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# AGENTS & CONSUMER PROTECTION

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Insurance rules and regulations vary from state to state. There are, however, widely accepted codes of behavior expected from licensed agents that fall under the category of consumer protection. Agents would be wise to mitigate the monetary and legal fallout that can result from consumer violations by practicing due care and complying with specific insurance code sections addressing consumer protection, as well as federal and state mandated laws under the title "deceptive or unfair trade practices".

- • **UNFAIR COMPETITION & UNFAIR INSURANCE PRACTICES BY AGENTS**

Agents should not participate in any unfair method of competition or unfair or deceptive act or practice in the business of insurance. Violators are typically subject to a hearing, usually before the State Department of Insurance, to show cause why a cease and desist order should not be made by the appropriate regulatory agency or board. If, after a hearing, it is determined that the agent's actions violate the rules of unfair competition and practices, a formal cease and desist order may be served. Violating such a cease and desist order is typically subject to various dollar penalties and administrative penalties such as injunctions, loss or suspension of license, and severe civil penalties such as high dollar fines, damage awards, and court fees to the injured parties. Areas of specific importance include:

- **Misrepresentation & False Advertising of Policy Contracts**

Making, issuing, circulating or causing to be made any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued is a violation of most insurance laws. Similar infractions occur in the misrepresenting of benefits or advantages promised or the dividends or share of the surplus to be received. Likewise, the misrepresentation as to the financial condition of any insurer, the legal reserve system upon which any insurer operates, inappropriate use of any name or title of a policy or class of policies for the purpose of inducing or tending to induce a policy holder to lapse, forfeit, or surrender his insurance is not permitted.

- **False Information & Advertising**

Most state insurance laws do not permit a licensed agent to engage in the making, publishing, disseminating, circulating or placing before the public, directly or indirectly, any form of notice, circular, pamphlet, letter or poster, or over any radio or television station an advertisement, announcement or statement containing any assertion or representation concerning the business of insurance or how another person conducts insurance business which is untrue, deceptive or misleading.

- **Defamation**

Defamation violations of insurance law occur where an agent is involved in making, publishing, disseminating, directly or indirectly, any oral or written statement, pamphlet, circular, article or literature which is false or maliciously critical of or derogatory to the financial condition of any insurer or which is designed to injure any person engaged in the business of insurance.

- **Boycott, Coercion & Intimidation**

Most states consider it unlawful for licensed agents to enter into any agreement or commit any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

- **False Financial Statements**

Restrictions are very clear that an agent violates the law when filing with any supervisor, public official or making, publishing, disseminating, circulating or delivering to any person, directly, or indirectly, any false statement of financial condition of an insurer with intent to deceive. This also includes making any false entry in any book, report or statement of any insurer with intent to deceive any agent, examiner or public official lawfully appointed to examine an insurer's condition or any of its affairs. Willfully omitting to make a true entry of any material fact pertaining to the business of such an insurer in any book, report or statement are similar violations.

- **Stock Operations**

It is considered unlawful to issue, deliver or permit agents, officers or employees to issue or deliver company stock, benefit certificates or shares in any corporation promising returns and profits as an inducement to sell insurance. Participating insurance contracts, however, are excluded from this category.

- **Discrimination**

An agent clearly violates insurance law in making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or life annuity or in the dividends or other benefits payable by such contracts. Similarly, there shall be no discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable under such contracts. Discrimination can also occur where individuals of the same class and of essentially the same hazards are refused renewability of a policy, subject to reduced coverage or cancelled because of geographic location.

- **Rebates**

Rebates permitted by law are authorized. Otherwise, it is a violation in most states to offer, pay or rebate premiums, provide bonuses or abatement of premiums or allow special favors or advantages concerning dividends or benefits related to an insurance policy, annuity or contracts connected with any stock, bond or securities of any insurance company. A rebate may also be classified as any readjustment in the rate of premium for a group insurance policy based on the loss or expense experience at the end of the first year, made retroactively only for that year.

- **Deceptive Name or Symbol**

Agents shall not use, display, publish, circulate, distribute or caused to be used or distributed any letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster or other document, literature bearing a name, symbol, slogan or device that is the same or highly similar to a name adopted and already in use.

- • **UNFAIR COMPETITION AND UNFAIR PRACTICES BY INSURERS**

Agents should know that the insurance companies they represent are also subject to the insurance and practice

rules above, as well as to specific deceptive or misleading acts in the areas of advertising, settlement practices, reporting procedures, discrimination (by race, disability, rates, renewal, benefits), investment practices, reinsurance restrictions, liquidations and more.

Violations of consumer protection issues by insurers will be met with an array of fines and penalties ranging from hearings before the commissioner, public hearings, judicial hearings and review, additional periodic reporting (beyond annual statements), investigative audits, dollar penalties, civil penalties to the more severe cease and desist actions and revocation of an insurer's certificate of authority to conduct business.

The following are some areas of consumer protection violations by insurers that should alert agents:

- **Unauthorized Insurer False Advertising**

The purpose of consumer protection laws in this area is obvious -- insurers not authorized to transact business in the state should not place, send or falsify any advertising designed to induce residents of the state to purchase insurance. This legislation is usually directed at "foreign or alien insurers" and defines advertising to include ads in the newspaper, magazine, radio, television and illustrations, circulars and pamphlets. Violations can also include the misrepresenting of the insurer's financial condition, terms and benefits of the insurance contract issued or dividend benefits distributed.

- **Unfair Settlement Practices**

Insurers doing business in a state are subject to rules and regulations detailing unfair claim settlement practices such as:

- Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages.
- Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies.
- Failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies
- Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear.
- Compelling policy holders to institute lawsuits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in the suits brought by these policy holders.
- Failures of any insurer to maintain a complete record of all the complaints which it has received during recent years (usually three years) or since the date of its last examination by the commissioner. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint.

- **Discrimination by Handicap**

An insurer doing business in a state may not refuse to insure, continue to insure or limit the amount, extent, or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely because of handicap or partial handicap, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonable anticipated experience.

- **Discrimination by HIV Testing**

In recent years, HIV-related testing in connection with an application for insurance has become commonplace.

If an insurer requests or requires applicants to take an HIV-related test, he must do so on a nondiscriminatory basis. An HIV-related test may be required only if the test is based on the person's current medical condition or medical history or if the underwriting guidelines for the coverage amounts require all persons within the risk class to be tested. Additional stipulations require that an insurer may not make a decision to require or request an HIV-related test based solely on marital status, occupation, gender, beneficiary designation or zip code. Further, the uses that will be made of the test must be explained to the proposed insured or any other person legally authorized to consent to the test and a written authorization must be obtained from that person by the insurer.

An insurer may not inquire whether a person applying for insurance has already tested negative from a previous HIV test. The insurer may inquire if an applicant has ever tested positive on an HIV-related test or has been diagnosed as having HIV or AIDS. The results of an HIV test are considered confidential, and an insurer may not release or disclose the test results or allow the test results to become known, except where required by law or by written permission from the proposed insured. Then and only then can results be released, but only to the proposed insured, a licensed physician, an insurance medical information exchange, a reinsurer or an outside legal counsel who needs the information to represent the insurer in an action by the proposed insured.

- **Discrimination in Rates or Renewal**

An insurer may not discriminate on the basis of race, color, religion, or national origin, and, to the extent not justified by sound actuarial principles on the basis of geographical location, disability, sex, or age, in the setting or use of rates or rating manuals or in the nonrenewal of policies.

- **Benefits Protection**

Insurers are duty bound to protect all money or benefits of any kind, including policy proceeds and cash values to be paid or rendered to the insured or any beneficiary under a life insurance policy or annuity contract. In essence, these benefits must inure exclusively to the person designated in the policy or annuity contract. They must be exempt from attachment, garnishment or seizure to pay any debt or liability of the insured or beneficiary either before or after the money or benefits are paid. They are also exempt from demands of a bankruptcy proceeding of the insured or beneficiary.

Of course, none of the rules prevent a proper assignment of any money or benefits to be paid by the insured, owner or annuitant in accordance with the terms of the policy or contract. Additionally, where a beneficiary of policy is responsible or an accomplice in bringing about the death of an insured, an insurer may withhold benefit payments to that beneficiary. However, the contingent beneficiary, who was not involved in the insured's death, may receive the stipulated benefits. Where no contingent is named, the benefits usually inure to the nearest living relative.

- **Health Policy Benefits**

In the health insurance industry, benefit payments are commonly assigned to a physician or other form of health care provider who furnishes health care services to the insured. An insurer may not prohibit or restrict the written assignment of benefits. When such an assignment is requested, the benefit payments shall be made directly by the insurer to the physician or health care provider and the insurer is relieved of any further obligation. Of course, the payment of benefits under an assignment does not relieve the covered person from any responsibility for the payment of deductibles and copayments. Further, a physician or health care provider may not waive copayments or deductibles by acceptance of an assignment.

- **Contract Entirety**

Every policy of insurance issued or delivered within the state by any life insurance company doing business in the state shall contain the entire contract between the parties. Furthermore, the application used to secure the insurance is usually made part of the contract.



- **Insurer Mergers**

The conditions and regulations necessary for two insurance companies to merge or consolidate are well documented in state insurance codes. Concerning consumer protection, however, it is important to know that all policies of insurance outstanding against an insurer must be assumed by the new or surviving corporation on the same terms and under the same conditions as if the policies had continued in force with the original insurer.

- **Reinsurance Assumptions**

A method used by one insurance company to insure or reinsure another insurance company is called stock assumption. Most insurance codes do not affect or limit the right of a reinsurer to purchase or to contract to purchase all or part of the outstanding shares of another insurance company doing a similar line of business for the purpose of reinsuring all of the business including the assumption of its liabilities.

Despite the practice of assumption reinsurance, some members of Congress in recent years have objected to the process, since there is no requirement to inform policy holders in advance that the insurance company behind their policy is relinquishing responsibility to another company, that is, the reinsurer. The reasoning behind their concern is that policy holders who have purchased coverage based on the financial condition and reputation of one company may suddenly find themselves insured by another company without warning or knowledge of the new company's abilities to pay their claims. To date, however, there is no definitive legislation passed to change reinsurance assumption.

- **Insurer Liquidation or Rehabilitation**

Each state has specific guidelines concerning when and how an insurance company is subject to regulatory intervention where an insolvency is possible. Most states have patterned these rules on one of two models:

**The Uniform Insurers Liquidation Act (UILA)** created by the National Conference of Commissioners on Uniform State Laws in conjunction with the American Bar Association.

**The Insurers' Supervision, Rehabilitation and Liquidation Model Act** developed by the National Association of Insurance Commissioners.

When a state determines that an insurer is in trouble, the insurance commissioner usually files an application to the court. The court petitions the insurance company to show cause why the company should not be placed in rehabilitation or liquidation. Once a company is placed under supervision, an injunction is issued to restrain the insurer, its officers, agents and others from any disposition of property without court approval. **Liquidation** is the more severe condition where the insurance commissioner must take title to the insurer's assets and use them to pay creditors and policyowners. **Rehabilitation**, on the other hand, allows for a restructuring of the insurer under the guidance of the commissioner. Unless the condition is extremely severe, companies are usually started in rehabilitation. If it is later determined that a restructuring will still not revive the insurer, a liquidation is ordered.

If an insurer is liquidated, all policy owners and other potential claimants **MUST** be informed and permitted to file a **proof of claim** with the insolvent estate. These claims will then be evaluated and a value established. Recent failures have demonstrated that claim values can be less than the amount due the policy holder. Under these conditions, a policy owner can file an appeal and seek a court decision before the actual liquidation of the company occurs. In order to protect the overall insurer estate, there are time limitations for filing these appeals.

Once all appropriate values are determined, the assets of the insurer will be distributed under a statutory procedure. This process requires that certain priority lien holders be paid in full, while others may divide what is left. The typical **liquidation order of priority** is as follows:

1. Liquidation expenses and costs

2. Unpaid wages of employees of the insurer
3. Taxes
4. Policy holders, insureds and guaranty funds
5. Reinsurers and all other claims

If a reinsurer indemnifies a liquidating company, it is only required to pay to the liquidator the actual loss it indemnifies. In other words, the reinsurer can only be called upon to pay deficiencies up to the limit it has agreed, once the ceding company, the liquidating insurer, has made all possible payments. This provision, which appears in most reinsurance contracts, is called an **insolvency clause**. The disadvantage of an insolvency clause is that policy owners, guaranty funds and other third-party claimants have no additional claim against reinsurance proceeds. An exception to this rule is where a **cut through clause** exists. A cut through endorsement would require a reinsurer to pay a loss or specified portion of a loss directly to the policy owner or insureds when an insolvency or another specific event occurs. General creditors and other third party claimants could be excluded under a cut through endorsement.

From the above discussion, it is obvious that the liquidation process can be extremely involved and lengthy. This is the reason that **guaranty funds** were established. They are an advance payment system to pay off individuals and groups who would be devastated by the liquidation process. A claim against a state guaranty fund is typically limited to residents of that state. Payments are limited to certain amounts, depending on the type of insurance purchased. Once a claim has been paid, the guaranty association becomes **subrogated** to the claimant's rights to further payments. Thus, a policy holder who collected from a state fund forfeits his claim rights against the insolvent insurance company.

## • • **DECEPTIVE OR UNFAIR TRADE PRACTICES**

In addition to specified insurance codes, insurance agents must answer to generalized consumer protection laws carrying titles such as "**Deceptive Trade Practices**" or "**Unfair Trade Practices**". For the most part, these **consumer laws apply to insurance** and agents because an insurance policy is deemed a "**service**" and the purchaser of a policy is deemed a "**consumer**". Therefore, insurance services fall within the meaning of widely adopted consumer protection acts. Agents are also pursued under consumer protection laws because some insurance codes do not specifically address certain questionable acts by agents where the misrepresentation or fraud occurs outside the limits of insurance business. In such cases, the damaged insureds or policy owners were not considered to be "consumers". By including the purchase of insurance services as a consumer transaction, the additional protection of deceptive or unfair trade practices acts can be invoked.

**The Uniform Consumer Sales Practices Act** was enacted by the federal government and adopted by many states to protect consumers from deceptive marketing practices and establish a uniform policy. The essence of this legislation, as well as local and state laws, is that "buyer beware" is an old attitude now replaced by real laws and enforceable legal limits. The Courts frown on oppressive and unconscionable acts and consider it the duty of any sales person and agent to disclose information available to him which gives him an unfair advantage in a sale. False statements constitute fraud, and the fine print in contracts may be construed, under certain conditions, as an intent to conceal.

### • **Unlawful Trade Practices**

False, misleading or deceptive acts or practices in the conduct of any trade or commerce are unlawful and subject to action by the appropriate codes of consumer protection. Such acts, which may apply to insurance agents and brokers, include, but are not limited to the following:

- Passing off services as those of another
- Causing confusion or misunderstanding as to the source, sponsorship, approval or certification of services offered

- Causing confusion or misunderstanding as to affiliation, connection or association with another
  - Using deceptive representations or designations of geographic origin in connection with services
  - Representing that services have sponsorship, approval, characteristics or benefits which they do not have.
  - Disparaging services or the business of another by a false or misleading representation of facts
  - Advertising services with intent not to sell them as advertised
  - Advertising services with intent not to supply a reasonable expectable public demand, unless the advertisements disclose a limitation on quantity
  - Representing that an agreement confers or involves rights, remedies or obligations which it does not have or involve, or which are prohibited by law
  - Misrepresenting the authority of a salesman or agent to negotiate the final terms or execution of a consumer transaction
  - Failure to disclose information concerning services which was known at the time of the transaction if such failure was intended to induce the consumer into a transaction which the consumer would not have entered had the information been disclosed
  - Advertising under the guise of obtaining sales personnel when in fact the purpose is to first sell a service to the sales personnel applicant
  - Making false or misleading statements of fact concerning the price or rate of services
  - Employing "bait and switch" advertising in an effort to sell services other than those advertised on different terms or rates
  - Requiring tie-in sales or other undisclosed conditions to be met prior to selling the advertised services
  - Refusing to take orders for the advertised services within reasonable time
  - Showing defective services which are unusable or impractical for the purposes set forth in the advertisement
  - Failure to make deliveries of the services advertised within a reasonable time or make a refund
  - Soliciting by telephone or door-to-door as a seller, unless, within thirty seconds after beginning the conversation the agent identifies himself, whom he represents and the purpose of the call.
  - Contriving, setting up or promoting any pyramid promotional scheme
  - Advertising services that are guaranteed without clearly and conspicuously disclosing the nature and extent of the guarantee, any material conditions or limitations in the guarantee, the manner in which the guarantor will perform and the identification of the guarantor
- **Burden of Proof**

To recover under deceptive or unfair trade practice acts, it is the claimant's burden to prove all elements of his

cause of action and that he is a "consumer" within meaning of the act.

