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Terri M. Vaughan, Ph.D., Co-Editor

**National Association
of Insurance Commissioners**

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The *Journal of Insurance Regulation* is sponsored by the National Association of Insurance Commissioners. The objectives of the NAIC in sponsoring the *Journal of Insurance Regulation* are:

1. To provide a forum for opinion and discussion on major insurance regulatory issues;
2. To provide wide distribution of rigorous, high-quality research regarding insurance regulatory issues;
3. To make state insurance departments more aware of insurance regulatory research efforts;
4. To increase the rigor, quality and quantity of the research efforts on insurance regulatory issues; and
5. To be an important force for the overall improvement of insurance regulation.

To meet these objectives, the NAIC will provide an open forum for the discussion of a broad spectrum of ideas. However, the ideas expressed in the *Journal* are not endorsed by the NAIC, the *Journal's* editorial staff, or the *Journal's* board.

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Donna Imhoff, J.D.

This article discusses the evolving standards governing the activities of insurance company boards of directors. These standards are essential to the NAIC Financial Regulation Standards and Accreditation Program and are derived from the annual statement, the *Financial Condition Examiners Handbook*, changes to the Model Audit Rule and the Risk-Focused Surveillance Framework. Directors who wish to assess their compliance in advance of a scheduled financial examination might use this article as the basis for a self-evaluation tool.

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Economic Security or Litigation Nightmare? 33

Mark D. DeBofsky, J.D.

Ultimately, the goal for both insurers and claimants is that meritorious disability insurance claims receive compensation. According to this article, the impact of the ERISA law on disability benefits has made that goal much harder for claimants to reach. The author suggests that there needs to be a reassessment by the U.S. Congress, the courts and the U.S. Department of Labor as to whether the law is meeting its purpose and what can be done to remedy the situation.

Lessons from the Texas Homeowners
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Robert Puelz, Ph.D.

In this paper, the recent crisis in the Texas homeowners insurance market is examined by focusing on three questions. First, how did the dual regulatory system influence insurer behavior? Second, which perils were important in driving the increase in prices observed during the time period of this study? Third, were other non-expected loss factors related to premiums leaving consumers in the potential position of misunderstanding why overall price increases were arising?

Commentary: The Attorney General, the SEC
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Richard E. Stewart

This commentary discusses the recent investigations and prosecutions of insurance malpractice by former New York State Attorney General Eliot Spitzer and the U.S. Securities and Exchange Commission (SEC). According to the author, these investigations created an opportunity for state insurance regulators to broaden the inquiry and go after the unattended issues.

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Editors' Perspective

The Spring 2007 issue of the *Journal of Insurance Regulation* (JIR) includes articles on a range of insurance topics, from how the Sarbanes-Oxley Act of 2002 (SOX) continues to impact insurance companies and state regulation to ERISA to property/casualty insurance in Texas. It also includes a commentary — a call to action addressed to the nation's insurance regulators — from a former NAIC president and superintendent of the New York State Insurance Department.

The first article, "Changes to the NAIC's Model Audit Rule: Sarbanes-Oxley Inspires Revisions" by Deborah L. Lindberg, an associate professor at Illinois State University, discusses revisions made to the NAIC Annual Financial Reporting Model Regulation (Model Audit Rule). Prof. Lindberg identifies provisions of the Sarbanes-Oxley Act that have been incorporated in whole or in part to the new regulations, and provides highlights of the new requirements.

Donna Imhoff, former deputy insurance commissioner in Maryland, in "Corporate Governance: A Self-Evaluation Tool for Insurance Company Directors" discusses regulatory activity in the post-Sarbanes-Oxley era. She discusses the accumulation of standards — derived from the annual statement, the *Financial Condition Examiners Handbook*, the NAIC Model Regulation Requiring Annual Audited Financial Reports and the NAIC Risk-Focused Surveillance Framework — governing the activities of insurance boards of directors. Imhoff discusses how such activities are essential to the NAIC Financial Regulation Standards and Accreditation Program and provides practical suggestions to directors regarding how to assess compliance in advance of a scheduled financial examination.

Mark DeBofsky, an adjunct professor of law and practitioner, in the article titled "Disability Insurance Under the ERISA Law: Economic Security or Litigation Nightmare?" argues that despite ERISA's goal of protecting workers and their families, ERISA has, in fact, turned into a shield for some to avoid paying legitimate benefits and has resulted in "nightmare" litigation. He includes a discussion of federal court cases involving claims for disability income benefits under ERISA plans.

Bob Puelz, a professor at Southern Methodist University, in "Lessons from the Texas Homeowners Insurance Crisis" examines how a dual regulatory system influences insurer behavior, perils driving the increase in prices and other non-expected loss factors related to premiums. Prof. Puelz finds that the market shifted to entities that were not subject to rate regulation and that among perils water losses were most important in their association with price levels.

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Richard E. Stewart, former NAIC president and superintendent of the New York State Insurance Department, provides a compelling and thought-provoking commentary of how in the 20th century, highly publicized crises in the insurance industry have resulted in better regulation, more competition in the industry and improved consumer protection. He argues that, as in the past, the investigations instigated by former New York State Attorney General Eliot Spitzer and the SEC, as well as the significant changes in the insurance business (such as company failures that enrich management at policyholder expense and "systematic refusals to pay property/casualty claims"), are opportunities for state insurance regulators. Stewart concludes that state insurance regulators, unlike in the past, are not paying attention and, therefore, are missing these key chances to modernize.

In this issue of JIR, we again include a new section, "Federal and State Legislative Update." This section was first included in the Winter 2006 issue of the JIR in an effort to provide enhanced information to our readership. It includes a summary highlighting some of the proposed legislation in the U.S. Congress that would impact the insurance market. In this issue, only health-related bills are highlighted. This section also includes legislation enacted in states and NAIC-related model regulations adopted by state insurance regulators. We welcome your feedback on whether you find this type of information to be useful.

The last section includes a legal update of federal and state insurance-related court cases, including post-Hurricane Katrina litigation.

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Changes to the NAIC's Model Audit Rule: Sarbanes-Oxley Inspires Revisions*

Deborah L. Lindberg, D.B.A.**

Abstract

In June 2006, inspired by the Sarbanes-Oxley Act of 2002 (SOX), the NAIC incorporated several provisions of SOX into its revisions of the Annual Financial Reporting Model Regulation (Model Audit Rule). The revisions apply not only to public insurance companies, but also to most mutual and privately owned insurers. While most of the revisions are not effective until reporting periods beginning January 1, 2010, affected insurance companies need to start preparing and planning now in order to meet the new requirements, which include management reporting on internal control over financial reporting. The external auditors of insurers, in addition to expressing an opinion on the fairness of the financial statements, will also attest to whether any unremediated material weaknesses in internal control over financial reporting were noted during the audit. The revisions to the Model Audit Rule also require that certain independence criteria be met by the auditors and members of the insurer's audit committee. This paper discusses which provisions of the Sarbanes-Oxley Act have been incorporated in whole or in part to the new regulations, and provides highlights of the new requirements.

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* This paper has benefited from helpful comments made by Jim Jones, Richard MacMinn and two anonymous reviewers. The author is also grateful for work performed by Illinois State University research assistant Jacob Thompson and thanks the Katie School of Insurance and Financial Services at Illinois State University for a faculty development grant to write this paper.

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Background

In response to corporate-reporting scandals (e.g., Enron and WorldCom), the U.S. Congress mandated sweeping changes in corporate governance and reporting by the passage of the Sarbanes-Oxley Act of 2002 (SOX). The SOX legislation was an effort to restore investor confidence in the financial reporting process by raising the standards for corporate accountability, corporate governance, ethical behavior and the audits of publicly traded companies (Andreason, 2005; Carmichael, 2004). Many constituencies have termed SOX the most significant legislation to affect corporate governance, financial disclosures, internal controls and the practice of public accounting since the Securities Acts of 1933 and 1934.

While the Sarbanes-Oxley Act of 2002 applies primarily to publicly traded companies, managers of all types of entities have considered encouraging their organizations to implement some or all of the SOX requirements (Derocher, 2003; Klimko, 2004; Lindberg and Parker, 2006). Consequently, inspired by SOX, in June 2006 the NAIC incorporated several provisions of SOX into revisions of the Annual Financial Reporting Model Regulation (Model Audit Rule) (NAIC, 2006a). The changes, like all provisions to the Model Audit Rule, apply not only to public insurance companies, but also to mutual and privately owned companies, unless they have less than $1 million in direct premiums in any calendar year and less than 1,000 policyholders (NAIC 2006a). This paper discusses which of the SOX provisions have been incorporated in whole or in part to the Model Audit Rule and provides highlights of the new requirements.

Internal Control over Financial Reporting

Management's Report on Internal Control over Financial Reporting

Insurers that have annual direct written and assumed premiums of $500 million or more will be required to file a "Management's Report on Internal Control over Financial Reporting" beginning with the reporting period ending December 31, 2010, and each year thereafter (NAIC, 2006a). Internal control over financial reporting is defined in Section 3I of the Model Audit Rule as "…a process effected by an entity's board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements…" Strong internal controls help ensure that receipts are properly recorded and expenditures are made in accordance with management's

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express authorization. In general terms, such internal controls:

1) Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;
2) Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements; and
3) Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements.

This change is based on Section 404 of SOX, which requires a publicly traded company's highest management to state whether the company's internal controls over financial reporting are effective. This requirement has been the most costly, time-consuming and, thus, most controversial SOX provision. Accordingly, contentious discussions related to the adoption of the requirements of Section 404 for insurance companies resulted in at least two major compromises: 1) as previously noted, only insurers with annual direct written and assumed premiums of $500 million or more will be required to file a report of the insurer's Internal Control over Financial Reporting; and 2) an insurer that is already subject to Section 404 reporting (either directly or through a parent) or an insurer who is SOX-compliant may file the Section 404 report, along with an addendum, to satisfy the requirements of the revised Model Audit Rule (NAIC, 2006a, Section 16).

The revised Model Audit Rule requires the Management's Report on Internal Control over Financial Reporting to have seven specific provisions. These provisions include a statement that management is responsible for establishing and maintaining adequate internal control over financial reporting and a statement as to whether management believes that internal control over financial reporting is effective regarding the reliability of financial statements prepared in accordance with statutory accounting principles (NAIC, 2006a).

Management of insurers must include a statement identifying the framework used by management to evaluate the effectiveness of the insurer's internal controls. It should be noted that nearly all companies that are currently subject to the SOX provisions use the Committee of Sponsoring Organizations of the Treadway Commission (COSO) *Internal Control – Integrated Framework* to assess internal controls. COSO is a private-sector initiative established in 1985 in response to problems in financial reporting at that time. COSO's stated goal is to improve the quality of financial reporting through a focus on corporate governance, ethical practices and internal control (Louwers, et al., 2007).[1] It is important to note that the *Model Audit Rule* states that an insurer has the discretion to use a framework other than COSO to assess its internal controls. Nevertheless, it is expected that most insurers will also use the COSO framework to evaluate controls (e.g., Protiviti, 2006).

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1. The Committee of Sponsoring Organizations (COSO) is composed of five financial associations: the Institute of Internal Auditors, the American Institute of Certified Public Accountants, the American Accounting Association, the Institute of Management Accountants and the Financial Executives Institute (Louwers et al., 2007).

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Criteria contained within the COSO framework have been used by both management and external auditors to evaluate an organization's internal control over financial reporting. COSO defines internal control as a process designed to provide reasonable assurance regarding the achievement of objectives in the following categories:

- Effectiveness and efficiency of operations
- Reliability of financial reporting
- Compliance with applicable laws and regulations

Exhibit 1
COSO Framework for Internal Control

The Committee of Sponsoring Organizations of the Treadway Commission (COSO) *Internal Control — Integrated Framework* describes five interrelated components of internal control:

- ❖ Control Environment
  - Management's Philosophy and Operating Style
  - Integrity and Ethical Values
  - Objectivity of the Board of Directors
  - Independence of Audit Committee Members
  - Presence of an Internal Audit Function
  - Commitment to Competence
  - Code of Conduct
  - Ethics Hotline
  - Hiring and Promotion Practices
  - Organizational Structure
- ❖ Risk Assessment
  - Likelihood and Significance of Risk, Including Fraud
  - Inherent Risk
  - Business Risk
  - Identify Critical Success Factors
  - Manage Risk
- ❖ Control Activities
  - Link Controls to Identified Fraud Risks
  - Performance Reviews
  - Segregation of Duties
  - Information-Processing Controls
  - Physical Controls
- ❖ Information and Communication
  - Information Systems and Technology
  - Training
- ❖ Monitoring
  - Ongoing Monitoring by Management
  - Evaluations by Internal Audit

Source: Louwers, Timothy J., Robert J. Ramsay, David H. Sinason and Jerry R. Strawser, 2007. *Auditing and Assurance Services*, 2nd edition, New York, N.Y.: McGraw-Hill/Irwin.

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Any unremediated material weaknesses over financial reporting identified by management as of December 31 of the immediately preceding year must be disclosed (NAIC, 2006a). An unremediated material weakness is one that has not been corrected (remedied) as of December 31 of the year being reported upon. A material weakness is defined as a condition that results in more than a remote likelihood that a material misstatement exists in financial statements (PCAOB, *Auditing Standard No. 2,* 2004*)*. Information is considered "material" if it is likely to influence decisions of users of the financial statements (Louwers, et al., 2007). If there are one or more unremediated material weaknesses in its internal control over financial reporting, then management is not permitted to conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements prepared in accordance with statutory accounting principles.

Exhibit 2 summarizes the seven provisions that must be included in Management's Report on Internal Control over Financial Reporting.

Exhibit 2
Management's Report on Internal Control over Financial Reporting

The management's report on internal control shall include:

1) A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting.
2) A statement that management has established internal control over financial reporting and an assertion to the best of management's knowledge and belief, after diligent inquiry as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles.
3) A statement that briefly describes the approach of processes by which management evaluated the effectiveness of its internal control over financial reporting.
4) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded.
5) Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there are one or more unremediated material weaknesses in its internal control over financial reporting.
6) A statement regarding the inherent limitations of internal control systems.
7) Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

Source: NAIC, Annual Financial Reporting Model Regulation, Section 16D.

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Scope of Audit and Report of Independent Certified Public Accountant

The independent auditor must always obtain an understanding of internal control sufficient to plan the audit (AICPA, 1972). In addition, SOX Section 404 requires that the auditors of companies subject to its provisions attest to and report on management's evaluation of internal controls and also report on the auditor's assessment of the effectiveness of controls. The Model Audit Rule does *not* have these attestation requirements (Protiviti, 2006). The absence of the SOX Section 404 attestation requirement was of critical importance in the insurance industry's willingness to accept the revised Model Audit Rule. However, all insurers must provide a written communication as to any unremediated weaknesses in their internal controls. The insurers' external auditors must attest as to whether any such unremediated material weaknesses in internal control over financial reporting were noted during the audit and, if so, provide a description of them. This communication shall be prepared by the auditor within 60 days after the filing of the annual audited financial report and should accompany the report on internal control for those insurers required to file a report (NAIC, 2006a). This communication is a change from the former Model Audit Rule, which required a report only if the accountant noted a significant deficiency during the audit of the financial statements. As previously noted, the term "material weakness" is a condition that results in more than a remote likelihood that a material misstatement exists in the financial statements (PCAOB, *Auditing Standard No. 2,* 2004). If no material weaknesses were noted, this should be stated.[2]

Auditor Independence

Principles of Independence

The principles of independence with respect to services provided by the independent certified public accountant are generally predicated on three basic principles: the accountant cannot function in the role of management; cannot audit his or her own work; and cannot serve in an advocacy role for the insurer (NAIC, 2006a). Violations of these principles are considered to impair the auditor's independence.

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2. "Significant deficiencies" are *not* required to be communicated by either the insurer or the auditor. However, the insurer is expected to maintain information about significant deficiencies communicated by the independent certified public accountant and make the information available for review by an examiner conducting a financial condition examination. A "significant deficiency" is defined as a condition that could provide more than a remote possibility of a misstatement that is more than inconsequential. Significant deficiencies are conditions that could adversely affect an organization's ability to initiate, record, process and report financial data in the financial statements (PCAOB, *Auditing Standard No. 2).*

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Prohibited Non-Audit Services

An audit firm will *not* be considered independent with respect to an insurer if it performs any of the eight prohibited non-audit services described in Section 7G(1) of the Model Audit Rule contemporaneously with the audit. In other words, under the revised Model Audit Rule, an insurance commissioner shall not accept an audited financial report prepared in whole or in part by an accountant that also performs a prohibited activity. These prohibited services include bookkeeping; financial information systems design and implementation; appraisal or valuation services; actuarial advisory services related to determining any amounts recorded in the financial statements; internal auditing services; management or human resources functions; broker-dealer, investment adviser or investment banking services; and legal services or expert services unrelated to the audit. In addition, the insurance commissioner may determine, by regulation, that other services are not permitted. It should be noted, however, that insurers having direct written and assumed premiums of less than $100 million in any calendar year may request an exemption (NAIC, 2006a, Section 7H).

Regarding actuarial advisory services, the auditor may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statements *only if* it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. Further, under certain conditions, an accountant's actuary may also issue an actuarial opinion or certification [NAIC, 2006a, Section 7G(1)(d)].

A certified public accountant that performs the audit of an insurer *may* perform tax services and other non-audit services, *if* the activity is approved in advance by the insurer's audit committee (NAIC, 2006a, Section 7I).

A summary of non-audit services that are prohibited by the revisions to the Model Audit Rule is provided in Exhibit 3.

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Exhibit 3
Prohibited Non-Audit Services

To be considered independent with respect to an insurer, a certified public accountant may not perform the following non-audit services contemporaneously with the audit:

1) Bookkeeping or other services related to the accounting records or financial statements of the insurer.
2) Financial information systems design and implementation.
3) Appraisal or valuation services, fairness opinions or contributions-in-kind reports.
4) Actuarially oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statements only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. Under certain conditions, an accountant's actuary may also issue an actuarial opinion or certification.
5) Internal audit outsourcing services.
6) Management functions or human resources.
7) Broker-dealer, investment adviser or investment banking services.
8) Legal services or expert services unrelated to the audit.
9) Any other services that the insurance commissioner determines, by regulation, are impermissible.

Source: NAIC, Annual Financial Reporting Model Regulation, Section 7G(1).

Audit Partner Rotation

The lead audit partner of the external audit firm may not act in that capacity for more than five consecutive years; the lead partner coordinates the audit and has primary responsibility for the audit engagement. In addition, there is a five-year "lay off" period during which a former lead partner may not act in that or a similar capacity for the same insurance company or its subsidiaries or affiliates for a period of five consecutive years [NAIC, 2006a, Section 7D(1)].

The NAIC has issued an *Implementation Guide (Guide) for the Annual Financial Reporting Model Regulation* (NAIC, 2006b). The Guide does not create additional requirements, but rather is intended to provide interpretive guidance and clarify the terms used in the Model Audit Rule (NAIC, 2006b). For instance, it provides answers to frequently asked questions about the limitations on the number of years an audit partner may serve in the capacity of lead audit partner for the audit of an insurance company. As an example, the Guide states that a partner who serves as the concurring (reviewing) partner from 2006 to 2009 could serve as the lead audit partner in 2010, because the Model Audit Rule does not prohibit a concurring partner from subsequently serving as the lead audit partner. The Guide also explains that a former lead partner can serve as the concurring review partner during the required five-year break in service (lay-off period) (NAIC, 2006b). The effective date for the requirements regarding audit partner rotation is for audits of the year beginning January 1, 2010, and thereafter.

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One-Year "Cooling Off" Period

In order to be considered independent, partners and senior managers previously involved in the audit of the insurer may not be a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer or serve in an equivalent position for the insurer during the one-year period preceding the date that the most current statutory audit opinion is due [NAIC, 2006a, Section 7L(1)].

Audit Committees

Requirements

The revised Model Audit Rule requires all insurers to have an audit committee, which is a committee established by the insurer's board of directors for the purpose of overseeing the accounting and financial reporting processes of the insurer. The audit committee will be directly responsible for the appointment, compensation and oversight of the external auditor.

The Role of the Audit Committee

Section 14 of the revised Model Audit Rule states that the audit committee is to preapprove all auditing and non-prohibited non-audit services provided to an insurer by the external auditor. The preapproval requirement is waived with respect to non-audit services if the insurer is a "SOX-compliant entity" or a direct or indirect wholly owned subsidiary of a SOX-compliant entity.[3] Also, the preapproval requirement of non-audit services is waived if:

1) The aggregate amount of all such services provided to the insurer constitutes not more than 5% of the total amount of fees paid to the audit firm during the fiscal year in which the non-audit services are provided;
2) The services were not recognized by the insurer at the time of the engagement to be non-audit services; or
3) The services are promptly brought to the attention of the audit committee and approved prior to the completion of the audit by the audit committee or by one or more members of the audit committee who are members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee (NAIC, 2006a, Section 7J).

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3. A "Sox-Compliant Entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002: i) preapproval requirements of Section 201; ii) audit committee requirements of Section 301; and iii) Internal Control over Financial Reporting requirements of Section 404 (NAIC, 2006a, Section 3M).

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The auditor of the insurer shall report to the audit committee:

- All significant accounting policies and material permitted practices.
- All material alternative treatments of financial information within statutory accounting principles that have been discussed with management, ramifications of the use of alternative disclosures and treatments, and the treatment preferred by the auditor.
- Other material written communications between the auditor and the management of the insurer, such as any management letter or schedule of unadjusted differences [NAIC, 2006a, Section 14F(1)].

Further, it is recommended that audit committee members meet periodically, with no management present, with the external auditor to discuss the strengths and weaknesses of the insurer's internal control environments, as well as other matters, as deemed appropriate.

Independence of Audit Committee Members

In general, each member of the audit committee shall be a member of the insurer's board of directors. A member of the audit committee, in order to be considered *independent*, may not accept any consulting, advisory or other compensatory fees from the insurer or be an affiliate person of the insurer or any of its entities. However, audit committee members *are* permitted to accept fees for serving on the audit committee, the board of directors or other committees of the board of directors (NAIC, 2006a, Section 14C). Similar to the preapproval of non-audit fees, independence requirements are waived if the insurer is a SOX-compliant entity or a direct or indirect wholly owned subsidiary of a SOX-compliant entity.

The proportion of audit committee members who must be independent depends on the written and assumed premiums of the insurer in the prior calendar year. If the prior calendar year written and assumed premiums are $300 million or less, there are no minimum requirements for the proportion of audit committee members who should meet independence criteria. When the prior year written and assumed premiums are more than $300 million but not more than $500 million, the majority (50% or more) of the committee members must be independent. The proportion of independent audit committee members shall be a supermajority (75% or more) when the prior calendar year direct written and assumed premiums are more than $500 million (NAIC, 2006a, Section 14G).

The requirements pertaining to audit committees are to take effect January 1, 2010 (NAIC, 2006a, Section 17F). A summary of the proportion of audit committee members who must be independent according to the revisions to the Model Audit Rule is provided in Exhibit 4.

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Exhibit 4
Proportion of Audit Committee Members Who Must Be Independent

Prior Calendar Year Direct Written and Assumed Premiums	Requirement
$0 to $300,000,000	No minimum requirements.
Over $300,000,000 to $500,000,000	Majority (50% or more) of audit committee members shall be independent.
Over $500,000,000	Supermajority (75% or more) of audit committee members shall be independent.

Source: NAIC, Annual Financial Reporting Model Regulation, Section 14G.

Section 14 of the revised Model Audit Rule states that the insurance commissioner has authority afforded by state law to require the entity's board of directors to enact *improvements* to the independence of the audit committee membership if the insurer is in a risk-based capital (RBC) action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition or otherwise exhibits qualities of a troubled insurer. Further, insurers with less than $500 million in prior year direct written and assumed premiums are encouraged to structure their audit committee with at least a supermajority of independent members (NAIC, 2006a, Section 14.).

Adoption of the Model Audit Rule

While the insurance industry is regulated at the state level, most states will likely adopt the changes to the Model Audit Rule, because the NAIC regulations are designed to protect the interests of policyholders. In other words, it can be argued that if the SOX provisions were needed for publicly traded insurance companies, then why would similar provisions not be needed for mutual companies operating in the same industry with similar concerns for financial transparency? Further, most state statutes contain language that requires insurers to provide annual audited financial statements that conform to the NAIC *Annual Statement Instructions* (Protiviti, 2006). This and other pressure toward uniformity in audits strongly suggests that states adopt uniform regulatory standards. It should also be noted that states can incorporate the provisions of the Model Audit Rule indirectly by including the requirements in the instructions for the annual statement. In addition, the revised Model Audit Rule is likely to be included in the NAIC's Financial Regulation Standards and Accreditation Program.

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Summary

By the passage of recent revisions to the Annual Financial Reporting Model Regulation, the NAIC has in effect adopted several provisions of the Sarbanes-Oxley Act of 2002. One of the primary revisions to the Model Audit Rule mirrors SOX Section 404, and will require insurance companies that have annual direct written and assumed premiums of $500 million or more to file a report of the insurer's "Internal Control over Financial Reporting" beginning with the reporting period ending December 31, 2010, and each year thereafter. The external auditors of these insurers will be required to attest as to whether any unremediated material weaknesses in internal control were noted during their audit. Revisions to the Model Audit Rule strengthen independence requirements for auditors and audit committees of insurers. Insurance companies that will be affected by the new provisions should start planning now in order to meet the new requirements.

