual fund companies," says Andrew Edelsberg, an analyst in the life/health group at insurance rating agency A.M. Best. Insurers and fund companies already compete in the 529 college saving account market, Edelsberg notes.

However, it's unlikely that big mutual fund companies will start buying insurers. Fund firms don't have the sales expertise to sell complicated insurance products; in addition, fund companies are considered much more adept at distributing a wide range of financial offerings from numerous companies than underwriting those offerings themselves.

Insurers have a much greater incentive to own their own mutual fund companies. In addition to cutting the cost of commissions on insurance, they already have experienced sales agents to sell mutual funds.

President Bush has proposed that the accounts be voluntary, and phased in over time, starting in four years. Observers expect insurance companies to put their political muscle behind the movement to create private accounts, since about \$65 billion a year will be up for grabs.

Insurers aren't the only financial services companies that could provide all-encompassing products for private accounts. General Electric's Financial Assurance unit, for instance, has recorded \$1 billion

in variable annuity sales year to date, while GE Asset Management boasts \$16.8 billion in mutual fund assets under management. Merrill Lynch's life insurance operations has sold \$763 million in variable annuities since Jan. 1, while Merrill Lynch Investment Managers holds \$56.6 billion in fund assets under management.

But insurers have the variable annuity numbers on their sides — and many already run mutual funds. The Hartford is the largest variable annuity provider, with \$15.2 billion in sales so far this year, and TIAA-CREF is second with \$13.1 billion. Other top providers include industry powerhouses AIG, Lincoln National, New York Life, Mass Mutual, and Northwestern Mutual.

These companies own mutual fund firms and offer the full spectrum of annuities, including equity-indexed annuities, which could play a big role in private accounts since they offer some protection on principal.

Because critics claim that many citizens may not be sophisticated enough to manage their retirement nest eggs properly, "there could be pretty tough strictures about how to withdraw" from the new accounts, says Eric Federer, director of business public policy in government affairs at KPMG.

For the insurance industry, annuities are the key. Annuities offer tax-deferred accumulation of investment funds that can be withdrawn at a later date. Many annuities are sold with riders or guarantees that pass some or most of the investment risk back to the insurance company issuer, in return for sales fees.

The product's investment protection — and the fact that the vehicles pay out in increments like Social Security — makes it almost certain that annuities will be an important part of any government program to institute private retirement accounts.

"The Bush Administration is talking annuitization, and that's our game," says Jack Dolan, a spokesman for the American Council of Life Insurers.

"Annuity needs to be a significant component of any individual accounts. Insurers are excited. We've got the expertise. I'm sure the administration will be turning to us on some of the nuts and bolts of creating these accounts."

The fees insurers charge to annuity holders are sometimes high enough to substantially eat into returns. However, A.M. Best's Edelsberg argues that the insurers will structure fees on private accounts to be competitive, just as they have to create appealing 529 proposals to win that business from state governments.

"Fees are a determinant, but so is quality," Edelsberg says. "You also pay for brand name and performance, customer service, and the products that you want. All of these will be a part of the equation."

The administration has yet to put a detailed private account plan on the table. But during his State of the Union address last month President Bush revealed that the plan would allow workers to contribute \$1,000 in the first year of the accounts, with the amount increasing \$100 per year, plus the rate of wage inflation.

The Social Security Administration estimates that administrative and management fees would equal some \$2 billion, or about 30 cents for every \$100 invested. While \$2 billion divided among many companies may prove insignificant to an insurer's bottom line, political observers say that the \$1,000 limit is likely to rise, enhancing the amount of the management fees along with it.

Carriers are hesitant to discuss private accounts, as they don't want to reveal strategies until Congress and the president hammer out a deal. So far, public opinion has been cool to the idea of private accounts or other significant changes in Social Security.

In addition, with so much money at stake and the competition for it so intense, no insurer wants to tip off rivals.

Typical are comments of Tim Benedict, a spokesman for The Hartford: "It's really evolving," he says. "We're watching it closely."

S-O Compliance Playing Big Part in Next M&A Wave

By Gary Larkin, Managing Editor, *Audit Committee Insights* March 3, 2005

Audit committees are finding out that the Sarbanes-Oxley Act of 2002 (S-O) has foisted upon them yet another new responsibility: greater involvement in the due diligence phase of a merger.

Although they're not required to do so, acquiring companies are expanding due diligence as a way to make sure the new, combined business will comply with S-O Section 404 and other mandates including requirements for assessing disclosure controls and procedures as well as internal controls over financial reporting. An acquiring company should assess the adequacy of the target's internal controls, and whether the acquisition will affect the acquirer's internal controls.