- **Legal Remedies**

Whenever the courts or consumer protection division of an insurance department have reason to believe that any person is engaging in, has engaged in, or is about to engage in any act or practice that may violate a trade or practices act, and that proceedings would be in the public interest, the division may bring action in the name of the state against the person to restrain by temporary restraining order, temporary injunction, or permanent injunction the use of such method, act or practice. In addition, there may be a request by the consumer protection division, requesting a civil penalty for each violation, possibly \$2,000, with a maximum total not exceed an established amount (typically \$10,000). These procedures may be taken without notification to such person that court action is or may be under consideration. Usually, however, there is a small waiting period, seven days or more, prior to instituting court actions.

Actions which allege a claim of relief may be commenced in the district court -- usually where the person resides or conducts business. The Court may make such additional orders or judgments as are necessary to compensate those damaged by the unlawful practice or act. Usually, there is a statute of limitations, typically two years, to bring such action.

# AGENT DUE CARE

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If an you sought the advice of a liability attorney concerning your responsibilities to clients, he would probably advise that you do the following:

- # Know **everything** possible about your client's financial and insurance needs
- # Have a complete understanding of **all** products you sell and present them fairly
- # Find the **most** suitable product for your client and make sure you place him with financially capable companies
- # Document **any** lack of knowledge with a full disclosure agreement
- # Require each client to sign a binding arbitration agreement for any misunderstanding or dispute

While this may be good advice, it is not always possible to follow for each and every client, and much current day education and training of agents offers little to promote it. More than likely, you and other agents are rewarded for bulk production and sometimes for simply choosing a particular carrier. Some industry groups and associations feel that too much money is spent on grooming and motivating sophisticated "salesmen" when there is a need for greater agent diligence.

The cornerstone of this insurance diligence movement is called **agent due care**. Roughly translated, due care is an agent's **professional and ethical handling and choice of company, product and sales presentation to best serve a client's financial planning**. Fundamental to due care is the understanding that all insurance is constructed of the same elements -- expenses; experience, that is, claims risk or mortality; and return or profit. Therefore, a policy that appears to be significantly better than others in the marketplace should be suspect. Once a suitable product can be found, the decision to buy should be based on the assumptions in the policy and the financial stability of the company. Policy illustrations and quotes are one method to make this assessment. Unfortunately, agents and clients are relying too much on these presentations to the extent that policies are rarely read. As a result agents should be sure that any projection or estimate disclose the assumptions that went into the projection and the fact that variations in these assumptions can significantly change insurance results. Recent laws have even made it mandatory to bold or highlight any "guaranteed" portions, as compared to simple projections. It is further suggested that illustrations be run again, without forecasting better times or improved rates into the future, to see if they still meet client expectations.

With reference to agents choosing safe companies to insure their clients, it will be demonstrated that agent due care involves many disciplines including: disclosure, diversification among multiple carriers, product variation diversification, regulatory knowledge, multiple rating verification, key ratio comparisons, periodic monitoring and more. A recent business magazine survey is a painful reminder to the industry that the road to agent excellence may still be cluttered with potholes and a fair share of detours. Money Magazine tested 20 insurance agents on their accuracy and clarity in explaining their insurance products and the role they played in a client's financial planning. Most of the agents failed simple standards of due care. In a like manner, few agents could probably demonstrate financial assumptions used to determine solvency of a chosen insurer -- either at time of purchase or later. Agents must realize, that doing "too little" concerning how and where they place client business can be hazardous to their financial health and moral responsibility to the people they serve. This takes on special meaning to agents when they discover that lawyers want to prove that a pocket rating card and other company supplied financial condition brochures may not be enough to demonstrate that an agent did his best in selecting a carrier who, after purchase, declined to unsafe or liquidated status.

No doubt, it will be the same attorneys who expect an agent to quote code and verse about the company, a policy

or illustration when something goes wrong. There is no question that young lawyers, and some very rich lawyers alike, are increasingly aware of the numerous legal theories available to hold the insurance producer liable for failing to meet some kind of professional standard. Could a jury be convinced, for example, that an insurance professional, especially one who has earned a designation such as CLU or CFP, neglected his professional duties in not explaining the full impact of estate taxation to a now deceased, but underinsured client? Is a casualty broker liable for placing a client with a B rated carrier that liquidates at the very time a client files a claim?

The answers to these questions are continually being litigated. The **significance**, however, is that the courts in just about every state, have made it absolutely clear that **insurance agents are selling a lot more than a mere contract of insurance. They are selling security, peace of mind and freedom from financial worry in the event of a catastrophic claim.** In essence, the marketing pitch that made the sale, i.e., "agent as counselor" or "problem solver", can be the malpractice attorney's "big stick".

## • • AGENT DUE CARE IN CHOOSING A COMPANY

Agent due care in choosing a company centers on the **ability to direct a client to an insurer that is solvent at the time of purchase and able to meet its contractual obligations.** An additional consideration is **diversification** to meet state guaranty fund protection and **on going monitoring** by private rating services. Policy owners must depend on agents for choosing insurers because they are generally unsophisticated in analyzing the financial complexities of solvency.

Agents should remember that businesses and individuals purchase property and liability insurance to minimize current financial losses. Life, health and annuity policies cover losses of future economic potential. In both cases, the purpose is to shift the financial consequences of loss. Sometimes, however, policy owners find that the "safety net" they purchased is not always as safe as it started out to be. The recent increase in frequency of insurance company failures and inability to pay claims is proof. It is further substantiated by the substantial increase in claims submitted to state guaranty funds which are forced to step forward and make good on failed promises of defunct or faltering companies.

An agent is engaged by a client because he is the insurance professional. Clients should rightfully expect to be placed with financially reliable insurers. Too often, it is believed that state regulators are monitoring solvency closely and will advise agents and brokers by some mysterious "hot line" -- it just doesn't happen that way -- and we have recent examples to prove this is not the case. Regulators of insurance companies, like regulators of financial institutions such as banks and thrifts, do not make public announcements of pending problems. This could cause a "run on the bank" or a "run on the insurance company". Severe disintermediation, withdrawal of policyholder funds or policy cancellations could initiate a complete collapse similar to what happened with Mutual Benefit Life. By stepping in without public warning or fanfare, regulators hope to avoid the severity of a takeover and minimize consumer panic. That is why an agent will not receive advance warning from regulators. Unless the agent is tracking solvency by demanding full disclosure from an insurer BEFORE AND AFTER involving a client, he may experience the unpleasant experience of dealing with a disgruntled client or his attorney who just read about an insurer's demise, complaints filed with the insurance commissioner, or worse, a surprise visit from the "60 Minutes" investigative team!

There are NO set rules on solvency due care techniques since the actual process must consider the risk capacity of a client, the current economy and the specific financial result or exposure needing coverage. However, there are some steps that agents might take to help mitigate bad choices. It is hoped that at least a few of the following sources and considerations will have application and will involve the agent in an area of due care that has been largely ignored. If this is considered too time consuming, an agent would be advised to concentrate only on those companies where this information can be acquired. In some cases, due care is not simply a matter of collecting a financial ratio. The story behind the numbers is often as important.

### • Using the Rating Services

An agent choosing a company for his or her client would be advised to consult the major rating services. The

activities of insurance company rating agencies have become increasingly prominent with the industry's recent financial difficulties and the well publicized failures of several large life insurers. The ratings issued by these agencies represent their opinions of the insurers' financial conditions and their ability to meet their obligations to policyholders. Rating downgrades are watched closely and can significantly affect an insurer's ability to attract and retain business. Even the rumor of a downgrade may precipitate a "run on the bank", as in the case of Mutual Benefit, and seriously exacerbate an insurer's financial problems. There is little doubt that rating organizations play a significant role in the insurance marketplace.

Some have expressed concerns about the potential adverse effect of ratings on particular insurers and consumer confidence in the insurance industry in general. Once the province of only one organization, A.M. Best, a number of new raters emerged during the 1980s. Questions have been raised about the motivations and methods of the raters in light of the recent sensitivity regarding insurers' financial conditions and what some perceive to be a rash of arbitrary downgrades. On the one hand, insurer ratings historically have been criticized for being inflated or overly positive. On the other side, there are concerns that raters, in an effort to regain credibility, have lowered their ratings arbitrarily in reaction to recent declines in the junk bond and real estate markets and the resulting insurer failures and diminished consumer confidence.

One consultant suggests a way to determine if an insurer is running into difficulty is to monitor several ratings. If the ratings vary widely, this should send a signal that there are other factors of concern regarding the insurer. A recent example is United Pacific Life. In 1992 it was rated A-Plus by Duff and Phelps, BBB by Standard & Poors and Ba-1 by Moody's.

- **On Going Monitoring & Policy Replacement**

Agent due care should also involve the on-going monitoring of a chosen company. In the past, there has been no legal premise to hold agents responsible for monitoring solvency of a company after the initial sale. However, in *Higginbotham v. Greer*, it is **suggested** that agents need to keep clients informed about significant changes in the financial condition of the company **on an on going basis**. An attorney might advise that an agent conduct any and all on going due diligence, document files and utilize published and third party testimonials -- especially to justify a case for switching or surrendering of a policy.

Agents must carefully consider any recommended move of client's coverage from a company rated "A" or better to a lesser rated carrier. Even if the intent was to provide superior coverage, the client's security position has technically downgraded. Agents might be advised to fully document files on why this recommendation was made.

- **Company Deals**

Agent due care should carefully consider companies that offer deals that are "too good to be true". Agents might be advised to at least be suspicious of a company offering a "better deal" than anyone else. It is common sense that something along the way will suffer, as it did in the case of some life companies that invested in junk bonds and many casualty companies which participated in deep discount premium wars where expenses and claim costs at times exceeded income. This can only represent a degenerative financial condition for the insurer.

Also remember that insurance professionals, as salesmen, want to believe something is a better product or a better company. By their very nature, salesmen often "get sold" as easy as some clients. It would be wise to be critical of all brochures and analysis distributed by a carrier which portray it to be the "best" or "safest".

- **Company Diversification, Business Lines & Parent Affiliation**

In the quest to satisfy due care, perhaps a strategy of multiple company coverage is the answer. For a client's life insurance needs, some combination of term, whole life, variable life or universal life may be employed to spread the risks among many different insurers and product lines. The variable life component could be

diversified even more by using multiple asset purchases. On the casualty side, similar diversification might be employed between business and home owners policies, workers' compensation, professional liability, etc.

The insurance consumer should also be educated by agents about the different types of insurers, i.e., stock versus mutual company, although it might be considered an error to generalize about the safety of an insurer or the price of its coverage or the service it provides, based solely on the insurer's legal structure. This disclosure may be particularly appropriate where an insurer, due to its legal structure, may NOT be covered by state guaranty fund protection, e.g., non-profit Blue Cross and Blue Shield. Or, where the legal structure of the product offered may NOT be "insured" by state funds, e.g., variable annuities.

An agent may not have many choices concerning the company he writes, e.g., worker's comp coverage can only be secured with a carrier willing to write worker's comp. It has been suggested, however, that agents may consider the nature of multi-line companies to determine if one of the lines is weak enough to "down-drag" a profitable line. An example could be a life company that also writes health insurance as a direct line of business or by affiliation. If health carriers become threatened under a new national health care proposal, it could spell trouble for an insurer's health line which can affect ALL lines of business written. Of course, this is not to say that a multi-line carrier cannot be profitable and solvent.

Who or what kind of company owns the insurer is another consideration. Is the parent sufficiently solvent that it will not recruit or siphon funds from the insurer? In a like manner, does the insurer own an affiliate that may likely need capital infusion from the insurer? Has the insurer recently created an affiliate, and are the assets in this affiliate some of the non-performing or underperforming investments of the original insurer? Is a merger in the offing that might mingle your client's A-rated company with a larger B+ company? In what partnerships or joint ventures does the insurer participate? Do these entities own problem real estate properties of the original insurer? Has the insurer invested in other insurance companies, and have those companies, in turn, invested back in the original insurer or one of its affiliates?

Name recognition can go a long way in giving a client a high level of comfort. In the early 1980's, for example, Cal Farm Insurance, a B rated company, was proud to point out that it was owned by the California Farm Bureau, a 100-year-old company. By the mid 1980's, however, Cal Farm Insurance was liquidated by the California Department of Insurance for overextending itself on financial guarantee bonds that it could not pay. Because the claimants were considered to be sophisticated investors, they received only 25 cents on the dollar and forced to foreclose on the properties behind the financial guarantee bonds themselves. The California Farm Bureau was not "forced" as a source to pay any deficiencies.

Other abuses have occurred with a slightly different twist. For example, Senate investigations have revealed that the failure of many insurers can be directly tied to the "milking" of these companies by a "non insurance" parent. Further, not all abuses have been on the side of the parent. Insurance companies themselves have been known to tap huge sums of capital from their parents, commingle assets and devise elaborate schemes, including sale and leaseback arrangements and the securitization of future revenues.

- **Conflicts of Interest**

Agents receive a commission for their expertise in selecting a suitable product and company. The fact that the agent receives this commission from the same company represents a definite conflict of interest. An ethical agent should disclose this fact in reference to the choice of the company selected. Where the commission is higher than normal, one might question the specific policy elements that will be affected, higher surrender or cancellation charges, etc or considerations about the financial qualifications of the insurer and include these facts in any disclosure. An insurer recently placed in liquidation, for instance, had a known history of paying higher than prevailing commissions.

- **Reinsurance**

Reinsurance is an effective tool for spreading risk and expanding capacity in the insurance marketplace. The



strength of the guarantees backing the primary company, however, are only as strong as the financial strength of the reinsurer. Abuses have occurred where the levels of reinsurance have been too high, the quality poor and the controls nonexistent. Industry analysts suggest that the total amount of reinsurance should not exceed 0.5 to 1.3 times a company's surplus. Agents should also be concerned about foreign reinsurance since U.S. regulator control and jurisdiction is difficult. See how much of the foreign reinsurer's assets are held in the United States. Ask if the reinsurer has directly guaranteed the ceding company or used bank letters of credit for this purpose. These credit letters have not been effective guarantees in the past. Also, under terms of the ceding contracts, can the reinsurance be "retroceded" or assumed by another reinsurance company -- it is possible to have layers of reinsurance which could create difficult legal maneuvering during a liquidation? Does the ceding contract have a "cut-through" clause which allows the reinsurer to pay deficient policy owners or insureds directly, rather than to the liquidator? Is the insurer writing a significant amount of new business that may require costly amounts of first- year reinsurance?

**Reinsurance surplus relief** is another area of concern to investigate. The first year that an insurance policy goes on the "books", the insurance company suffers a loss. This is attributed to laws related to the accounting valuation of the policy and the high costs or expenses paid in the first year, such as commissions, etc. A loss to an insurer also reduces a company's surplus. A strain on surplus can create all kinds of problems with regulators and lenders, so insurance companies go to great lengths to shore up their surplus from the losses of first year policies. This may be accomplished by raising additional capital or through some form of financing. More often than not, however, an insurance company will simply call up the local reinsurance company and obtain surplus relief reinsurance. Once in place, surplus reinsurance provides the ceding company, the insurer who uses the reinsurance funds, with assets or reserve credits which improve the insurers earnings and surplus position. The major difference between using reinsurance to cover first-year losses and a loan is how the transaction is reported. When an insurer obtains a loan, the accountant must record a liability. Reinsurance for surplus relief, however, is NOT considered a liability under statutory accounting because the repayment is tied to future profits of the policy or policies being reinsured. Collateral for the reinsurance, in essence, is future profits. Thus, reinsurers run substantial risks when the ceding company cannot pay. The fee or interest for providing the reinsurance is typically from 1 percent to 5 percent of the amount provided.

Regulators are well aware of reinsurance surplus relief practices. Over the years, they have introduced rules which attempted to minimize abuses. The 1992 Life and Health Reinsurance Agreements Model Regulation was adopted by the National Association of Insurance Commissioners for implementation starting in 1994. The National Association of Insurance Commissioners also adopted a 1988 regulation which reads as follows: ". . . If the reinsurance agreement is entered into for the principal purpose of providing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the unexpected potential liability to the ceding insurer remains basically unchanged".

- **Size of Company & Loan Portfolio**

What percentage of an insurer's nonperforming or underperforming real estate projects have been "restructured" -- sold and self-financed to a new owner at favorable terms to eliminate a "drag" on surplus?

Statistically, fewer failures have hit companies with assets greater than \$50 million. It is thought that larger companies have more diverse product lines, bigger sales forces, better management talent--in essence, they are better equipped to ride out financial cycles. In recent widescale downgrading of insurers, A.M. Best seems to have favored significantly larger companies in the over \$600 million category. However, another advisor feels that a small, well capitalized companies can deliver as much or more solvency protection as a large one suffering from capital anemia.