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Corporate Governance: A Self-Evaluation Tool for Insurance Company Directors

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Abstract

Enactment of the federal Sarbanes-Oxley Act of 2002 (SOX) sparked intense debate before the NAIC over whether it should adopt new corporate governance standards for insurers that correspond to those of the federal law. The NAIC's new standards, adopted in June 2006, supplement standards already in effect for insurers.

In the midst of discussions over the appropriate insurance regulatory response to SOX principles, the NAIC adopted another measurement for corporate governance specifically tailored to the insurance industry for assessment of risk management processes. Adopted in 2004, this new tool for financial regulators anticipates that boards and their individual directors take an affirmative role in measuring, managing and monitoring the risks associated with the insurance business.

This article discusses the evolving standards governing the activities of insurance company boards of directors. These standards are essential to the NAIC Financial Regulation Standards and Accreditation Program and are derived from the annual statement, the *Financial Condition Examiners Handbook*, changes to the Model Regulation Requiring Annual Audited Financial Reports (Model Audit Rule) and the Risk-Focused Surveillance Framework. Before enactment of SOX, NAIC uniform financial standards and state insurance regulation included review of board of director functions and director activities, although, in most cases, without specific sanctions. While corporate governance might not have been a prominent issue in financial examinations, it has long been an established part of the examination. New corporate governance standards and the discussion surrounding their adoption have highlighted the importance of reviewing director functions and activities as part of the financial examination of insurers. In some states, more careful review of current standards during the examination process might ensue.

Directors who wish to assess their compliance in advance of a scheduled financial examination might use this article as the basis for a self-evaluation tool.

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Introduction

For publicly traded companies, the Sarbanes-Oxley Act of 2002 (SOX) has resulted in intense scrutiny of the activities of boards of directors. Against the backdrop of national discussions on corporate governance and new NAIC corporate governance standards, directors of insurance companies should understand how state insurance regulators currently evaluate director activities as a function of financial regulation. In light of the newly adopted standards, directors also should understand how board activities might be evaluated in future financial examinations. Indeed, corporate directors would be prudent to conduct a self-evaluation and to review corporate responsibilities in advance of any scheduled financial examinations.

The activities of corporate directors of any insurance company — whether or not the company is publicly traded — are subject to review by state insurance regulators. The discussions about corporate governance within the NAIC since the U.S. Congress adopted SOX, which undoubtedly were closely monitored by all insurance regulators, almost certainly have magnified the importance of corporate governance and director activities within the context of financial examinations.

Standards established by the NAIC, under the Financial Regulation Standards and Accreditation Program, provide corporate directors with a framework for self-evaluation. Adopted in 1990, the Accreditation Program has resulted in uniformity of financial regulation standards across all accredited jurisdictions. Through annual reporting and financial examinations, state insurance regulators continually evaluate insurers against NAIC standards.

To be complete, however, the self-evaluation also must incorporate standards imposed by an insurer's state of domicile under any state-specific laws governing director activities that supplement those laws the state has adopted to comply with the NAIC Accreditation Program. Each state is unique in its approach.

As the basis for a self-evaluation tool that focuses on director responsibilities, this article discusses:

- Uniform standards applied by solvency regulators in a financial examination;
- Newly adopted NAIC changes to annual financial reporting standards that correspond to SOX standards, which become effective January 1, 2010; and
- NAIC guidance on the role of directors in risk management.

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Current NAIC Standards Governing Director Activities

Annual Statement Reporting

In an accredited state, each insurer must file an annual statement in the form approved by the NAIC. The General Interrogatories section of the annual statement blank includes several questions specifically addressing activities of the board of directors. The questions establish three basic rules for directors:

- The board or one of its committees should review the purchase or sale of all investments of the company.
- The board should keep a complete and permanent record of all its proceedings and those of its subordinate committees.
- There should be an established procedure for disclosure to the board of any material interest or affiliation on the part of any officer, director, trustee or responsible employee that is likely to conflict with the individual's official duties.

The General Interrogatories also ask for the total amount loaned during the year to directors. The amount reported must include separate accounts, but exclude policy loans. If any such loans were made, the amount of loans outstanding must be reported.

Criteria Applied to Director Activities in a Financial Examination

A critical component of the Accreditation Program, and an important tool for financial regulators, is the NAIC *Financial Condition Examiners Handbook* (Examiners Handbook). The Examiners Handbook guides examiners in the questions they ask and the materials they review in evaluating business and corporate practices, including director activities, as part of the financial examination process. The Examiners Handbook, intended for use in all accredited jurisdictions, offers a measure of uniformity in the review and analysis of insurance company solvency by the company's domestic regulator. Because there is a uniform procedure for review and analysis, all states in which an insurer is authorized to do business can rely on the quality of the financial examination carried out by the domestic regulator. While the Examiners Handbook, per se, does not establish standards of conduct for corporate directors, nonetheless the guidance it gives to examiners does imply that standards exist.

The Examiners Handbook divides the financial examination process into three major phases. Directors should be aware of the phases and the progression of questions within each phase that relates to board activities. Directors should understand the appropriate response to each question. Absent an independent understanding of the response, a director should seek the information from management, corporate counsel or board colleagues.

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Planning Phase

General guidelines on planning a financial examination describe procedures for management assessment. The following questions about the board of directors are included in the guidelines:

- Are criteria and terms for board membership sufficient to enable the effective monitoring and oversight of management?
- Does the board effectively monitor and oversee management activities?

A related question under the heading "Management Competence" asks whether a member of management has ever been a director of an insurance company that, while the individual was a director, became insolvent or was placed in conservation, was enjoined or ordered to cease from violating any securities or insurance law, or suffered suspension or revocation of its certificate of authority in any state. An affirmative answer might lead an examiner to question a board's effectiveness in monitoring and overseeing management.

The Examiners Handbook includes an Examination Planning Questionnaire as an exhibit. A number of items relate to the board of directors, as listed below.

- Is there an audit committee? How many members are outside directors? How often does the committee meet? Are minutes of meetings prepared and retained?
- From the articles of incorporation, describe the duties assigned and performed by the board of directors, its audit committee and other committees.
- Has the company developed a long-term strategic plan? How often is it reviewed and updated?
- Do internal auditors prepare and follow written audit programs? Is the scope of internal audit activities planned in advance with the board of directors?
- Do internal auditors have direct access to the board of directors?
- Are financial statements submitted at regular intervals to the board of directors?
- Does the board of directors review and approve financial information for public distribution; e.g., filings with regulatory bodies?
- Are all investment activities approved by the board of directors?
- Do reinsurance agreements require formal review and approval before execution by the board of directors?
- Are transactions with employees, directors and officers regularly reviewed for compliance with regulatory requirements?

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Examination Phase

General procedures for conducting examinations include a review of the minutes of board of directors' and committee meetings. The procedures instruct examiners to read the minutes of all meetings of the board of directors and important committees.

Good business judgment dictates that corporate minutes be accurate and complete. Specific instructions in the Examiners Handbook offer some guidance on the question of completeness of corporate minutes:

> The examination team should read the minutes of all meetings of the board of directors, shareholders, and executive and other important committees for the entire examination period through the end of fieldwork. *Matters affecting the annual statement* should be cross-referenced to the appropriate work papers. (Emphasis supplied.)

The Examiners Handbook addresses the first two of the three basic rules for directors derived from the annual statement blank: Board review of the purchase and sale of investments and maintenance of a permanent record of board proceedings. As to the third rule, established disclosure procedures, examiners conducting a financial examination would review the annual statements filed since the last examination, and presumably, would review the procedure for disclosure by directors of any material interest or affiliation that is likely to conflict with an individual's official duties. The form and content of the disclosure and the standard for measuring the impact of a potential conflict might differ from state to state. Unless a state's law imposes a standard, the form, content and substance of a disclosure would be measured by a subjective standard — that of the most senior regulator who signs the examination report.

Post-Examination Phase

As to general procedures on post-examination follow-up, the Examiners Handbook instructs examiners to contact the company to elicit the extent of corrective action resulting from an examination report. It concludes, "lack of satisfactory corrective action by the company may be cause for consideration of official proceedings against the directors and officers."

Once again, unless a state's law imposes standards for determining what constitutes "satisfactory" corrective action and for deciding which "official proceedings" will be brought against directors and officers, the standards necessarily would be subjective.

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Newly Adopted Standards: Director Oversight in Financial Reporting (Effective January 1, 2010)

In June 2006, the NAIC adopted the Annual Financial Reporting Model Regulation (the Model), which revises and renames the Model Regulation Requiring Annual Audited Financial Reports (Model Audit Rule), to impose on insurers new requirements corresponding to some of the standards applicable to public companies under the federal Sarbanes-Oxley Act of 2002 (SOX).

The new requirements, which become effective January 1, 2010, alter requirements for independent auditors, add new corporate governance standards and require internal control over financial reporting for companies having annual premium in excess of $500 million.

Before the effective date, the Model must be adopted by law or regulation in each jurisdiction that wishes to comply with the NAIC Accreditation Program. Although a minority of states has incorporated the Model Audit Rule into their financial regulatory programs based on its reference within the annual statement instructions, those states now must join the majority of accredited jurisdictions to adopt the financial reporting requirements through the formality of the legislative or regulatory process. Similarly, those jurisdictions that have used a legislative or regulatory process to adopt the Model Audit Rule must reactivate that process to adopt the Model changes.

Various summaries of the Model have been available since its adoption. The new requirements generally correspond to similar provisions of SOX. Consistent with the intent of this article, the summary below emphasizes the impact that changes will have on insurance company directors, individually and collectively as a board.

Applicability of the Annual Financial Reporting Model Regulation

The Model applies to every authorized insurer except those having direct premiums of less than $1 million in a state in any calendar year or less than 1,000 policyholders of direct policies nationwide at the end of the calendar year. In any given state, the commissioner may make a finding that compliance is necessary for an insurer that otherwise may be exempt due to its size. This provision on general applicability is unchanged from the Model Audit Rule.

There are several exemptions within the specific requirements of the Model. For directors, the most notable is the exemption from new audit committee standards for insurers that already are SOX-compliant.

Establishment of Audit Committee

While the boards of directors of many insurers already have established an audit committee, the Model expressly requires an audit committee. For an insurer within a holding company system, the controlling person may elect to

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have its audit committee act as the audit committee for the insurer. To exercise the election, the controlling person must give written notice to the insurance commissioner before issuance of its annual audit and must describe the basis for the election.

The Model describes an audit committee as a body established by the board of directors for the purpose of overseeing the accounting and financial reporting of an insurer. If a board of directors fails to designate an audit committee, the entire board constitutes the audit committee.

The Model adopts standards for audit committees, but exempts an insurer that is required to be compliant or is voluntarily compliant with SOX provisions relating to preapproval of certain auditing services by the auditing committee, audit committee independence requirements and internal control over financial reporting. Unless an insurer is exempt, the standards as stated in the Model apply. However, an insurer with direct written and assumed premiums less than $500 million may apply to the insurance commissioner for a hardship exemption from the provision requiring direct responsibility of the audit committee over the accountant handling the audited financial report and from the audit committee independence requirements. The Model does not describe what constitutes a hardship, but an Implementation Guide for the Model describes circumstances that might constitute hardship as those based on business type, availability of qualified board members, or organizational structure. It would seem that the application for an exemption and the determination of a hardship might vary somewhat from state to state.

Audit Committee Oversight of Financial Reporting

An insurer's audit committee is directly responsible for appointment, compensation and oversight of the work of an accountant preparing and issuing an audited financial report. Oversight includes resolution of disagreements between management and the accountant regarding financial reporting. Each accountant shall report directly to the audit committee.

The audit committee shall require the accountant to report specified information, including:

- All significant accounting policies and material practices;
- All material alternative treatments of financial information within statutory accounting principles that have been discussed with management; and
- Other material written communications between the accountant and management.

Under current standards suggested by the planning questionnaire in the Examiners Handbook, directors already should be familiar with audit programs and the scope of internal audit activities, and therefore have the basis of knowledge for interpreting and evaluating the information accountants must report under the Model. Beginning no later than January 1, 2010, directors would be prudent to ensure that board minutes document that the audit

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committee has established a direct relationship with the accountant issuing the annual audited financial report and that the audit committee receives and maintains the information specified in the Model.

Audit Committee Independence Requirements

The Model establishes standards for independence of board members who serve on the audit committee of an insurer whose direct written and assumed premiums for the preceding calendar year exceeded $300 million.

To maintain independence a director, other than as a member of the board, may not accept any consulting, advisory, or other compensatory fee from the insurer or its affiliate or subsidiary.

An insurer with more than $300 million in prior year written and assumed premiums shall have a majority (50% or more) independent membership.

An insurer with more than $500 million in prior year written and assumed premiums shall have a supermajority (75% or more) independent membership.

Drafting notes to the Model state that all insurers with less than $500 million in written and assumed premiums are encouraged to structure their audit committees with a supermajority of independent members; and a state's law may authorize its insurance commissioner to impose independence of audit committee members for insurers that exhibit qualities of a troubled insurer. As previously noted, an insurance commissioner may grant a hardship exemption from the independence requirements.

Directors should be familiar with developments in the laws of the insurer's domestic state related to corporate governance and any materials the insurance commissioner may publish on director independence in the form of regulations and financial examination reports.

Qualifications of Independent Certified Public Accountants

The Model adds provisions intended to assure auditor independence. The provisions are similar to those contained in SOX.

Audit Partner Rotation

The Model changes the rotation and disqualification period, established by the Model Audit Rule, for independent certified public accountants who audit insurers. Disqualification specifically applies to the audit partner having primary responsibility for an audit, rather than to any persons responsible for rendering an audit report. The Model reduces from seven years to five years the consecutive period during which the audit partner may have primary responsibility for an insurer's audit. It also increases to five years the period of disqualification due to five years of consecutive service.

The Model continues the current practice, under the Model Audit Rule, allowing an insurer to request an exemption from the rotation, but requires an application for an exemption to be made at least 30 days before the end of a calendar year. An insurer that has an approval for the exemption must file the approval with its annual statement.

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Limitation on Non-Audit Activities

The Model prohibits the insurance commissioner from accepting an annual audited financial report prepared by an accountant who provides an insurer, contemporaneously with the audit, certain non-audit services. The insurance commissioner may grant an exemption to an insurer having direct and assumed premiums of less than $100 million in any calendar year.

The prohibition on contemporaneous non-audit services is based on *three principles of auditor independence* expressly described in the Model: an accountant cannot function in the role of management, cannot audit the accountant's own work and cannot serve in an advocacy role while conducting an independent audit.

Contemporaneous non-audit services that would disqualify an accountant are:

- Bookkeeping or other services related to accounting records or financial statements;
- Design and implementation of financial information systems;
- Appraisal or valuation services, fairness opinions or contribution-in-kind reports;
- Actuarially-oriented advisory services involving the determination of amounts recorded in the financial statements;
- Internal audit outsourcing services;
- Management functions or human resources;
- Broker-dealer, investment adviser or investment banking services;
- Legal services or expert services unrelated to the audit; and
- Other services the commissioner determines, by regulation, are impermissible.

Under limited circumstances, an accountant's actuary may issue an actuarial opinion on an insurer's reserves. In addition, if the audit committee approves a service in advance, an accountant may engage in non-audit services, including tax services, that are not expressly prohibited and that do not conflict with the *three principles of auditor independence*.

In light of the direct responsibility of the audit committee over the accountant engaged in preparing the insurer's financial reports, directors should understand how the Model defines independence for accountants and the limits on non-audit activities that an accountant may provide. In addition, directors should know the *three principles of auditor independence* and be prepared to apply those principles to activities not specifically described in the list of services that would disqualify an accountant.

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Audit Committee Approval of Services

The audit committee shall give advance approval for all auditing services and non-auditing services that the independent certified public accountant provides the insurer. The advance approval requirement does not apply to an insurer that is compliant with SOX or is a direct or indirect wholly owned subsidiary of an entity that is so compliant.

Limitation on Company Officers Formerly Employed by Accountant

A member of an insurer's board, its president, chief executive officer, controller, chief financial officer, chief accounting officer or equivalent position may not have participated in an audit of the insurer as a partner or senior manager of the insurer's accountant within the one-year period preceding the date of the most current statutory opinion. An insurer may apply for an exemption of the prohibition based on unusual circumstances. An insurer that has an approval for the exemption must file the approval with its annual statement.

Officer and Director Liability for Conduct Related to Accountant Work Product

The Model specifies behavior that would result in sanctions against an officer or director. The prohibition is stated in terms that generally would apply criminal sanctions. However, whether commission of the specified behavior constitutes criminal conduct and whether the conduct would be subject to conviction as a misdemeanor or felony rests with state policymakers who adopt the Model in their respective states through the legislative process. The new language of the Model emphasizes the important fiduciary responsibility each member of a board of directors has with respect to a company.

Under the new language, an officer or director may not, directly or indirectly:

- Make or cause a materially false or misleading statement to an accountant in connection with any audit, review or communication required under the Model.
- Omit to state or cause another to omit to state a material fact necessary to ensure that statements are not misleading to an accountant in connection with any audit, review, or communication required under the Model.
- Take any action to coerce, manipulate, mislead or fraudulently influence an accountant engaged in an audit if the officer or director knew or *should have known* that the action could result in rendering financial statements to be materially misleading. (Emphasis supplied.)

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In light of the direct relationship the audit committee must have with the accountant, directors should be particularly attuned to the personal liability the Model imposes on perceived abuses of that relationship. They should refrain from any actions that, though innocent, give the appearance of being misleading, coercive, manipulative or otherwise prohibited. Directors also should understand the specific sanctions associated with this liability in the insurer's state of domicile.

Internal Controls

The Model establishes two requirements related to the internal control a company maintains over its financial reporting. The first applies to all insurers and relates to information required in the annual audit; it mandates a specific communication for all audits. The second applies only to insurers having direct and assumed premiums in excess of $500 million; it mandates those insurers to submit a report on internal control over financial reporting.

The Model defines internal control over financial reporting to be a process effected by the board of directors, management, and other personnel designed to provide reasonable assurance of the reliability of financial statements through the following:

- Maintenance of records;
- Recording of transactions; and
- Timely detection of unauthorized transactions.

Communication of Internal Control Related Matters Noted in an Audit

An accountant who prepares an insurer's annual audited financial statement must prepare a written communication as to any unremediated material weaknesses in internal controls over financial reporting noted in an audit. The Model requires that if no unremediated material weaknesses were noted, the communication should so state. The communication, which is governed by standards issued by the American Institute of Certified Public Accountants (AICPA), must be filed with the domiciliary insurance commissioner within 60 days after the filing of the annual audited financial report.

If the accountant describes unremediated material weaknesses and does not provide a description of corrective remedial actions, the insurer must provide the commissioner with the description.

Management's Report of Internal Control over Financial Reporting

The Model requires certain insurers to file with the commissioner a report on internal control over financial reporting. An insurer must file the report if:

- It has annual direct and assumed premiums of $500 million or more (excluding premiums reinsured with federal crop and flood programs).

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- The commissioner requires the report because the insurer is in any risk-based capital (RBC) level event or is deemed to be in a hazardous financial condition.

An insurer may file its or its parent company's report prepared in accordance with SOX Section 404 if:

- The insurer is directly subject to SOX Section 404.
- The insurer is part of a holding company system whose parent is subject to SOX Section 404.
- The insurer or its parent, though not directly subject SOX Section 404, is a SOX-compliant entity.
- Along with the Section 404 report, the insurer files an addendum. The addendum must:
    - Include a positive statement by management that no material processes related to preparation of the insurer's audited financial statements are excluded from the Section 404 report; or
    - If internal controls having a material impact on preparation of the insurer's audited financial statements are excluded from the Section 404 report, include a report on the internal controls not covered by the Section 404 report.

The bases for all assertions made in the report on internal control must be documented and made available when the insurance commissioner conducts a financial examination.

The Role of Directors in Risk Management

In Plenary session in September 2004, the NAIC adopted the Risk-Focused Surveillance Framework. The Framework proposes ways in which the financial examination process may assess an insurer's risk prospectively, in part through assessment of risk management processes such as board of director effectiveness and corporate governance activities. The Framework states that it intends to enhance the current retrospective examination-based process for identifying insurers at financial risk. The Framework describes the bases for a regulatory program, necessary steps in carrying out the program, and characteristics that can be identified with strong, moderate, and weak risk management in the insurance industry.

While the Framework seems to intend uniformity, there are no calculations on which to base regulatory judgment. Consequently, the extent to which a board or its directors, individually, manage risk will be measured by the subjective standard of the insurer's state of domicile. As a guide to regulators the Framework describes "Five Elements of a Sound Risk Management Process", or controls an examiner might review when assessing a company's aptitude for risk management.

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The Framework places responsibility for risk management squarely on the board's shoulders. Notably, the first element of a sound risk management process is active board and senior management oversight. As described in the Framework, regulatory review of this element includes evaluation of whether the board, in conjunction with senior management:

- Identifies and has a clear understanding of the types of risk inherent in business lines and has taken appropriate steps to ensure continued awareness of any changes in the levels of risk.
- Has been actively involved in development and approval of policies to limit risks, consistent with the insurer's risk appetite.
- Is knowledgeable about the methods available to measure risks for various activities.
- Carefully evaluates all risks associated with new activities and ensures that proper infrastructure and internal controls are in place.
- Has provided adequate staffing and designated staff with appropriate credentials to supervise new activities.

The next three elements might not be measurable in specific board actions, but directors should expect regulatory review to include board influence and oversight in these areas. The second, third and fourth elements of sound risk management as described in the Framework are, respectively:

- Organizational policies, procedures, and limits that have been developed and implemented to manage business activities effectively;
- Adequate risk measurement, monitoring and management information systems to support all business activities; and
- Established internal controls and the performance of comprehensive audits to detect deficiencies in the internal control environment.

The last of the five elements of a sound risk management process is compliance with laws and regulations. Recognizing that insurers operate in a highly regulated environment, the Framework states that review of this element includes an evaluation of:

- Whether the board and senior management establish policies and processes to proactively ensure compliance.
- Periodic reporting to the board of compliance initiatives, successes and problems.

The Framework establishes a risk assessment process that is somewhat more complicated than the snapshot representing the five elements of sound risk management. However, this article focuses on board responsibilities and the five elements comprise a relatively concise statement of those responsibilities as they relate to measuring, managing and monitoring the risks associated with the insurance business.

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After the 2004 adoption of the Framework, the NAIC began drafting corresponding changes to the Examiners Handbook so that regulators could apply the risk assessment process to prospectively evaluate business and corporate practices within the financial examination.

Risk-Focused Examinations: Future Trends in Regulatory Assessment

Current regulatory assessment of directors, as carried out through annual statement reporting and the criteria applied to director activities in a financial examination, is undergoing a modernization process, evidently in response — at least in part — to national discussions on corporate governance. Directors who know and understand the current system are likely to note dramatic changes between their company's most recent examination and any future examination.

In Plenary session in December 2006, the NAIC adopted revisions to the Examiners Handbook that were being drafted during the two years that had elapsed since adoption of the Framework. Early in 2007, the NAIC published and distributed the new edition of the Examiners Handbook, which incorporates the revisions. As a next step toward adoption of the revisions as uniform standards, the NAIC Financial Regulation Standards and Accreditation (F) Committee will consider mandatory use of the 2007 Examiners Handbook in accredited jurisdictions beginning January 1, 2010. The implementation date for mandatory use coincides with that of the Model and its newly adopted standards. Unless and until use of the 2007 Examiners Handbook becomes a uniform standard, its application in any particular state is discretionary; and presumably the regulator could use the 2007 edition for examination of some companies and the 2006 edition for examination of other companies.

The concepts underlying the 2007 Examiners Handbook are not foreign to the regulatory arena; those concepts form the basis for current guidelines for the planning and examination phases under current uniform standards. However, the level of scrutiny of governance, management and the enterprise as a whole is more intense than the level heretofore applied by insurance regulators to a healthy insurer. The result is a new approach to financial examinations that is quite different from previous editions of the Examiners Handbook. Directors should gain a general understanding of the guidance to examiners, and ensure that the company is ready to respond to this new trend in financial examinations. At a minimum, directors should view a copy of the Examiners Handbook and ask company financial officers and legal counsel to explain aspects of the revisions that might change the scope of a financial examination for their particular company. Directors who wish to understand in more detail how their role will be assessed should read Exhibit M – Understanding the Corporate Governance Structure. In its six pages, the Exhibit sets forth a series of questions and key measures of good governance the examiner should apply to assess the board and to understand the company's organizational structure and assignment of authority and responsibility. In several references to the board of directors, the Examiners Handbook calls for evaluation of the appropriateness

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and effectiveness of the “tone at the top.” Even if a uniform definition could be articulated for “tone at the top,” any such evaluation most certainly would be subjective.

For boards that have delegated governance to management or otherwise have been distant from company operations, the Examiners Handbook suggests that more active oversight might be warranted. While the guidance is intended to be flexible for use with a variety of insurers, the overriding expectation for directors of all insurers seems to be that they carry out their responsibilities in a manner that is both knowledgeable and thorough.