As it oversees management's due diligence, the audit committee often should consider whether their company should take advantage of a Securities and Exchange Commission one-year reporting exemption on the target company's controls.

In the pre-closing process, management and the board of directors should decide whether or not to use the "reprieve," according to KPMG's James Aldridge, a principal in the firm's transaction services practice.

"The audit committee should be ensuring that management is undertaking an appropriate due diligence process," Aldridge says. "Then they have to ask what is management's plan for integrating the acquired company's controls after acquisition and in time for the next reporting deadline."

"Had the one-year exemption not been in place, then I think there would be fewer deals being closed later in the year," he says. "

Under S-O, a company has to include an acquired business in its Section 404 report and attestation for the year in which the acquisition closes. However, in June the SEC approved an exemption that permits the acquiring company to exclude the target company's business from the Section 404 report and attestation if the acquiring company meets certain disclosure requirements.

The acquiring company must identify the acquired business, and disclose that management excluded the acquisition from its report on internal control over financial reporting. The company must also indicate the significance of the acquired business to the consolidated financial statements, and disclose any material change to its own internal controls over financial reporting due to the acquisition.

David Keith, senior financial analyst for Bellevue, Wash.-based M&A services provider Corum Group Ltd., doesn't see many of his firm's technology company clients exercising the exemption.

"Most buyers want to quickly assimilate the company, so we are seeing companies [assess internal control over financial reporting] as quickly as possible," Keith says. "The timing of the internal controls issue has not popped up yet."

However, a recent Corum Group report found that in 2004 technology mergers often took 12 months to close, as more people had to sign off on deals because of the S-O Section 404 report and attestation.

Perhaps more telling was the report's finding that some acquiring companies want to close a transaction earlier in the year, so they can have enough time to consolidate the financial reporting of the seller and meet S-O compliance requirements.

Keith has seen such due diligence take less time, particularly when the target is a public company that already complies with S-O Section 404.

"Buyers are much more comfortable," he says. "Many have done several deals in

the age of S-O by now. We have been advising sellers to educate themselves, and for those that are private companies, to make them as S-O compliant as they can before they enter into M&A discussions."

Saks Inc. audit committee chairman C. Warren Neel believes there is still pressure to close a deal earlier in the year. "There's some speculation that there will be more M&A action in the first, second, or third quarters of the year," Neel says.

Neel also heads up the University of Tennessee's Corporate Governance Center. "The thinking is [that] with one of these transactions, if you are going to have a 404 issue you'd want more time to fix it," he says.

Even as it is already busy overseeing its company's own financial reporting process, the audit committee also has some responsibility for oversight of due diligence.

"At a minimum, audit committees need to be involved in the process pre-closing, ensuring that when the closing occurs [management has assessed that] the financial statements will be true and accurate," says Ed Mason, partner at the law firm of Foley & Lardner in Chicago. "Sarbanes-Oxley places the audit committee [into] the process [much earlier]."

Mason, whose law firm completed a case study last year on the impact of governance reforms on mergers, has seen audit committees become quite involved in other aspects of due diligence.

"The board may use the audit committee as a special committee to see if [the merger] is valued properly," Mason says.

Neel believes that the audit committee needs to provide the necessary oversight for the parts of due diligence that the full board has assigned to it. Sometimes that may mean dealing directly with outside parties involved in a deal.

"You want to make sure you have an engaged committee — if you have a

possible transaction, it gets involved with the investment bank," he says. "The committee has to ask, 'what is our process of deliberation?' and then say, 'if we are going to do a transaction, here is the process.'"

An important part of the audit committee's oversight of the due diligence process is to consider if management has fully analyzed those provisions of the actual stock purchase or asset purchase agreement that pertain to internal controls over financial reporting.

"Some of the warranties on internal controls in the agreements have gotten beefed up," Mason says. "In many cases, the [acquiring company] may seek indemnification from the target company if internal control issues arise after closing."

There's a lot at stake: as of Feb. 2, the dollar value of mergers and acquisitions for 2005 was \$132.45 billion, compared to \$85.37 billion in January 2004, according to Mergerstat.

"[The cost of compliance] now becomes part of the letter of intent negotiations — who is going to cover what costs," Corum Group's Keith says. "In order to get a deal done today, there must be an atmosphere of give and take, which means both parties agree to some cost sharing, with the buyer assuming a larger portion of the cost."

In a KPMG Audit Committee Institute survey taken last fall during a series of roundtables, 34 percent of respondents said complying with S-O caused some meaningful increase in the cost of the deal. The survey seems to indicate clearly that S-O has imposed an additional cost on merger and acquisition activity.

KPMG's Aldridge sees the S-O cost as an essential component of the overall due diligence effort. "It's a risk awareness and mitigation exercise," he says. "You need to consider the risks in consummating the deal. You then balance those risks against the access you get and the time and money it takes to get due diligence done."