- **State Admission**

Checking that an insurer is licensed or admitted to do business in the state at least assures that the company has met solvency and financial reporting standards. Most states offer toll free numbers for these inquiries. Some states will also divulge the rank of an insurer by the number of complaints per premium volume. Agents should

realize, however, that to date no court has allowed an insured who has suffered a loss as a result of an insurer insolvency to recover from a state run department of insurance for failure to regulate the solvency of the insurer.

- **Risk Based Capital**

Risk Based Capital guidelines could prove to be one of the most useful tools for quantitative analysis. In a nutshell, it is a **capital sufficiency test** which compares actual capital, surplus, to a required level of capital determined by the insurer's unique mix of investment and underwriting risks.

Guidelines for this new regulation took effect in 1994 for life and health companies and 1995 for property/casualty insurers. **Risk Based Capital** is the brainchild of the National Association of Insurance Commissioners. Since its inception, the National Association of Insurance Commissioners has strived to create a national regulatory system by the passage of **model acts** or policies designed to standardize accounting and solvency methods from state to state. Risk Based Capital is one of many "model acts" recently adopted by the National Association of Insurance Commissioners.

The **Risk Based Capital Model Act** defines acceptable levels of risk that insurance companies may incur with regards to their assets, insurance products, investments and other business operations. Insurers will be required, at the request of each state insurance department, to annually report and fill out Risk Based Capital forms created by the National Association of Insurance Commissioners. Formulas, under risk based capital, will test capitalization thresholds that insurers must maintain to avoid regulatory action; recalculate how reserves are used; reduce capitalization required for ownership of affiliated alien insurers and non-insurance assets; and allow single-state insurers to qualify for exemption from reinsurance capitalization if their reinsurance doesn't exceed 5 percent of total business written. The risk based capital system will set minimum surplus capital amounts that companies must meet to support underwriting and other business activities. Because the standards will be different for each company, the guidelines run counter to existing state-by-state regulations that require one minimum capitalization requirement for all insurers regardless of their individual styles of business or levels of risk.

Insurers reporting Risk Based Capital levels of say less than 70 percent to 100 percent may be subject to strict regulatory control. Scores from 100 percent to 150 percent might be issued regulatory orders requiring specific action to cure deficiencies. Higher scores might receive regulatory warnings and corrective action stipulations. Attaining 250 percent or more, would relieve an insurer from any further Risk Based Capital requirements in a given year.

It is clear that Risk Based Capital encourages certain classes of investment over others. For example, an **asset-default test** under Risk Based Capital, called C-1, establishes varying reserve accounts be established for various classes of investments based on their default risk. These amounts could be as much as 30 percent for stocks and low quality bonds and 15 percent for real estate owned as a result of foreclosed mortgages. Industry critics say that the **C-1 surplus requirements** alone could be far greater than all other categories of Risk Based Capital like mortality risk assumptions, interest rate risks and other unexpected business risks. Since the 1994 Risk Based Capital reports are based on 1993 financial conditions, many insurers have already started to restructure their portfolios to avoid as many C-1 assignments as possible. This has included the wide scale disposition of real estate and real estate mortgages, the repackaging of real estate products into securities and large reductions in "junk bond" holdings. Despite these efforts, C-1-rated classes of assets continue to represent a sizeable share of insurer portfolios. In many cases, companies have very few options to unload foreclosed real estate as long as the market continues soft. A Saloman Brothers Inc study of almost 500 insurance companies clarifies the problem. Using 1992 financial reports for these insurers, the median level of surplus capital was found to be at 189 percent of their respective Risk Based Capital levels. Even though, a majority of companies exceeded the 150 percent threshold--thus, not requiring regulatory correction--the results indicate that hundreds of companies did not measure up. The concern by industry groups is that when Risk Based Capital is enacted, the results could generate significant "bad press" which could weaken demand for individual company and industry products. There is also speculation that companies will change investment portfolios to achieve higher Risk Based Capital ratios. This may critically hamper real estate investing for a some time to come.

On the surface, Risk Based Capital seems to solve many regulatory concerns. Solvency rulings are standardized from state to state and specific action is mandated across the board. This would appear to be acceptable by insurance companies who could now predict regulatory response in any state. However, as we have seen, Risked Based Capital could also adversely affect financially sound companies simply because they own more real estate -- performing or not.

Some in the industry also feel that the Risk Based Capital rules are simply too restrictive, subjecting many of the best known insurers to immediate regulatory action and "bad press". This, in turn leads to a "run on the bank" that could tip these insurers into worse condition. The concern of these parties is that the risk based capital system doesn't falsely identify adequate capitalized insurance companies and undercapitalized ones as being adequately capitalized. Too much is concerned with the type of investment, rather than its quality. Just how companies react to these guidelines remains to be seen. As mentioned, many life and health insurers have already changed their investment strategies to more favorably align with risked based capital guidelines by selling their large scale real estate investments and junk bonds.

## • • **AGENT DUE CARE IN CHOOSING PRODUCT**

If an agent is truly using due care in selecting the right policy, ***before selling*** the policy

- The agent should obtain specific information on the client's current and anticipated risk exposure and review all existing policies.
- The agent should request and review a "specimen" policy and policy amendments for every insurance contract he is marketing.
- The agent should make sure that the client clearly understands the type and limit of coverage being purchased; the responsibilities of each party, the insured and the insurance company; and the services that will be provided by the agent.
- Once in force, the agent has a continuing due care responsibility to monitor policy needs. Regardless of the sequence of policy decisions, agents must recognize that the choice of a policy is viewed differently between agent and client. An agent seeks coverage as a means of transferring pure risk. A client views policies in terms of obtaining reduced uncertainty, i.e., in most cases, your customers can only hope that the policy they purchase is appropriate. That is why agents are vital players in any insurance purchase. The greater agent due care exercised, the more valuable the service. It is also why, when viewed from an agent's liability, that ALL options should be disclosed.

## • **Policy Choices & Risk Management**

The process by which agents help clients select the most suitable policy is known as ***risk management***. The two basic rules concerning risk management are:

- The size of potential losses must have a reasonable relationship to the resources of the client
- Benefits of risk reduction must be related to its cost

In essence, these rules advise risk takers not to risk more than they can afford to lose, to consider the odds and not to risk a lot for a little.

The agent must also consider a client's ***pure risk*** vs. ***speculative risk***. Both pure risk and speculative risk involve uncertainty, but in pure risk, the uncertainty relates only to the occurrence of the loss. In other words, there is no chance for a profit to be made. Speculative risk offers the opportunity for both gain and loss. An example of a speculative risk is when a dilapidated apartment burns and is replaced with new housing. Society can gain from speculative risk. However, the agent would do better to concern himself with the pure risk losses of the client. In the above case, for example, does the apartment policy provide pure risk provisions, such as a "lost

rent clause" to provide the client and his family sufficient cash flow while the new apartment is being built?

The **process of risk management** requires setting and achieving goals in at least four areas: pure risk discovery, options to deal with the risk, implementation and on going risk monitoring.

**Pure, risk discovery** requires knowledge about a clients assets, income and activities of his family or business. Several sources can be valuable, including: financial records (balance sheet and income statement), specific information on each asset (location, title replacement cost, perils, hazards they are exposed to). Questions about sources of income and expenses help determine the client's ability to self-insure all or a portion of any potential loss. Physical inspections of the client's home and business might also pinpoint additional liability loss hazards. This can even include a study of all existing contracts such as leases, employment contracts, sales and loan agreements.

Even when exposures are detected, no estimate of the maximum loss potential can be made with absolute confidence, since matters concerning the timing of a client's death, disability or health problem can change the desired resource amount. The same is true concerning property and liability exposures -- depth and breadth are hard to quantify.

**Options to deal with risk** can be evaluated after specific risks have been identified. The risk manager's goal is to reduce the "post loss" resources needed by the client using the most efficient method. In essence, this is the age old battle of balancing costs and benefits. That is why risk management almost always implies hiring one or more insurance companies to carry the burden. In this decision, however, there is temptation to resist paying for excess coverage of any type which can rob the client of cash flow that could otherwise be used to build assets more quickly and less expensively -- specifically, assets that are needed to provide for the present or to create a "living" for the future. As part of this consideration, it may just be that the client pays premiums for many years, is never disabled or does not die earlier than his life expectancy. Or, he may never sustain a loss of property. The professional agent will should advise the client that this too, is a possible outcome.

Factors to consider include personal and business resources the client may wish to devote to covering losses (cash, assets, bonds, etc), available credit resources, the use of higher than average deductibles and any possible claims for reimbursement the client may make against outside parties who may be legally responsible to help pay all or part of the loss. Of course, it is likely that the major transference of risk, or the final source of loss coverage, is the insurance contract.

**Implementation** of the insurance contract is made after the agent has developed specifications for coverage, established criteria or standards for insurers; compared rates and terms for the most efficient contracts and arranged for all contractual requirements, like the application, rating history, specimen tests, inspections, etc. Probably the most important contribution the agent can make at this phase is in aiding client indecision. Clients and agents alike can be frequently confused by the continuing arguments favoring term versus whole life or the value of an inflation rider to protect future property values. The result of these conflicting considerations and advice can be that too much time is spent wallowing in indecision about levels and type of protection for what reasons. The fallout may be over insurance or under insurance or no insurance at all. The professional agent who practices due care will also provide counseling to bring these decisions to settlement.

**On going Risk Monitoring** can be as crucial as any one or all of the processes involved in risk management. Simply put, after the implementation of the appropriate policy, it should be the agent's duty to review coverage annually, evaluate on going adequacy, stay current with new coverage that might better suit the client's needs, alert the client when the policy needs to be renewed and be available to assist in servicing needs such as title changes, claims assistance, alternative payment planning, etc.

While the process of risk management is conceptually similar across most product lines . . . life, health, disability, property, casualty . . . the analysis of exposure is quite different. Following is a discussion of

possible due care precautions an agent might explore when working in each product line. In cases where the agent does NOT handle multiple lines of insurance, a simple disclosure and referral may be advised to meet minimum due care.

## • • **DUE CARE -- LIFE/HEALTH**

Questionable ethics in the 1980's created new demands for the agent of the 1990's and beyond. For life and health agents, past abuses have centered around twisting, wholesale replacement, deceptive advertising, misleading illustrations and other unethical acts. Regulators have responded with replacement policy forms, insurer fines, agent reprimands, and in some cases, revocation of licenses. To compound the problem, the industry's image has been further tarnished by solvency problems. Further, stiffer competition, declining interest rates and thinner profit margins have impacted how insurers and agents work together -- less support in marketing and support materials. The bottom line in either case is that agents are forced to work harder and smarter. In lieu of sitting back and waiting for the market to improve, industry forecasters say that agents must accept new roles to survive. The trend toward "agent as counselor" is the most obvious path. Repeat business, referrals and long-term rewards must center more around client needs, rather than the products agents wish to sell. Putting oneself out to be knowledgeable in many financial matters, however, will come with a price tag. Both regulators and clients will hold insurance professionals to ever higher standards. Agent due care will be more important than at anytime in our industry's history. This will involve a commitment by agents to polish skills and acquire a systematic approach to filling client needs. Following are some basic due care discussions which may help the agent get started. Of course, every situation will vary and require constant refinement:

### • **Life Insurance Risk Analysis**

Before determining the amount of life insurance needed by a client, due care would involve the agent and client in a discussion concerning the various types of life insurance available . . . annual renewable term, deposit term, decreasing term, level term, whole life, modified whole life, single premium whole life, universal life, variable life, etc. The attributes of these different policies are best left to a course on basic life insurance. However, it is critical, under due care, that agents recognize the "pure risk" need of clients and counsel them on the proper choice. For example, persuading a client to accept a high monthly premium whole life policy with a settlement payoff that leaves a significant financial gap at the death of a breadwinner, is NOT exercising due care. This is not to imply that whole life forms of insurance are inappropriate. Rather, there are situations here a client's age and situation call for the agent to consider future estate settlement costs and liquidity as prime directives in making policy choices. There may even be conditions where due care by the agent might involve a recommendation for a client to carry little or no life insurance at all. Issues regarding life insurance needs for singles, non working spouses and children are often debated among financial planners and agents alike.

One process for determining an estimate of the amount of life insurance needed is called **capital needs analysis**. Financial planning courses cover this process in considerable detail and typically include a sample capital needs worksheet. For purposes of due care by agents, factors to consider by agents include:

#### • **Capital needs for family income**

Most families will be able to maintain their standard of living with about 75% of the former breadwinner's income. Depending on the skills and resources of the surviving spouse, this fund may be large enough to provide lifetime income or for a specified period of transition.

#### • **Capital needs for debt repayment**

Typical debts to consider include home mortgages, charge cards, bank notes, business debt, etc. A decision can be made to totally liquidate the debt or to use life insurance proceeds to set up a "sinking fund" to make payments for the life of the loan or a specified period.

#### • **Other Capital Needs**

This might include emergency reserve funds, estimated to be between 50 percent and 100 percent of a client's annual after-tax income, and possible college education funds for surviving children.

- **Estate Settlement Costs**

Final expenses can be expensive. Uninsured medical costs and funeral expenses are one aspect. In addition, there are federal and state death taxes. Although the Economic Recovery Tax Act of 1981 eliminates the federal estate tax on property passed to a surviving spouse, the estate of the survivor may face a large death tax liability. Further, there have been recent attempts by Congress to lower the exemption levels. State death taxes vary considerably.

- **Current Assets Available for Income Production**

What current assets, such as savings accounts, investments, real estate, pension plans, etc, are currently available for income production or liquidity needs to offset the capital needs above?

- **Net Capital Needs**

By combining the above factors, the agent can arrive at the net capital needed to be replaced by life insurance.

Where capital needs analysis indicate that a \$500,000 gap will occur at the death of the breadwinner(s), the agent's ***due care life insurance recommendation*** should be for \$500,000 of life insurance. Anything less could leave the client ***underinsured***. Lesser amounts may be purchased where the client cannot afford the premiums or makes the choice to carry less. If there are additional concerns, such as a client's long-term health, the agent might be advised to disclose his recommendation even though a more expensive policy with less coverage is purchased.

On going monitoring of capital needs is necessary to plan for new client objectives, repositioning of debt, inflation, estate settlement changes and potential health problems that may prohibit coverage in the future.

Another due care consideration concerning life insurance is ***ownership or title of the policy***. Agents should recognize conditions where it would be beneficial to keep life insurance proceeds out of a client's estate by using a life insurance trust or alternative ownership. Due care may be sufficient where agent disclosure of estate tax consequences of life insurance owned by a client and a proper referral to a competent estate planning attorney is pursued.

### ***Essential Life Insurance Due Care Questions***

- ! What existing death benefit sources does the client have? Group life, survivor's income, individual plans, association group life plans, pension plan death benefits.
- ! Who is insured? Is someone contributing economically who must be added?
- ! Do all death benefits, along with available assets, meet client objectives?
- ! Are there other needs to consider such as dependents with special problems? Business debts? Personal debts?
- ! Are there existing life policies that can be cash surrendered or tax exchanged to more efficient plans?
- ! Is waiver of premium available? Is this a desirable benefit for this client?
- ! Is there accidental death benefit or double indemnity? If so, is this desirable or can it be dropped in favor a lower premium?
- ! Is coverage guaranteed renewable? To what age? Is the client's health stable enough to change policies?
- ! Is coverage decreasing term? Is the balance sufficient?
- ! Is there a substandard rating that can be removed?
- ! Are there policy dividends? Is the client making the best use of these dividends? Or, would reduced premiums be recommended?
- ! What are the settlement options available at death? (Lump sum, payment options, insurance trust, etc)
- ! Is there a plan for the "common disaster"?

- **Disability Insurance**

Statistics have surfaced which indicate that the average person is three times more likely to suffer a lengthy disability than die. Providing a source of financial income in the event of a major disability is probably the most overlooked portion of client financial planning.

By definition, a **disability** can be a temporary or permanent loss of earned income due to illness or accident.

### **Essential Disability Due Care Questions**

- ! How much monthly protection is needed? Is an individual policy needed to supplement work plans?
- ! When does protection need to start? (30, 60, 90 days etc -- the elimination period), i.e., can the client "self-insure" for a period of time?
- ! Does the client have discretionary income to buy needed protection?
- ! Is the coverage noncancellable or guaranteed renewable? Can a block of insureds, including your client, be cancelled?
- ! If multiple policies are owned (employer, association, individual), will the benefits of one be reduced by the other? Is there a case for eliminating a policy?
- ! Is there an employer supported uninsured sick-pay plan available?
- ! What is the definition of a disability in the client's policy? How severe? How long?
- ! Does the policy include occupational and non-occupational coverage?
- ! Is there a substandard rating or waiver of condition? Will the company remove it? Will another company write without a waiver?
- ! Is there a waiver of premium benefit? Would this be necessary for the client?