Conclusion

This article has reviewed the uniform standards that apply to the governing board of an insurance company under the NAIC’s Accreditation Program, along with risk management and new corporate governance standards that the NAIC will incorporate into the Accreditation Program in the foreseeable future. However, the uniform standards are only part of the corporate governance equation. Each state has authority to adopt additional standards applicable to its domestic companies. A self-evaluation can be complete only if it incorporates the requirements an insurer’s state of domicile places on the board and its directors individually.

A highly defined set of responsibilities and new liabilities accompany appointment to the governing board of an insurance company. Lest the board as a whole be judged for any act or omission inconsistent with those responsibilities, each director individually should understand the entire set of responsibilities. As appropriate, board minutes or reports appended to the minutes should document compliance with uniform standards and with any state-specific standards applicable to the insurer.

Under the current system for regulatory assessment of directors, there is some exposure to subjective evaluation. However, the degree of subjectivity is limited because it exists within annual statement reporting and financial examinations, both of which view board activities retrospectively. Directors should be aware that future trends in regulatory assessment, as evidenced by the 2007 Examiners Handbook, incorporate prospective evaluation into the system. Subjectivity, a necessary component of any prospective view, can either clarify or obscure that view.

To carry out their corporate responsibilities collectively as a board, each director in an individual capacity should have a reasonably complete understanding of all aspects of the company. Directors who comprise the board’s audit committee will be held to a higher standard than other directors, commensurate with their fiduciary responsibility and the knowledge of financial matters they would be expected to bring to a board appointment.

If multiple board appointments have been an attractive sideline in the past, new responsibilities and the probability that insurance regulators will closely monitor and evaluate one’s actions as a director may make them less so in the future.

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Disability Insurance Under the ERISA Law: Economic Security or Litigation Nightmare?

Mark D. DeBofsky, J.D.*

Introduction

Insurance company statistics show that "one out of five 35-year-olds will experience a disability that lasts three months or more before age 65."[1] Working women are even more adversely affected and are deemed "three times more likely than men to miss work due to a disability related illness."[2] According to the Social Security Administration, which pays benefits to disabled individuals incapable of engaging in any work whatsoever,[3] more than 2.1 million individuals applied for Social Security disability insurance in 2005, a 4.39% increase over the prior year.[4] Thus, meeting one's economic needs in the event of disability is a major concern.

Most individuals who are covered by disability insurance receive that coverage from their employers as a benefit of their employment.[5] As such, any dispute over the benefit payment is governed by the Employee Retirement Income Security Act (ERISA).[6] Unquestionably, the ERISA law was enacted to

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1. www.massmutual.com/mmfg/service/di/whygetdi.html.
2. www.efmoody.com/insurance/disabilitystatistics.html.
3. For a definition of "disability" under the Social Security disability program, see 42 U.S.C. §423(d)(1)(A).
4. www.ssa.gov/OACT/STATS/dibStat.html.
5. *See, generally,* J. Wooten, *The Employee Retirement Income Security Act of 1974 — A Political History* (U.Cal. Press 2005).
6. 29 U.S.C. §1001 *et seq.* The ERISA law's scope extends to benefits provided for the welfare of employees, which includes disability insurance. 29 U.S.C. §1002(1). However, it does not include situations where the employer simply makes insurance coverage available for employees to purchase. *See, Johnson v. Watts Regulator Co.,* 63 F.3d 1129 (1st Cir. 1995).

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provide substantial protection to employees based on the statute's preamble, stating its intent to:

> protect … participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal Courts.[7]

Assurance that disability benefits will be available in time of need is crucial because, as one judge has recognized, "decisions whether and how to ensure that disability does not lead to poverty are obviously of great societal importance."[8] Social Security does not completely fill that role because it provides only a small portion of earnings replacement, society relies on private insurers. Yet, preemption of disability insurance claims by the ERISA law has, despite its salutary purpose, been fraught with peril as one court noted:

> There are also obvious drawbacks to relying on private insurers, however. Although the profit motive drives companies toward efficiency, it creates a substantial risk that they will cut costs by denying valid claims. The market is somewhat inapt to punish insurers for engaging in such practices, particularly if the denials are not too flagrant, because the complexity of the insurance market and the imperfect information available to consumers make it difficult to determine whether an insurer is keeping its costs down through legitimate or illegitimate means. An individual claimant who encounters an insurance company that is disposed to deny valid claims must struggle to vindicate his rights at a time when he is at his most vulnerable. Often a newly disabled person will simultaneously confront increased medical bills and either termination of employment or diminished pay.

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7. 29 U.S.C. §1001(b), quoted in *Varity Corporation v. Howe,* 116 S.Ct. 1065, 1078 (1996); *Black & Decker Disability Plan v. Nord,* 538 U.S. 822,123 S.Ct. 1965, 1970 (2003). "ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." Quoting *Firestone Tire & Rubber Co.* v. *Bruch,* 489 U.S. 101, 113, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989) (internal quotation marks and citations omitted).

8. *Radford Trust v. Unum Life Insur. Co. of America,* 321 F.Supp.2d 226, 240 (D.Mass. 2004).

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> The judiciary provides a check on these potential abuses; under ERISA, aggrieved claimants can seek redress in the courts of justice. Congress and the courts have made two decisions, however, that limit this checking effect. The first is to place limitations on judicial review of plan administrators' and fiduciaries' decisions similar to the ones placed on judicial review of governmental agency action, even though, unlike officials in governmental agencies, administrators and fiduciaries are not answerable to the public or to elected officials. Second, and perhaps more troubling, the courts have interpreted ERISA to restrict or eliminate the role of juries in deciding disputes between claimants and insurers.[9]

Another court expressed similar worry:

> *Caveat Emptor!* This case attests to a promise bought and a promise broken. The vendor of disability insurance now tells us, with some legal support furnished by the United States Supreme Court, that a woman determined disabled by the Social Security Administration because of multiple disabilities which prevent any kind of work cannot be paid on the disability insurance she purchased through her employment. The plan and insurance language did not say, but the world should take notice, that when you buy insurance like this you are purchasing an invitation to a legal ritual in which you will be perfunctorily examined by expert physicians whose objective it is to find you not disabled, you will be determined not disabled by the insurance company principally because of the opinions of the unfriendly experts, and you will be denied benefits.[10]

Judicial commentary has led to media scrutiny. The story of how a law intended to protect employee benefits has been used to shield insurers was told in the *Los Angeles Times* by Peter G. Gosselin in his article, "The Safety Net She Believed in Was Pulled Away When She Fell."[11] The *Wall Street Journal* similarly reported that the ERISA statute "has evolved into one that covers far broader territory and can have an unanticipated effect, tilting the playing field in favor of employers and serving as a legal shield for them."[12] Unfortunately, there is much to be concerned about; a law enacted for the protection of plan participants has been construed by the courts in a manner that has caused great uncertainty, if not outright harm.

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9. *Id.*

10. *Loucks v. Liberty Life Assur. Co. of Boston,* 337 F.Supp.2d 990 (W.D.Mich. 2004) (vacated following settlement).

11. *Los Angeles Times*, August 21, 2005.

12. Ellen Schultz, "A Hobbled Star Battles the NFL," *Wall Street Journal,* December 3, 2005.

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The Transformation Wrought by ERISA

Transforming "garden variety" insurance cases into ERISA claims has always been viewed with skepticism by the federal judiciary. The 7th U.S. Circuit Court of Appeals remarked in the health benefits context:

> All this is not to deny the strangeness, as an original matter, of transforming disputes between employees and insurance companies over the meaning of the insurance contract into suits under ERISA. But the Supreme Court crossed this Rubicon in Metropolitan Life Ins. Co. v. Taylor, supra, reversing Taylor v. General Motors Corp., 763 F.2d 216 (6th Cir. 1985), which had held that a suit under the group insurance policy was not a suit under the ERISA plan pursuant to which the policy had been issued. Although we find it difficult to understand why such cases should be litigated in federal court, we are unable to escape the pull exerted by the statute, the administrative regulation, and the precedents.[13]

Another judge, writing in a law review commented about the ERISA law's effect:

> Occasionally, a statute comes along that is so poorly contemplated by the draftspersons that it cannot be saved by judicial interpretation, innovation, or manipulation. It becomes a litigant's plaything and a judge's nightmare. ERISA falls into this category. In Florence Nightingale Nursing Service, Inc. v. Blue Cross and Blue Shield,[14] I started my opinion with these three sentences:
>
> > A hyperbolic wag is reputed to have said that E.R.I.S.A. stands for "Everything Ridiculous Imagined Since Adam." This court does not take so dim a view of the Employee Retirement Income Security Act of 1974. Instead, this court is willing to believe that ERISA has lurking somewhere in it a redeeming feature.[15]

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13. *Brundage-Peterson v. Compcare Health Services Ins. Corp.,* 877 F.2d 509, 512 (7th Cir. 1989).
14. 832 F. Supp. 1456 (N.D. Ala. 1993), aff'd, 41 F.2d 1476 (11th Cir. 1995).
15. *Id.* at 1457.

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> Since writing Florence Nightingale, I have changed my mind. ERISA is beyond redemption. No matter how hard the courts have tried, and they have not tried hard enough, they have not been able to elucidate ERISA in ways that will accomplish the purposes Congress claimed to have in mind. For more than ten years, I have consistently and constantly criticized ERISA, and I feel no compunction in lifting passages from my prior opinions as I write this article. I cannot plagiarize myself.[16]

Perhaps the U.S. Congress imagined the paternalistic goals of the ERISA law would protect claimants. Sadly, that has not proven to be the case at all. On October 3, 2005, the California Department of Insurance accused the world's largest disability insurer, UnumProvident Corporation of unfair claims practices. California's report was the third market conduct investigation of the UnumProvident Corporation and its subsidiaries[17] that corroborated the conclusions made in numerous court rulings finding pervasive claim abuses by affiliates of the UnumProvident Corporation.[18]

Few questions have been raised, however, about why an insurer would risk the consequences of engaging in such pervasive misconduct. The answer, perhaps, lies in the regime created by the courts' interpretation and application of the ERISA law. Insurers have become well-aware of the advantages that have been handed to them as a result of court rulings that claims brought under their policies are pre-empted[19] by the ERISA law. Although ERISA preemption ostensibly does not extend to state laws that regulate insurers, the U.S. Supreme Court has narrowly interpreted that exception to find the ERISA law insulates insurers from punitive damages and "bad faith" awards that exist in the non-ERISA context.[20] Not surprisingly, insurers have reacted to that development by seeking to expand ERISA preemption, as one insurer's internal memo shows:

> A [company] task force has recently been established to promote the identification of [disability] policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators

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16. William Acker, Jr., "Can the Courts Rescue ERISA?" 29 Cumb.L.Rev. 285, 285–86 (1999).

17. See, report of John Oxendine, Georgia Insurance Commissioner, November 30, 2000, and a multi-state market conduct investigation report (covering 49 states and the U.S. Department of Labor) issued November 18, 2004.

18. *See, Radford Trust, supra.,* 321 F.Supp.2d at 247-48 n.20 (cataloguing cases).

19. Section 514 of the ERISA statute, 29 U.S.C. §1144, preempts any state law that "relates to" an employee benefit plan.

20. *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987); *Aetna Health Inc. v. Davila,* 542 U.S. 200, 124 S.Ct. 2488 (2004).

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> may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, [a company employee] identified 12 claim situations where we settled for $7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $0.5 million.
>
> In order to take advantage of ERISA protection, we need to be diligent and thorough in determining whether a policy is covered. [While] our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action.[21]

A leading ERISA-law scholar, professor John Langbein of the Yale Law School, has taken note of this situation and has written:

> Broadly speaking, there are two plausible interpretations of the Unum/Provident scandal. Unum could be such an outlier that the saga lacks legal policy implications. On this view, a rogue insurance company behaved exceptionally badly; it got caught and sanctioned; and its fate should deter others. My reading of the events is less sanguine: … a self-interested plan decisionmaker will take advantage of its license under *Bruch* to line its own pockets by denying meritorious claims. Unum turns out to have been a clumsy villain, but in the hands of subtler operators such misbehavior is much harder to detect.[22]

Professor Langbein is entirely correct. It was not the preclusion of punitive damages alone that led to the current situation. The real transformation of insurance claims governed by the ERISA law occurred after the U.S. Supreme Court's 1989 ruling in *Firestone Tire & Rubber Co. v. Bruch*,[23] which had the effect of conferring a special status on insurers who issue policies governed by the ERISA law by giving them unparalleled authority to determine claims in their discretion. *Firestone* ruled that any benefit plan, be it funded or insured, is entitled to a standard of judicial review that gives deference to the insurer's findings so long as the plan says that benefits will be paid only if the plan

21. "Provident Internal Memorandum," titled "Re: ERISA," from Jeff McCall to IDC Management Group and Glenn Felton, October 2, 1995, Bates No. GSCONF 2893, available at www.micethatroar.com/erisa-memo.pdf.

22. Langbein, "Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA" at 12 (June 26, 2006, draft available at www.law.yale.edu/faculty/2940.asp). (Accepted for publication in *Northwestern University Law Review*.)

23. 489 U.S. 101 (1989).

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administrator determines in its discretion that the claimant is entitled to them.[24] This was a startling conclusion in light of the observation made in *Luby v. Teamsters Health, Welfare and Pension Trust Funds*,[25] where a federal court of appeals explained:

> Plan administrators are not government agencies who are frequently granted deferential review because of their acknowledged expertise. Administrators may be laypersons appointed under the plan, sometimes without any legal, accounting or other training preparing them for their responsible position, often without any expertise in or understanding of the complex problems arising under ERISA, and, as this case demonstrates, little knowledge of the rules of evidence or legal procedures to assist them in factfinding.[26]

However, *Luby* has been ignored while the discretionary powers of insurers have been expanded. The regime that has followed has been the courts' betrayal of the protections of employee benefits promised by the U.S. Congress by limiting claimants' rights and remedies, and by encouraging increasingly aggressive claims denial tactics by insurers.

Fundamental Due Process?

In addition to questions about insurers' fairness in administering claims, ERISA cases are litigated in a *sui generis* manner that departs dramatically from other forms of litigation. While some courts have characterized ERISA claims as "review proceedings," that interpretation lacks statutory support. Civil actions authorized by §502 of the Employee Retirement Income Security Act[27] are not "review proceedings" of a claim record. The U.S. Congress' authorization of a "civil action…to recover benefits due … under the terms of [a] plan"[28] should entitle claimants to a plenary court proceeding rather than a claim record review under the principles enunciated in *Chandler v. Roudebush*.[29]

In *Chandler*, the identical issue arose with respect to employees bringing civil actions to redress discrimination in federal employment pursuant to §717(c) of the Civil Rights Act.[30] While some lower courts had ruled that such actions involved a review of the record made at prior administrative proceedings, the U.S. Supreme Court overruled those decisions and held that federal employees were entitled to discovery and a trial rather than a review proceeding,

24. For more detail on this topic, read the author's article, titled "Discretionary Clauses and Insurance," which was published in the Fall 2006 issue of the JIR.
25. 944 F.2d 1176 (3d Cir. 1991).
26. 944 F.2d at 1183.
27. 29 U.S.C. §1132(a) (2006).
28. *Id.*
29. 425 U.S. 840 (1976).
30. 42 U.S.C. §2000e *et seq.*

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explaining: "Nothing in the legislative history indicates that the federal-sector "civil action" was to have this chameleon-like character, providing fragmentary de novo consideration of discrimination claims where "appropriate," ibid., and otherwise providing record review."[31] The U.S. Supreme Court added:

> In most instances, of course, where Congress intends review to be confined to the administrative record, it so indicates, either expressly or by use of a term like "substantial evidence," which has "become a term of art to describe the basis on which an administrative record is to be judged by a reviewing court." Ibid. e.g., 5 U.S.C. §706 (scope-of-review provision of Administrative Procedure Act); 12 U.S.C. §1848 (scope-of-review provision applicable to certain orders of the Board of Governors of the Federal Reserve System); 15 U.S.C. §21(c) (scope-of-review provision applicable to certain orders of the Interstate Commerce Commission, the Federal Communications Commission, the Civil Aeronautics Board, the Federal Reserve Board, and the Federal Trade Commission); 21 U.S.C. §371(f)(3) (scope-of-review provision applicable to certain orders of the Secretary of Health, Education, and Welfare).[32]

Applying *Chandler's* analysis, it is evident that nowhere in the statute itself or in the legislative history of the ERISA law is the term "substantial evidence" used; nor is there any support for a conclusion that the U.S. Congress intended that ERISA civil actions would be review proceedings.

Many courts have cited ERISA's statutory history as a rationale for deeming ERISA claims review proceedings, deriving that conclusion from a congressional report describing ERISA as providing "a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously,"[33] However, a closer examination of that quotation shows it can be traced to Senate Report 93-383 accompanying S.1179, a predecessor to the bill that eventually became the ERISA law. The draft bill afforded pension claimants the opportunity to pursue a grievance or arbitration proceeding before the U.S. Secretary of Labor; and the report refers to such a proceeding as providing "the opportunity to resolve any controversy over [ ] retirement benefits under qualified plans in an inexpensive and expeditious manner … Accordingly, the committee has decided to provide that controversies as to retirement benefits are to be heard by the Department of Labor."[34]

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31. 425 U.S. at 861.
32. 425 U.S. at 862 n.37.
33. *Perry v. Simplicity Engineering,* 900 F.2d 963, 967 (6th Cir. 1990).
34. S.Rep. 93-383, reprinted in 1974 U.S. Code Cong. and Admin. News 5000.

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That provision was dropped from the final bill, however;[35] and nowhere in the ERISA statute are there provisions limiting the manner in which the courts are to resolve civil actions brought by plan participants. On the contrary, the conference report explained that ERISA civil actions "are to be regarded as arising under the laws of the United States in similar fashion to those brought under Section 301 of the Labor-Management Relations Act of 1947."[36] According to *Textile Workers Union v. Lincoln Mills*,[37] Section 301[38] requires the federal courts to "fashion from the policy of our national labor laws" a federal common law governing the interpretation of collective bargaining agreements that includes plenary proceedings that even encompass trials before juries.[39]

Nor can any argument be made that pre-suit appeals authorized by ERISA §503[40] substitute for plenary judicial proceedings. The statutory history of that provision makes it clear that the absence of an evidentiary hearing or even an arbitral forum prior to suit mandates plenary procedures.[41] Further, the absence of an administrative hearing or discovery proceedings from the claim regulations applicable to §503,[42] while such provisions are included in relation to adjudication of other ERISA violations,[43] underscores the need for plenary proceedings for plan participants who initiate civil actions to redress benefit claim denials.

Moreover, the U.S. Supreme Court has also signaled that ERISA suits were intended to be plenary proceedings. In *Firestone,* the court explained: "Unlike the LMRA[44] [29 U.S.C. §186(c)(2) 2006], ERISA explicitly authorizes suits against fiduciaries and plan administrators to remedy statutory violations, including breaches of fiduciary duty and lack of compliance with benefit

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35. Sen. Jacob Javits, one of ERISA's main sponsors, explained that House conferees were opposed to an administrative dispute mechanism "on grounds it might be too costly to plans and a stimulant to frivolous benefit disputes, and at their insistence it was dropped in conference." 3 Legislative History of ERISA, n. 4 at 4769.

36. H.R. Conf. Rep. 93-1280, 93d Cong., 2d Sess. 327 (1974).

37. 353 U.S. 448, 456 (1957).

38. 29 U.S.C. §185.

39. See, Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry, 494 U.S. 558 (1990).

40. 29 U.S.C. §1133 (2006).

41. According to the House conference report, §1133 was included as a compromise between the original House bill, which had no such provision and the Senate bill, which provided for review and arbitration of benefit disputes. H.R.Rep.No.93-1280, 93d Cong., 2d Sess., reprinted in 1974 U.S.Code Cong. & Ad.News 5038, 5108.

42. 29 C.F.R. §2560.503-1 (2006).

43. 29 C.F.R. §§2560.502i-1, 2570.7 and 2570.11 (2006).

44. Cases such as *Beam v. Intl. Org. of Masters, Mates and Pilots,* 511 F.2d 975, 980 (2d Cir. 1975) had characterized Labor Management Relations Act of 1947 (LMRA) proceedings as seeking review of trustees' determinations after pointing out that "review in this case is not the examination of a dispute between an insurance company with a boilerplate contract on one hand and a consumer on the other." In contrast, that is exactly what occurred here; and unlike benefit trusts established under the LMRA, where both management and the employees appoint trustees, the decision-maker here was an insurance company, further supporting this court's distinction between claims under the LMRA and ERISA claims.

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plans."[45] Subsequently, the U.S. Supreme Court commented in *Rush Prudential HMO, Inc. v. Moran*,[46]

> [ERISA] requires plans to afford a beneficiary some mechanism for internal review of a benefit denial, 29 U.S.C. §1133(2), and provides a right to a subsequent judicial forum for a claim to recover benefits, §1132(a)(1)(B). Whatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of primary conduct, *not a uniformly lenient regime of reviewing benefit determinations* (citation omitted) (emphasis added).

Of at least equal importance is the U.S. Supreme Court's finding that the U.S. Congress created a civil action for plan participants with the intent that the law not result in "less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted."[47] Before ERISA, federal courts applied contract law to resolve employee benefits disputes.[48] Unquestionably, but for the ERISA law, disputes involving benefit denials issued by insurers would be resolved through plenary court proceedings.[49] Moreover, even under the common law of trusts, which underpins much of the ERISA statute according to *Firestone*, plenary proceedings were the norm prior to ERISA.[50] Thus, in the words of a commentator critical of how the ERISA law has been interpreted:

> Yet even if there were some basis for believing that the treatment of a benefit suit as an evidentiary proceeding would interfere with "prompt resolution of claims by the fiduciary," the rationale would still fail. For it to be plausible, one would have to add two premises: that "prompt resolution of claims" is something Congress intended for the protection of sponsors and fiduciaries; and that such protection of sponsors and fiduciaries is more important than protection of the

45. 489 U.S. at 110.
46. 536 U.S. 355, 385 (2002).
47. 489 U.S. at 114.
48. *See, Brief of Solicitor General as Amicus Curiae* in *Firestone*, 1987 U.S. Briefs 1054, at 5 n.7xo.
49. *See, e.g., Cox v. Washington Natl. Insur. Co.,* 520 S.W.2d 76 (Ct.App.Mo. 1974) (employer sponsored disability benefit claim accorded plenary civil procedure); *Antram v. Stuyvesant Life Insur. Co.,* 287 So.2d 837 (Ala. 1973) (same).
50. *See, e.g., Barnett v. Ross,* 333 Pa. 510, 3 A.2d 923, 925 (Pa. 1939) (in an action for breach of implied trust by fiduciary, plaintiff beneficiary may seek a bill of discovery in equity to support a claim of existence of trust and misconduct of alleged trustee); *Phelps Dodge Corp. v. Brown,* 112 Ariz. 179, 540 P.2d 651 (1975) (jury trial conducted); *Matthews v. Swift & Co.,* 465 F.2d 814 (5th Cir. 1972) (plenary bench trial of pension and disability claim despite arbitrary and capricious standard of review).

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> participants' right to receive benefits due. Merely to state these premises is to reveal their untenability.[51]

Even if one accepts the premise of allowing a deferential standard of review to apply to claim adjudications, courts should not blur the distinction between a plenary proceeding and a *de novo* standard of court review. Even under an arbitrary and capricious standard of review, a court must examine in the first instance whether the decision-maker "entirely failed to consider an important aspect of the problem [or] offered an explanation for its decision that runs counter to the evidence."[52] Another expression of the content of a review under an arbitrary and capricious standard suggests that such an examination, while deferential:

> inherently includes some review of the quality and quantity of the medical evidence and the opinions on both sides of the issues. Otherwise, courts would be rendered to nothing more than rubber stamps for any plan administrator's decision as long as the plan was able to find a single piece of evidence — no matter how obscure or untrustworthy — to support a denial of a claim for ERISA benefits.[53]

Consequently, a showing of whether a plan administrator's determination is arbitrary and capricious requires that the claimant be afforded the same tools as any other litigant bringing a civil action in the district court. Rule 1 of the Federal Rules of Civil Procedure mandates applicability of the rules to all civil actions other than those enumerated in Rule 81, with no exception made for ERISA cases. Indeed, in *New Hampshire Fire Ins. Co. v. Scanlon,*[54] the U.S. Supreme Court explained the presumption against summary proceedings in any claim governed by the Federal Rules of Civil Procedure:

> Summary trial of controversies over property and property rights is the exception in our method of administering justice. Supplementing the constitutional, statutory, and common-law requirements for the adjudication of cases or controversies, the Federal Rules of Civil Procedure provide the normal course for beginning, conducting, and determining controversies. Rule 1 directs that the Civil Rules shall govern all suits of a civil nature, with certain exceptions stated in Rule 81 none of which is relevant here. Rule 2 directs that "There shall be one form of action to be known as 'civil action.'"