Will Health Savings Accounts Change How Health Dollars Are Spent?

By Michael Galicia, Associate Director, KPMG *Insiders*
January 19, 2005

Health savings accounts (HSAs), considered a major piece of the White House's health care reform plans, could put a squeeze on providers as patients shop on the basis of price.

As HSAs entail patients bearing a higher percentage of upfront costs, consumers will have a greater incentive to find the best deals — not unlike comparison shopping for any other good or service.

"Health care does not compete like other industries," says Hal Heaton, a professor at Brigham Young University's Center for Entrepreneurship.

"When was the last time you saw an advertisement by a health care provider that says, for example, 'come to us for the highest quality kidney stone removal at the lowest price'?" Heaton says. "Today, health care competes by offering the most sophisticated service at the highest cost, because no one pays much attention to cost."

Made available as part of Medicare reform legislation on Jan. 1, 2004, advocates say HSAs will catch on as employers and employees become familiar with the concept.

HSAs represent the Bush's administrations primary vehicle to curb health care spending, and "the accounts are definitely here to stay," says Don Yesukaitis, an advisor to KPMG's health care practice in Washington, D.C.

"Price has always been an issue, but now it's more of a reality to consumers," he says. "Co-pays are higher, deductibles have gone up, and education of the accounts are key."

The HSA provision of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 allows virtually anyone with a high-deductible health plan — at least \$1,000 for single coverage and

\$2,000 for families — to open an HSA. Employees and employers can contribute pre-tax dollars to the accounts, which accrue interest tax-free and can move with employees from company to company. Unlike health flexible spending accounts (FSAs), unused balances roll over each year.

But since HSAs allow individuals to keep unused money, account holders have an incentive to look for the best deals.

"[Consumer-based health plans] teach and empower consumers to take financial control of their health care spending; HSAs are the centerpiece of this new approach," says Dr. Stephen D. Neeleman, CEO of HealthEquity and co-author of "The Complete HSA Guidebook."

At a Galen Institute conference last February, several insurance companies said consumers with HSAs not only pay more attention to their health, but are frequent users of low-cost resources such as nurse hotlines and online information.

Those consumers also use preventive services and are more careful in discretionary expenses; they've reduced emergency room and outpatient physician visits while increasing generic drug consumption.

"Hospitals, doctors, and pharmacies have been dependent upon a third-party payer system that has resulted in a system where pricing was not important to consumers, and therefore not readily accessible," Neeleman says. "Health savings accounts and other market forces will change the structure where price is an important competitive component."

BYU's Heaton says that HSAs will help health care providers create "massive entrepreneurial efforts" for low-cost specialization and quality.

The U.S. House of Representatives' Joint Committee on Taxation estimates that 1 million HSAs will be sold this year.

Insurers say they sold just a few thousand HSAs last year, mainly to individuals and small businesses, but are expecting the numbers to rise as medium-sized and

large companies buy into the concept. According to a Mercer Human Resource Consulting survey, more than 70 percent of employers are considering offering HSAs by 2006.

Health insurer Aetna's consumer-directed product, which includes HSAs, has about 13,500 members. According to research, Aetna HealthFund participants saw medical cost increases of 3.7 percent during 2003, while use of some preventive care measures increased by as much as 23 percent.

"HSAs are a relatively new product, but we see tremendous growth in consumer directed health plans," says Betsy Sell, an Aetna spokeswoman.

Some form of HSAs have existed for more than a decade. Consumer-driven health plans have included medical savings accounts (MSAs), health reimbursement arrangements (HRAs) and FSAs. These have been used to pay for medical co-pays, dependent care, dental and vision plans and other costs, with tax-deductible or pre-tax dollars.

However, they generally have restrictions — they can't be taken to new jobs or carried over to the next year — that HSAs don't.

In addition, third parties can act as HSA administrators, meaning banks and credit unions can offer HSAs to their customers as either a trust or a custodial account. Funds can be invested in the same types of investments as IRAs.

The variety of distribution channels, White House backing, and their apparent effects on health care consumption might make some providers nervous. But despite their potential to spark major change in patient behavior, it's probably too early to expect anything on a wide scale.

"How the benefit is perceived will determine the success of the program," says KPMG's Yesukaitis. "IRAs, 401(k)s, all these benefits have taken the same road. HSAs have to be proven and right now there's a wait-and-see attitude."

The information provided in the above articles is of a general nature and is not intended to address the specific circumstances of any individual or entity. In specific circumstances, the services of a professional should be sought. The views and opinions are those of the author and do not necessarily represent the views and opinions of KPMG LLP.

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