Similar to life insurance, due care analysis by the agent involves "need analysis". Through inquiries and available financial papers the agent should determine the current after-tax income needs of the client. This amount could be reduced by expenses that might be eliminated due to the disability. For example, if the client is homebound, he will not need to cover transportation costs of commuting to work or other work related expenses. Next, an adjustment for possible government benefits can be made using Maximum Benefit Amounts that might be available from Social Security. Minimum employment history and limitations on the term of protection covered should also be considered. Other adjustments that an agent should investigate include earned income continuing from other family members, investment income that might be derived from current assets and inflation to keep pace with cost of living increases.

For just about every client, the above process will establish that some form of disability protection is generally needed beyond the limits granted social security, and in some cases private, employer provided protection.

Once a disability need is established, it can be compared to the participation limits allowed by insurers and the ability of clients to afford it. **Disability due care** would involve an agent/client discussion explaining how disability insurers may ONLY offer certain maximum allowable coverage tied to income, e.g. a client who earned an after tax monthly income of \$7,500 might be eligible for a maximum of \$3,000 of monthly disability coverage. There may also be limits of how long this protection is covered, e.g., 24 months, five years, or to age 65. Further, there may be minimum waiting periods before coverage begins, e.g., 90 days, 180 days, etc. Also, there may be reductions in the amount of disability protection paid based on the degree of the disability, e.g., a partial disability that allows a client to continue working may reduce benefits substantially. Finally, watch for renewability features. Some policies are truly noncancellable and guaranteed renewable. Others may appear to be renewable unless cancelled by "class". Thus, if an insurer has a particularly bad block of business with a higher than normal claims experience, it can cancel that class of insureds. Clients need to be counseled that the "gaps" in coverage outlined by these events require them to seek alternative forms of protection, develop contingency plans or rely on available pension plans, family members and accumulated savings to make ends meet during times of disability.

- **Health Insurance**

Health insurance is one of the most valuable segments of risk management and the most difficult to predict. This is further complicated by recent efforts to create a national health care system. Hours of agent due care to develop a long term plan for clients may be broadsided by an entirely different style of health care brought on by federal directives.

The most efficient form of health protection is by group coverage. Group insurance is the predominant way of providing health insurance today with a definite trend toward HMOs (health maintenance organizations). ***Due care in health counselling*** would involve factfinding to determine sources of social insurance available to the client such as Medicare and occupational worker's compensation. Any gaps in coverage need to be filled through blanket health coverage or medical benefits under a liability policy if the health condition developed as a result of an accident.

In addition, an agent-to-client discussion should cover points concerning:

- **Basic Eligibility**

Exactly who is covered? Does "family" include the subscriber, spouse, one, two or more children? How old can the children be and still be covered? Does this change if the children are married? Will family members lose their eligibility when they turn 65 and Medicare takes over? How will a divorce affect a members coverage? Will a foreign or out of state residency longer than six months affect coverage? How long will a retarded or physically handicapped child or member be covered?

- **Total Maximum Coverage**

A limit to coverage could be present in form of duration and/or a dollar cap. Is this a "lifetime cap"? Is this cap per family member or for the entire family? A lifetime cap of between \$2 and \$5 million, per family member would not be uncommon and might be considered a minimum considering the high cost of medical care.

- **Deductibles**

How much is the deductible, if any exists? Is it per family member? Per year? Is there a maximum deductible per family? Are there specific deductibles for medicines vs. health care? Are there deductible surcharges if the client does NOT pre register with the insurer, say for non emergency care?

- **Stop Loss & Co-Payments**

After deductibles, is the client expected to share or co pay any medical expenses? Is there an established time, usually after a specific amount of expenses have been incurred, that the co pay will stop and benefits will be 100% covered by the insurer?

- **Pre-Existing Conditions & Waivers**

Are certain known pre-existing health conditions prohibited or waived? If waived, for how long? Is there a waiting period for unknown pre-existing conditions? Some policies specify a 6 to 12 month waiting period for listed conditions such as: hernia, tonsils, adenoids, hemorrhoids, varicose veins, nasal surgeries, foot and toe surgeries, breast reductions, otis media (ear problems), etc.

- **Exclusions**

Possible policy exclusions or highly limited protection might include conditions and services as follows: medical costs exceeding limits, unlisted services, service covered by occupational insurance (worker's compensation, etc), health problems due to acts of war, government provided services, Medicare benefits, services from relatives, private nursing fees, custodial care, long-term care, inpatient diagnostics (x-rays not related to specific surgery), dental and hearing aids, vision care, speech therapy, cosmetic sex changes, infertility, weight reduction, orthopedic devices, maternity care, outpatient drugs, acupuncture, nutritional counselling, physical or occupational therapy outside the hospital.

Some "bare bones" plans may cover costs ONLY at prescribed hospitals, although emergencies are typically covered no matter where. Some only pay for procedures incurred in the hospital by hospital employed physicians, i.e., regular doctor visits or follow-up sessions are not covered unless specified by the hospital doctor. Further, many plans may cover certain hospital procedures but NOT the supplies, e.g., a blood transfusion procedure may be covered, but NOT the cost of blood.

One of the latest trends is the requirement that certain procedures, such as organ and tissue transplants, be pre-authorized. Additionally, some procedures, like bone marrow transplants, are considered experimental and not



covered under any conditions.

Mental health and home health care are usually very limited areas of care. Dollar limits per day with annual maximums are not uncommon, as are maximum visits per year.

- **Guaranteed Renewability & Rate Changes** Can the insurer modify or change premium costs? Under what conditions? Can a class or "block" of subscribers be changed without changing rates for all subscribers? Can the subscriber be canceled? If so, how long will benefits last if client is in the middle of a health crisis?

- **Important Dates & Notification**

While many of the above exclusions and limitations are typically spelled out in policy brochures or in bold print, issues of important dates and notifications can "fall through the cracks". Proper due care would involve a discussion or memo to the client concerning policy timelines. Examples include: "All claims must be filed within 15 days on approved claim forms"; "the insurer must be notified within 60 days of any newborn or adopted children"; "annual notice is required to sustain coverage for a retarded or handicapped child who is older than the specified age limits"; "a family member must apply for his or her own plan within 31 days of the main subscriber's ineligibility"

Agents who handle multiple lines of insurance . . . life, health, disability, property/casualty . . . must consider the impact of health insurance on the client's financial planning. A medical catastrophe can permanently devastate a family. Despite the importance of life insurance, disability protection and certain property/casualty coverage, health insurance is a clear priority. It would NOT be considered due care for an agent who handles different product lines to market a \$250 per month whole life insurance plan to a financially limited client when there was NO health insurance in place. A more prudent approach would combine a "basic hospital plan" for major medical emergencies at \$150 per month and a term life plan for \$100 per month. Even the agent who specializes in a specific product line should exercise due care to inquire that clients have health coverage in place or at least budget for same before selling other forms of insurance.

### ***Essential Health Coverage Due Care Questions***

- ! What available sources of health care are available to your client -- group plans (employer provided), HMO's, Medicare, other?
- ! Does your client have enough medical expense benefits to meet basic hospital needs or major medical expenses?
- ! What family members of the client require coverage and are they eligible? Does the client or family member need supplemental coverage?
- ! Should the client terminate any existing or duplicate medical expense premiums?
- ! Does the client have dependents who have or will soon terminate coverage under the family plan? If so, can they purchase their own? What conversion rights do they have?
- ! Is your client's policy guaranteed renewable?
- ! Does the client's health care continue to protect dependents in the event of his or her death?
- ! Does the client have a substandard rating or waiver of coverage? Will the insurer remove it? When? Will another company write without the waiver or rating?

- **Annuity Analysis**

Due care concerning annuity investing first involves factfinding to determine what portion, if any, annuities should play in a client's overall financial plan. Next, a needs analysis should be conducted to uncover growth vs. income requirements, risk tolerance, liquidity specifications, now and in the future, and whether tax deferral benefits are worthwhile to pursue.

Who should invest in annuities? One rule of thumb follows that a client looking for a long-term investment with a tax bracket greater than 15 percent might consider annuities. Other likely candidates include moderate or high tax bracket individuals looking for a conservative way to shelter current income or growth over a long period of time, i.e., retirement monies.

Fixed rate annuities might be an alternative for CDs, GNMA's (Ginnie Maes), T-Bills or other similar obligations. Variable annuities are better geared to individuals who seek tax deferral, yet willing to ride with the ups and downs that accompany stock and mutual fund investments.

Once an annuity can be established as an appropriate investment opportunity, agents must carefully weigh the following choices and discuss same with each client:

- **Immediate Annuity vs. Deferred Annuity**

Clients may have current income needs or the desire to defer income for greater growth. Perhaps a combination is appropriate. Tax planning and liquidity are key considerations for the agent.

- **Single Premium vs. Flexible Premium**

Clients generally have a lump sum to invest or need to accumulate by paying into a savings plan. Short and long-term liquidity is an important consideration.

- **Fixed Rate vs. Variable Rate**

Clients may have needs to lock-in their yields or go for growth. One group is typically a CD type investor as opposed to those who are willing and able to incur greater risk. Agents need to carefully explain the potential loss of principal possible in variable plans. Agents should review potential interruptions in return of principal and yield that can develop with either fixed or variable contracts.

- **Yield vs. Guarantees**

It is logical that the stronger the guarantee the lower the yield. Agents must explain that a higher first year yield may include bonuses or special incentives to invest that later disappear. This type of contract should be compared to other contracts that may offer a slightly lower yield that is locked in for a specific period, i.e., determining overall predictable yield over time is important due diligence. In the same vein, a disclosure would be appropriate as to the method used by the insurer to adjust yield. A contract with a guaranteed yield spread may be more appropriate for some clients than a yield that is adjusted by the insurer's board of directors. Equally important is whether yield is banded, i.e., are yields adjusted separately for certain blocks of investors or are investors who entered five years ago given the same yield as new investors.

- **Yield vs. Liquidity**

Clients demanding easy access to their money should be prepared to settle for lower overall yields. Agents need to go farther to determine special needs such as the potential for large sums of money to pay for a potential illness or nursing home. Certain contracts allow penalty free withdrawals for special circumstances. Due care dictates that agents carefully and clearly explain all surrender charges associated with the contract and when they occur.

- **Maturity options**

Annuity contracts may mature at specific ages. This can affect BOTH a client's long-term investment planning as well as tax planning. A client wishing to plan for long term deferral to age 95, for example, might be disappointed to learn that the contract must annuitize at age 85. Further, agents MUST disclose the potential tax affect of a maturing annuity. Pre-1981 Annuities deliver principal first, then tax interest or appreciation. Post 1981 annuities tax interest or appreciation first then deliver principal. Also to be considered is annuitization of the contract where a systematic withdrawal and payoff of the contract over time delivers some principal and taxes interest and appreciation with each payment.

- **Withdrawals & IRS Penalties**

Where the client is withdrawing all or part of an annuity contract PRIOR to age 59.5, he should be apprised of the ten percent IRS penalty for early withdrawals. At present, this can only be avoided where the annuitant dies or becomes substantially disabled or, where annuitization is chosen within one year of investing in the annuity contract.

- **Guaranteed Death Benefits**

Where agents assist in estate planning, due care would involve a disclosure concerning death benefits. Most fixed rate contracts guarantee the return of principal and any appreciation (interest left to grow). However, agents

should uncover and review factors concerning potential surrender penalties or how they may be avoided, as well as the basis of the guarantee. Is the death benefit guarantee, for example, the greater of ALL contributions of principal OR simply the value of the contract on the date of the annuitant's death?

- **Settlement Options & Taxes**

Clients should be made to understand that, at best, annuities represent tax deferral, not tax free income. Unless the beneficiary of the annuity is a surviving spouse, taxes on the accumulated growth will be due -- there is NO step-up in basis. The tax liability is the difference between the amount invested subtracted from the value of the annuity contract, multiplied by the beneficiary's tax bracket. Options to mitigate this include five year or lifetime annuitization of the contract.

Other settlement options that should be discussed with the client include possible options such as life annuity, joint and last survivor, lifetime with period certain, etc.

- **State Guaranty Fund Coverage**

Rules governing state guaranty coverage should be disclosed to the client. If the State does NOT permit advanced disclosure concerning guaranty fund protection, the agent should privately exercise diligence in planning annuity purchases. The primary concern? Is the full amount of the annuity covered against insurer failure. Perhaps due care is served by diversifying among several insurers and/or between fixed AND variable contracts to take full advantage of guaranty protection.

- **Titling Options**

If the agent is advertising tax and estate planning advice he should disclose the consequences of titling contracts. Where no tax or estate counselling is provided, the agent should still exercise due care by disclosing the fact that titling consequences may result and offer to refer a competent attorney or tax expert before any purchasing decisions. As a general rule, the death of an owner or annuitant triggers a death benefit which carries tax liability. Unless the survivor beneficiary is the spouse, the beneficiary must take a lump sum and pay the tax or annuitize over a minimum five-year period. An important area for agents to investigate is whether the annuity contract enforces or waives surrender charges where a death of the annuitant or owner has occurred. In some contracts, the surrender charge can be deferred where an owner dies and a contingent owner is allowed.

### ***Essential Annuity Due Care Questions***

- ! Is the client interested in growth or income?
- ! Is the client interested in current income or retirement income? How soon does he need to start receiving income?
- ! How much risk is the client ready to accept today and in the future? Could he stand the loss of his entire investment? How would an interruption in income affect him?
- ! What are the client's liquidity needs in the short-, intermediate- and long-term?
- ! What is the client's federal/state tax bracket? Does tax deferral through annuities make sense?
- ! Is the client under age 60, and is it likely that he will need to withdraw major portions of the annuity in the future? Will the ten percent penalty offset the benefits of tax deferral?
- ! Does the client demand full and complete protection of principal? Or, can the client afford to take risk in hopes of greater appreciation using variable contracts?
- ! Is the preservation of principal more important to the client than the effects inflation may have against a fixed yield?
- ! What are the survivor spouse/family needs in the event the client dies? How can these needs be accomplished?

- **Business Insurance**

The risk managing agent recognizes that due care extends to businesses as well as individuals, since businesses are composed of the same people. The illness, disability or death of these people represent an exposure to businesses in terms of their survivability and commitments to principals, employees and their families. ***Due care business analysis*** involves a determination of the reduced revenues and increased expenses that may result from

the death or disability of a key person in the business, including the possible costs to replace or sell the business, if necessary.

The degree of risk protection in business insurance varies by the person who is affected and the legal structure of the company. Following are some due care considerations for three major forms of ownership -- sole proprietors, partners and corporations:

- **Sole Proprietorships**

There is no legal distinction between personal and business assets . . . debts of the business are debts of the sole proprietor's estate. Agents should determine needs or ***preloss arrangements*** of the surviving family to continue the business, sell it or liquidate it in the event of the owners death and disability. Capital deficiencies can be filled through the appropriate insurance line.

- **Partnerships**

The legal relationship between partners is personal . . . each is fully responsible for acts of the business and business debts of all others. If a partner withdraws or dies, the partnership must be terminated or reorganized. The disability of one partner can also create a significant financial strain on the entire business. Due care planning here involves learning the wishes of the surviving family and surviving partners. Where a deceased or disabled partner's family wishes to exit the business a ***buy-sell agreement*** can satisfy the purchase of his share with the business passing to the surviving partner. Alternatively, the heirs of the deceased may become partners or sell the lost partner's interest, assuming this is permitted in the partnership agreement. Again, preloss arrangements covering the possibility of reduced revenues and higher expenses during this transition must be considered.

- **Corporations**

Most agents will deal with the "close corporation" where the stock is closely held by a few individuals and not offered for public sale. Typically, the stockholders are also employees of the company. In this case, situations similar to the partnership can develop. A key employee or stockholder can become disabled or die creating additional financial burdens on the company. Most corporation charters provide that remaining stockholders can purchase the share of the withdrawing or deceased shareholder. The risk manager needs to uncover the "formula" for purchase and plan available funds via buy-sell policies, disability protection, health care, etc.

Other significant due care factors concerning business insurance include planning for taxes and liability. For planning purposes, most transfers or sales of business interest become part of your client's gross taxable estate for purposes of death taxes. Income taxes become a factor in corporations where the challenge is to transfer assets out of the corporation without claims of dividend. This is a very complicated area of planning best left to other courses. The issue of liability will be discussed in sections below.

### ***Essential Business Insurance Due Care Questions***

- ! Who will control the business when your client dies or becomes ill for an extended period?
- ! Will there be a market for the business if it has to be sold?
- ! Will the business provide adequate income for the heirs of your client?
- ! How will the value of the business affect the taxes and liquidity needs of your client's estate?
- ! Will the client be able to continue in business if one of his associates dies?
- ! How will working capital be kept intact where a partner or owner dies or is seriously disabled?
- ! How can a business be transferred to a new owner without shrinkage in value?
- ! What will become of your client's interest in the business if he or she retires?