51. Jay Conison, "Suits for Benefits under ERISA," 54 U.Pitt.L.Rev. 1, 57-60 (1992).

52. *Motor Vehicle Mfr. Ass'n v. State Farm Mutual Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

53. *McDonald v. Western-Southern Life Ins. Co.,* 347 F.3d 161, 172-173 (6th Cir. 2003) (citation omitted).

54. 362 U.S. 404, 406 (1960).

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By imposing a lenient regime of claim review, outside of the scope of the normal rules of procedure, claimants are denied a fair consideration of their claims by the court. As professor Langbein remarks:

> Deciding a case on the merits is indeed more time-consuming than presuming the correctness of somebody else's self-serving decision. Because, however, Congress determined to subject ERISA-plan denials to federal judicial review, and because ERISA's draconian preemption provision suppresses the state law causes of action that existed for many such cases before ERISA, the proper role of the federal courts is to decide these cases fairly and not slough them off onto biased decisionmakers.[55]

Thus, the courts need to more carefully examine the regime they have created.

The Value of Discovery

The only feasible way to ensure fairness in ERISA claim disputes is if the right to take discovery is preserved. Because courts are being called upon, even under an arbitrary and capricious standard of review, to assess the quality of the evidence presented, the only means by which the courts can be assured the evidence presented is scientifically and clinically valid and free from bias is through discovery. For precisely that reason, in *Calvert v. Firstar Finance, Inc.*,[56] the 6th U.S. Circuit Court of Appeals noted concern about consultants hired by insurers to review claims: "As the plan administrator, Liberty had a clear incentive to contract with individuals who were inclined to find in its favor that Calvert was not entitled to continued LTD benefits."[57] Consequently, the 6th Circuit made it clear that discovery would provide "a better feel for the weight to accord this conflict of interest." 409 F.3d at 293 n.2. The court was referring to the insurer's conflicting roles as plan administrator and benefit payor.

55. Langbein, Trust Law, *supra.* at 34–35.

56. 409 F.3d 286 (6th Cir. 2005).

57. 409 F.3d at 292. The U.S. Supreme Court also commented in *Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 832 (2003) that "physicians repeatedly retained by benefits plans may have an incentive to make a finding of 'not disabled' in order to save their employers['] money and preserve their own consulting arrangements." (citation omitted).

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The majority of federal courts approve of discovery aimed at uncovering potential bias.[58] However, the 7th Circuit has remained adamant in denying claimants the opportunity to take any discovery whatsoever. Most recently, in *Semien v. Life Insurance Co. of North America*,[59] the court reiterated a general prohibition against discovery, allowing discovery only if the insured could first produce credible evidence justifying discovery. However, the court's reasoning is circular because it is usually impossible to present such evidence without first conducting discovery. Without discovery, an insured is left with no means of proving bias or establishing the insurer's decision was arbitrary and capricious. Indeed, discovery fulfills professor John Henry Wigmore's assertion that cross-examination is "beyond any doubt the greatest legal engine ever invented for the discovery of truth."[60]

Where discovery has been allowed in ERISA cases, the results have been enlightening. For example, in *Bedrick v. Travelers Insur. Co.*,[61] depositions of the insurer's consultants taken by the plaintiff in a claim challenging a health insurer's denial of physical, speech and occupational therapy to a child suffering from cerebral palsy showed bias and a lack of adequate expertise. *Miller v. United Welfare Fund*[62] also relied on deposition testimony of a disability benefit plan administrator to find that none of the decision-makers involved in denying a claimant's request for benefits understood the medical information in the claimant's file, thus leading to a conclusion that the benefit determination was arbitrary and capricious. Thus, as *Nagele v. Electronic Data Sys. Corp.*[63] observed:

> as the arbitrary and capricious standard requires courts to scrutinize, although deferentially, decisions by plan fiduciaries for lack of reasonableness, including the absence of substantial evidence, such deficiencies in the administrative review function can be significantly illuminated through the reasonable exercise of standard discovery devices available in federal civil practice.[64]

58. For example, the 1st Circuit allows discovery relating to corruption in the claim review process. *Liston v. Unum Corp. Officer Severance Plan,* 330 F.3d 19 (1st Cir. 2003). Conflict of interest discovery is also permitted in the 2nd Circuit (*Zervos v. Verizon N.Y., Inc.,* 252 F.3d 163 (2d Cir. 2001)); the 3rd Circuit (*Pinto v. Reliance Standard Life Insur.Co.,* 214 F.3d 377 (3d Cir. 2000)); the 5th Circuit (*Kergosien v. Ocean Energy, Inc.*, 390 F.3d 346, 356 (5th Cir. 2004) ("There is no practical way for the extent of the administrator's conflict of interest to be determined without the arbitrator going beyond the record of the administrator.")); the 8th Circuit (*Farley v. Arkansas Blue Cross & Blue Shield,* 147 F.3d 774 (8th Cir. 1998)); the 9th Circuit (*Tremain v. Bell Industries,* 196 F.3d 970 (9th Cir. 1999)); and the 11th Circuit (*Moon v. American Home Assur.Co.,* 888 F.2d 86 (11th Cir. 1989)).

59. 436 F.3d 805 (7th Cir. 2006).

60. 5 J. Wigmore, Evidence §1367, p. 32 (J. Chadbourn rev. 1974).

61. 93 F.3d 149 (4th Cir. 1996).

62. 72 F.3d 1066, 1072 (2d Cir. 1995).

63. 193 F.R.D. 94 (W.D.N.Y. 2000).

64. 193 F.R.D. at 104.

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Therefore, because the arbitrary and capricious standard of review is made more meaningful, rather than diminished, by allowing discovery, the disallowance of discovery appears unfounded.

The Misapplication of Administrative Law

It is hard to understand how the courts have created their unique adjudicative procedures for ERISA claims. The only possible answer is that rather than applying the framework established by the Federal Rules of Civil Procedure for the adjudication of civil actions, the courts have transformed the ERISA law into a quasi-administrative law devoid of the protections that comprise a fair administrative hearing.[65] Instead of recognizing insurers' conflicts, courts have analogized insurance companies' claim processes to the equivalent of a judge presiding over a trial. However, that model has been rejected. *Gaither v. Aetna Life Ins. Co.*[66] relied on an earlier ruling, *Gilbertson v. Allied Signal, Inc.*,[67] in rejecting a judicial model of claim administration in a disability benefit case governed by the ERISA law:

> Aetna's position seems to be that as a plan fiduciary, it plays a role like that of a judge in a purely adversarial proceeding, where the parties bear almost all of the responsibility for compiling the record, and the judge bears little or no responsibility to seek clarification when the evidence suggests the possibility of a legitimate claim. The authority just cited suggests that Aetna has the wrong model. Indeed, one purpose of ERISA was "to provide a nonadversarial method of claims settlement" (citation omitted). In *Gilbertson v. Allied Signal, Inc.,* we explained what this nonadversarial process should look like:
>
> > [ERISA and its implementing regulations require] a meaningful dialogue between ERISA plan administrators and their beneficiaries. If benefits are denied . . . the reason for the denial must be stated in reasonably clear language, . . . [and] if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it. There is nothing extraordinary about this: it's how civilized people communicate with each other regarding important matters.
> >
> > 328 F.3d 625, 635 (10th Cir. 2003) (emphasis added) (citation omitted).

65. *See, generally,* DeBofsky, "The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims," 37 *John Marshall Law Review* 727 (2004).

66. 394 F.3d 792 (10th Cir. 2004).

67. 328 F.3d 625 (10th Cir. 2003).

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> While a fiduciary has a duty to protect the plan's assets against spurious claims, it also has a duty to see that those entitled to benefits receive them. It must consider the interests of deserving beneficiaries as it would its own. An ERISA fiduciary presented with a claim that a little more evidence may prove valid should seek to get to the truth of the matter.[68]

Indeed, the reason *Gaither* rejected the analogy between ERISA plan administrators and federal judges is that a self-interested insurer lacks the judiciary's independence. Surely, any judge asked to decide a dispute where the judge's personal physician was a crucial witness would recuse.[69] Paradoxically, however, many courts find no impropriety in insurers' reliance on their employee-physicians' opinions rather than independent reviews or examinations.

Nor are disability benefit claims adjudicated under the ERISA law comparable, as some courts apparently believe, to Social Security benefit disputes. Unlike the "Social Security Administration [which] is a public agency that denies benefits only after giving the applicant an opportunity for a full adjudicative hearing before a judicial officer, the administrative law judge,"[70] insurers are private entities who are under no statutory duties to conduct hearings before neutral decision-makers. Hence, in comparing claim decisions made by insurers in disability benefit cases to Social Security benefit determinations, the courts need to question why they have given private insurers more authority and why there is less penetrating review of insurers' claim determinations than an administrative agency receives.

Further, without giving the plaintiff the opportunity to cross-examine the insurer's consultants, the Court of Appeals' conclusion in *Semien*[71] that the reviewing doctors' opinions "demonstrate a thorough consideration of the available information"[72] has no evidentiary support. Acceptance of the consultants' reports as substantial evidence without the plaintiff being given the opportunity to cross-examine the witnesses would even run afoul of administrative procedures. Based on the U.S. Supreme Court's seminal ruling on due process in *administrative law* claims, *Richardson v. Perales*,[73] a case involving Social Security disability benefits, non-examining consultants' reports are insufficient. In *Perales*, the court ruled an *examining* physician's report may constitute substantial evidence in an administrative proceeding only when nine separately enumerated assurances of trustworthiness were met.[74] None of those

68. 394 F.3d at 807-808 (10th Cir. 2004).

69. According to 28 U.S.C. §455(a), "[a]ny justice, judge, or magistrate judge of the United States shall disqualify himself in any proceeding in which his impartiality might reasonably be questioned." The goal of 28 U.S.C. §455(a) is to "avoid even the appearance of partiality." *Liljeberg v. Health Servs. Acquisition Corp.,* 486 U.S. 847, 860 (1988).

70. *Herzberger v. Standard Insur. Co.,* 205 F.3d 327, 332 (7th Cir. 2000).

71. *Supra,* note 88.

72. 436 F.3d at 812.

73. 402 U.S. 389 (1971).

74. 402 U.S. at 402-406.

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protections, which include the tribunal's acceptance of reports only if prepared by percipient witnesses who had personally conducted a clinical, scientifically valid medical examination, and only when the claimant retained the opportunity to cross-examine the authors of the reports, are present in ERISA cases. Nor are pre-suit appeals in ERISA claims, which are decided by the insurance company that has already denied benefits, adjudicated by a body possessing the same neutrality and objectivity as an administrative agency, or even by an arbitrator.[75]

Accordingly, ERISA benefit adjudications performed by insurance companies are fundamentally different from Social Security disability claims because "the agency operates essentially, and is intended so to do, as an adjudicator and not as an advocate or adversary."[76] Despite such marked differences, as one federal appellate judge pointed out in a dissenting opinion, claimants in ERISA benefit disputes are "effectively precluded as a matter of law any procedural challenge to an ERISA plan administrator's decisions, thereby giving those decisions a uniquely privileged position in the entire field of administrative or quasiadministrative law."[77] Consequently, some courts have begun to recognize that the inaptness of drawing an analogy between Social Security claims and disability insurance cases and have cautioned against importing "administrative agency concepts into the review of ERISA fiduciary decisions."[78]

The U.S. Supreme Court has also weighed in on evidentiary considerations in ERISA claims. In *Black & Decker Disability Plan v. Nord*,[79] the court ruled that while an ERISA plan administrator need not give special deference to the opinions of treating doctors in disability benefit disputes, plan administrators must still base their findings on "reliable evidence."[80] However, that begs the question of what constitutes reliable evidence. Courts have been crediting the opinions of non-examining medical consultants without giving claimants the opportunity to cross-examine those consultants for evidence relating to potential bias, insufficient expertise or disregard of relevant evidence. Therefore, in order to assess whether the plan administrator's evidence is "reliable," as *Nord* requires, claimants must have the opportunity to conduct appropriate discovery and be accorded a plenary hearing.

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75. *See,* H. Friendly, "Some Kind of Hearing," 123 U. Pa. L. Rev. 1267, 1279-95 (1975) in which the author identified the necessary characteristics of a fair administrative hearing: 1) an unbiased tribunal; 2) notice of the proposed action and the grounds asserted for it; 3) an opportunity to present reasons why the proposed action should not be taken; 4) the right to call witnesses, including the right to cross-examine adverse witnesses; 5) the right to know the evidence at issue; 6) the right to have a decision based on the evidentiary record; 7) the right to counsel; 8) a record; 9) articulated reasons for the decision; 10) public attendance; and 11) judicial review. Most of these factors are completely absent from ERISA claims.

76. *Perales,* 402 U.S. at 403.

77. *Perlman v. Swiss Bank Corp.,* 195 F.3d 975, 983 (7th Cir. 1999) (Wood, J., dissenting).

78. *Brown v. Blue Cross & Blue Shield of Alabama, Inc.,* 898 F.2d 1556, 1564 n. 7 (quoting *Van Boxel*) (11th Cir. 1990).

79. 538 U.S. 822 (2003).

80. 538 U.S. at 834.

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In all other federal civil litigation, the Federal Rules of Civil Procedure and Federal Rules of Evidence guard against inadmissible evidence. On summary judgment proceedings, Rule 56 of the Federal Rules of Civil Procedure and Federal Rule of Evidence 802 prohibit consideration of hearsay evidence; and Federal Rule of Evidence 702 precludes consideration of expert opinions unless the scientific reliability of such opinions has been established as a threshold matter. Absent admissible evidence, it is inappropriate for courts to avoid trials and to enter a summary judgment.[81] Lacking any evidentiary proceeding, courts have no means of assessing whether the evidence on which the plan denial was based is admissible or even "reliable."

In a context comparable to ERISA claims, in *Gehin v. Wisconsin Group Insurance Bd.,*[82] the Wisconsin Supreme Court held that hearsay medical reports may not sustain a denial of disability benefits — even in an administrative agency setting — because:

> The harm to claimants in having their income continuation insurance benefits terminated on the basis of controverted written hearsay medical reports, without an opportunity to cross-examine the authors of those reports exceeds the burden on the Group Insurance Board to call a witness to corroborate those hearsay medical reports.[83]

Gehin relied heavily on *Richardson v. Perales* in finding administrative hearings that denied the claimant the right to cross-examine the authors of adverse medical reports lacked sufficient due process guarantees. The court also cited a Mississippi Supreme Court ruling that held:

> It is quite likely that the bench and bar would be scandalized if this Court should approve the receiving in evidence of ex parte, unsworn statements of persons other than doctors, even in Workmen's Compensation cases.
>
> While doctors occupy an important role in our scheme of things, they are, after all, merely human, and may not be considered wholly free from the frailties that beset the rest of us. There is nothing, therefore, in the fact that a witness may be a member of the medical profession that reasonably may be said to justify his exemption from the requirements and restriction which would apply to others giving testimony in an adversary proceeding. The admission of the reports constitutes reversible error.[84]

Gehin teaches an important lesson that has yet to be learned in ERISA disputes.

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81. Fed.R.Civ.P. 56(e).

82. 278 Wis.2d 111, 692 N.W.2d 572 (Wis. 2005).

83. 692 N.W. at at 590.

84. 692 N.W.2d at 589 (citing *Georgia-Pacific Corp. v. McLaurin,* 370 So.2d 1359, 1362 (Miss. 1979)).

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Potential Solutions

Given the huge economic disparity between consumers and insurers, the law of insurance bad faith developed to force insurers to apply fair and reasonable claims practices or face lawsuits seeking punitive damages. Similar standards ostensibly exist under the ERISA law that place an obligation on insurers and other plan administrators to act exclusively in the interest of plan participants and their beneficiaries for the purpose of paying benefits.[85] However, that provision was substantially weakened by a U.S. Court of Appeals ruling that found the ERISA law imposes no obligation for the fiduciary to place its "thumb on the scale in the participant's favor."[86] Although that finding might have been appropriate in the *Wallace* case because even the claimant's treating physician refused to certify ongoing disability, without a mechanism to enforce ERISA's fiduciary obligations, as the multi-state and California regulators learned, the tendency is to deny claims that would likely have been payable had appropriate claim practices been applied. Nor is this a new phenomenon. Several years ago, a federal district judge in California observed in a disability benefit case:

> [T]he facts of this case are so disturbing that they call into question the merit of the expansive scope of ERISA preemption. UNUM's unscrupulous conduct in this action may be closer to the norm of insurance company practice than the Court has previously suspected. This case reveals that for benefit plans funded and administered by insurance companies, there is no practical or legal deterrent to unscrupulous claims practices. Absent such deterrents, the bad faith denial of large claims, as a strategy for settling them for substantially less than the amount owed, may well become a common practice of insurance companies.
>
> Consequently, ERISA may need to provide a greater deterrent to bad faith conduct in the administration of ERISA plans. The Court continues to believe that providing for punitive, "bad faith," or compensatory damages beyond the amount of the claimed damages would adversely disturb the balance struck by ERISA. However, for the first time, it believes that at least in the case of insurance-funded and administered plans the public interest would be advanced if ERISA contained a statutory penalty which could be imposed by the Court in extraordinary cases.[87]

85. 29 U.S.C. §1104(a)(1) (2005).

86. *Wallace v. Reliance Standard Life Insur. Co.,* 318 F.3d 723, 724 (7th Cir. 2003).

87. *Dishman v. Unum Life Insur.Co. of America,* 1997 WL 906147 *11 (C.D. Cal. 5/9/1997).

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To be sure, no one is suggesting that insurers should pay non-meritorious claims. However, it is apparent that insurance companies have not been meeting their responsibility to compensate deserving policyholders and the courts have inadequately policed the insurers' conduct.

Ultimately, the goal for both insurers and claimants is that meritorious claims receive compensation. The impact of the ERISA law on disability benefits has made that goal much harder for claimants to reach, however. It is evident that there needs to be a reassessment by the U.S. Congress, the courts and the U.S. Department of Labor (the agency that oversees the administration of the ERISA law) as to whether the law is meeting its purpose and what can be done to remedy the situation. Disability benefits are too important to entrust to resolution by private insurers whose findings receive greater deference than that accorded to government agencies and judges. Instead of creating incentives leading to claim denials, insurers must be motivated to give more careful and fairer consideration to disability benefit claims.

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Lessons from the Texas Homeowners Insurance Crisis*

Robert Puelz, Ph.D.**

Abstract

In this paper, the recent crisis in the Texas homeowners insurance market is examined by focusing on three questions. First, how did the dual regulatory system influence insurer behavior? Second, which perils were important in driving the increase in prices observed during the time period of this study? Third, were other non-expected loss factors related to premiums leaving consumers in the potential position of misunderstanding why overall price increases were arising? The findings reported indicate that the market shifted to entities that were not subject to rate regulation and that, among perils, water losses were most important in their association with price levels. In addition, prior period losses and unexpected loss deviations were statistically related to current prices likely exacerbating consumer misunderstanding about why they were experiencing increases in their premiums. An implication from this crisis for regulatory authorities is that quick understanding then communication is crucial to ameliorating market disruption.

I. Introduction

Whenever insurance markets show stress there is an opportunity for researchers to reflect on evident consumer anger, managerial reactions and regulatory responses. Indeed, when the insurance environment is in a condition that brings political and economic stakeholders to a common table, an experiment is created that permits exploration of a) why the problem was created; and b) the thornier issue of how the problem can be interpreted so

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differently across stakeholders. The recent crisis in the Texas homeowners insurance market provided such a case. Consumers became frustrated over prices and benefits, insurer management was challenged to find profitability in the homeowners line and regulators carried the burden of weighing protecting the people versus ensuring insurance companies' solvency and ample supply. Questions remain about which factors caused upward price pressure and the role, if any, of a dual regulatory system of regulated and non-regulated rates that was in existence during the time of this crisis.

The theoretical approach taken in this paper is grounded in the regulatory policy work of Meier (1991, 1998) whose thesis, when applied to insurance, suggests that regulatory policy changes depend on the competence and expertise of the insurance department vis-à-vis insurance consumer interest groups, insurer interest groups and the "political elites." [1] Two challenges confronted by stakeholders in the Texas homeowners insurance crisis were product complexity and the differing consumer perceptions of the costs and benefits under the contract, further widening misunderstandings and challenging regulatory policy-making. For example, consider the scenario of an insurance customer who received substantial premium increases even though the customer never filed a claim. Often, such customers discount the anxiety reduction benefit of insurance and focus on the relationship between their rising price and self-perceived risk, even if that perception is not well informed, a phenomenon that Svenson (1981) has documented in the auto insurance market. When additional price increases occur unexpectedly, consumer discontent is taken to a higher level.

The practical objectives of this research are to shed light on a) whether particular perils were predominate in their effect on homeowners insurance prices; b) the extent to which observable prices embody information beyond expected losses that include deviations and other elements not easily understand by consumers; and c) the extent to which insurers and their customers were being switched to non-regulated carriers, or at least away from regulated carriers. As will be discussed, this research provides an analysis of the peril-specific relationship of changes in homeowners premiums and includes measuring the relationship between loss lags and other uncertainty deviations that may be difficult for consumers to understand, thereby giving policymakers insight into the negative consumer sentiment during this crisis. Evidence offered herein shows water losses stood out in their impact on premiums and that a lagged loss history and a factor for unexpected deviations were statistically significant in their association with premiums in the Texas homeowners insurance market.

The balance of this study proceeds as follows. In Part II, a brief background into the Texas political and insurance climate during the recent homeowners insurance crisis is considered, along with a market analysis of the dual regulatory system that existed during the time. In Part III, a preliminary analysis of insurance company performance in the Texas homeowners market for regulated and non-regulated entities is contrasted with California and Illinois with company-level data to address whether homeowners insurance costs have

1. See Licari (1998) for a general discussion of the framework of regulatory policy.

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been rising for insurers. These states were chosen, in part, because a) they have experienced changes to insurance regulation; b) their size; and c) the availability of data that permits a contrast to Texas. In Part IV, a more rigorous empirical analysis is outlined and a panel data set is discussed. The data, supplied by the Texas Department of Insurance, range across the years 1996 through 2001. In this section, groundwork is developed to assess particular perils that are predominate in their effect on homeowners insurance prices and the extent to which observable prices embody information beyond expected losses. Part V sets out the findings of the testing and Part VI contains concluding observations.

II. Background

The Texas insurance environment is well populated (22 million people) and has displayed the attributes of substantial changes in insurance prices while maintaining *both* a regulated and a deregulated environment for the same coverage. The crisis analyzed in this paper had implications beyond the insurance market to the real estate market and the interest of lenders.[2] Moreover, insurers asserted that water-associated mold claims were at the heart of the problem, contending that the "policy never was intended to cover mold claims" and should not be treated as a dynamic contract subject to coverage interpretation over time.[3] On September 24, 2002, the structure of the Texas homeowners insurance market appeared tenuous when Farmers, the second-largest writer of homeowners contracts, announced their intention to cease writing or renewing homeowners insurance contracts in Texas. During this time frame, Green (2002) noted that consumer complaints about excessive rates in Texas rose 3,000% between the second quarter of 2001 and the second quarter of 2002, putting politicians on notice by their constituencies.

2. The Texas insurance problem has received the focus of the Real Estate Center at Texas A&M University (http://recenter.tamu.edu/tgrande/vol9-2/1556.html), which discusses home affordability when insurance prices are increasing. The breadth of Texas insurance markets is included in the insurance commissioner's annual report. At www.tdi.state.tx.us, one may find annual reports over the past few years and is a good source of information on a variety of insurance market elements, including specific insurers and the percentage of the homeowners market they hold. Additional author's note: Links to Web sites reported in this paper might no longer exist in precisely the same syntax. Readers should contact the site owner or the link's author to locate the information referenced herein.

3. Hartwig (2002) presents the mold coverage issue, www.iii.org/media/hottopics/insurance/mold2. While the "mold exclusion" in homeowners policies is common across states, the interpretation of a water loss differentiates Texas from other states. As discussed by Hartwig (2002) in "Mold and Homeowners Insurance," Texas policies "have historically covered damage arising from the continuous and repeated seepage of water. In virtually all other states, water damage — the most common cause of loss in homes — is covered only if it is of a sudden and accidental nature."

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Noteworthy to the debate was the observation that Texas law permitted a dual regulatory system, opening a path for insurers to sell contracts through non-rate regulated entities. In 1991, Texas moved to a +/- 30% benchmark flex-rate system for property insurance rates but left a loophole in the law that exempted Lloyd's entities from this rating law, effectively omitting them from the benchmark system.[4] State law clearly offered an incentive to insurers to switch blocks of policyholders to non-rate regulated underwriters or for customers to switch from a regulated insurer to a non-rate regulated insurer that might be in a different insurer group. Table 1 suggests a migration took place to a market where prices were not regulated.[5] Media and subsequent political reactions linked deregulation and rising prices, implying that insured homeowners were being charged rates that were not justified.[6]

Table 1
Texas Homeowners Premiums Written

	Proportion of Premiums in Regulated Insurers	**Proportion of Premiums in Non-Rate Regulated Insurers**
1996	29.98%	70.02%
1997	21.83%	78.17%
1998	15.43%	84.57%
1999	11.34%	88.66%
2000	9.24%	90.76%
2001	5.42%	94.58%

Source: Texas Department of Insurance. Data were assembled from a 2006 request to the TDI for market information that reflected premiums written for insurer groups by entity type.

4. According to the Texas Department of Insurance, "Farm Mutual, County Mutual, Lloyd's and Reciprocal Insurers are exempt from insurance laws unless specifically stated in its Chapter or unless the specific law actually names the type of company in the article." For example, A Lloyd's company exemption may be found in the Texas Insurance Code, www.tdi.state.tx.us/commish/code.html. For discussion about this issue, see the research report prepared by the House Research Organization of the Texas House of Representatives, www.capitol.state.tx.us/hrofr/interim/int77-1.pdf, in which it is discussed that Lloyd's companies were originally exempt from the 1991 benchmark pricing system because "they comprised only 20% of the market and generally covered specialty risks at rates lower than the standard rates."

5. Another important phenomenon might have also occurred that led to the movement by insurers to use an unregulated entity to insure customers. That is, Lloyd's rates may have been lower for consumers than the regulated rates, which gave an opportunity to agents to increase agency market share. This would be encouraging anecdotal evidence of competitive activity in this market.

6. By contrast, Brough (2001) and Harrington (2000) have argued that insurance consumers are best served by competition and deregulation. Moreover, as noted by a referee, the intention of opening a deregulated market might have been for it to serve in place of a Fair Access to Insurance Requirements (FAIR) plan residual market alternative.

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To explore the movement further, Table 2 details the results among the 10 leading insurer group writers of homeowners policies over this same period. Moving vertically down is the descending rank of insurer groups by the overall quantity of premiums written over the 1996 to 2001 period. The data utilized in assembling Table 2 was first examined by taking the total quantity of premiums written by an insurer group in a given year and seeing how the quantity was allocated between an insurer group's non-regulated and regulated entities. In Table 2, the focus is solely on the percentage of an insurer group's business attributed to non-rate regulated sales. Focusing on the "big three" — State Farm, Farmers and Allstate — it is clear that an increasing proportion of their premiums were being allocated to the non-rate regulated sector. With the exception of USAA, the data in Table 2 reveal that if an insurer group was not selling fully via a non-rate regulated entity in 1996 that it was doing so by 2001.[7]

Table 2
Proportion of Non-Rate Regulated Group Business

	1996	**1997**	**1998**	**1999**	**2000**	**2001**
State Farm	73.56%	90.13%	99.29%	99.17%	99.19%	99.16%
Farmers	85.95%	87.80%	90.03%	92.19%	94.44%	96.13%
Allstate	72.97%	76.81%	81.09%	82.93%	85.62%	93.42%
USAA	71.36%	69.38%	67.35%	65.59%	62.36%	74.38%
Travelers	42.05%	44.62%	60.55%	94.54%	94.39%	96.35%
Nationwide	84.50%	86.56%	88.57%	89.58%	94.92%	97.6%
Safeco	69.84%	79.96%	81.65%	99.64%	100.00%	100.00%
Chubb	100.00%	100.00%	99.96%	99.90%	99.86%	99.90%
Texas Farm Bureau	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Consolidated	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Source: Texas Department of Insurance. Data were assembled from a 2006 request to the TDI for market information that reflected premiums written for insurer groups by entity type.

7. The data in Tables 1 and 2 were received under a 2006 data request from the Texas Department of Insurance. Proportions in non-rate regulated entities vary only slightly from the data used to assemble Figure 1 and Table 3, which were originally compiled in 2002 under a different data request.

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III. Preliminary Analysis: Comparing California, Illinois and Texas

To put the Texas dual regulatory results in broader context, we begin by comparing the Texas experience to California and Illinois during a similar time period because this permits a view into three of the five largest states that have contrasting regulatory dynamics and general data that were available.[8] The data are taken from annual report information filed by insurers with the NAIC, and were sourced for this study from state-assembled datasets. Statutory page 14 of the annual report is a premium and expense exhibit that focuses on premiums, losses and expenses attributable by line of insurance and by state. The analysis considers all insurance entities that sold homeowners insurance in Texas from 1996 through 2001. It includes insurers that wrote policies in both price-unregulated companies and price-regulated companies. Thus, not only is it of interest to examine whether insurers have experienced rising costs, but also were the non-regulated companies, where prices are unconstrained by regulatory mandate, more profitable for insurers?

Figure 1 and Table 3 depict loss ratio experience for homeowners contracts in the California, Illinois and Texas markets. While the risk attributes of an insured home in one state are difficult to contrast with an insured home in another state, the proportion of losses to premiums is comparable, particularly with regard to managerial sensitivity about the relative profitability of these markets. From 1996 through 2001, the California experience in the homeowners market was relatively stable, with a loss ratio fluctuating from a low of 0.48 in 1997 to a high of 0.64 in 2001. The Illinois experience was somewhat "u-shaped" with a relatively high loss ratio in 1996 (0.93), stability in 1997 through 1999, followed by a upward movement to a high of 1.08 in 2001. By contrast, the Texas experience over these years reveals a trend similar to Illinois but different from California, highlighted by the years where insurers had a loss ratio of 0.84 in 2000 and 1.18 in 2001; a losing business segment for the industry as a whole even before taking company expenses into account.[9]

8. See D'Arcy (2002) for a discussion of the Illinois deregulation experience. The California data came from www.insurance.ca.gov/RRD/RSU/MktShr2001/MktShr2001.htm and the Illinois data came from www.ins.state.il.us, where in the latter the loss ratios for 1997 and 1998 are approximated from Figure 11 in this annual report. Texas data came originally from www.tdi.state.tx.us/general/forms/tdirpts.html. All data sets were originally assembled in 2002. Loss ratios do not consider other factors that positively affect an insurer's profitability, such as investment income and capital gains, yet it is a ratio widely considered by insurance management and regulatory overseers.

9. Statistical tests for differences between California and Texas loss ratios were significant at only the 0.08 level; however, the differences between Illinois and California, and Illinois and the Texas entities were statistically significant at the 0.01 level. The near-term trend in these results appears to be consistent with the widespread concern over profitability by insurance executives, which is highlighted in the October 2002 presentation, "What's Keeping CEOs Awake at Night?" by Robert P. Hartwig, www.iii.org/media/industry/outlooks/unitedstates.

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Figure 1

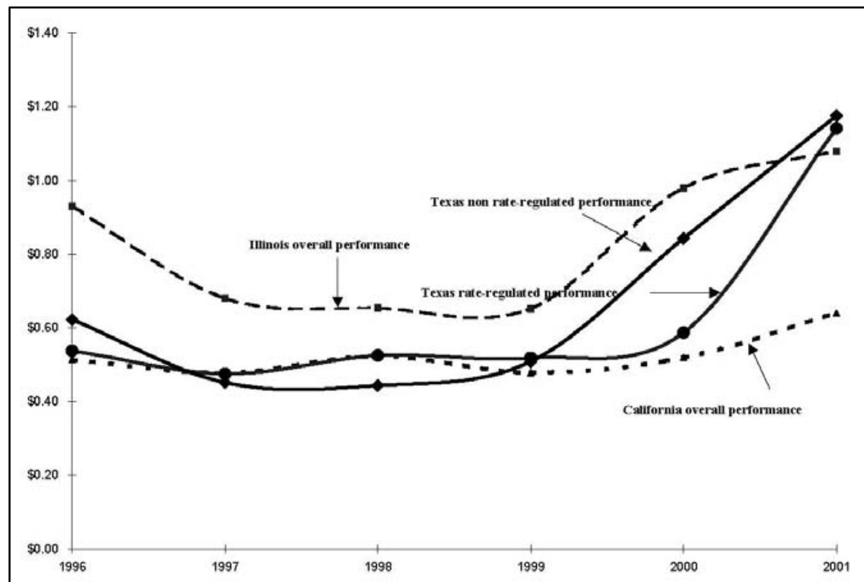

Table 3
Homeowners Market — Loss Ratio

	California Overall	Illinois Overall	Texas Overall	Texas Rate-Regulated Insurers	Texas Non-Rate Regulated Insurers
1996	$0.51	$0.93	$0.60	$0.54	$0.62
1997	$0.48	$0.68	$0.46	$0.47	$0.45
1998	$0.52	$0.65	$0.46	$0.53	$0.44
1999	$0.48	$0.65	$0.51	$0.52	$0.51
2000	$0.52	$0.98	$0.84	$0.59	$0.84
2001	$0.64	$1.08	$1.17	$1.14	$1.18

Source: Texas Department of Insurance. Loss ratio reported excludes consideration of loss adjustment expenses incurred.

Further, in Figure 1, it is of interest to note that insurer profitability in a deregulated environment such as Illinois is worse than the regulated Texas and California counterparts. While it may be the case that the deregulated market was composed of a higher-risk profile and pricing that did not anticipate this profile, another view of the Illinois experience is that consumers were benefiting because of the closer relationship between premiums and losses. That is, taking the view that losses arise as random events, then the premium cushion in Illinois was small relative to the Texas and California experiences from 1996 through 2000, suggesting this deregulated insurance market was prone to reasonable pricing.

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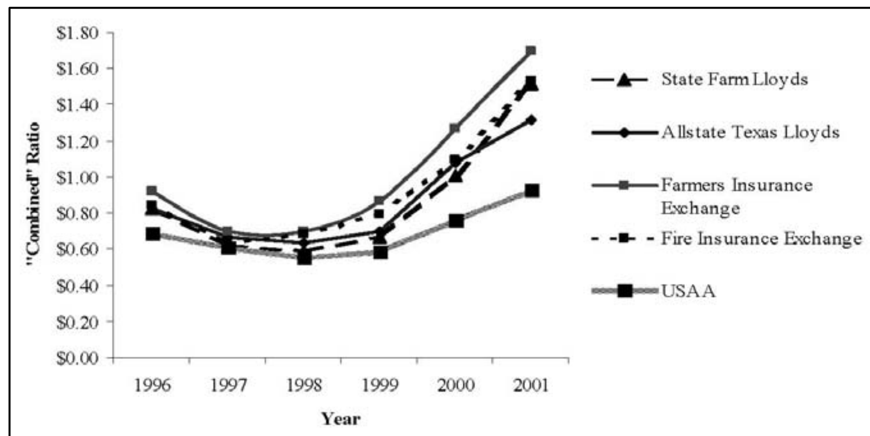
IV. Texas Homeowners Experience

Interstate comparisons aside, closer exploration within Texas also yields interesting findings. Recall from Table 1 that the predominant insuring intermediary for the Texas homeowners market was the non-rate regulated entity; hence, overall industry profitability in the homeowners market is heavily weighted toward this business form. While the non-rate regulated insurers had loss ratios in Texas below their rate-regulated counterparts from 1997 through 1999, this legal form experienced deterioration in their loss ratio sooner after 1999. In 2000, the loss ratio was much higher in the non-rate regulated entity, indicating that insurers' overall operating performance suffered relative to the benefits received by consumers. Note, however, that rate-regulated performance by 2001 nearly caught up, because the slope of the trend line for companies that are rate regulated is more steeply sloped.

To further explore the Texas setting, Figure 2 provides a more complete view of profitability by considering approximated "combined" ratios of the top five writing entities in the Texas homeowners market from 1996 through 2001. The entities — State Farm Lloyd's, Allstate Texas Lloyd's, Farmers Insurance Exchange, Fire Insurance Exchange and USAA — wrote about 68% of the Texas homeowners market in 2001. The results in Figure 2 illustrate the upward trend in these insurers' homeowners losses from their most profitable point, 1998. Among the top five writers, USAA was clearly the most profitable entity yet its diminishing insurance profitability trend has been upward, too, though not as severe as their competitors. From 2000, the trend had been particular severe for State Farm Lloyd's and Farmers Insurance Exchange. In all cases, it appears that it would have been difficult for insurers to continue offering homeowners coverage without raising prices to consumers.

Figure 2
Top Five Insurance Entities (by Premiums Written)



Source: Texas Department of Insurance.

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Thus, it is clear that the insurance industry in Texas had been losing money underwriting homeowners insurance in this market, and the rate at which they were losing money was trending higher for rate-regulated companies. This leads to a regulatory conundrum: While capping or lowering rates may be, in the short-run, politically appealing, the prospect of moving to a more rate-regulated environment moves insurance management into a box. On the one hand, insurance firms are about taking risk; that is what they do. On the other hand, no business proposition where a product or service has expected costs that exceed its expected revenue ought to be offered. In this event, management is better off doing nothing rather than participating. This may have been part of Farmers strategy to announce their intention to not sell homeowners insurance.[10]

While it appears clear that insurers have not done well in the Texas homeowners insurance market, the aggregate data among market share leaders do not reveal the sources of their difficulty. To explore the source of losses by peril, a dataset compiled by the Texas Department of Insurance (TDI) that attributes and isolates Texas losses by peril is examined across *all insurers* operating in Texas. The data include loss frequency and loss severity information for homeowners (HO), farm and ranch owners (FRO), tenants (TN) and dwelling (DW) for the 1996 through 2001 time period, although only homeowners data are used in the subsequent analysis. Further, the data are broken down by six perils, in particular, if the cause of loss was fire, wind, water, theft, vandalism and malicious mischief (VMM), a catch-all "Other" category for property losses not fitting into these categories and, finally, a liability loss category, Section II of the homeowners contract.[11]

The loss data have the redeeming feature of being broken down by peril; however, losses represent only paid losses rather than paid losses plus an amount set in reserve for losses incurred but not yet paid. In other words, the data used in this section make insurers look more "profitable" than their economic reality. Losses defined as "incurred losses" were reported in the data used in the preliminary analysis section because they were available and arguably provide a fuller explanation of insurer contractual responsibility and insurance operating performance. Because paid losses and not incurred losses are used in this section, distinctions in annual loss amounts are summarized in Table 4. Estimates for loss reserves can be substantial as reflected by the difference in columns (2) and (1) for the 2001 year, where incurred losses are about 22% greater than paid losses.[12]

10. The complete answer to Farmers' strategy is no doubt more complicated and might have included political maneuvering, managerial and regulatory obstinacy and other positioning strategies.

11. The data is derived from the residential stat plan exhibits and includes premium and loss information associated with the Texas Windstorm Insurance Association (TWIA). According to Gary Gola of the TDI, "the policy counts and Exposure for TWIA are not included as that would be double counting since the TWIA is a supplement to a regular Homeowners policy."

12. The substantial differences between paid and incurred losses during the latter years of the period examined might exist due to the protracted settlement process of mold claims.

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Table 4

Year	(1) Source: TDI Losses Paid	(2) Source: Statutory Page 14: Direct Losses Paid	(3) Source: Statutory Page 14 Direct Losses Incurred
1996	1,353,705,211	$1,391,013,902	$1,382,897,123
1997	1,099,907,113	$1,138,054,841	$1,118,004,785
1998	1,161,552,262	$1,191,922,988	$1,194,948,538
1999	1,349,008,422	$1,380,488,021	$1,421,627,819
2000	2,210,066,294	$2,293,972,741	$2,431,007,220
2001	2,879,769,083	$2,992,111,146	$3,648,017,214

Source: Texas Department of Insurance.

To explore "by peril" effects, the dollar value of a property loss claim from 1996 to 2001 is reported in Table 5, "Texas Statewide HO Loss Information by Peril." In this table, the dollar amount of loss is normalized per policy and by the dollar value of exposure in each year; the latter being a statistic that is sensitive to changes in building costs and inflation.[13] Examining columns (1) and (2) reveals that the magnitude of wind and water claims bears a substantial weight in total loss costs. Furthermore, while fire, wind, theft and VMM have been relatively stable contributors to loss costs over time, the magnitude of water losses more than doubled between 2000 and 2001 on a per policy and a per $1,000 of exposure basis. The Other and Liability categories showed an increasing percentage change in severity from 1996 to 2001 on a per policy and per $1,000 exposure basis.[14]

13. See www.casact.org/pubs/dpp/dpp90/90dpp559.pdf.

14. The information used in Table 5 and Figures 3 through 5 was found originally (2002) at the Texas Department of Insurance Web site, www.tdi.state.tx.us/general/forms/tdirpts.html.

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Table 5
Texas Statewide Homeowners Loss Information by Peril

Peil	Year	(1) $ Losses per policy	(2) $ Losses per $1,000 exposure
Fire	1996	$100.88	$0.7958
	1997	$96.53	$0.7243
	1998	$89.88	$0.6645
	1999	$54.86	$0.3756
	2000	$57.02	$0.3757
	2001	$76.65	$0.4775
Wind	1996	$200.36	$1.5805
	1997	$104.16	$0.7815
	1998	$117.46	$0.8684
	1999	$148.94	$1.0198
	2000	$344.21	$2.2679
	2001	$286.88	$1.7873
Water	1996	$126.48	$0.9977
	1997	$123.99	$0.9303
	1998	$126.17	$0.9328
	1999	$118.83	$0.8137
	2000	$166.51	$1.0971
	2001	$364.98	$2.2738
Theft	1996	$31.39	$0.2476
	1997	$28.61	$0.2146
	1998	$26.30	$0.1944
	1999	$28.05	$0.1921
	2000	$27.76	$0.1829
	2001	$29.25	$0.1822
VMM	1996	$3.14	$0.0247
	1997	$4.00	$0.0300
	1998	$2.80	$0.0207
	1999	$2.84	$0.0195
	2000	$2.41	$0.0159
	2001	$2.88	$0.0179
Other	1996	$22.41	$0.1768
	1997	$25.76	$0.1932
	1998	$23.66	$0.1749
	1999	$49.98	$0.3422
	2000	$51.62	$0.3401
	2001	$63.79	$0.3974
Liability	1996	$19.71	$0.1555
	1997	$19.82	$0.1487
	1998	$20.93	$0.1547
	1999	$37.14	$0.2543
	2000	$38.59	$0.2543
	2001	$45.72	$0.2849

Source: Texas Department of Insurance.

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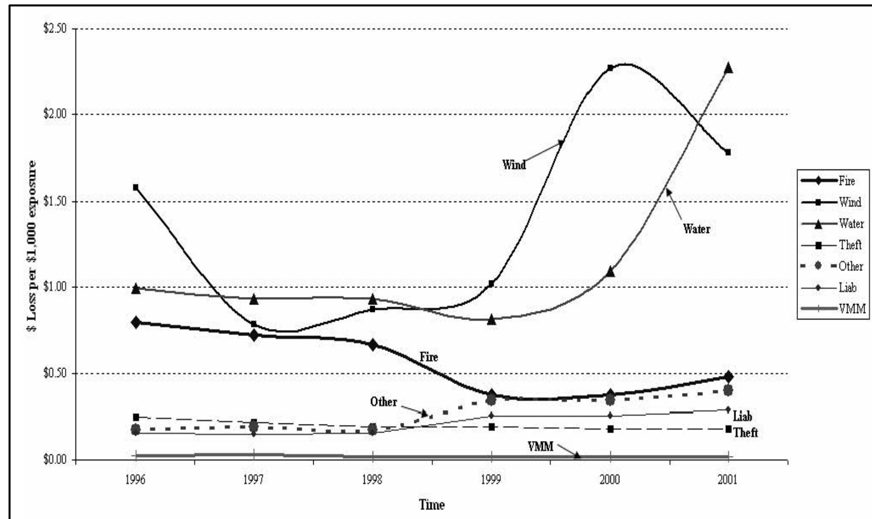
Figure 3
Texas Statewide Figures



Source: Texas Department of Insurance.

Figure 3 illustrates the change in statewide dollar losses for property perils over time scaled for total statewide insurance company exposure. While fire, theft, VMM, liability and the other peril category have shown only modest changes, wind and water perils are much more variable with the water peril exhibiting a substantially increasing rate of change from 1999 to 2001.

Given that the dataset is detailed by county, it is possible to explore how a particular county's by-peril distribution of losses is contrasted with the overall state. That is, the fire, wind, water and theft perils loss costs compared to total loss costs suffered by county residents for a given year. This historical pattern of losses is benchmarked against Texas statewide proportions so that county constituents can assess how their actual experience has faired relative to statewide averages, although it is important to note that geographical location brings the magnitude of risks to bear across counties differentially. As an example, Figure 4 provides a graphical representation of four major property perils for Harris County, Texas (the Houston area) because, according to the U.S. Census Bureau, it is the largest county in the state.[15] Moving vertically, the first four charts show the dollar proportion of losses by peril for Harris County relative to the statewide averages of Texas's 254 counties. The bottom chart in Figure 4 is a view of Harris County's homeowners total paid losses relative to total premiums paid, or a paid loss ratio. While this measure incorporates only paid benefits received by consumers from the homeowners contract relative to the costs (the premiums paid), it excludes the administrative costs of the

15. A similar analysis has been done on each of the 254 Texas counties and can be obtained from the author upon request.

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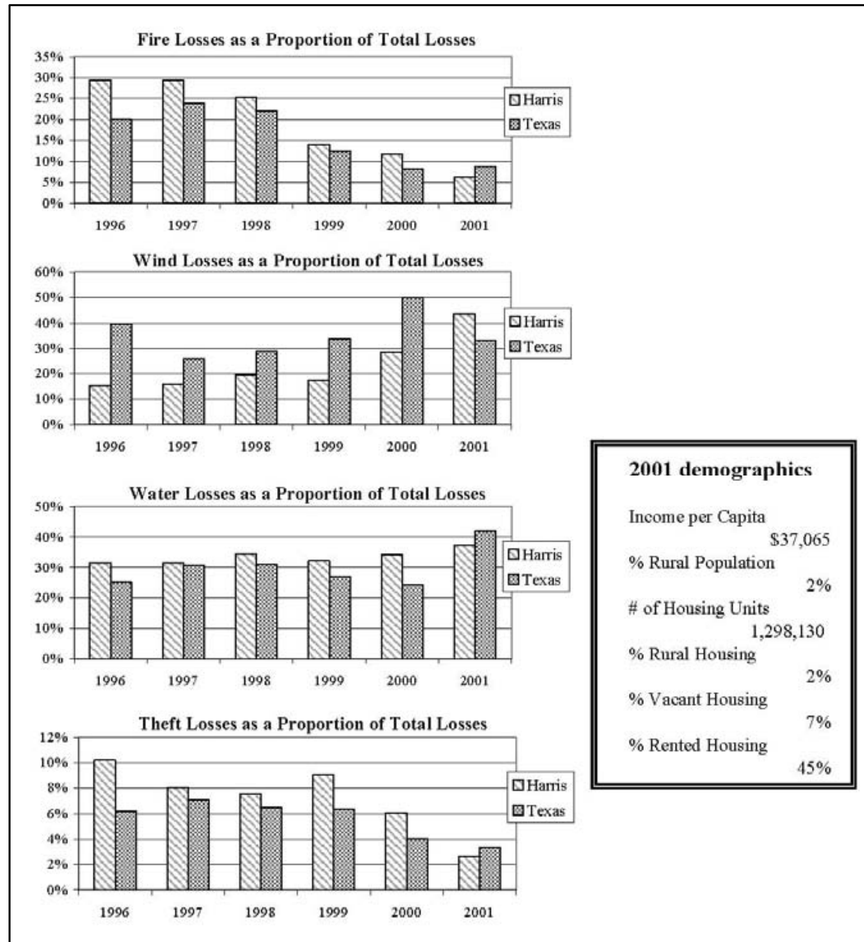
homeowners product and reserves set aside by insurers for losses not yet paid; therefore, it is an upwardly biased measure of insurer profitability.[16]

Figure 4
Harris County, Texas



Source: Texas Department of Insurance.

16. The by-peril annual data represent paid losses and not incurred losses. Still, from an insurance management view, the information can be useful for identifying problems or opportunities, hence strategy.