- • **DUE CARE -- PROPERTY & CASUALTY**

Risk management in the property/casualty arena is extremely complicated, yet the primary goal is the same as other forms of insurance -- the transfer of risk. However, a higher standard of due care and agent liability exist in property/casualty because of binders, indemnity disputes and redlining.

- **Binders**

A binder can be written or oral. At the point when the client says "I want it" and the agent says "You're covered", a binder has occurred. Immediately upon creating any oral binder, the agent should make note of the terms of coverage, when the binder was made and the parties involved. Further, to reduce the possibility of disputes, the agreement should be reduced to writing as soon as possible.

Abuses occur where agents do NOT have binding authority, yet lead clients to believe they do. Likewise, clients may use binders as a means of obtaining free insurance for limited periods.

- **Indemnity Issues**

Property and casualty insurance contracts are contracts of indemnity in that they provide for compensating the insured for the amount of loss or damage. Due care is accomplished when an adequate amount of compensation is provided that will avoid profit or loss from a peril or hazard.

Elementary insurance defines a **peril** as the cause of a loss. Fire, lightening and collision are all examples of perils. A **hazard** is anything that increases the chance of loss. A loose gas connection to a main heater system is an example of a hazard. Hazards, however, can also take shape in "morale" form. Reckless driving is one such example of a morale hazard.

- **Redlining Issues**

While there are, as yet, no formal rules on "insurance redlining", there is pending legislation that would force insurers to comply with rules similar to Community Reinvestment requirements now imposed on banks. If passed, a majority of the burden would fall on underwriters. However, agents should be aware that clients living in inferior, low income or minority communities should NOT be denied application for coverage. The logic behind this is obvious -- without access to insurance, clients would not be able to buy housing.

Compared to life and health contracts, it can be said, that fewer property/casualty policies are read by clients. There is generally less understanding of liability orcasualty matters, and therefore, a greater reliance is placed on agent advice and counsel. That is why proper **due care** would encourage clients to read their policies and help them review the fine print to fully understand exact limits of coverage, define perils, clarify what constitutes a hazard and recognize policyowner duties. Having specimen policies available for this purpose should be standard procedure.

Areas where agents should exercise additional due care involve the "agent as counselor". Insurance is the first line of defense in asset protection. The role of the property/casualty agent in preserving what clients have already accumulated is vital. This should not occur, however, without also recognizing the value of other forms of insurance, i.e., A deluxe homeowner's policy should be scaled back where high premiums might not allow clients to purchase basic health insurance. There may also be validity to the argument that insurance premiums should not be so excessive as to preclude clients from starting necessary retirement savings plans.

In addition to these points, there are many contributions that can be made by agents to promote greater client understanding of **risk, loss control and proper valuation**. (See below). By educating clients in these disciplines, a higher level of insurance efficiency will be realized. The result can be stabilized or lower premiums through a lower claims experience. It is true, that this may NOT initially improve agent commissions, but in the long run client retention and income stability will be greater.

### ***Essential Liability Due Care Questions***

- ! What is the insured's "insurable interest"?
- ! Is the peril covered?
- ! Is the property covered?
- ! Is the type of loss covered?
- ! Is the person covered?
- ! Is the location covered?
- ! Is the time period covered?

- ! When does the policy take effect?
- ! Are there hazards that exclude or suspend coverage?
- ! What are policy owners duties after a loss?
- ! What are the insurer's options in settling a loss?
- ! What are the time limits for the policy owner to recover from the insurer?
- ! What are the time limits for the insurer to pay a claim?

Next, a due care discussion might include:

- **Risk**

A client's perception of risk influences how insurance dollars are spent and, to some extent, how the industry is regulated. Unfortunately, much of society has set a low priority on reducing risk, i.e., "That's why I buy insurance". Many in the industry, however, feel it is extremely important to reassess societal views on risk by assuming more responsibility for risk consequences. An example would be clients who continue to build in flood plains or high-risk fire areas, despite knowledge of their existence. When disaster strikes, should these individuals receive subsidies through taxpayer financed state and federal disaster aid, government flood control projects and mandatory shared-market insurance programs? Should accident victims who violate seatbelt laws receive full compensation? Should people who live in hurricane and earthquake country be responsible to better secure a structure with inexpensive metal ties? Some believe that people must realize what they can do for themselves before risk priorities can change. Agents can play a valuable role in helping clients accept a certain level of risk and strategies to reduce it.

- **Loss Control**

In the insurance industry, the process of risk reduction is called loss control. Loss control procedures involve the steps necessary in eliminating exposures to risk and reducing their frequency or severity. Today, loss control makes the workplace safer and reduces a broad range of liability exposures in homes as well. Offering loss control advice and services to clients has potential rewards as well as risks. Reasons agents might consider advising clients on safety issues include: client credibility, client retention, new client generation, insurer qualification and attractability, favorable insurer status and additional profits where "advice fees" are permitted by law. With competition stiff, some larger agencies are establishing entire subsidiaries to perform loss control-for-fee services. In these cases, loss control fees can represent from two percent to ten percent of total agency revenues. Smaller companies may contract to outside loss control consultants or simply rely on insurer provided services. Loss control services can run the gamut from standard, non-controversial safety recommendations to complicated compliance advice. Whatever level of service provided to attract or retain clients, agents should realize that loss control advice exposes him to additional liability. There may also be statutory violations, particularly in the commercial area, for offering safety expertise without required licensing.

Code compliance is an extremely important area of loss control. It is a discipline usually reserved for underwriters and typically outside the venue of agents. This does not mean it should be ignored by the agent. Due care should involve the agent at least to the extent of a physical inspection of the property to determine that fire sprinklers are indeed in place or that a security fence has been installed around a construction site before delivery of materials. The importance in doing so is underscored by a mitigation of exposure when an accident hits -- particularly by third parties.

- **Valuation**

A recent survey by a well known real estate statistics firm found that almost 70 percent of the homes in the U.S. are underinsured by an average of 35 percent. With an increased awareness of this problem, many insurers of large policies are sending appraisers to high-value neighborhoods to determine if policy replacement values adequately reflect current values. In addition, companies are directing it encouraging agents to re-evaluate coverage levels. In many cases, this involves inspections of properties to account for recent improvements, such as finished basements, patio covers, garage conversions; deterioration; code compliance to rebuild; i.e., new hurricane or earthquake standards; and illegal uses, e.g., a business run out of the home. Bringing inadequately covered premises to full coverage levels increases underwriting income, which may allow a carrier to lower rates within a class of policy owners. Equally important is the liability protection afforded carriers and agents. Both were targets of litigation for misrepresentation and negligence after the catastrophic Oakland fires in California.

- **Homeowners Insurance**

Agents should exercise due care in several important capacities:

- **Selection of Policy**

The selection of policy type . . . HO-1, HO-2, HO-3, HO-4, HO-6 and HO-8 . . . should be a function of client need. Obvious factors to consider include dwelling type, dwelling size, dwelling construction, dwelling replaceability, additional structures, type and extent of personal property, loss of use and basic liability. Refinement of the process occurs where agent due diligence uncovers clients the true "limits of need" and special circumstances. This can only be accomplished by interview or systematized factfinding concerning key issues:

- **Value**

The amount of dwelling insurance requested is typically a reflection of the mortgage amount. Does this reflect the true replacement value? Is an appraisal in order for larger policies or where a special construction has been used? Remember, like kind and quality does not mean "exact" kind and quality. Clients must understand that replacement cost is limited to the style, quality and function of the destroyed or damaged property. Few or no allowances are made for increased costs of repair or reconstruction caused by ordinances or laws regulating construction or repair. An example is new construction school fees or special fees that are currently charged for construction that were not around when the client's house was built.

Concerning personal property, does an inventory exceed policy limits? Is replacement value available? Should items be "scheduled" like paintings, historical documents, original manuscripts, exotic pets, etc?

Are "sublimits" of the policy meeting client needs, cash, gold, coins, stamps, securities, deeds, trailers, jewelry, watches, furs, precious stones, silverware, guns, etc.?

After primary values are established, the client's "insurable interest" must be determined since a policy owner will NOT recover for an amount greater than their insurable interest.

- **Eligibility**

Due care discussions with clients should cover circumstances where their eligibility to recover a claim may be jeopardized. Is the policyowner the intended owner occupant or does he intend to rent the property? Will only one family occupy? Is a business being operated out of a home? Are there code violations like additions without permits, zoning violations, etc? Will the client be unable to perform his duties to mitigate losses (draining pipes to prevent freezing, maintaining heat if the structure is vacant, minimal repairs to protect the property from further damage, etc.)? Is a detailed inventory necessary to track descriptions, purchase dates, values, etc? Are clients aware that they should hold on to damaged property and make it available for adjuster inspection? Do clients need to produce books of account or fill out a proof of loss? Will the client be available to assist and cooperate with the adjuster? Are insureds aware that they should NOT make any voluntary admissions of guilt or make voluntary payments to someone they have injured? Many of these circumstances can be brought to surface in an initial meeting or physical inspection of the property.

- **Deductibles**

Clients should be apprised of their deductible options. Although higher deductibles mean lower premiums and lower agent commissions, they represent a fair opportunity for clients accept part of the financial consequences of risk taking. This, in turn, can lead to fewer claims and a generally more stable client.

- **Policy Exclusions**

If the policy is in "readable form" it should be easier for the client to pinpoint policy exclusions. Some obvious disclosures, however, should include exclusions related to damages caused by earthquakes, flooding, sewer flooding, flooding driven by wind, power interruption, owner neglect, war, freezing of appliances or pipes (especially if vacant over 30 days), theft of a dwelling under construction, breakage of glass if vacant over 30 days, continuous or repeated seepage from plumbing or heat & air system, normal wear & tear, latent defects, mechanical breakdowns, rust, mold, wet or dry rot, contamination, smog, settling, cracking, expansion of pavements, patios, foundations, walks, walls, floors, roofs or ceilings, rodent or pest infestations.

- **Liability & Liability Exclusions**

Primary to determining liability limits is the client's overall exposure. What is his or her personal net worth that could be at risk? Will the limits of the policy or an umbrella cover the exposure? Are there any liability exclusions in the policy that leave the client uncovered? Some common areas of neglect include: Boats over 50 horsepower, aircraft, motor vehicles loaned or rented by the insured, certain professional services, most business pursuits, outside premises, cases where insured is liable for worker's compensation, for damage to property used by or rented by the insured, etc.

- **Auto Insurance**

Auto policies are typically divided into different segments covering liability, medical, uninsured motorists and damages (comprehensive, collision, towing, labor and transportation expenses). Insuring agreements traditionally offered "split limits" which apply to each person for each occurrence of liability, damage, etc. Today, the trend is more toward a single limit of liability, which can expanded within the policy or through the addition of umbrella coverage, that applies to all covered liability losses arising out of an accident regardless of the number of persons injured or the amount of separate property damage. Minimum due care considerations in this area include:

- **Policy Limits**

A needs analysis to determine that liability limits of the policy adequately shield client assets and meet financial responsibility laws of the state which may assign specific minimums relating to liability, bodily injury, property damage and/or uninsured motorist coverage.

- **Policy Eligibility**

Clients should be apprised of the specific vehicles eligible for coverage, e.g., private passenger autos owned or leased, longer than six months, AND those which are NOT eligible, e.g., less than four wheel vehicles, autos used to carry persons or property for a fee and those needing to be named as additional vehicles, e.g., trailers, off-road vehicles, etc. Clients should also be advised that new or replacement vehicles must be reported within 30 days of purchase to receive full coverage. Clients with poor driving records should be referred to assigned risk plans or "fair" plans organized through state programs.

- **Policy Conditions**

Agents should direct clients to specific areas of the policy pertaining to "duties of the insured after an accident". Clients should be told that they should promptly notify the company of the accident, the time limits within which they should act and steps that they should take to reasonably protect the covered auto from further harm or damage. Policyowners must provide sufficient evidence of loss, cooperate in any insurance investigation and notify the police if a hit-and-run driver is involved or if the covered auto is stolen.

- **Policy Endorsements**

Clients should know the options they have to broaden their coverage to include coverage such as full replacement cost, towing and labor costs, rental reimbursements, specialized vehicle coverage, extended nonownership liability, additional damage coverage for special vehicles, named nonowner endorsements, coverage for special personal property coverage for items like tapes, CDs, CBs, portable phones, etc. Some attorneys might advise agents to prepare a written list of available endorsements and the applicable cost to present with the original quote. Clients who incurred claims but refused the option to buy these endorsements would have a difficult time pursuing agents for not making them available.

- **Policy Exclusions**

Due care discussions should also disclose to clients items of coverage specifically excluded. Examples include: property being transported, bodily injury to an employee of a covered person, motorcycles, off-road vehicles, etc. Also excluded is coverage in areas outside the United States, its territories or possessions and Canada. Clients should understand that an endorsement for extended coverage should be considered when travelling outside these domains.

- **Policy Effective Date**



It should be clear that coverage begins at 12:01 AM standard time on the date of inception to 12:01 AM on the date of expiration.

- **Named Insured**

Who is the insured? Is the insured the policy owner, his spouse, a resident of the household, other family members?

- **Auto User**

Is everyone who uses the auto a named insured?

- **Associated Named Entities**

What is the name of any other person or organization who may not use the auto but may still have legal responsibility for the acts of omissions of the covered insured?

- **Commercial & Professional Lines**

Commercial and professional insurance takes many forms: investment and commercial property coverage, business owners insurance, farm coverage, commercial auto plans, commercial liability policies, for directors, officers and professionals, workers compensation and more. A full discussion of each goes beyond the scope of this course. However, there are some important due care factors for agents to disclose and discuss with clients.

- **Policy Limits**

As with most other forms of insurance, a client needs analysis should determine the extent of assets to protect, including any personal exposures. Policy endorsements and/or commercial umbrella protection may be considered as options. Special occurrences may have individual limits which must be evaluated for each client. For example, a "products-completed" limit may be small for a bakery but should be expanded for a lawnmower repair service.

- **Eligibility**

Rules of eligibility in the commercial arena are very complex. Suffice to day, clients should be aware of ALL limitations that might exclude coverage, including: building size or height restrictions, e.g., buildings not exceeding 15,000 square feet and no more than four stories; business class restrictions, e.g., office uses permitted / manufacturing prohibited or retail permitted / restaurants prohibited, etc. Where liability is concerned, is the policy based on a "claims made" basis or a "claims occurred" basis? Clients should be well informed that coverage may exist ONLY while they are in business and paying premiums. A claim made ten years after a client retires can be financially devastating.

- **Policy Endorsements**

Due care should involve the listing of available options to extend coverage, reimburse for loss of use, loss of rents, loss of income, business expense coverage, builders risk protection, for buildings under construction, add or exclude specific accidents, products, work or locations, employment occurrences (termination, defamation, discipline, discrimination, etc), liquor liability, products completed protection, pollution liability, malpractice, errors and omissions, personal and advertising violations, contractual liability, employee use of vehicles coverage, product defects or deficiencies, product recall protections, inflation upgrade protection, replacement cost coverage, personal effects protection, debris removal, etc.

- **Scheduled Losses**

The exact property or premises covered should be disclosed, buildings, insured's business personal property and the personal property of others located at the business premises. In the case of liability policies, premises and operations exposure is the heart of coverage. Options should also be disclosed concerning upgrades to broader forms of coverage perils like extended reporting periods or extending coverage beyond termination of the policy, earthquake damage, crop insurance, livestock, loading/unloading accidents, window glass breakage, falling objects, weight of snow, water damage, etc.

- **Policy Exclusions**

As important as what is covered, clients should understand exactly what is excluded: Building ordinances, government actions, power failure, water damage, bursting pipes, explosion of steam boilers, mechanical breakdown, money, animals, autos for sale, illegal property, underground pipes, fences, antennas, signs, etc.

- **Named Insured**

Since multiple parties may share insurable interest, it is important that ALL parties understand that the "first insured" is typically the "notified insurance partner". In the event of cancellation and policy changes, the conditions of the policy normally name the first insured to be responsible to notify other named insureds. In essence, the first insured is the "point man" for most policy transactions.

- • **DUE CARE -- QUOTES & ILLUSTRATIONS**

In the past few years, media "sound bites" and state regulator attention concerning the financial stability of insurers has been the primary focus of agent due care. Not far behind are the issues and supporters demanding agent due care in choosing the right policy -- after all, an industry cannot rise to professional status, perhaps even survive, if its members take a "sale at all cost" attitude. Both these issues have and will be the target of new company compliance procedures and new regulatory standards. These efforts, however, have been pursued more in a "broad brush" fashion with an emphasis on concerns such as fraud, misrepresentation and twisting.

Many professional agent groups feel that due care should include a new dimension: illustrations and quotes. The reason? Most insurance purchasing decisions are made by clients and agents using illustrations and quotes. Minor variations in the assumptions that go into these projections can produce dramatically different results -- especially if they are spread over long periods of time.