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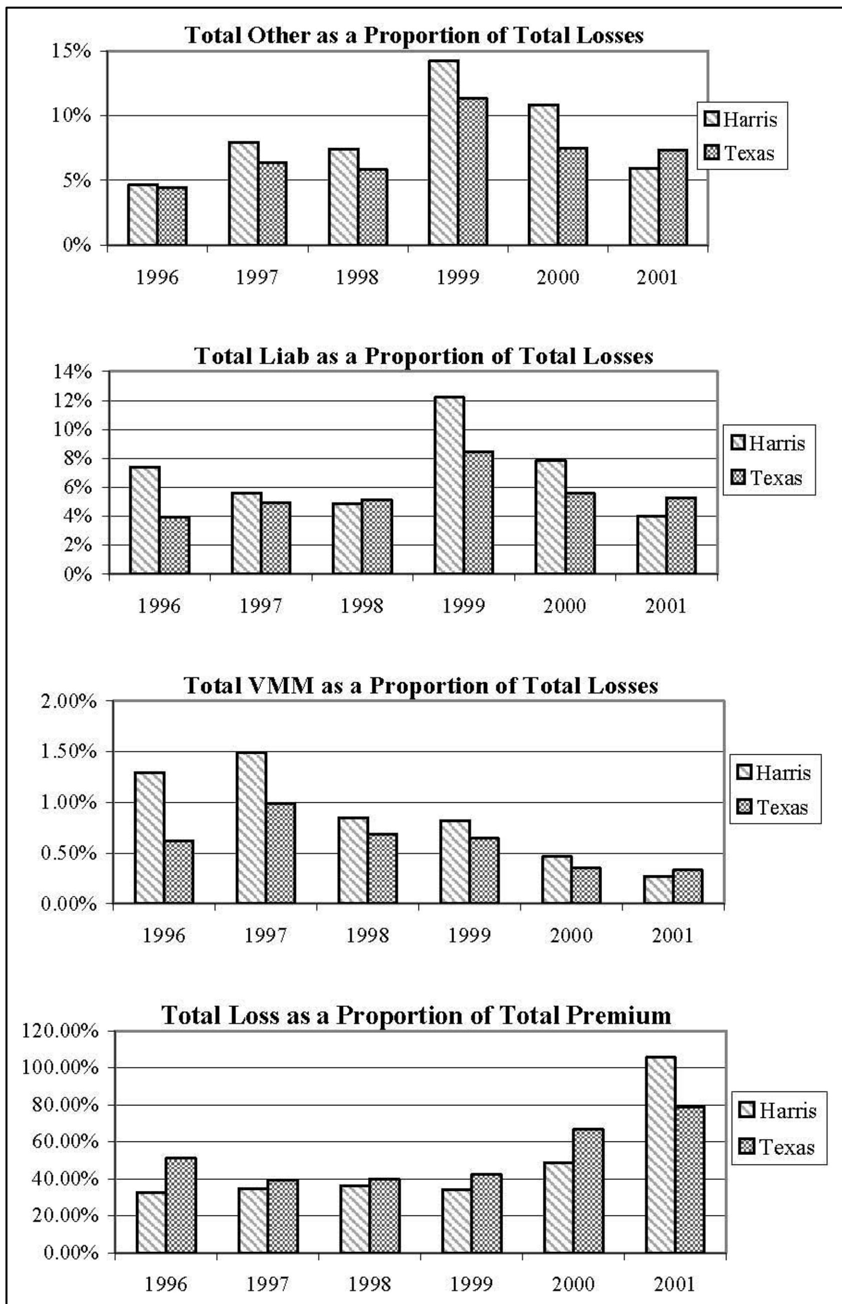
Figure 4 (Cont'd)
Harris County, Texas



Source: Texas Department of Insurance.

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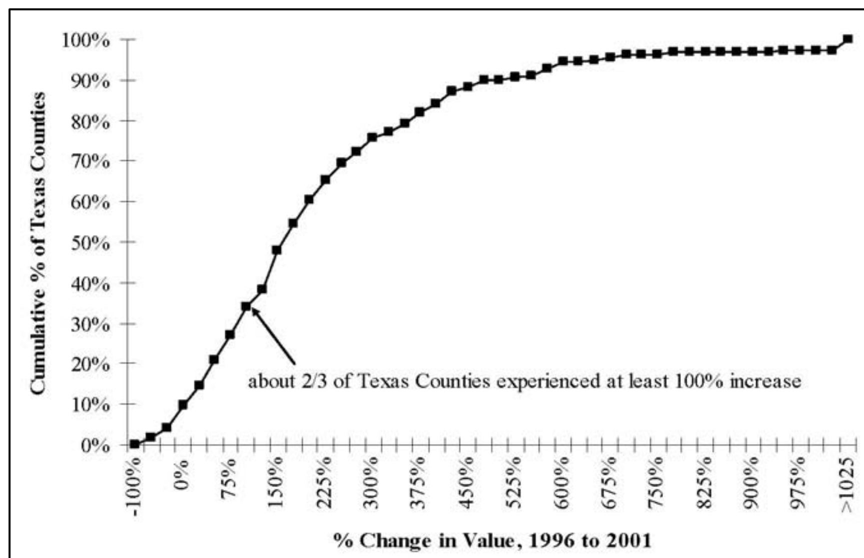
One glimpse into the sources of rising claims is to focus on the water peril because problems associated with mold were the "hot button" insurance issue in Texas. The value of a paid water loss per policy by county was considered in 1996 and in 2001 and the percentage change calculated for each county. While a few, particularly small, counties had no water losses in either 1996 or 2001 and, thus, were removed from consideration in Figure 5, 246 of Texas' 254 counties remained for this descriptive analysis. The cumulative distribution histogram reveals a spread in the water loss value changes, and the notable fact that about two-thirds of Texas counties experienced at least a 100% increase in the value of a paid water loss on a per policy basis. By contrast, a similar analysis for the fire peril indicates that about two-thirds of Texas counties had a change in the value of a fire loss per policy of up to 25%, with more than half of the counties showing a negative change in value from 1996 to 2001.

Figure 5
Change in Value of Water Loss Policy per Policy by County



Source: Texas Department of Insurance.

V. Hypothesis Testing and Empirical Results

To obtain a clearer understanding about the Texas homeowners market, the questions addressed in this study need an enhanced analytical framework. The work of Klein and Grace (2001) provides a useful perspective for empirical testing in homeowners insurance markets; in particular, their clarity on the issue of a broader empirical framework for analysis that overcomes myopic inferences

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that can be made from examining data in only a tabular, univariate format.[17] In other words, a more complete empirical specification, where the relationships of interest are explored, while controlling for other county-specific factors that may be related to risk of loss, better assists in understanding some of the issues surrounding this insurance crisis.

A testable hypothesis of interest is whether observed pricing in this market is related to changes in the unexpected claims experience by insurers after accounting for factors "normally" priced in this market and other control variables. Thus, while we want to know with precision whether variations in homeowners premiums have been associated with perils that are the source of expected loss in this market, we are also interested in whether insurers are building into their premium calculus factors, in addition to expected loss elements, that could be less well understood by insurance consumers.

Testing of these hypotheses is undertaken while controlling for a variety of county-specific, economic and environmental variables that are expected be related to the economics of the homeowners insurance market and the premium per $1,000 of exposure. County-specific data come from a few sources. First, 1990 and 2000 U.S. Census data are used to proxy information on these variables. Because the time period of the study is from 1996 through 2001, 1990 census data are applied to years 1996 through 1999 and 2000 census data are used for the years 2000 and 2001. Income data, obtained from the Bureau of Economic Analysis, were available for each year of the study.[18] Other control variables include a county's total housing units; the percentage of rural housing units relative to total housing units; the percentage of units that are vacant relative to total housing units; the percentage of occupied housing that is rented; the average household size of an occupied housing unit; the crime rate; and the percentage of the population that is nonwhite.

The association between homeowners premiums and perils, while controlling for county-specific environmental and demographic factors, is specified as

(1)

$$\begin{aligned}\ln \text{Prem} &= \beta_0 + \beta_1 \cdot \text{Fire} + \beta_2 \cdot \text{Wind} + \beta_3 \cdot \text{Water} + \beta_4 \text{Theft} + \beta_5 \text{Other} + \beta_6 \cdot \text{VMM} + \beta_7 \cdot \text{Liab} \\ &+ \beta_8 \cdot \text{Deviation}_{t-1} + \beta_9 \cdot \ln \text{Income} + \beta_{10} \cdot \ln \text{Hous} + \beta_{11} \cdot \ln \text{RHous} + \beta_{12} \cdot \ln \text{Vacant} + \beta_{13} \cdot \ln \text{Rent} \\ &+ \beta_{14} \cdot \text{Crime} + \beta_{15} \cdot \ln \text{Size} + \beta_{16} \ln \text{Nonwhite} + \beta_{17} \text{Year} + \beta_{18} \cdot \text{Fire}_{t-1} + \beta_{19} \cdot \text{Wind}_{t-1} \\ &+ \beta_{20} \cdot \text{Water}_{t-1} + \beta_{21} \cdot \text{Theft}_{t-1} + \beta_{22} \cdot \text{Other}_{t-1} + \beta_{23} \cdot \text{VMM}_{t-1} + \beta_{24} \cdot \text{Liab}_{t-1} + \varepsilon\end{aligned}$$

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17. Klein and Grace (2001) provide a rigorous examination of red-lining in the Texas homeowners insurance market and find loss ratios "roughly equivalent" between ZIP codes distinguished by low and high minority representation; an extension of the work by Harrington and Niehaus (1998) in urban automobile insurance markets. In their econometric discussion, they raise the issue of omitted variable bias; in this paper, the potential bias could exist where the association between peril types and premiums is clouded by the absence of variables that are correlated with homeowners loss perils and other independent variables that are also associated with premiums. Panel data methods are used to mitigate this problem.

18. See www.bea.gov/bea/regional/reis.

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where the dependent variable (Prem) is the natural logarithm of the county premium per $1,000 of exposure in year t.[19]

Each of the peril variables — Fire, Wind, Water, Theft, Other, VMM and Liab —are defined as the dollar losses per $1,000 of exposure in a year for a given Texas county. The estimation equation also includes a one-year lag of the peril variables to test whether a given year's premium also reflects an association with prior year losses and the corresponding lags are included as the last seven variables of the estimated equation (1). Support for the hypothesis that premiums per $1,000 of exposure are related to peril-specific current losses per $1,000 of exposure would be exhibited by statistically significant positive coefficients, β_1 through β_7. In theory, current pricing in a competitive insurance market is based on expected losses. Thus, if the estimated coefficients on lagged loss perils are positive, then such evidence would support a view that factors other than the current perils themselves are related to the current premium, which increases the dimension by which consumers can misunderstand how their policy is priced. Similarly, an associated question is whether the premium is related to an uncertainty measure, captured by the variable deviation. Deviation approximates uncertainty when actual losses differ dramatically from actual premiums. Initially, deviation is set to 0 for each county. Deviation takes a non-zero value when the difference between total losses and total premiums is greater than zero for a given county in a given year. In particular, it is calculated as the natural log of entire quantity: total losses multiplied by an expense factor less total premiums for a given county in a given year per $1,000 of exposure. The expense factor used is 1.15.[20] The expected sign of the coefficient on the deviation variable is uncertain because there is no *a priori* reason to suspect how variances from expectation are captured in this empirical specification.

The premium for homeowners insurance might also be affected by a county's environmental and demographic factors, and eight variables are included to control for these phenomena.[21] The measure of average income per capita for each Texas county is expected to be related to lower overall premiums, which would be consistent with the evidence of Klein and Grace (2001) that as total wealth increases, claim costs decline. lnHous represents the number of housing units per county. Larger counties are expected to have more cost efficiencies in handling claims than smaller counties. Thus, it is expected the larger counties will be associated with lower premiums because of administrative savings. Degree of urbanization is defined as the percentage of

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19. It is important to note that the dependent variable is specific to premiums for homeowners multi-peril contracts; contracts that are limited to residential dwelling owner-occupants or townhome unit owner-occupants. See Texas Personal Lines Manual, Insurance Council of Texas, Austin.

20. Using statutory page 14 data supplied by the TDI, the expense factor is an approximation across homeowners market participants in Texas, which considers the proportion of commissions, brokerage expenses, taxes and license fees to premiums written.

21. As noted by a referee, other control variables may be germane to this problem. For example, a construction cost index, home age and other measures of home valuation. Unfortunately, these data were not readily available in the format prescribed by the empirical model.

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total housing units that have been classified by the U.S. Census Bureau as rural housing. Higher values for the urbanization variable, lnRHous, are expected to be associated with lower premium rates, because higher proportions of rural housing might indicate more geographic spread and less density. The variable, lnVacant, is the proportion of total housing units that have been classified as vacant or not currently occupied. Higher rates of vacancy are expected to be related to higher premiums because structures absent inhabitants create additional uncertainty for insurers and the deficiency of a loss control mechanism that exists in owner-occupied housing.

The variable lnRent is the proportion of a county's occupied housing units that are rented. Higher proportions of rental housing might be also capturing a wealth effect that creates the expectation that lower premiums are associated with lower proportions of renters, or higher wealth if the results would be consistent with the Klein and Grace (2001) findings. Crime is a measure of a county's crime activity and is measured by considering a crime index, calculated as the total number of crimes per 100,000 of population by county and year.[22] It is expected that higher crime rate counties will be associated with higher homeowners premiums. Finally, three other variables are included in the model. lnSize is the average size of a household and lnNonwhite is the proportion of a county's population that is not white; additional controls for any differences in homeowners insurance pricing that could be due to a county's socio-economic conditions not captured by the other variables. The coefficient on Year captures the annual rate of change in premiums per $1,000 of exposure across the 1996 through 2001 time period not attributable to the loss perils and other right-hand side values.

Prior to describing the final sample some of the estimation issues need to be addressed. Equation (1) is being applied to a sample of counties, each of which is observed over a six-year time period, or a panel data set. Fortunately, panel data methods help to overcome prospective omitted variable bias that might exist because of unobserved effects.[23] An additional consideration is that the theory tested in this paper requires a right-hand side variable (deviation) that is a lagged transformation of the premium dependent variable; hence, an endogeneity problem arises that raises a potential problem in the consistency of the estimated parameters. To address these econometric concerns equation (1) is estimated with a procedure attributed originally to Arellano-Bond (1991) and extended by Arellano and Bover (1995).[24]

22. The author is grateful to Lori Kirk at the Texas Uniform Crime Reporting service for assisting with the collection of these data.

23. See Wooldridge (2002).

24. The Arellano-Bond procedure is undertaken in Stata using the xtabond2 package that was written by David Roodman, Center for Global Development, Washington, D.C. Roodman's package description provides a good background and reference to this stream of literature.

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The final sample numbered 243 counties across the years 1996 to 2001.[25] The final dataset numbered 1,458 observations, with the dependent variable defined as the total county premium for homeowners insurance divided by the amount of insurance exposure (in 000s). The mean value of the dependent variable, after taking the natural logarithm, is 2.147 with a standard deviation of 0.22. This relatively low degree of variability is reflected in the stability of premiums per exposure over the examination period. Table 6 provides summary statistics on the independent variables included in the study.[26]

Table 6
Sample Statistics (n = 1,458)

Variable	Mean	Standard Deviation
Perils:		
Fire	$0.8466	$1.0893
Wind	$2.7293	$6.6095
Water	$0.9440	$0.7471
Theft	$0.1529	$0.1265
Other	$0.3688	$0.8106
Liability	$0.2572	$0.5525
VMM	$0.0160	$0.0279
Other Explanatory Variables:		
Crime	2,832.91	1,608.98
Income	$20,490	$4,923
Proportion Rural Housing	0.5685	0.2951
Housing Units	30,377	106,531
Proportion Vacant	0.1899	0.0846
Proportion Rent	0.2719	0.0693
Household Size	2.68	0.2717
Proportion of Population Non-White	0.1862	0.0943
Year	1998.5	1.7084

25. Two issues regarding the final sample are noted. First, there were instances when the raw data for some of the loss perils per $1,000 of exposure carried negative values. Because there were seven perils examined by year and county, there were originally 10,626 data points, of which 46 had these negative values. When a negative value was given, the loss value per $1,000 of exposure was set to "0." Second, a few smaller counties were excluded from the final sample when there was insufficient data for at least one of their six years. Excluded counties were Borden, Childress, Crane, Glasscock, Hudspeth, Jeff Davis, King, Kenedy, Loving, Roberts and Sterling.

26. The sample statistics are unweighted because each county is treated equally without consideration for relative population counts, except for the housing count variable.

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To provide for a consistent estimation of equation (1) and to address the violation of the strict exogeneity assumption inherent in the model because the deviation variable is endogenous, the Arellano-Bover (1995) procedure is undertaken.[27] Equation (1) is estimated by an instrumental variables procedure where the instruments include its lagged first differences as well as equations in levels. The Hansen J-test for over-identification was not rejected (^{2} = 10.18), indicating that the instruments as a group are not correlated with the error term and, therefore, are reasonable. T-statistics are based on robust standard errors due to Windmeijer (2005).

Table 7
GMM Estimates of Empirical Equation (1)

	GMM IV Panel Data Estimator	
	Coefficient	**t-stat**
Intercept	2.219	4.25
Perils:		
Fire	0.00882	2.98
Wind	0.00130	3.23
Water	0.01781	4.65
Theft	0.02626	0.79
Other	0.00061	0.30
Liability	0.00951	3.05
VMM	0.24140	2.24
Proxy for Uncertainty:		
Deviation $_{t-1}$	-0.04443	-3.02
Control Variables:		
Crime	0.00003	2.24
ln(Income)	0.08315	1.68
ln(Housing Units)	-0.12202	-9.35
ln(Proportion Rural Housing)	-0.06017	-3.32
ln(Proportion Vacant)	0.07539	2.35
ln(Proportion Rent)	-0.03693	-0.78
ln(Household Size)	0.02742	0.23
ln(Proportion of Population Non-White)	-0.01566	-1.07

27. See Wooldridge (2002), p. 300, for a discussion of strict exogeneity and the problems that arise when there are lagged dependent variables on the right-hand side of the estimated equation. OLS results may be obtained from the author upon request.

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Table 7 (Cont'd)
GMM Estimates of Empirical Equation (1)

Lagged Perils:		
Fire $_{t-1}$	0.01315	4.16
Wind $_{t-1}$	0.00564	2.84
Water $_{t-1}$	0.04271	4.15
Theft $_{t-1}$	0.04772	1.19
Other $_{t-1}$	-0.00589	-1.92
Liability $_{t-1}$	0.01653	3.71
VMM $_{t-1}$	0.24618	2.60
F-Stat	13.79	
n	1215	

Note: The Arellano-Bond (1991) test for AR(1) in first differences was rejected (z = 2.51), while the same test for AR(2) could not be rejected (z = 0.98).

Results in Table 7 indicate the importance of the association between the value of insured peril losses and the current premium as coefficients are positive and statistical significance predominates. In addition, we find evidence of a statistically significant positive relationship between the majority of one-year lagged representations of these perils and the current premiums. In other words, when insurers experience higher prior year losses in a given county for a given peril, it is associated with higher premiums. For our measure of uncertainty, deviation, the findings indicate a negative and statistically significant relationship between deviations and current premiums. The results on loss lags and our uncertainty measure indicate that homeowners insurance prices during this crisis were changing in association with factors perhaps not readily understood by insurance customers, in addition to changes in actual claim experiences. Thus, the evidence suggests that when insurers confronted a dynamic and unexpected claims environment, that risk information among market participants became more skewed, which likely exacerbated discontent in this insurance market.

Next, we can focus on the coefficient values themselves to gauge the level of association each of these statistically significant perils has to the variation in premiums. The empirical equation is in "semi-log" form; therefore, we can calculate the elasticity of premium per $1,000 of exposure relative to the peril.[28] Exponentiation of the empirical equation ln Prem = f(X) yields Prem = $e^{f(X)}$. Thus, for example, ∂Prem/∂Fire = $\hat{\beta}_1 \cdot e^{f(X)}$. Rearranging $e^{f(X)}$ to the left-hand side implies $\hat{\beta}_1$ = ∂Prem/∂Fire $\cdot$ (1/Prem) and the elasticity is obtained by multiplying both sides of the equation by the mean value of the Fire variable.

28. See http://garnet.acns.fsu.edu/~dmacpher/teaching/ECO5421/Pdf/chap6b.pdf for a discussion of the elasticity calculation.

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Mean values from the overall sample were used. In this instance, 0.00882 · 0.8466 = 0.007467 — which reveals the percentage change in premium per $1,000 of exposure for a 1% change in the dollar amount of current year fire losses per $1,000 of exposure — is 0.747%, on average, over the 1996 to 2001 period. The association between all the perils and the premium can be considered in a similar fashion.

Table 8
Association Among Perils Relative to Fire

Perils	Estimated Elasticity	% Difference Relative to *Fire*
Water	0.016813	125.16%
Fire	0.007467	-
VMM	0.003862	-48.27%
Wind	0.003547	-52.49%
Liability	0.002446	-67.24%

Evaluation of the relative magnitudes of the individual perils permits an exploration of which perils were important during this crisis. To set a standard for comparison, the elasticity on Fire is used as a benchmark to assess relative impact of the perils on homeowners premiums. Table 8 lists the elasticities of the statistically significant property perils with respect to the premium and the differences are contrasted with the fire peril, Fire. As can be seen from the table, VMM and Liability categories provide less of an impact compared to the fire peril for the sample period. Notable are wind and water. The estimated elasticity for the Wind peril is about 53% smaller than the Fire peril elasticity, while the Water peril is about 125% larger. The elasticity of the Water peril is about 374% greater than the elasticity of the Wind peril. Thus, while variations in perils help explain variations in premiums, the Water peril played an extremely important role during the sample period.

Among the control variables, the coefficient on lnHous is negative, supporting the hypothesis that larger counties (reflected by the number of housing units per county) are associated with lower premiums, perhaps reflecting cost efficiencies in handling claims among larger counties. The coefficient on the urbanization variable, lnRHous, is also negative, supporting the hypothesis that as an increasing percentage of a county's total housing units are classified as rural that premiums per $1,000 are lower, reflecting density and geographic diversification not found among more urban environments. The proposition that higher proportions of housing that are classified as vacant are associated with higher premiums per $1,000 of exposure is supported by the positive coefficient associated with lnVacant. This finding may be indicative of the additional uncertainty insurers confront with non-occupied housing. Two variables, average income per capita by Texas county and the percentage of a county's housing that is rental, were hypothesized to be associated with the wealth impact argument of Klein and Grace (2001). It was hypothesized that income (proportions of renters) would be negatively (positively) related to

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premiums per $1,000 of exposure. While the proportion of renters was not found to be related to premium, higher levels of income were found to be positively related to premiums contrary to prediction. Finally, while household size and the proportion of the county that is non-white were not found to be significantly related to premium, higher levels of crime rates were found to be statistically associated to higher premiums, consistent with prediction.

VI. Concluding Remarks

While it is clear that observed price changes in homeowners insurance were most sensitive to changes in water losses, other phenomena were observable during this crisis. Given the choice of two regulatory regimes, insurance supply switched to non-rate regulated entities during the time period their performance deteriorated. Switching to non-rate regulated entities did not mitigate profitability problems, as was discussed in Section IV and supported by the data in Table 2. From 1999 through the ending date of this study, the extent to which consumers were feeling the impact of higher prices was not related to insurers reaping extraordinary profits in this line.

The complexity of insurance can quickly lead to misunderstandings about the product, price and provider performance, for which the regulatory authority can serve an important role. Results in this study indicate that "non-expected loss" factors were associated with price changes, which likely exacerbated negative consumer sentiment about their homeowners premium obligations because the cause of increasing costs might not have been well understood.

In this crisis, legislative response was swift via the passage of Senate Bill 14 in June 2003. This legislative solution in Texas brought rate regulation to all insurers and their homeowners customers initially in "prior approval" format and now in "file and use."[29] The Texas Department of Insurance now offers very good information to consumers about their rights and expectations related to water claims and mold.[30] Whether one advocates "re-regulation" or deregulation, an implication of these findings is that the sharing of quality information among stakeholders ought to be a primary regulatory objective. As risks change, high speed at understanding and communicating the impact is vital to avoiding consumer anxiety and market disruption. A nimble regulatory authority will encourage such an outcome.

29. Details of Senate Bill 14 may be found at www.tdi.state.tx.us/bulletins/b-0024-3.html.
30. See www.tdi.state.tx.us/consumer/cb074.html.

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Commentary: The Attorney General, the SEC and the Commissioners of Insurance

Richard E. Stewart*

Abstract

The insurance business has changed enormously in recent years, for better and for worse. State regulation has not kept up. The list of serious, unattended regulatory issues is embarrassingly long. Among them is the large number of company failures, some arranged to enrich owners and management while undercutting protection for policyholders. Another is systematic refusal to pay claims. A half dozen more such issues are sitting there, begging for regulatory attention and waiting to explode.

The issues this article takes up are not the run-of-the-mill items that appear on the agenda of every NAIC meeting. They are of institutional importance to state regulation of insurance. They go to its basic functions and loyalties. They are the sort of issue that will decide whether or not state regulation survives.

The recent investigations and prosecutions of insurance malpractice by former New York State Attorney General Eliot Spitzer and the U.S. Securities and Exchange Commission (SEC) created an opportunity for state insurance regulators to broaden the inquiry and go after the unattended issues. To date, they have not acted. Precedent suggests they should.

Twice in the history of American insurance regulation, outsiders have invaded the turf of the states. The Armstrong investigation in 1906 led to the invention of modern financial regulation, especially of life insurance. The

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South-Eastern Underwriters Association antitrust decision in 1944 led the insurance industry, especially property-casualty insurers, out of the world of cartels and into the world of competition.

In both episodes, the states took the intrusion as an opportunity to bring their whole system up to date. It could happen again today. So far, there is no sign of it.

The Attorney General, the SEC and the Commissioners of Insurance

Every modern society regulates banking and insurance. Why? Two reasons.

They are essential to most everything else a society wants to do. And, they share a characteristic that makes them unstable. They take a customer's money first and, in return, give only a promise of money and services some time in the future.

Government's role is to help ensure that the promise of the insurer or bank is kept. The techniques differ.

Some ancient societies used regulation by example. When a taker of deposits didn't return them on demand, they cut off his head and paraded it through the streets on a pole. Nowadays, societies use regulation by administrative rule.

In the United States, insurance is regulated by administrative rule. For historical reasons, the regulatory agencies are part of state government, not federal. State regulation of insurance is almost 150 years old, making it the oldest American primary regulator of business.

Recent Events

In the past three years, former New York state Attorney General Eliot Spitzer and the U.S. Securities and Exchange Commission (SEC) have accused prominent insurance companies and brokers of serious violations of state and federal law. While not admitting guilt, the accused have settled quickly.

Every one of Mr. Spitzer's and the SEC's allegations was squarely within the jurisdiction of the state insurance regulators. So one wondered where the regulators were.