With the advent of computers, multiple page illustrations, some with graphics, literally predict results a client can expect from almost any given product, at any given time in the future using an almost unlimited choice of assumptions. Agents also use mass mailing technology that can tap public records, such as property values, ages, names to personalize and customize a quote without even visiting the property or client. Stiff competition has made the use of computerized quotes and illustrations widespread. Given the sophistication and high quality of these proposals, agents and clients are depending more and more on the face value of the illustration, rather than the actual policy itself. In many instances, clients and agents alike completely pass on reading the policy. This, in turn, has resulted in some surprises for clients and the call for greater scrutiny of sales presentations from professional associations and some regulators.

The problems that surface with most illustration sales relate to the disclosure of assumptions made in illustrations, e.g., interest rates that went down instead of up, insurer insolvencies that could not meet minimum policy rates and/or return of principal, surrender values well below projected results, premiums that were expected to "vanish" simply continued, premium quotes well below replacement value of the property, quotes that do not reflect necessary endorsements, etc. For the most part, the responsibility of misleading illustrations lie with insurer actuaries and marketing departments that produce them. Some agents have also manipulated quotes to specifically avoid true comparisons, i.e., presenting only projected cash values NOT guaranteed values OR quoting skeleton plans void of necessary endorsements.

In recent cases, the misuse of illustrations has led to significant charges of questionable sales tactics by state regulators. The MetLife case involved fines totaling \$20 million among 40 state agencies and \$75 million in restitution to as many as 60,000 customers. Shortly after these fines were levied, the Florida department of insurance filed charges against the company's top agent and 86 other agents accusing them of fraudulent sales practices.

While there is no one single solution to the problem, some remedies are underway in the areas of education, disclosure and better illustration design. In the MetLife case, the company has created a corporate ethics and compliance department which will audit agent offices in the area of sales techniques, including the use of illustrations. Regulators have threatened to prohibit certain proposal techniques altogether, require specific "full disclosure" requirements. Others are launching new compliance orders like requiring insurers to conduct internal

investigations designed to uncover illegal illustration marketing practices. Further, the National Association of Insurance Commissioners has outlined the misuse of policy illustrations as a violation of their **Unfair Trade and Practices Act** and Congress has proposed the **Insurance Marketing and Sales Reform Act** to strengthen consumer protection laws concerning advertising and illustration mishandling by agents, brokers and insurers.

Currently, illustration disclosure is different from company to company. Certain professional organizations and government agencies, such as the National Association of Insurance Commissioners, are proposing "model" illustration disclosures. In the mean time, some states have already passed laws requiring agent due care to disclose all assumptions of the quote and/or highlight or bold the guaranteed portions of these proposals to contrast the "anticipated" results. Further, insurance companies are required to answer certain questions in their annual statement filings pertaining to the "basis" of dividend and interest rate projections. These questions include:

- What is the company's opinion of its ability to continue supporting current dividends and nonguaranteed elements (interest rates).
- Are company assumptions of these factors exceeding the company's current experience level.

To a great extent, the answers to these questions fall on the shoulders of company actuaries. For the most part, these individuals maintain personal standards of practice that require full and complete disclosure. The Society of Actuaries has also promoted education of this problem to its members and the Academy of Actuaries has made recommendations to the National Association of Insurance Commissioners (NAIC) on possible regulatory actions that could be useful now and in the long term.

Some industry groups, feel that much of the pressure to greatly restrict or eliminate the use of illustrations is unwarranted. They believe that illustrations can be a valuable tool to educate clients with visual interpretations of their options. Rather than scrap the entire illustration system, for example, it is suggested that, as a minimum, **agent illustration due care** can focus on treating the client fairly by implementing the following considerations:

- Specimen policies should be on file to compare with specific illustration issues and/or client questions.
- Before doing business with a specific company, request a copy of illustrations for policies the agent intends to handle. Clear up any questions as soon as possible. If the company's management say they don't know the answer, or they avoid requests altogether, it may be a clue that they will handle client policies in a similar way.
- Agents should be certain that all illustration pages are printed and that all projected interest rates are disclosed and discussed with the client.
- Particular attention should focus on matters of age, gender, classification, avocations, past experience and other "default" conditions of the illustration.
- Be sure that the client receives all pages and disclosures.
- Look for sudden jumps in cash values or premiums -- especially in later years.

# AGENT LIABILITY

by Affordable Insurance Educators  
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The selling of insurance can lead to many differences. When an insurance agent and his client cannot resolve these differences, agent liability may result. Claims against an agent or broker may surface as a result of events that occur BEFORE or AFTER a policy has been issued. Cases and expensive litigation have surfaced for matters as basic as a producer failing to secure the type or amount of coverage requested by the client to seemingly "blue sky" claims where clients have demanded recoupment of losses and damages simply because of a professional relationship, real or not, that existed between agent and client. Other claims span the legal gamut -- client losses from insurer failure, insurers refusing to pay a claim, misrepresentation, fiduciary oversights, etc.

There is considerable confusion among insurance producers concerning their legal liability to retain reliable insurance protection and service client needs. The fact is, no one has developed a "bullet proof" method to avoid a claim from an aggrieved policy owner. To help mitigate potential conflicts, some say that agents and brokers should limit themselves to specific areas operations and practice reasonable due care. In addition, insurance producers should DEFINITELY purchase and maintain appropriate professional errors and omissions liability insurance. Of course, ALL professional liability policies have "gaps" in coverage, yet they will offer the agent some reasonable protection and perhaps minimize costly legal representation for many errors and omissions.

## • • AGENT LIABILITY BASED ON STATUS

The most critical questions in determining agent liability is the extent to which state licensing and agency status obligates the agent in the procuring of insurance coverage for clients. This process involves the investigation of many areas, including: The Law of Agency, Producer's Status (relationship to the client/insurer) and the classification of the producer as Agent or Broker.

### • The Law of Agency

The **Law of Agency** is the area of law that determines producer status and specifically binds the agent/broker for his acts and his omissions or errors. Simply stated, the law of agency, for most states, establishes many categories of insurance agents and concludes that the authorized acts of the agent automatically create duties and obligations an agent must follow. These responsibilities occur as between agents and principals (insurance companies) and as between agents and third parties (clients). An **agency relationship** begins when agents are granted authority to operate by expressed, implied or apparent agreement. This can be **created by contract or agreement** or it can take the form of casual mutual consent.

A person who markets insurance is typically referred to as a **producer**. The insurance market contains many kinds of producers -- **general agents, local agents, brokers, surplus or excess-line brokers or agents and solicitors**. Following is a brief description of these categories:

### • General Agents

The general agent assumes many responsibilities, greater liability and usually incur higher business expenses. As a result, they are typically paid the highest commissions. In the property/casualty field, many sales agents with general agent contracts do not serve all the functions of a general agent but are important enough to their insurers to receive general agent commissions. In all lines of insurance, general agency contracts, or similar classifications, are frequently awarded as a competitive device to obtain or retain a particularly outstanding agent or firm.

- **Local Agents**

The local agent represents the insurer. He or she may represent more than one company. Commission schedules are typically lower for local agents because they do not usually perform technical services usually reserved for the general agent or branch/regional office; such as underwriting, policy implementation, claims support, etc., and are subject to a lower level of liability than other agent categories. The local agent is principally a sales representative of the insurer who acquires business and counsels clients.

- **Brokers**

Theoretically, brokers are agents of insurance buyers and not of insurers. Their job is to seek the best possible coverage for clients. This is can be accomplished in a direct manner with the broker acting as salesperson or through a network of agent contacts. Premiums paid by clients include the cost of commission paid to the broker by the insurance company, so the client indirectly pays the commissions of both the broker and agent. In the liability/casualty area, some brokers maintain a loss-control staff to help counsel clients on safety and prevention matters thereby aiding clients to secure a lower premium. In a sense, these brokerage firms act as insurance and risk managers.

- **Surplus Brokers / Agents**

Sometimes a client will seek a highly specialized coverage not written by an insurer licensed in a home state. Examples might be an unusually high excess liability plan, auto racing liability, strike insurance, oil-pollution liability, etc. To handle these limited lines of coverage with "non-admitted" insurers, states typically license surplus or excess line agents and brokers.

- **Solicitors**

Another type of producer is the solicitor who usually cannot bind the insurer or quote premiums. The solicitor seeks insurance prospects and then handles the business through a local agent, broker, branch office or service office.

Producers can also be classed as ***actual agents/brokers*** -- those given express or implied authority -- or ***ostensible agents/brokers*** -- those whose actions or conduct induces others to reasonable believe the they are acting in the capacity of an agent/broker. An agent binds his principal when he acts within the scope of his or her authority. The exception is when an agent and an insured are proved to have colluded with intent to defraud an insurance company. In such a case, the principal or insurer is not culpable or bound by the policy. Insurance companies always attempt to tightly define or narrow the authority of agents to limit their exposure to agent wrongdoing. However, no matter how independent the agent may be, the law generally considers the agent and the insurer as one and the same. So, the insurer is most often legally responsible for the acts of the agent and are regularly sued by third parties (clients of the agent) who feel they have been wronged. Of course, when a policyowner sues his insurance company, agents are often named for various breaches of duty between client and agent. Agent liability may also exist where insurance companies sue their own agents. Insurance companies may and do exercise their right to sue the agent under various legal theories for indemnity of any judgement losses they may have through a policy owner claim (see Liability From Insurer Claims Against Agents -- later this chapter)

- **Insurance Producer Status**

When marketing insurance, the agent may assume the character of a mere sales representative or the specified agent of the client. For most insurance transactions, it is generally found that an **agency relationship** exists between an agent and his insurance company since there is typically a pre-existing **agency contract** between the

parties (the agent and the insurer). This relationship is distinguished from a **principal-agent relationship** where the client requests that the agent accomplish a **specific** result such as "Buy \$150,000 of coverage from XYZ Company".

All too often, however, the courts have the difficult task of trying to determine **who initiated the relationship**. This can be almost impossible to resolve. In most instances, however, the law leans to the assumption that the **majority** of insurance transactions are **agency relationships** even though the client may have called the insurance agent first. Otherwise, the mere fact that clients request coverage . . . which they do in virtually every instance . . . would establish a principal-agent status every time. The courts feel this is NOT an appropriate conclusion. Of course, a **written disclosure agreement** indicating that the agent was a representative of the insurance company would go a long way to clarify that the status between the agent and client WAS NOT agent-principal.

In some agent liability cases, status is not a consideration. Where agents exceed or work outside the scope of their agency contracts, for example, they assume liability. Also, where an agent has deceived or misrepresented a client, liability is assumed. In either instance, it is doubtful that the court will care whether an agency status or agent-principal relationship existed -- agent wrongdoing is actionable.

## • **Agent vs. Broker**

In actions against an insurance agent, the plaintiff's attorney will first try to **determine** whether the agent's status is that of an agent or a broker. The outcome of this initial task will provide the malpractice attorney with legal procedures and strategies to proceed against the agent, his insurer, his errors and omissions insurer or ALL OF THE ABOVE. For this reason, it is extremely important for agents to know their legal status.

An **agent** is legally defined as "a person authorized by and on behalf of an insurer, to transact insurance". Agents must be licensed by the state and typically require a **notice of appointment** be executed. This document appoints the licensed applicant as an agent of that insurer in that state. Thus, an insurance agent is the agent of the insurer, NOT the insured (client). Of course, an insurance agent may be the appointed agent of more than one insurer.

An insurance **broker** is "a person who, for compensation on behalf of another person, transacts insurance, other than life with, but not on behalf of, an insurer". Brokers must be licensed through most states and are not prohibited from holding an insurance agents license as well. A broker who is also a licensed agent is deemed to be acting as the insurer's agent in the transaction of insurance placed with any insurer who has a valid notice of appointment on file. Basically, an insurance broker is an independent business or business person that procures insurance coverage for clients. Brokers generally receive commissions from the insurer once coverage is actually placed, and except when collecting premiums or delivering the policy, is the agent of the insured for all matters connected with obtaining insurance coverage, including negotiation and placement of the insurance (**Maloney vs. Rhode Island Insurance Company**). Typically, brokers are insurance professionals who maintain relationships with several insurers but are not appointed agents of any of them.

The **purpose** of determining whether the insurance producer was **acting as a broker or as the insurer's agent** when an insurance contract was placed helps establish the theories of liability that the client may plead and what defenses the agent or his insurer may raise. In many court cases, it is not clear whether the producer was acting as a broker or an agent so, attorneys typically plead their case under the banner of each status. Agents should be prepared to prove or disprove the degree and status of agent-to-client relationship at any given time.

Under basic liability theory, a client and his attorney may find it quite difficult to seek recovery from a producer acting ONLY as an agent. **Traditional agency law** in most states concludes that the **insurance agent, acting as agent of the insurer**, owes duties primarily to the insurer. Of course, this assumes that the agent performed in the ordinary course of his or her duties as agreed between the agent and insurer per terms of the **agency contract**. Where an agent is acting properly, a person wronged by an agent's negligence has a cause of action

against the **principal or insurance company**, although this does NOT preclude clients from naming the producing agent also. Another general rule of agency law states that if an insurance agent acts as the agent of a disclosed principal, the principal -- NOT THE AGENT -- is liable to the client (**Lippert vs. Bailey - 1966**).

Despite rules favoring protection of the agent producer, it should be made clear that **agent wrongdoings** outside the **agency contract** and other torts, may still subject the agent to liability exposure.

Another area where agents may be subject legal action is **dual agency**. Dual agency can occur where an agent assumes additional duties by agreement or by professing to have special expertise. When a dual agency exists, the agent may be held liable for a breach of duty owed directly to the insured and, perhaps, liable to the insurer as well (**Kurtz, Richards, Wilson & Co vs. Insurance Communicators Marketing Corp - 1993**).

**Broker liability** is a very different picture. The insurance broker is normally considered the insured's agent and owes duties to the insured. Brokers can be liable if these duties are not adequately performed. Additional liability can accrue where the broker is ALSO acting as the agent of the insurer. Here, the insurer may pursue the broker for breach of duty. One very important **reason** why broker liability is greater than agent liability lies in the fact that the broker, when acting within the scope of authority granted by the client, binds or obligates the client to perform. Obviously, the broker is in a position of greater trust and, therefore, bears greater liability.

Another legal challenge to brokers can surface from their own insurer. Where a dispute arises and the named insurance company can make out the party who solicited the insurance business to be a broker, rather than an agent, then any errors and omissions on the part of that party will exempt the insurance company for those errors and omissions.

## • • AGENT LIABILITY CREATED BY CONTRACT DISPUTES & PROMISES

Regardless of producer status, agent or broker, disputes develop where terms of an insurance contract are violated or promises are not kept. Producers can be liable under **two primary proof centers**: 1) The existence of an insurance contract or principal-agent agreement or an implied agreement, and 2) The breach of contract or nonfulfillment. The existence of contracts and agreements is fairly clear cut. **Primary breach of contract**, however, can surface under any of the following headings:

### • **Failure to Act/Procure Coverage**

This is one of the most important areas of agent/broker liability. In a typical transaction, a broker agrees to procure a certain type of coverage for an insured. It is well established that the broker has a duty to exercise **reasonable care** in procuring that coverage (**Jones vs. Grewe - 1987**); a failure to actually procure coverage (**Keller Lorenze Company vs. Insurance Associates Corp - 1977**); or, a failure to perform some function related to the insurance coverage -- failure to see that policy was actually provided (**Port Clyde Foods vs. Holiday Syrups - 1982**); or, failure to forward premiums to prevent lapse (**Spiegel vs. Metropolitan Insurance**). Liability may also be held to result from an agreement to procure a desired coverage at the lowest obtainable premium rate (**Hamacher vs. Tummy - 1960**).

### • **Failure to Notify Lack of Coverage**

Agents/brokers can be liable for silence or inaction, as in the failure to reasonably notify the applicant that the agent is **unable** to obtain insurance (**Bell vs. O'leary - 1984**).

- **Failure to Place Coverage At Best Available Terms**

As part of the duty to exercise good faith, reasonable skill, and ordinary due diligence in procuring insurance, the **broker** has a duty to be informed of the different insurers and policy terms and to place coverage at the best available terms. If other brokers working in the same market knew that better terms were readily available, the broker who failed to obtain these terms for the client could be liable for the client's loss (**Colpe Inv. Co vs. Seeley & Co - 1933**). This case dealt primarily with the fact that the broker failed to obtain "coinsurance" clauses that were commonly available and carried a lower premium. This must be distinguished from cases proving that the broker does NOT have an absolute duty to obtain the lowest possible rate (**Tunison vs. Tillman Ins. Agency - 1987**).