The answer is nowhere. Except in a face-saving way, they were simply absent. They've been playing catch-up ever since.

The Spitzer-SEC invasion of insurance regulation contained both a securities story and an insurance story. In catching up, the insurance regulators, like everyone else, followed the securities story. That was a mistake.

The Spitzer-SEC invasion created a big opportunity for the insurance commissioners and state legislatures. Why? Responding to shocks like Spitzer-SEC is, on the record, the only way regulation can reform itself on a large scale. The commissioners responded to the opportunity as a threat. That was a mistake, too.

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There is plenty of reforming to be done. Too many serious regulatory issues have been piling up unattended to. The reasons for the pile-up are in the extremely conservative nature of government regulation of business — any government and any business.

It is rare for regulatory agencies to reform themselves on their own. Instead they respond to outside stimuli. The stimuli are usually on an agenda put forward by the regulated industry. So the agencies do not reform themselves spontaneously and from within. They react. They patch problems.

The Present Situation

The insurance business changes all the time. Recently competition, consolidation, technology and financial engineering have brought change at a pace never seen before.

Regulation is not keeping up, because the neglected issues are not on the industry's agenda. Today, following regulatory tradition, the insurance commissioners are patching the specific problems that the Spitzer-SEC investigations dug up.

Here are examples of big, recent changes in insurance, together with the regulatory issues they raise. For each one, the appropriate first step would be for the insurance commissioners to study it, for none has an obvious answer. With each topic is a summary of apparent facts to be verified or disproved as part of the study.

One, the Exit of Traditional Property-Casualty Insurers

Companies leave by insolvency, merger and "restructuring." Exit is a consequence of the overpopulation of the insurance business in its uncompetitive past — 1,000 companies[1] and half a million agents. With the cartel gone, the market has no room for most of them.

The exits are to be expected and, in economic terms, are desirable. But the timing and methods of exit call for study.

The first problem with the exits is the insurance regulators' delay in recognizing and acting on them.

For purposes of solvency regulation, loss reserves are the crucial entry on a property-casualty insurer's books. They can extend over long periods of time — 10 years and more — and can be highly imprecise. Yet loss reserves are what a regulator has to act on. The regulator cannot wait until the cash runs out, which will usually be years after the balance sheet should have shown insolvency. In the meantime, the failing insurance company will in desperation have done a lot of damage to itself and others.

Regulators do not like to shut down failed companies. The process is disagreeable and regulators see a company failure on their watch as a black

1. A.M. Best reported on 2,358 companies in 2005, but after taking account of common ownership, there were 972 insurance organizations. A.M. Best, *Best's Aggregates & Averages, Property-Casualty*, 2006 Edition.

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mark. Their natural impulse is to put it off, which means delaying recognition of insolvency. The wide latitude for loss-reserve estimates, plus the long period of reserve uncertainty, makes delay even easier than it used to be. Such delay is an old problem, and it has withstood successive refinements in detection technique, such as early-warning ratios, risk-based capital standards and closer involvement of credit rating agencies.[2]

At some point in a company's decline, however, the insurance commissioner has to acknowledge insolvency or at least serious trouble. What happens next poses the second issue with insurance company exits: who benefits.

Traditional solvency regulation was to protect policyholders against an insurer's inability to pay claims in full. Now it has become popular to respond to insolvencies or near-insolvencies in ways that favor the owners and managers of the failing insurance company and that shortchange its policyholders.

The simplest way to achieve that result is to split the failing company in two: a "good company" and a "bad company." The hopelessly unprofitable business, typically with large claims pending, goes into the "bad company," together with an amount of assets that management's chosen actuary will certify as sufficient. The bad company does not write new business and, after the outstanding claims are run off, it will be liquidated.

The "good company" gets the profitable business, with no outstanding big claims. It gets all the failing company's assets above the minimum required to get the actuary to sign off. Guess where management is. The company is saved in name only. Management escapes the consequences of its past. Owners can look forward to a profitable future. Through stock options, the insiders have a fresh chance to get rich.

The policyholders consigned to the "bad company" must fight a scorched-earth refusal to pay claims and eventually fight a liquidator. Why? Because the "bad company" is going out of business. It has no reputation to protect, not to mention that the run-off managers are likely to get any money that is left at the end. Examples include Home, Republic, Crum & Forster, INA and Lloyd's of London. Such restructurings require regulatory approval, and approval has been given every time.

The main purpose of insurance regulation is supposed to be the protection of policyholders. Here the regulators appear to be protecting failed companies and failed managements at the expense of policyholders.

Two, Misuse of Reinsurance

Reinsurance is the valuable practice of spreading risks around the insurance market. The laying off of risk is properly recognized by both regulatory and general business accounting. The idea is that liabilities arising out of the laid-off risk are moved from the laying-off (or ceding) insurer's balance sheet to the reinsurer's balance sheet.

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2. For a fuller discussion, see Stewart Economics, *Managing Insurer Insolvency 2003*, Foundation for Agency Management Excellence, 2003, pp. 23–25, available at www.stewarteconomics.com/publications.

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But it is possible to make the accounting benefit far exceed the value of the risk laid off. The paradigm of abuse occurs when no risk of loss at all is transferred, and yet the transaction is given 100% credit on the ceding insurer's balance sheet.

Examples include nearly all of the big insurance company insolvencies of the past 20 years. At the time they were taken over by the state, the failing companies had surplus-inflating "financial" or "finite" reinsurance on their books.

What's wrong with that? Statutory and GAAP accounting require that loss reserves be reported at their ultimate settlement value. Finite and financial reinsurance discount the reserves to present value, which can be half the required reserve. The reinsurance premium only slightly exceeds the present value. The rest is shown as profit on the ceding company's income statement and equity on its balance sheet.

Financial reinsurance is tempting. The "equity" it puts on the balance sheet costs as little as 2% a year, whereas raising equity in the capital markets costs 13% or more. Financial reinsurance is available to every company, no matter how broke, because the reinsurer assumes no risk. The ceding company becomes weaker (by the premium) but its financial statements look stronger. That is misleading to policyholders, brokers, investors and regulators.

Commentators today often treat finite reinsurance as something new, just as 10 years ago they treated it as something imaginative. In fact, it is neither.

It was well known 25 years ago[3] and was explained and ridiculed in two leading financial journals at the time.[4] Similar ways of subverting the conservatism of statutory accounting date back to the 1920s, and the most venerable of all was invented in 1863.[5]

The insurance commissioners have known about these gimmicks, and have debated them publicly, for a long time. The commissioners have "frowned upon" them,[6] but they have never issued a clear, definite and universal rule — one that conscientious managements can obey and conscientious regulators can enforce — and they have been reluctant to enforce the rules they have.

Such waffling has led insurers, reinsurers, brokers, lawyers, investment bankers, actuaries and accountants — all highly compensated for their efforts — to test how far they can go and how ingeniously they can disguise what they are doing.

The same techniques have also infected primary insurance. Some of the largest liabilities for pollution and asbestos have been removed from the balance sheets of industrial corporations by financial insurance deals. In general, nobody — not the insurance commissioners or any federal agency — has any

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3. Under names such as "loss portfolio transfer" and "aggregate excess of loss."

4. Carol J. Loomis, "How Fireman's Fund Stoked Its Profits," *Fortune*, November 28, 1983, pp. 99–104; Mary Rowland, "Games Insurers Play With Loss Reserves," *Institutional Investor*, November, 1983, pp. 183–189.

5. R. Carlyle Buley, *The American Life Convention, 1906–1952* (New York: Appleton-Century-Crofts, 1953), pp. 169–179.

6 . New York State Insurance Department, *Examination of Insurance Companies*, New York, 1954, Vol. 3, p. 553.

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idea how much financial insurance and reinsurance is out there, inflating profit and equity of both insurers and industrial corporations. This is not just an AIG-GenRe problem.

Since the Spitzer-SEC exposures of misuse of financial insurance and reinsurance, the insurance regulators have not sat around doing nothing. The NAIC now requires the property-casualty annual statement to disclose finite reinsurance.[7]

But if we look more closely, the insurance regulators are doing again what they have been doing all along: developing rules so abstract and subjective that they cannot be enforced even-handedly, sanctioned only by disclosure. To get balance sheet credit, the risk transferred must be "substantial," which means "more than remote."[8]

Even the basic questions may have been misconceived. We ask how little risk transfer will qualify for credit. But shouldn't we be asking whether disproportionate credit should be allowed at all? We ask what's wrong with using reinsurance to discount "artificially high" reserves to present value. But shouldn't the question be "why require reserving to ultimate in the first place?"

Regulatory wooliness has been the substitute for clarity for about a century. Requiring only disclosure now fits right into the tradition. Using disclosure instead of a prohibition or a limitation or an approval requirement is a major regulatory policy decision in favor of permissiveness.

Three, Systematic Denial of Property-Casualty Claims

If an insurer fights a claim, rightly or wrongly, two things happen. Payment is delayed, and the policyholder becomes willing to settle for less. From the insurer's viewpoint, it can earn more from investing the premium (more time and lower cost of funds). Investing premium is where insurers make most of their money.

In the past 25 years, both commercial and personal insurance companies have gotten much tougher about paying claims. In property-casualty coverages, it is unlikely that any claim for more than $1 million has been paid without a fight in the past 25 years.[9]

It is not a small problem. The RAND Corporation estimates that 88% of the money spent to clean up pollution has, instead, gone to the frictional costs of fighting over who should pay for it.[10]

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7. Each company's CEO and CFO are also required to attest to following statutory accounting rules for the reinsurance credit taken on the annual statement. The NAIC has considered, but has not adopted, requiring insurers to bifurcate their finite reinsurance transactions by accounting for the insurance and financial portions separately.

8. The specific requirements, which were adopted in 1994, are outlined in SSAP No. 62 of the NAIC *Accounting Practices and Procedures Manual*.

9. For a fuller discussion, see Richard E. Stewart and Barbara D. Stewart, "The Loss of the Certainty Effect", *Risk Management and Insurance Review*, 2001, Vol. 4, No. 2, p. 33, available at www.stewarteconomics.com/publications.

10. L.S. Dixon, *Superfund and Transaction Costs: The Experiences of Insurers and Very Large Industrial Firms* (RAND Doc. CT-102, 1992). For asbestos bodily injury, transaction costs took 63% of the total spent by both insurers and policyholders. Deborah

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Denying the validity of a policyholder's coverage is especially efficient. One policy can respond to thousands of claims. Defending a large number of claims involves a large number of lawsuits and is very expensive for insurers. Denying coverage involves only one lawsuit.

Widespread coverage denial is often attributed to an unexpected tidal wave of asbestos and pollution liability claims. That is not quite true; but however it began, systematic denial of coverage is now a profit-maximizing strategy, designed to increase earnings, share prices and executive compensation. The know-how may even have been carried from insurer to insurer by management consultants.

Policyholders have been screaming about systematic claims denial for 25 years. The biggest lawsuits of all time and in any field have been over insurance coverage. But the insurance commissioners have shown little interest in the coverage controversies. The big ones they have left to the courts. The little ones they have attacked only after public exposure by someone else, typically investigative reporters or plaintiffs in a class action.

Thirty-five years ago, the NAIC developed an unfair claims practices model law and 49 states enacted it.[11] The statutes apply to commercial and personal insurance, property and liability, large and small. Today's coverage-denial techniques certainly look like violations of the model's specific prohibitions.

Any insurance department (or group of departments) could at any time conduct a closed-claim examination of any licensed insurer, to confirm what is going on. Any court could order it. The NAIC did exactly that 96 years ago, and it led to major reforms.[12]

Four, the Dominance and Conflicting Interests of Big Brokers

Regulation of intermediaries is the oldest activity in American insurance regulation. It was designed for small, local agents, and it hasn't changed much in 150 years.

During the past century and a half, the agency business has changed completely. Now it is dominated by multinational corporations called brokers, a name that understates the breadth of their activities and their market power.

Mr. Spitzer's initial allegations were about brokers rigging bids, not securities fraud. The key question was contingent commissions, under which insurance companies pay bonuses to agents who bring in especially large amounts of business that is profitable for the insurance company. The brokers

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Hensler and others, *Asbestos Litigation in the U.S.: A New Look at an Old Issue*, 37 (RAND Doc. DB-362.0-ICJ, August 2001).

11. Except Mississippi.

12. "Investigation of Settlements with Policyholders by Companies Doing An Industrial Health and Accident Business," *Proceedings of the National Convention of Insurance Commissioners, Volume II* (1911). Among the reforms was the replacement of industrial accident insurance by workmen's compensation.

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were placing clients with insurers that paid them, the brokers, the highest commissions or that had bonus targets based on premium volume.[13]

Contingent commissions have existed since the 1880s, as has hidden agent compensation.[14] Arguments over the merits of contingent commissions have gone on just as long.[15]

In other kinds of business, analogous practices — called “push-money” and “payola” — have long been controversial. Manufacturers have paid grocery stores push-money under the table to get more space on shelves. Recording companies have made secret “payola” payments to disc jockeys to play their records. Push-money and payola have been successfully attacked as anti-trust violations, commercial bribery and fraud. And grocery stores and disc jockeys aren’t even fiduciaries.

Yet in insurance, basic questions about such payments have never been addressed, let alone answered. The regulatory response has simply been disclosure.[16] Do the insurance commissioners consider contingent commissions permissible? Are they OK for agents but not for brokers? Are they OK if disclosed? How can buyers and claimants tell when the intermediary is representing the insurer, when it is representing the customer and when it is representing neither but only itself?

Five, Outsourcing Regulation

Government has a choice about how to provide services. It can use government employees or it can contract with outsiders. Both are accepted practices, and both have long been used by regulators. Contracting out has recently become fashionable under the name “outsourcing.”

In recent years, the insurance regulators have massively shifted toward contracting out — in examination, solvency regulation, claims adjustment and liquidation. Whatever else it does, outsourcing puts government money into the pockets of the private firms that receive the contracts.[17]

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13. Shortly thereafter, Mr. Spitzer went after life companies writing retirement annuities for the same practices.

14. Fire insurance companies evaded their own agreements on maximum commission rates by “renting desk room in agents’ offices, furnishing vacations, knives, watches, pew rent, pocketbooks, furniture, clocks, Thanksgiving turkeys, clothing and Medford rum.” William Hamlin Wandel, *The Control of Competition in Fire Insurance* (The Art Printing Company: Lancaster, PA, 1936) pp. 80–81.

15. Wandel, pp. 85–88.

16. The NAIC amended the Producer Licensing Model Act to require brokers to disclose all sources of their compensation, as well as obtain permission to receive it, from their customers. “NAIC Adopts Model Legislation Calling for Broker Disclosures,” NAIC news release, December 29, 2004. See also Michael McRaith, *Testimony of the National Association of Insurance Commissioners Before the Committee on the Judiciary, United States Senate, Regarding State Regulation of Insurance Under the McCarran-Ferguson Act*, June 20, 2006, pp. 11–14, available at www.naic.org.

17. An example of problems that can arise from government outsourcing is in Shane Harris, “Outsourcing Iraq,” *Government Executive*, July 1, 2004, available at www.govexec.com/features/0704-01/0704-01s4.htm.

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The reasons for outsourcing may be on its merits: limitations on government hiring and staff expenditures and a sincere belief that the outsiders are better. But outsourcing may also be grounded in patronage, reciprocity and cronyism — not to mention campaign contributions, promises of future employment and worse.

Akin to outsourcing is passing off regulatory functions to other kinds of government agency, principally the courts. Before the first insurance departments were created (1860s), the only agency of government a policyholder could turn to was the courts. That had been the case for 200 years. Then several states came to see advantages in giving primary jurisdiction to specialized agencies. The courts were relegated to reviewing narrowly what the agencies did.

In recent years, that shift of jurisdiction has been reversing itself. The insurance commissioners have been defaulting responsibility for unpleasant and invidious duties to the courts. Examples are approving rate increases, clarifying policy terms and managing insolvencies.

Courts are not designed to set public policy but to resolve disputes. The public policy generally emerges after many decisions. Courts are not suited to balancing many interests and points of view. They consider only two. Judges cannot possibly become expert in one specialized field after another. The unwonted jurisdiction lands in the lap of the judiciary because the more appropriate agencies have not acted effectively or have not acted at all.

Six, the Transformation of Life Insurance

The immense American life insurance industry, and its regulation, were built on two products. One was the deferred-dividend policy, or semi-tontine, which had no cash values. It sold like crazy but invited abuse by companies and agents, and it was outlawed a century ago.

The other product was the opposite: level-premium, or “individual ordinary,” life insurance, whose cash values were a big selling point. Individual ordinary life was a godsend in the 19th and early 20th centuries, when families feared the early death of the breadwinner and life insurance was the only way to provide for his survivors.

Today the prevailing fear is outliving the family’s savings. Individual ordinary life is just the opposite of what is needed. Today’s most popular kinds of life insurance are vehicles for investment and then payout in later years. Variable annuities and other equity-linked “wealth accumulator” policies are among them.

To make their variable products even more attractive, companies have added stop-loss guarantees and bail-out options. The traditional life insurance business did not have to cope with such complex “embedded derivatives.” Those embellishments helped bring down Baldwin-United and Executive Life, two of the largest insolvencies in history.

The biggest life insurance company insolvencies ever have been in the past 30 years and have been of companies selling rapidly into the old-age survivors market without fully appreciating the risks in it. Some of the biggest life

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insurance frauds of all time have come in the same time period, as agents and companies sold individual ordinary life policies (not needed, but highly profitable) by dressing them up as annuities (needed, but far less profitable), and more recently by selling annuities to seniors who did not need them at all.

The mighty American life insurance industry is melting down before our eyes. The old individual ordinary policies still on the books are now highly profitable, because their high sales costs were written off long ago. But the policies that are selling today are less profitable and perhaps not profitable at all.

As the old policies run off and can no longer carry the unprofitable new ones, what will the regulators do? Judging by the record to date, nothing except react one case at a time using traditional regulatory tools. If insurance regulation is to have any better response, the time to get working on it is right now.

How Regulation Gets Reformed

Quite a list! The piled-up issues go to the heart of insurance regulation. They involve its purpose and loyalties, its ability to adapt and its willingness to refrain from protecting the regulated industry from change and competition. They are matters of institutional significance to the state insurance regulatory system. Unaddressed, each one and certainly several together could take down the whole system.

By contrast, the issues usually on the insurance commissioners' agenda are items from the industry's agenda or the agenda of some industry segment. Contemplated changes are minor and well within the consensus of regulator and regulated.

If issues of institutional importance continue to build up unattended, sooner or later one or more will explode in catastrophe or scandal. At that point, the insurance commissioners will likely be seen as part of the problem, not to be entrusted with devising the solution.

Only a handful of times in all regulatory history have regulators in any field mustered from within themselves what it takes to keep abreast of rapid, fundamental change. Regulatory agencies are not self-renewing. Usually it takes an intruder from outside the regulatory power structure and outside the culture of the subject industry. Mr. Spitzer and the SEC are such intruders.

The vital role of external intrusion is well demonstrated in insurance. What has led to broad reform has been a shock from outside the closed system of business-and-government. It has always involved protagonists from outside the insurance world applying ethical standards from outside the insurance culture. Without the shock, the regulators and the industry would just have patched the problem and resumed business as usual.

A strong, external shock is a natural occasion for outsiders and insiders to look down to the basic purposes of the regulatory effort and to test how well their inherited rules, practices and attitudes fit in. State regulation of insurance has been through such an episode not just once but twice in its history. That is the main reason state regulation is still around.

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Lessons from the Past: 1906

The first episode is called the Armstrong investigation. During the 19th century, the U.S. life insurance industry grew explosively. The largest New York life companies were the largest financial institutions in the world. They grew so fast by selling a product that was meretriciously appealing but easy for agents and companies to manipulate: the deferred-dividend, or semi-tontine, policy.

The immense assets of the companies were unregulated. Their sales practices were unregulated. The use of company money by board members and executives for their other interests was unregulated. Policy terms — particularly whether life policies should have cash values — were unregulated.

The New York State Insurance Department busied itself with matters of concern to life insurance companies — rebating of commissions by agents, shifting ("twisting") clients among companies and raising the barriers to entry into the agency business.

Just after the turn of the 20th century, two events shook that clubby world. The unregulated cash of the largest company (Equitable) became the prize in a fight between two of the greatest investment bankers of all time (J.P. Morgan and Jacob Schiff) for money to complete their mergers of corporate America. And about the same time, the foppish son of the founder of that same company was feted at a party said to have cost $400,000 (now $5 million) in company funds.

That did it. The New York State Legislature set up a committee to look into all aspects of the life insurance business. The committee was led or, better, inspired by Charles Evans Hughes and Louis Dembitz Brandeis, later two of the finest justices of the U.S. Supreme Court.[18]

During the summer of 1906, the committee took testimony from the titans of banking and insurance. Then it made recommendations that set the framework for the regulation of life insurance for the next 100 years and to the present day. It propelled the states ahead of the federal government in the regulation of financial institutions, and it propelled New York to dominance in insurance regulation.

As President Theodore Roosevelt said in 1905,[19] insurance regulation at that time was "ineffective" and "burdensome," and he was far from alone in wanting it shifted to the national government. Without the Armstrong investigation, the federal government would probably have taken over. But a few years after the Armstrong investigation, the idea of federal regulation just faded away.

Lessons from the Past: 1944

The second time an outside shock led to broad reform is called the South-Eastern Underwriters Association (SEUA) case. At the turn of the 20th century

18. Mr. Hughes was counsel to the Committee and Mr. Brandeis was counsel to the policyholders of Equitable.

19. 59th Congress, 1st Session, quoted in Buley, p. 240.

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the fire insurance business had set up an effective cartel, fixing prices and coverage terms. The companies had been trying to do it since the 1830s, but had only succeeded after the insurance commissioners put their power behind the price-fixing agreements.

What the states did was use their ability to revoke the licenses of agents to make them use only cartel companies. They also allowed the companies to coerce agents into using only cartel rates and policy forms. If an agent nonetheless used an independent company, rate or form, the cartel companies would "pull out of his office," that is, boycott him. And the insurance departments could revoke his license.

If the Organization of Petroleum Exporting Countries (OPEC) had such powers, it could forbid every gas station in America from pumping non-OPEC oil products. It could tell every station and every oil company how much to sell and what to charge at every step downstream from discovery to consumer. And if anyone didn't play ball, they could run him out of business.

Against that background of official enforcement of collusive pricing, in 1936 the boss of the Kansas City political machine took a $500,000 bribe (today $6 million) to have the Missouri insurance commissioner approve a fire insurance rate increase. Word got out, and the two were sent to prison.[20]

The U.S. Antitrust Division, under legendary trust-buster Thurman Arnold, wondered why one rate increase in one kind of insurance in one middle-size state could be worth so much. The division's investigation into price-fixing by the fire insurance companies led to the indictment of one of the cartel offices (SEUA) for violating antitrust law. Arguments that federal law could not reach the insurance business were rejected by the U.S. Supreme Court.

The SEUA decision began the decline of cartel pricing in property insurance. It was a momentous change. The state follow-through dealt not just with price fixing but also with a host of other regulatory issues.

Just before the SEUA episode began, what had the insurance commissioners been doing? They certainly had not been looking at price-fixing agreements, even though official support of them put insurance at odds with nearly all the rest of American business, and even though the insurance commissioners themselves were acting as cartel enforcers.

Instead, they were attending to the insurance industry's agenda, such as controlling agent commissions by extending the cartel[21] and fending off a federal investigation of the economic power of life insurers.[22]

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20. Lawrence H. Larsen and Nancy J. Hulston, *Pendergast!* (Columbia, MO: University of Missouri Press, 1997), pp. 130–151.

21. From 1922 through 1948, the New York State Insurance Department, then the leading insurance regulatory agency in the country, devoted much effort to controlling competition in agent compensation. See articles by three New York insurance superintendents: James A. Beha, *Acquisition Cost Control* (New York: Herbert-Spencer, 1922); Francis R. Stoddard, *The History of Acquisition Cost in New York* (no publisher given, 1944); and Robert E. Dineen, *Commissions: New Developments in a Continuing Problem* (New York: Insurance Department, 1949).

22. Hearings that began in 1939 by the Temporary National Economic Commission into the concentration of economic power in the life insurance business led to fears of federal takeover of insurance regulation if not the business itself. See Buley, pp. 838–862.

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The insurance commissioners had left unattended a pile of issues as high as in the pre-Armstrong years. But the SEUA case saved them, forcing them to change from opposing competition to fostering it. Most of the changes in insurance since the SEUA decision have flowed from that single big one. And the insurance commissioners would never, ever have done it on their own.

The Future

The stack of unattended issues is now just as high as it was before Armstrong and SEUA.

Armstrong and SEUA were external shocks, with agencies outside insurance regulation applying legal and moral rules from outside insurance regulation. They stunned the business, but the governmental responses, state and federal, were immediate and positive. Having no enthralling second story line, as securities fraud is to the Spitzer-SEC shock, the two earlier episodes stayed focused on insurance.

The chosen solutions entrusted to the insurance commissioners the leading role in long-term implementation of the outsiders' ideas. Years later, state regulation of insurance was still in place and much better for the experience.