**Collateral issues** concerning breach of contract include the following:

- **Policy Promises & Provisions**

Agents should ALWAYS review client policies and retain "specimen policies" on file to answer prospect/client questions and compare with policies received. In most states, agents are legally bound to describe accurately the provisions of policies they procure for their clients (**Westrick vs. State Farm Insurance - 1982**). Many lawsuits, for example, have been pursued on misunderstood policy time limits which restricted the clients ability to perform or file a claim. Agents can easily become a focus of this dispute. Another misinterpretation might be: What is an "accident" defined to be? An insurer may deny a claim for lack of requirements establishing an "accident". Or, what is "reasonable medical treatment"? Some agents might be taught NOT to volunteer information on an issue such as this. But, insurers and agents will be held to hold a fiduciary duty to their insureds to disclose full and complete information. Failure to do so may result in a claim of fraud (**Ramirez vs. USAA Casualty Insurance Co - 1991**).

- **Agent Promises**

From time to time, agents make promises that EXCEED what the actual policy promises. Obvious violations would be intentional or unintentional misquoting of policy limits, specified coverages and exclusions. Agent liability also existed in a case where a producer promised to arrange "complete insurance protection" for a business or where an agent promised to, but never did, evaluate an appraisal of an individual's property or to determine its "insurable value" in order to insure a certain percentage of that value. Additionally, an agent might promise to implement or increase a client's coverage "immediately" yet actual coverage might not be in force for 24 hours or until expiration of the existing policy. Less obvious, but equally as serious, are failed promises. A recent example is the marketing of "personal pension plans". Clients, who were promised a "pension plan", received a universal life insurance policy. Agents involved in this scheme are now subject to huge fines, client actions and possible license revocation.

- **Advertising Promises**

In addition to contractual promises, agents must carefully review advertising provided by the insurer to make sure it honestly reflects the promises of the policy. Violations that result in claims would probably not be actionable against the agent, but may name the agent nonetheless or may establish some form of "alleged" agreement that binds the agent / insurer.

- **What Policies Say vs. What They Mean**

No matter how clear the language, all policies will contain areas of ambiguity. The universal rule of **policy ambiguity**, generally upheld by most state courts, goes something like this: If the policy could imply to a reasonable or average policy holder that coverage is in force, yet that exact language does not exist in the policy, then coverage DOES extend to the policy holder. Agents may easily be involved in claims resulting from contract ambiguity.

- **Minimum Standards**

Courts have upheld that even though a policy does not promise to expressly act in good faith and fair dealings, it is the minimum that policy holders can expect. Speaking to agents, not only does the agent owe a duty to the



insured, but also owes a duty of good faith and fair dealings to the insurer (**American Indemnity vs. Baumgart - 1982**).

## • • **LIABILITY CREATED BY AGENT TORTS**

In an action against an agent or broker, the plaintiff's (client's) attorney rarely distinguishes between contract and tort wrongdoings. BOTH are routinely pleaded. In the case of tort action, the **proof centers** on 1) Applicable professional standards and 2) The broker/agent's acts or omissions that do not meet these standards. Who decides what these standards are? In most court cases, the plaintiff's attorney will arrange for "expert testimony" by an agent or broker working in the same field. The fundamental issue is whether the accused broker's professional judgment and methods were appropriately exercised in line with acceptable standards. Following are some important areas of agent wrongdoing (torts) considered to be outside professional standards:

### • **Negligence & Misrepresentation**

Agents and brokers can be liable for failure to procure the requested coverage (**Mayo vs. American Fire & Casualty - 1972**). Wrongdoing also occurred where an agent promised to procure "complete" business premises liability coverage and represented that a policy he procured afforded the desired protection when, in fact, it omitted coverage for a freight elevator occasionally used to transport people (**Riddle-Duckworth inc vs. Sullivan - 1969**). In **Hardt vs. Brink**, the agent was negligent in failing to advise fire insurance coverage on a leasehold made known to him by the client in advance. Another agent negligently obtained non-owner motor vehicle liability coverage for a client knowing it would NOT provide the coverage desired (**Rider vs. Lynch - 1964**). In **Walker vs. Pacific Indemnity Co - 1960**, the agent negligently obtained a policy with smaller limits of coverage than had been agreed upon. In yet another case, the agent notified the client that the original insurer was insolvent and that a replacement policy would be needed. The broker replaced this policy with a new policy having LESS coverage. The broker was held personally liable for \$150,000 because of the gap between the insured's primary and excess coverage (**Reserve Ins Co vs. Pisciotta - 1982**). Liability was also upheld in the case where a lending institution which was licensed to sell credit life insurance failed to offer it to a client who later died (**Keene Investment Corp vs. Martin - 1963**). Finally, in **Anderson vs. Knox - 1961**, an agent represented that \$150,000 of life insurance, where premiums were so high that they had to be bank financed, was a suitable plan for an individual earning less than \$10,000 per year knowing that it was not suitable or with willful disregard as to the suitability of the plan.

### • **Bad Faith**

The insurance agent runs a great risk of personal liability in the event that he is less than fair or reasonable when dealing with either the insured or claimant. Agent liability may accrue due to unfair conduct by agents or allegations of fraud, deceit, misrepresentation or the statutes dealing with unfair settlement practices when the agent is acting as a claims representative for the insurance company or in his individual capacity, independent of the agency. Agents must remember that the number one reason that people purchase insurance policies through agents is for service. When an insured makes a request to procure coverage or turns in a claim, he is not bargaining for promises, but rather action. Additionally, the insured is under the assumption that, due to his prudence in securing insurance in the first place, he will have peace of mind in knowing that he is being protected by the insurance company. Any breaches of this **reasonable expectation** will usually subject the insurance company and the agent to the exposure of insurance bad faith practices and a breach of the fiduciary duties owed to the insured.

Most bad faith liability occurs in the property/casualty areas under the title of "claim avoidance". Some agents play judge and jury with client claims by advising them to NOT submit a claim since it would be cheaper to repair the vehicle or property or pay his own medical bills rather than incur potential insurance rate increases or even cancellation. Such conduct will expose agents to a breach of his fiduciary duty to the insured as well as a breach of the implied-in-law covenant of good faith and fair dealings. It may also be a breach of the unfair claims practices act in some states. This kind of agent deception even justifies potential punitive damages (**Independent Life & Accident Ins Co vs. Peavy - 1988**).

## • • **LIABILITY CREATED BY CLIENT/AGENT RELATIONSHIPS**

The insurance agent/broker is increasingly regarded as a professional to whom clients turn for advice and guidance in insurance matters. In some states, the insured's pattern of reliance on the broker's advice has been the basis for a **higher standard of duty (Hardt vs. Brink - 1961)**. Relationship liability generally occurs on two fronts: 1) Contributory and 2) Agents as Fiduciary.

### • **Contributory Liability**

When an agent holds himself out to be an "expert", a "specialist" or a "professional", he is creating **contributory liability** and may be held to higher than normal standards or standards beyond the disciplines of insurance. The earning of credentials or designations further compounds the agent's exposure, since he is considered, in the eyes of the law, to be subject to a higher standard of knowledge and responsibility. Yet, faced with stiffer competition, agents are almost forced to upgrade their image by earning designations and/or creating marketing "niche" expertise with titles and job descriptions like: financial planner, estate planner, retirement planner, "one-stop" insurance agency, loss control consultant, etc. Contributory liability relationships have also been cast simply because an agent as **ALWAYS** handled a clients business over the years, so much so, that clients have **blindly depended on their advice**. The result of these "titles" and "agent trust" is a higher level of culpability. In fact, plaintiff attorneys have and continue to develop **legal strategies** that establish contributory liability of agents by multiple approaches,, including:

- The insurance purchaser usually is not versed in the intricacies of the insurance business. Prospective insureds seek the assistance of the insurance "specialist" and come to rely on his knowledge. In some cases, the reliance on the agent is total and complete. When the agent procures coverage that turns out to be defective in some way or fails to make arrangements, the applicant should have a cause of action against the agent. This takes on more meaning today as agents and brokers have increasingly promoted their professional expertise in serving the public's insurance needs.

Advertising has clearly effected the importance and desirability of acquiring insurance through the offices of a specific or independent insurance agents who possess substantial or special expertise that can be used to guide the consumer. As a result of such advertising, many clients undoubtedly have reasonable expectations that these agents are independent business entrepreneurs and, in some instances, are capable of expertise in a wide variety of business areas.

- In most insurance transactions, the agent can generally be shown to have acted as a "dual agent" -- representing BOTH the insurer and client. As such, he owes a duty to exercise due care and reasonable diligence in the pursuit of the client's insurance business regardless of the insurer chosen or represented by the agent.

- The availability and wide subscription of errors and omissions insurance for agents creates an argument that agents can be liability targets in any insurance disputes. In years past, the absence of such coverage may have constituted a significant factor in support of the proposition that the agent might not be liable.

### • **Agents as Fiduciaries**

Sometimes, agent liability just comes with the territory. Or, it is aggravated by special agent relationships where the insurance contract is established as a collateral issue of some greater purpose such as financial planning, exclusive insurance agency arrangements, promises to provide "complete coverage", etc. New legal theories are continually attempting to establish an agent selling an insurance contract as a principal fiduciary and as probable "deep pockets". This is an increasing possibility where the agent is the "exclusive" insurance provider for clients or in cases where the client, over a significant period of time has come to be totally dependent on insurance

decisions made by the producer.

Another area of fiduciary exposure deals with Employment Retirement Income Security Act (ERISA) qualified funds. Many life agents help clients establish and fund retirement plans using insurance products. Under ERISA, a plan must designate a fiduciary to administer its operation. An **ERISA fiduciary** has been interpreted to be **any person exercising managerial control over the plan or its assets, regardless of their formal titles.** In recent years, the U.S. Labor Department, the federal agency that administers ERISA, has become more aggressive in reviewing insurance funded plans and the link to agents as fiduciaries. It is even proposed that agents and brokers can **unintentionally** become ERISA fiduciaries simply by how they advertise and market their retirement plan services.

In the past, it was typically the owner of the business, the board of directors or a specifically assigned fund manager that was considered the principal fiduciary. ERISA imposes a variety of duties on fiduciaries of life, health and retirement benefit plans, including a duty to act for the exclusive benefit of plan participants and beneficiaries. The act also establishes prohibited transaction rules governing plan fiduciaries that would disallow, for example, a fiduciary receiving personal benefit from a third party dealing with the plan. Does this mean that an agent who helps establish a retirement plan recommends products to fund the plan and who receives a commission for doing so violates these rules? The answer lies in whether the **agent** is actually **deemed a fiduciary.** If the agent arranges to receive a fee for consulting on the pension plan, he is clearly a fiduciary. **If the agent has an ongoing relationship with trustees of a plan who regularly accept the agent's proposals without advice from other consultants, he can be classed as a fiduciary of the plan.** On the other hand, where the agent is only acting in the capacity of an agent, offering a choice of products from which to choose, and as a member of a team of plan consultants, he is less likely to be classed as a fiduciary.

To summarize, ERISA fiduciary status may be established where the trustees of a retirement plan "relied" heavily on the agent's advice in the purchase of insurance contracts. In **Brink vs Dalesio - 1981**, the agent was found liable for unsound insurance purchases because the plan trustees relied on his advice. In **Reich vs. Lancaster - 1993**, the agent was again found liable as a fiduciary when insurance transactions absorbed the majority of the fund's assets. In addition, the agent failed to disclose his compensation or relationship with the insurer. Since the fund trustees were inexperienced in insurance matters and accepted every recommendation offered by the agent he was considered a fiduciary. In **Kerns vs. Benefit Trust Life**, an agent, as a courtesy, notified employees that their group term life coverage had lapsed shortly before their employer's death. But, he failed to forward the insurance company's routine offer to reinstate coverage and was found responsible. In yet another case, a Louisiana district court held that an insurance agent was a fiduciary to a profit sharing plan, even though he only **sold** a whole life policy in the plan's name. The policies later proved unsatisfactory from an investment and tax perspective. In support of their decision, the court stated that the primary purpose of a qualified retirement plan is to provide retirement benefits. The plan can provide life insurance death benefits only if those benefits are incidental to the retirement benefits. "Incidental", under IRS guidelines, would allow for premium payments LESS THAN 50% of the aggregate employer contributions to the plan. In the Louisiana Case (**Schoegal v. Boswell**), the plan had purchased life insurance on a plan participant IN EXCESS of 50%. Since the ERISA rule on incidental benefits had been violated, and the life insurance agent had violated the rule, he was declared a fiduciary and seemingly responsible for the taxes, penalties and possible disqualification of the plan. In further implicating the agent, the court pointed to Boswell's (the agent's) strong relationship with the custodian bank, management of the company, its employees and the plan administrator, deciding that he was *"...clearly more than a mere salesman"*. In the court's view, he had sufficient discretionary authority and control to be a plan fiduciary. Fortunately, the court's ruling has recently been appealed and reversed on the basis that agent Boswell lacked the necessary authority and control over the plan investments and because there was no underlying agreement that his advice would serve as the primary basis for investment decisions for the pension plan. While this is a favorable decision for agents, it demonstrates the extremes and aggressive legal action to which agents are vulnerable, particularly if the insurance transaction does NOT produce the anticipated or desired results for plan participants.

## • • **LIABILITY FROM INSURER CLAIMS AGAINST AGENTS**

When most agents assess professional liability, they think client lawsuits. But agents and brokers also face exposure from the insurers they represent. When agents are sued by their insurer it is most likely for a violation of the law of agency. Most agents are familiar with the term fiduciary duty. Between agent and principal, the insurer, **fiduciary duty** of the agent prevents him from competing with the principal concerning the subject matter of the agency or from making a "secret profit" other than what is stipulated or agreed as commissions. Beyond this, however, agents are bound to his insurer by other **statutory duties**. They include Duty of Care and Skill, using standard care and skill; Duty of Good Conduct or acting so as not to bring disrepute to the principal; Duty to Give Information by communicating with the principle and clients; Duty to Keep Accounts by keeping track of money; Duty to Act as Authorized; Duty to be Practical and not attempt the impossible; and Duty to Obey or comply with the principal's directions. A violation of these duties can be considered grounds for termination or legal exposure to the principal or insurance company.

Following are some case examples:

- **Basic Agency Violations**

When an agency agreement exists between agent and insurer, the agent/broker has a duty to exercise reasonable care. The agent is considered a fiduciary of the insurer. He or she must exercise skill and diligence and is liable for negligence that induces the insurer to assume coverage on which it suffers a loss. Brokers who have agency agreements with insurers have been found liable to the insurer for clerical mistakes -- incorrect policy dates, erroneous limits of liability and omissions of endorsements.

- **Misappropriating Premiums**

As representatives of the insurer, agents and brokers owe a fiduciary responsibility to the insurer to remit premiums collected from clients promptly or hold them in a trust account. In **Maloney vs. Rhode Island Insurance Company - 1953**, the agent converted premiums to his own use, facing liability to the insurer and possible criminal charges for embezzlement.

- **Failure to Disclose Risk Factors**

An agent has a duty of good faith and loyalty to his insurer and may be liable for negligently inducing the insurer to issue coverage on which it suffers a loss (**Clausen vs. Industrial Indemnity - 1966**). In this case, it was successfully argued that an insurer may obtain indemnity from a broker, if the broker knows or should know that insurer is relying on the broker to supply information about the insured, the information furnished is incomplete or incorrect, the incomplete or incorrect information is material to the decision to accept or decline the risk, and the insurer is forced to pay a loss under a policy that the insurer would NOT have issued had complete and accurate information been provided by the broker. In a similar case (**New Hampshire Insurance Co vs. Sauer - 1978**), the insurer sued its agent, alleging negligence for failing to notify the insurer of the exact nature of the insured's business when applying for business interruption coverage. The jury attributed 70 percent of the loss to the insurer and 30 percent to the agent's negligence.

- **Failure to Cancel or Notify of Cancellation**

Agents do not normally have an obligation to the insurer with respect to cancelling an insured's coverage. For example, if the policy is billed directly, the insurer usually notifies the insured directly of the insurer's intent to cancel and, thereafter, of the actual cancellation. The broker/agent is typically "out of the loop". However, a broker who has undertaken responsibilities in cancelling coverage, through agreement with the insured, owes the insurer a duty to follow the insurer's instructions promptly and correctly. In **Mitton vs. Granite State Fire Insurance Company - 1952**, an agent was accepted as the insurer's general agent for purposes of signing policies, issuing endorsements, etc. As the insurer's agent, the broker was instructed by the insurer to obtain a flood and landslide endorsement from an insured. If the insured refused to accept such an endorsement, the agent was to notify the insurer who would cancel the policy. The broker failed to do either and was held liable to the insurer for the insured's flood damage.

- **Authority to Bind**

An agent may be a general agent with general powers, or his powers may be limited by the insurer. Some agents are authorized to issue insurance contracts that bind the insurer, they have binding authority. Some agents may have binding authority only as to certain classes or lines of coverage.

Legally, the agent possesses the powers that have been conferred by the company or those powers that a third party has a right to assume he possesses under the circumstances of the case. Under some circumstances, however, an insurer is forced to concede that statements made by its agent or representative were made, and these statements bound the insurer to pay a loss sustained. In **Troost vs. Estate of DeBoer - 1984** the agent exceeded his binding authority yet his acts and representations were relied upon by the insured. The agent was held liable for the insurers' losses.