Such a benign outcome is unlikely this time. One reason is that the insurance commissioners have shown no inclination to use the Spitzer-SEC exposures to take up neglected issues. A second reason is that, unlike Armstrong and SEUA, this time others are involved and watching. They would be more than willing to pick up any responsibility the states ignore. They are the national government, the courts, the rating agencies and the plaintiff's bar. And prominent insurance executives are already calling for the federal government to take over insurance regulation from the states.

To summarize, we have a good idea why regulation needs the occasional external shock to sort itself out and get current, and we know how helpful the Armstrong and SEUA shocks were. A similar opportunity for insurance regulatory reform in the wake of the Spitzer-SEC shock was missed. It is too early to tell what the consequences of that miss will be.

Nor do we know for sure that, even at this late date, it would be impossible for the insurance commissioners or even a single commissioner, or state or federal legislators, to use the shock to justify a sweeping examination of the big neglected issues in insurance regulation.

That is just what happened twice in the past, when exceptional people were in charge. They recognized that some kinds of business — and insurance is such a business — require government rules and government attention if they are to function efficiently and honorably.

Those exceptional people also understood that regulatory rules and practices continually get out of date. They used the shock from outside to launch a broad, deep and overdue review of the insurance and regulatory world.

Why not do it again?

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Federal and State Legislative Update*

Federal Legislation

The summary below highlights some of the pending insurance-related federal legislation. This edition of the federal legislative update only includes bills on health insurance.

State Innovations Grant Program

U.S. Sens. Jeff Bingaman (D-NM) and George V. Voinovich (R-OH) reintroduced S.325, the Health Partnership through Creative Federalism Act on January 17. U.S. Representatives Tammy Baldwin (D-WI) and Tom Price (R-GA) reintroduced companion legislation in the House, H.R.506 the same day. Both bills would create a new grant program for the federal government to encourage innovative state solutions to expand health insurance coverage to the uninsured.

S.325 and H.R.506 would create a State Health Coverage Innovation Commission to evaluate grant applications submitted by states, groups of states and municipal governments to implement health reforms that significantly expand coverage. The commission would be charged with making recommendations to Congress to fund state plans that represent a variety of approaches to covering the uninsured. Congress would then consider the recommended applications through an expedited procedure. Apart from grant funds appropriated under the program, the program must be "budget neutral," taking into account the plan's impact on all federal spending, revenue and tax expenditures.

Both the House and Senate bills were introduced in the 109th Congress, but did not receive action.

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* This article was provided by the NAIC Legal Division. This is not a summary of all insurance-related legislation. This update does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the bills cited should be consulted. The NAIC attempts to provide current information; however, readers should consult state law for additional adoptions and subsequent bill status.

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President's Health Care Budget Proposals

In his State of the Union address and in his budget submission to Congress, President George W. Bush outlined a two-pronged health care proposal that would change the tax treatment of health benefits and would reprogram Medicaid funds currently directed toward hospitals that treat a disproportionate share of low-income patients to create a new federal grant program.

The tax element of the President's proposal would shift the tax treatment of health insurance premiums to count them as taxable income for employees, while providing a new standard deduction for all those who purchase health insurance. The new deduction — $7,500 for individuals and $15,000 for families — would be indexed to the U.S. Consumer Price Index.

The tax provisions would be paired with a new "Affordable Choices Initiative" that would redirect a portion of Medicaid Disproportionate Share Hospital Payments to fund grants to states to help low-income individuals, or those with medical conditions that make them difficult to insure, purchase basic private health insurance at affordable premiums. The administration has suggested a number of strategies that states could adopt to provide this coverage, including high-risk pools, direct premium assistance and small-business and individual-pooling initiatives.

Healthy Americans Act

On January 18, U.S. Sen. Ron Wyden (D-OR) introduced S.334, the Healthy Americans Act. The legislation, which has been referred to the Senate Finance Committee, would create an individual mandate to purchase health insurance and create Health Help Agencies in each state to facilitate the purchase of non-group policies that are comparable to coverage through the Federal Employees Health Benefit Plan. As a result, all employer-provided coverage would be phased out.

Employers not currently providing coverage would be required to immediately begin making "Employer Shared Responsibility Payments." All employers would be required to make such payments after two years. Under the bill, all coverage would be guaranteed-issue and could not use health status, occupation, genetic information, gender or age as rating factors. Subsidies would be provided, on a sliding scale, for those below 400% of the federal poverty level.

Mental Health Parity Act

The Senate Health, Education, Labor and Pensions (HELP) Committee has passed legislation (S.558) that would create greater parity in the provision of mental health benefits. Specifically, the bill states that *if* a group health plan includes mental health benefits then financial limitations (co-pays, deductibles, limits, etc.) and coverage limitations (inpatient days, outpatient days, etc.) for the mental health benefits must be the same as substantially all other benefits.

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Employers with fewer than 50 employees are exempted, as are companies for which the cost of coverage for mental health and substance abuse benefits exceeds 2% of total plan costs in the first year or 1% in each year thereafter. State laws impacting financial and coverage limits would be preempted.

S.558 is expected to move to the Senate floor for consideration in spring 2007. The House has not yet acted on this legislation.

Genetic Nondiscrimination Legislation

Both the House Education and Labor Committee and the Senate Health, Education, Labor and Pensions (HELP) Committee have passed legislation (H.R.493 and S.358, respectively) to expand the prohibition against genetic discrimination by group health plans and health insurance issuers in the group and individual markets. The Senate bill is expected to move to the floor in spring 2007. The House bill has also been referred to the Energy and Commerce and the Ways and Means Committees.

The bills prohibit enrollment and premium discrimination based on information about a request for or receipt of genetic services and prohibit any requirement of genetic testing. The bills also make it unlawful for employers, employment agencies, labor unions or training programs to discriminate against an individual or deprive an individual of employment opportunities based on genetic information. The bills include penalties for violations.

State Legislation Related to NAIC Models

Coordination of Benefits Model Regulation (#120)

Idaho Admin. Code r. 18.01.74

Idaho amended its Coordination of Benefits rule during the fourth quarter of 2006. This rule incorporates the NAIC Coordination of Benefits Model Regulation by reference.

760 Ind. Admin. Code 1-38.1

Indiana amended its Coordination of Benefits rule during the fourth quarter of 2006. This rule incorporates the NAIC Coordination of Benefits Model Regulation by reference.

Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)

Iowa Admin. Code r. 191-36.5

Iowa added Subsection 36.5(6)(d)(5) to its Individual Accident and Health – Minimum Standards regulation. This subsection adds incarceration as a permissible reason for limiting or excluding coverage for illness, treatment or medical conditions in disability income protection policies.

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Annual Financial Reporting Model Regulation (#205)

Colo. Code Regs. §3-1-4

This regulation repeals and repromulgates §3-1-4 to be consistent with the NAIC Annual Financial Reporting Model Regulation. Colorado did not adopt the NAIC's model language in total; however, §3-1-4 incorporates several sections of the model. Colorado made several changes to this regulation, including moving the prior Subsection 2B to Section 3, as well as moving the prior Section 7 to Section 8. Section 8 – Qualifications of Independent Certified Public Accountant incorporates Subsections A – F of the NAIC's model. This regulation became effective January 30, 2007.

Annuity Disclosure Model Regulation (#245)

Colo. Code Regs. 4-1-12

Colorado adopted the NAIC Annuity Disclosure Model Regulation during the fourth quarter of 2006. This regulation protects consumers and fosters consumer education about annuity contracts. It specifies the minimum information that must be disclosed and the method for disclosing it in connection with the sale of annuity contracts. The goal of this regulation is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.

Modified Guaranteed Annuity Model Regulation (#255)

Cal. Code Regs. tit. 10 §2534.20 to §2534.30

California amended several sections of §2534 to be more consistent with the NAIC Modified Guaranteed Annuity Model Regulation. California specifically revised §2534.28 – Modified Guaranteed Annuity Contract Requirements to require companies to obtain written approval from the commissioner before deferring a cash surrender benefit either at maturity or upon surrender of the contract. Additional changes address premium tax and minimum nonforfeiture amounts.

Suitability in Annuity Transactions Model Regulation (#275)

La. Admin. Code. §37:11701 to §37:11717

Louisiana adopted the NAIC Suitability in Annuity Transactions Model Regulation during the fourth quarter of 2006. This regulation sets forth standards and procedures to ensure that the insurance needs and financial objectives of consumers are met during transactions involving annuity products. Louisiana adopted this model in its entirety, including the NAIC's optional recordkeeping section as Section 37:11715.

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Mich. Admin. Code r. 500.4151 to 500.4165

Michigan adopted the NAIC Suitability in Annuity Transactions Model Regulation during the fourth quarter of 2006. This regulation sets forth standards and procedures to ensure that the insurance needs and financial objectives of consumers are met during transactions involving annuity products. Michigan does not use the same section headings as the NAIC model. In addition, this regulation is titled "Annuity Recommendations to Consumers."

Disclosure of Material Transactions Model Act (#285)

Colo. Code Regs. §3-1-13

Colorado amended its Disclosure of Material Transactions regulation. In addition to renaming the section headings, Colorado renumbered this regulation. Several changes were made to Section 7 – Confidentiality, including adding the ability of the commissioner to share information with the NAIC.

N.J. Admin. Code §11:1-39.1 to §11:1-39.6

New Jersey amended its Disclosure of Material Transactions regulation. New Jersey substituted "Office of Solvency Regulation" for "Division of Financial Examinations" in the address portion of the regulation.

Insurance Holding Company Model Regulation with Reporting Forms and Instructions (#450)

N.J. Admin. Code § 11:1-35.1 to §11:1-35.13

New Jersey amended its Insurance Holding Company Regulation. New Jersey substituted "Office of Solvency Regulation" for "Division of Financial Examinations" on the form to be submitted to the state.

Credit for Reinsurance Model Regulation (#786)

Colo. Code Regs. §3-3-3

Colorado adopted the NAIC Credit for Reinsurance Model Regulation in its entirety. In addition, Colorado added an additional definitions section to its regulation.

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Model Regulation Permitting the Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities (#815)

211 Code of Mass. Regs. 58.01 to 58.06

Massachusetts adopted the NAIC Model Regulation Permitting the Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities during the fourth quarter of 2006. This regulation recognizes, permits and prescribes the use of mortality tables that reflect differences in mortality between preferred and standard lives in determining minimum reserve liabilities.

S.D. Admin. R. §20:06:51:01 to §20:06:51:05

South Dakota adopted the NAIC Model Regulation Permitting the Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities during the fourth quarter of 2006. South Dakota does not use the same section headings as the NAIC model.

Actuarial Opinion and Memorandum Regulation (#822)

Idaho Admin. Code r. 18.01.77.000 to 18.01.77.024

Idaho adopted the NAIC Actuarial Opinion and Memorandum Regulation during the fourth quarter of 2006. This regulation sets out requirements for the submission of an actuarial opinion, as well as rules that apply to the appointment of an actuary. Idaho included several procedural sections in addition to these requirements.

211 Code of Mass. Regs. 132.01 to 132.10

Massachusetts amended its Actuarial Opinion and Memorandum Regulation during the fourth quarter of 2006. Massachusetts made several changes to this regulation, including Section 6 – Statement of Actuarial Opinion Based on an Asset Adequacy Analysis and Section 7 – Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary. These sections were entirely rewritten to be consistent with the NAIC model.

Mich. Admin. Code r. 500.991 to 500.997

Michigan adopted the NAIC Actuarial Opinion and Memorandum Regulation during the fourth quarter of 2006. This regulation sets out requirements for the submission of an actuarial opinion, as well as rules that apply to the appointment of an actuary. Michigan adopted the NAIC model in its entirety.

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State Legislation

Delaware — HB 446: Dependent Coverage

A bill to require insurers to allow covered dependents to elect coverage until dependent's 24th birthday, even if carrier's contract provides that coverage terminates at a specific age prior to the dependent's 24th birthday. The bill does not require coverage prior to the bill's effective date and does not require that an employer pay all or part of the cost of coverage for the dependent. Effective October 10, 2006.

Florida — CS/HB 1-A: Property Insurance Reform

A bill to provide comprehensive insurance reform in Florida's property/casualty insurance market. The following are highlights and are not intended to summarize all portions of this extensive bill:

- Citizens Property Insurance, the state-run insurer, is no longer required to set its rates above the top 20 other insurers in the market.
- Insurers must offer homeowners insurance policies that allow the policyholder to decline coverage for wind damage. This flexibility would generally only be available if the property is free and clear of mortgages.
- Insurers are prohibited from attaining "excess profits," measured over a 10-year period, according to thresholds specified in the bill.
- Effective January 1, 2008, insurers are prohibited from "cherry-picking." Insurers who write auto policies in Florida and homeowners policies in other states (but not Florida) will be prohibited from continuing this practice.

The bill was signed by the governor on January 25, 2007. The bill allows insurers until June 1, 2007, to adjust rates in compliance with the bill's provisions. On January 30, the Florida Office of Insurance Regulation issued an emergency order that freezes any increase in property insurance rates and prohibits nonrenewal and cancellation of policies prior to the bill's implementation.

Maine — 2005 ch. 532: Dependent Coverage

A bill providing that coverage for dependents who are full-time students until a certain age must continue if the student is unable to attend school on a full-time basis due to a physical or mental illness or an accidental illness. Written documentation may be required by insurer. Effective August 23, 2006.

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Maryland — HB 1405: Coverage of Students

A bill providing that students over the age of 18 who would be covered as full-time students cannot be excluded if they are enrolled in school less than full-time due to a documented disability. The student must maintain a course load of at least seven credit hours per semester in order to remain covered. Effective October 1, 2006.

Michigan — HB 5816: Dependent Coverage

A bill continuing coverage for a dependent child who is a full-time or part-time student in the event that the student takes a leave of absence due to illness or injury. The student's attending physician shall provide written certification that the leave of absence is medically necessary. The coverage shall continue for one year from the last day of attendance or until the dependent reaches the terminating age, whichever period is shorter. Effective January 1, 2007.

New Hampshire — HB 37: Michelle's Law (Coverage of Students)

A bill providing that coverage for a full-time dependent student over the age of 18 shall continue during the dependent's medically necessary leave of absence for a period of one year or until the coverage would otherwise terminate, whichever comes first. Documentation and certification shall be submitted to the insurer by the student's attending physician. These provisions apply to individual and group health insurance policies. Effective June 22, 2006.

New York — SB 8482: Timothy's Law (Mental Health Parity)

A bill to ensure that mental health coverage is provided on terms comparable to other health care and medical services. The bill applies to insurers delivering a group or school blanket policy, hospital service corporations, health service corporations and medical expense indemnity corporations. These entities shall provide coverage comparable to medical coverage provided under the policy for adults and children with biologically based mental illness. Provisions shall not apply to group purchasers or contract holders with 50 or fewer employees. Effective January 2, 2007.

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Ohio — SB 116: Mental Illness Parity

A bill to prohibit discrimination in group health care policies in coverage provided for diagnosis and treatment of biologically based mental illnesses. The bill includes diagnostic and treatment services for mental illness in the statutory definition of "basic health care services." Insurers may offer coverage for diagnosis and treatment of mental illness without offering coverage for all other basic health care services. However, insurers must offer mental illness coverage in order to provide coverage for any other basic health care service. Effective March 29, 2007.

Rhode Island — SB 2211A: Dependent Coverage

A bill requiring that insurance contracts cover an unmarried child under the age of 19; an unmarried child who is a student under the age of 25 and who is financially dependent; and an unmarried child of any age who is financially dependent and medically determined to have a physical or mental impairment expected to result in death or expected to last for a continuous period of not less than 12 months. Effective January 1, 2007.

Vermont — SB 285: Dependent Coverage

A bill providing that coverage for a full-time dependent student over the age of 18 shall continue for the student's medically necessary leave of absence from school for a period not to exceed 24 months or the date on which coverage would otherwise terminate, whichever comes sooner. Documentation and certification of the medical necessity shall be submitted to the insurer by the student's treating physician. The bill also amended the requirement of coverage for a dependent child who has achieved the limiting age but is incapable of self-sustaining employment. The bill broadened the scope of mental or physical disability beyond mental retardation, cerebral palsy, epilepsy or physical handicap. Approved May 30, 2006.

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Abstracts of Significant Cases Bearing on the Regulation of Insurance

Kara D. Binderup*

U.S. Courts of Appeals

Retail Indus. Leaders Assoc. v. Fielder, 2007 WL 102157 (4th Cir. Jan. 17, 2007)

The Fall 2006 issue of the *Journal of Insurance Regulation* reported on the U.S. District Court's (District of Maryland) decision to grant summary judgment to the Retail Industry Leaders Association (RILA) in its constitutional challenge to Maryland's Fair Share Act, which would have required employers with more than 10,000 employees to spend up to 8% of total wages on health insurance or face a penalty. The law only affected Wal-Mart at the time of its passage. The Court of Appeals for the 4th Circuit affirmed the lower court's ruling that the Act was preempted by ERISA, as it directly regulates employers' provision of healthcare benefits. The court also ruled that RILA had associational standing to challenge the act, that the preemption issue was ripe for judicial review and that the Tax Injunction Act did not bar RILA from claiming preemption. On the tax injunction issue, the court found overriding evidence that the act's primary purpose is to regulate healthcare spending, not to raise revenue through the penalty provision.

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U.S. District Courts

Cooper v. Pacific Life Ins. Co., 458 F.Supp.2d 1368 (S.D. Ga. Sept. 18, 2006)

In this securities-fraud class action brought by purchasers of variable annuities, the district court denied the defendant's motion to decertify the class. The plaintiffs allege the defendant failed to state that its variable annuities' tax-deferral feature was unnecessary and duplicative when used in conjunction with tax-deferred retirement accounts. They further allege a failure to ensure that appropriate suitability determinations were made. The defendant argued that it sent notices and memoranda to its registered representatives encouraging disclosure of the tax-deferral redundancy. The court found the import of these steps is a question of fact for a jury. The court also rejected the defendant's argument that the omission of the redundancy was not material, as the information was included in the total mix of information available to a reasonable investor. Finally, the court ruled that a jury could find class-wide liability for insufficient suitability oversight, even where registered representatives made independent suitability determinations.

Hurricane-related Litigation

In re Katrina Canal Breaches Consolidated Litigation, No. 05-4182 (E.D.La. Feb. 2, 2007)

The Winter 2006 issue of the *Journal of Insurance Regulation* reported on a consolidated, uncertified class action called *In re Katrina Canal Breaches Consolidated Litigation*. The action survived a majority of insurer defendants' motions to dismiss when Judge Stanwood R. Duval of the U.S. District Court for the Eastern District of Louisiana held the defendants' flood exclusions to be ambiguous. In subsequent rulings, Judge Duval granted summary judgment dismissing claims against contractors and engineers for work performed on the canals, holding that the claims were preempted under the Louisiana statutes. He denied motions to dismiss filed by the Orleans Levee District and the Sewerage and Water Board. Finally, Judge Duval denied the United States' motion to dismiss claims against the U.S. Army Corps of Engineers.

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Broussard v. State Farm Fire & Cas. Co., No. 1:06CV6 (S.D.Miss. Jan. 11, 2007)

Judge L.T. Senter of the U.S. District Court for the Southern District of Mississippi held State Farm liable for $223,000 on a property claim brought by the plaintiffs, who lost their home and contents as a result of Hurricane Katrina. This initial ruling was in response to the plaintiffs' motion for judgment as a matter of law. Judge Senter granted the motion and directed verdict on the property claim, which State Farm had denied in its entirety, asserting uncovered flood damage. Judge Senter found that "no evidence has been introduced from which any finder of fact could reasonably determine what part of the loss of the Broussards' property is attributable to water as opposed to wind." Determination of punitive damages was left to the jury, which awarded $2.5 million. The jury found clear and convincing evidence that State Farm engaged in malicious or grossly negligent conduct in denying the claim. In a subsequent ruling, Judge Senter reduced the punitive damages to $1 million.

Woullard v. State Farm Fire & Cas. Co., 2007 WL 208519 (S.D. Miss. Jan. 26, 2007)

Judge Senter denied this motion for preliminary approval of a proposed class-action settlement that would have resolved the claims of all State Farm policyholders with insured property in Jackson, Harrison and Hancock counties, Mississippi, with coverage in effect when Hurricane Katrina hit. Judge Senter found insufficient evidence on numerosity and similarity of claims. The settlement guarantees minimum recovery only for "slab cases," where nothing is left of the home. Other categories of damage have no guaranteed recovery. Judge Senter found that, although State Farm committed to pay at least $50 million under the settlement, there was no way to tell how thinly the sum might be spread among the class members. Judge Senter also expressed concerns about the complex claims procedure, binding-arbitration provisions and the proposed attorneys' fees.

Tomlinson v. Allstate Indemnity Co., No. 06-00617 (E.D. La. 2007 Feb. 8, 2007)

Plaintiffs dropped this lawsuit at the close of evidence during a jury trial. The Tomlinsons suffered property damage to their home as a result of Hurricane Katrina. They alleged that the payout of $150,000 was insufficient for covered damages. The defendant filed a brief during the trial claiming that the plaintiffs had made material misrepresentations regarding their damages. The defendant contended that policy language would bar any recovery whatsoever if the policyholder had made material misrepresentations in their claim.

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Landry v. La. Citizens Property Ins. Co., No. 85571 (La. 15th Dist. Jan. 4, 2007)

Plaintiffs' home was rendered a total loss due to Hurricane Rita in 2005. The trial court granted the plaintiffs' motion for summary judgment. The defendant offered payment for that part of the damage it calculated was caused by wind, asserting the remaining flood damage was not covered under the policy. The plaintiffs argued that because their policy was a "valued policy," under which Citizens had assigned a value to the property as a whole, they were entitled to the policy limits pursuant to Louisiana's Valued Policy law (LSA-R.S. §22:695). The court ruled that the statute holds Citizens liable for the total value if any part of the damage is covered and the property is a total loss. The court indicated that, if the defendant had included a method of loss computation allowing offsets and deductions for flood damage, it might not have been liable for the full value of the property.

State Courts

Zimmerman v. Office of Ins. Regulation, 944 So.2d 1163 (Fla.Dist.Ct.App. Dist. Dec. 13, 2006)

Policyholder class appealed from the Florida Department of Insurance's denial of its rate challenge. The department is now known as the Florida Office of Insurance Regulation (OIR). The plaintiffs were insured against windstorm damage by the Florida Windstorm Underwriting Association (FWUA), the state-run insurer of last resort in Florida. FWUA is now known as Citizens. The OIR and Citizens went to arbitration in 1999 over a proposed rate increase, resulting in the arbitrator's approval of almost a 100% increase over several years. In 2001, the appellants filed a statewide class action against Citizens and the OIR challenging the validity of the rate increases and seeking premium refunds. The circuit court granted summary judgment in favor of the defendants. Appellants appealed. The First District Court of Appeal ruled that no cause of action exists in the circuit court for refunds of premiums paid. Such a request must be directed to the OIR. The court of appeal did not reach the two arguments of the present appeal, filed after the appellants petitioned the OIR for relief and were denied: (1) that the 2000 increase was invalid because no public hearing was held; and (2) that private arbitration to set Citizens' rates was unconstitutional.

In the present appeal, the Fourth District Court of Appeal ruled that the appellants' claims are barred by collateral estoppel. The First District's decision in the previous appeal indicated that the appellants should petition the OIR to determine whether the rate change was excessive or unfairly discriminatory. The OIR ruled they were not, and the ruling constituted a final decision on the fully litigated question of whether the rate-setting process was valid. The two remaining arguments from the first appeal are still unnecessary to consider.

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State Administrative Proceedings

In re MercyCare Ins. Co. & MercyCare HMO, 06-C29951 (Office of the Ins. Comm'r, Wis. Dec. 8, 2006)

Respondents challenge the determination by the Wisconsin Office of the Commissioner of Insurance (OCI) that they violated Wisconsin's insurance code by denying coverage for benefits sought by two surrogate mothers. MercyCare's certificate of coverage listed surrogate mother services as non-covered. Wis. Stat. §632.895 requires every group disability insurance policy that provides maternity coverage to provide maternity coverage for all persons covered under the policy. Coverage may not be subject to exclusions or limitations that are not applied to other maternity coverage. MercyCare argued that a covered person can obtain maternity services when the person is not a surrogate mother, and that this constitutes equal treatment of all covered persons. The commissioner ruled that MercyCare was treating one person's pregnancy expenses differently than another person's pregnancy expenses based on an intensely personal decision; i.e., whether to become pregnant and for what reason. MercyCare may deny coverage of certain procedures related to surrogacy, but it may not deny coverage of generally covered maternity services because the insured is a surrogate.

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Cummins, J. David and Richard A. Derrig, eds., 1989. *Financial Models of Insurance Solvency*, Norwell, Mass.: Kluwer Academic Publishers.

Manders, John M., Therese M. Vaughan and Robert H. Myers, Jr., 1994. "Insurance Regulation in the Public Interest: Where Do We Go from Here?" *Journal of Insurance Regulation*, 12: 285.

National Association of Insurance Commissioners, 1992. *An Update of the NAIC Solvency Agenda*, Jan. 7, Kansas City, Mo.: NAIC.

"Spreading Disaster Risk," 1994. *Business Insurance,* Feb. 28, p. 1.

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