- **Premium Financing Activities**

Frequently, brokers play a role in helping clients finance their insurance premiums by bringing the insured and the financing entity together. There have been cases where the financing company has been the victim of fraudulent schemes misleading them into issuing loans to nonexistent insureds. In an effort to recover its losses, the financing entity may look to the insurer on grounds that the broker was acting on the insurer's behalf in arranging the financing, even though the insurer may not have given the agent explicit authority to engage in premium financing activities. In **New England Acceptance vs. American Manufacturers Mutual Insurance Company - 1976**, an insurer was held liable for its agents actions in such a financing scheme because it was "implied" that the agent had been authorized to conduct premium financing. In a similar case, **Cupac vs. Mid-West Insurance Agency - 1985**, the court held that the insurer had **not authorized** its agent to engage in premium financing activities because nothing in the agency agreement referred to such activity. The agent was held liable. Various states have split on the decision that the business of premium financing is an integral part of the business of insurance.

Insurers may also lash out against agents under the National Association of Insurance Commissioners "**Unfair Trade Practices Law**" which many states have enacted. It states:

"Persons (defined to include insurance companies and insurance agents) are prohibited in engaging in "unfair methods" of competition and deceptive acts and practices." Including, "making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance."

Under this code, it is conceivable that an insurer could commence litigation naming an agent where the company's insolvency was related to agent "derogatory" actions. Consider a case similar to **Mutual Benefit Life**, where agents were actively involved in the disintermediation or withdrawal of "blocks" of client policies after rating drops occurred. Ultimately, this "run on the bank" was deemed the single greatest issue contributing to the companies liquidation. Were agents exercising "due care" for clients or breaching their legal and "unfair practice" duties to their contracting company? Look for future court cases to solve this one.

- • **LIABILITY CREATED BY INSURER FAILURES**

To date, few courts have held that insurance brokers or agents are liable for the losses that policy owners might suffer from an insurer insolvency. Be assured, however, agents continue to be sued and pursued for malpractice in this area, and there are countless legal theories being proposed to force accountability. The basis for most tort actions where an insolvent insurance company is involved lie in certain cases and written code sections. At first glance, these regulations imply that agents are not responsible for involving a client with an insolvent company or a carrier that eventually is state liquidated. Here is how the law of liability reads in most states:

**"The general rule in the United States is that an insurance agent or broker is not a guarantor of the**

**financial condition or solvency of the insurer from which he obtains coverage for a client." (Harnett, Responsibilities of Insurance Agents and Brokers).**

In an actual case against a California agent, **Wilson v. All Service Insurance Corp (1979)** 91 Cal App.3d 793,153 Cal. Rptr. 121, similar results accrued:

**"An insurance broker has no duty to investigate the financial condition of an insurer that transacts business in California pursuant to a certificate of authority because the scheme of licensing and regulation of insurers administered by the Insurance Commissioner was sufficient for this purpose and could be relied upon by the broker when placing insurance."**

Before an agent rejoices in knowing that laws of this nature are on the books, he must realize that regardless of this implied protection, court cases continue to be tried. In *Wilson v. All Service Insurance*, for example, the client commenced a lawsuit in 1975 and even though the agent prevailed, the decision was not rendered until 1979 -- that's four years of attorney and court fees! So aggressive was the client that two different appeals to the State Supreme Court were attempted involving more defense fees. One must also ask . . . If agent liability laws and codes represent a "safe harbor" and if agents are "untouchable", why do professional liability policies **REFUSE to defend and REFUSE to indemnify** agents where an insurer insolvency arises? It is clear, when an agent involves a client in a company that later develops financial problems, the agent, who himself may be victim of the liquidation, can be sued and may be left to fend for himself against client claims and possible indemnification suits from his or her own company.

The legal caveat that "muddies the waters", relevant to agents and insurer failures, is the results of a 1971 lawsuit -- **Williams-Berryman Insurance v. Morphis, (Ark. 1971)** 461 S.W.2d 577, 580. It proclaims the following:

**"The agent or broker is required to exercise reasonable care, skill and judgment in procuring the insurance, and a failure in this regard may render him or her liable for losses covered by the policy but not paid due to the insolvency of the insurer."** What is "reasonable care"? In *Wilson v. All Service* (above), the fact that the carrier was an admitted company proved to be adequate care. In *Higginbotham & Associates v. Green*, 738 S.W.2d 45 (Tex Ct App, 1987), however, the courts further clarified:

**"If, for some reason, it is shown that the agent or broker knew, or should have known, that the insurer was insolvent at the time of placement, he or she may be liable for the loss caused by insolvency."**

In all these cases, the agents won, or prevailed on appeal. The reader should be aware, however, that in addition to the expense of lengthy litigation a pattern is established. The burden of **agent liability involving financially distressed insurance companies is greater today for two reasons:** 1) Because more liquidations are in process, and 2) Because the courts want agents to be more responsible for their actions.

In addition to these known precedents and cases, agents are continually subjected to harassment suits from disgruntled clients and others that are settled out of court. Because these settlements are not published, it is impossible to know the depth and breadth of the problem. Most agents, however, know someone or has had some personal experience to realize they occur frequently. One such case involved an Oregon couple who invested their \$26,000 retirement fund in an annuity with Pacific Standard Life in 1987. About three years later, they attended a financial planning seminar where they learned that their insurance company had been taken over by the California State Insurance Departments due to losses in "junk bond" holdings. The couple immediately demanded a surrender of their policy. Of course, they were blocked from withdrawing their money by the conservators and the six-month payment delay provision in their policy. Seven months later they received a check for about 70 percent of their annuity value. The agent was threatened with legal recourse to obtain the deficiency. After weighing the possibility of a lengthy court case and to keep an action from going public, the agent agreed to pay. From the above court recitals, this agent may clearly have had no exposure. The least path of resistance, however, was to pay the client and move on. Fortunately, the dollars involved were controllable. But what of the situation where multiple clients are seeking reimbursement or the numbers are significant? The

answer is not easy to predict, but the solution involves a multi-faceted approach to limiting exposure while still providing service.

- **Misrepresentation & Insurer Failures**

Insurer insolvency cases against agents may be based on **misrepresentations** by agents. Where agents have made expressed warranties or specifically agreed to supply a solvent carrier or one with stated or minimum amounts of capital are the most obvious areas where liability abounds. An even worse situation occurs where an agent knowingly distorts actual capital or asset statistics of an insurer to make it more appealing. A similar violation occurs where an agent represents that he made a **detailed investigation** of the insurer when, in fact, he did not. Examples where agent liability is not so clear, however, include cases where an agent convinces a client to surrender or cancel a policy from one company for a policy of another company and it is determined that the second insurer is weaker and maybe even liquidated at some later date. In this instance, the law might interpret the agent actions to be more than just a "usual transaction", where a policy product is simply "sold". Here, the agent acted more as an **advisor**. His actions might appear to be assurances that the new company is better than the old company when, in fact it was not, for purposes of generating a commission.

In yet another legal strategy, agents may be culpable by his statements of confidence. Saying things like, "**trust me**" or "**I guarantee it**" could be construed as a warranty by the agent. Since most agents find it impractical to "clear" every representation with compliance departments, many oral declarations are made in the course of a sale or counseling clients. Technically, a guaranty should be in writing, but this would not stop an attorney from pursuing a talkative agent who made similar representations to more than one client. A common example is in the area of "safety" regulations. The following are terms probably used everyday by agents and though they stop short of creating an absolute financial guarantee for policy owners, they infer financial stability and give the purchaser a measure of confidence that the company behind the product is financially secure. An agent who cites these utterances is likely to responsible for their veracity:

- **Regulation by State Insurance Departments**

An agent might say: "All insurers are regulated by the State Insurance Departments in the states in which they do business. These departments enforce the states' insurance laws. These laws cover such areas as insurer licensing, agent licensing, financial examination of insurers, review and approval of policy forms and rates, etc. Generally speaking, an insurer's and reinsurer's operations are at all times subject to the review and scrutiny of state regulators."

- **Minimum Capital and Surplus Requirements**

"Among the requirements imposed by state laws are minimum capital and surplus requirements. These provide that an insurer or reinsurer will not be allowed to do business unless it is adequately capitalized and has sufficient available surplus funds with which to conduct its operations."

- **Minimum Reserve Requirements"**

State laws require insurers and reinsurers to post reserve liabilities to cover their future obligations so that financial statements accurately reflect financial condition at any given point in time."

- **Filing of Annual Statements**

"Insurers and reinsurers are required to file annually a sworn financial statement with each insurance department of the state in which they do business. This detailed document provides an open book of the insurer's financial posture and is reviewed closely by state regulators."

- **Periodic Examinations**

"State regulators perform examinations or audits in the home office of insurers and reinsurers as often as they deem necessary, but generally no less frequently than every three years. The primary purpose of such

examinations is to verify the financial condition of the insurer. In addition, a reinsurer may perform period audits of the company they reinsure. Finally, an annual audit is also conducted by a public accounting firm."

- **Statutory Accounting**

"In reporting to state regulators, insurers and reinsurers are required by state laws to practice "statutory accounting", as opposed to conforming with "generally accepted accounting principles (GAAP). The statutory method is generally acknowledged to be a more conservative approach and thus much less likely to overstate a company's true financial condition."

- **Investment Restrictions**

"State insurance laws restrict the manner in which insurers and reinsurers can invest the funds they hold. Insurers and reinsurers generally may invest only in assets of a certain type or quality and must diversify their investments to minimize overall risk."

- **Guaranty Funds**

"It is possible that, in spite of these and other safeguards, an insurer could become insolvent. If this should occur, there still remains the likelihood that a policy owner will retain most, if not all, of the value of his policy from funds still remaining with the insolvent insurer. Moreover, many states have enacted what are commonly known as "guaranty fund" laws for the added protection of the policy owners of insolvent insurers. These laws generally provide that other insurers doing business in that state will contribute funds to alleviate any deficiency of assets in the insolvent insurer. The provisions of the laws generally cover all policyowners, wherever located, of insurers domiciled in such states and all residents of such states who are policy owners of insurers who are not domiciled in such states, but who are authorized to do business there. The law in some states limits the amount of protection provided to a policyowners to an amount of \$100,000. Other states have higher or no limits."

Many states disallow advertising or use of any statements regarding state fund insurance prior to the sale. The premise is that guaranty fund warranties made to fortify the financial security of a weaker insurer could lull the public into overlooking the need to deal with sound companies. Further, violations of sales tactics using guaranty funds may cost an agent more than a liability suit. It may result in additional monetary fines and license suspension.

- **Agent Relationships & Insurer Failures**

Often, agents develop special relationships with clients which can result in additional liability exposure. This can occur when an agent has handled all the insured's business or when a client has come to completely depend on the agent for all his insurance decisions and the agent knows it. In these cases, there may be legal authority to proceed against the agent where losses due to insolvency occur. Even when faced with limited success, policy holders and their attorneys have pursued agents asserting a "personal" claim -- that is, the culpable conduct of a **third party** (the agent) was personal to the policy holders, who relied upon that wrongful conduct. Also, never let it be said that policy holders cannot sue an agent for any reason. This "right" has been upheld under **Matter of Integrity Insurance Co., 573 A.2d 928 (1990)**.

One justification for placing **tort responsibility** on the agent is the conclusion that :

**"The risk of loss in an insolvency setting should not rest with the insured or the claimant."**

Cal Ins Code, 780-790.1 (Dearing 1991), N.Y. Ins Laws, 2401-2409 (1990), Mass Ann Laws ch 175, 2B (1990).

In essence, the courts are sympathetic concerning an insured's need for complete protection. This stems from the **special circumstances** that surround an insurance contract, i.e., **the insured and insurer are not equal partners since the insured cannot protect itself by contract. Also, the insured cannot bargain or require a provision of the policy to protect or indemnify for a potential insolvency. The insured can only seek other insurance with a more stable company. And, even when an insured is informed about the financial condition**



***of an insurer, the courts feel that they would lack the knowledge and experience necessary to evaluate financial statements, reports and solvency terms like surplus, reserves, etc. Finally, an insured cannot mitigate or control his damages since insurance cannot be purchased after a loss, i.e., the insured could have already paid for a benefit he cannot receive if an insolvency occurs.***

Recent legal research, which will be cited in claims against agents, presents a clear and loud indictment of agent and broker responsibility (A Proposal for Tort Remedy For Insureds of Insolvent Insurers Against Brokers, Ohio State Law Journal, vol 52, 4 (1991):

**"When one considers all of the factors of tort recognition, including the social policy aspects, the argument for the establishment of a tort duty on the part of the collateral parties (agents, brokers, reinsurers, etc)to the insurance relationship is compelling. Placing a duty on the collateral parties to investigate and monitor reasonably the solvency of insurers with which they deal yields a much more socially advantageous result. This duty logically extends the duty already existing for brokers to exercise care in the placement of insurance with solvent insurers. The proposed duty, however, requires affirmative investigation and monitoring. This investigation and monitoring should, at least, include an evaluation of National Association of Insurance Commissioners' data, Insurance Regulatory Information System data, ratings service data, and any other public information and general information circulating within the industry. Thus, the duty requires a more thorough investigation than present law apparently requires brokers to make. In addition, the duty continues past the placement of the insurance or the commencement of the insurance relationship."**

**"The duties of these public parties is a high duty that encompasses nonfeasance (Pennsylvania v. Roy, 102 U.S. 451, 456). Imposing a duty on collateral parties (agents, brokers, reinsurers, etc) to conduct a reasonable investigation and monitoring of the solvency of insurers, and imposing liability for a failure to abide by that duty accords with prior treatment of public entities."**

Congress has also chimed in by suggesting that:

**"Brokers should be required to check the integrity of the people and records which determine ultimate premiums and losses charged on policies".**

*"Failed Promises", Testimony before the Subcommittee on Oversight and Investigations for the U.S. House of Representatives (1990).*

# INSURANCE REGULATION

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## ## WHY REGULATE INSURANCE?

In his book *Insurance Risk*, Howard Blanchard suggests three **reasons for the need to regulate** the insurance business: 1) The value of an insurance contract is only as good as the insurer's ability and willingness to fulfill the promises of the policy contract -- today and possibly decades away; 2) a system of insurance requires public confidence; and 3) insurance is a technical subject which requires skills and specific knowledge beyond the grasp of most people -- many individuals running insurance companies are attorneys, and attorneys have been accused, by some, of complicating simple issues and routine procedures.

Blanchard cites several good examples of why regulatory intervention is important. A whole life policy, for example, may conceivably be in force for 80 years. If the insurer is sound and competently managed when the policy is first approved, its financial condition and management could, in the absence of safeguards, change during the remaining tenure of the policy. Also, in large measure, the continued solvency of an insurance company depends on the quality of its investments. If insurers are not held to some course of action that will continuously enable them to meet their obligations through sound investment practices, policy holders could suffer. Without any form of regulation or self policing, less than honest insurance managers might succumb to the temptation to seize present profits without concern for future solvency. Further, one must allow for the fact that most insurance contracts are written for the benefit of third parties, some of whom have little or no direct voice in the choice of an insurer. An example might be workers compensation or liability policies contracted through a broker. Many consumers who purchase these policies receive protection but may not even know the name the carrier, much less its financial condition. Obviously, their positions are improved where some form of insurer regulation is in place. In addition to these considerations, it is common knowledge that insurance is difficult to understand and the operations and locations of insurance companies are distant, complicated and highly specialized. Also, many state regulators are attorneys. As such, they are in a better position than most to represent the general public and penetrate the maze of financial accountability that insurers must heed.

Of course, none of this adulation for regulation should be construed to mean that state regulators are perfect. But, between their efforts and the work of industry groups, the industry has been relatively successful in maintaining a historically high level of solvency and done much to protect the public from a few schemes that might, in their absence, be nothing short of racketeering. Events before the days of strict regulation are evidence enough of such possibilities.

## ## THE HISTORY OF INSURANCE REGULATION

Before 1850, insurers operated with little formal or direct regulatory supervision in the United States. The **power of insurers was defined in their charters**. In 1851, the New Hampshire Legislature created a **full-time board of insurance commissioners**. Massachusetts and Vermont enacted similar legislation in 1852, New York in 1859

and Rhode Island in 1865.

As the number of companies expanded, the need for regulation grew -- especially around the time of the Civil War. During this period, incompetency and dishonesty caused many insurer failure. Policy owners were devastated and the entire industry became suspect. An 1869 United States Supreme Court decision, (**Paul v. Virginia**) held that insurance was NOT interstate commerce, and therefore not subject to the control of the federal government. That decision left insurance regulation in the hands of the various states. In the late 1800's, however, the Supreme Court ruled on many "public interest" cases which later, in 1914, resulted in legislation that established the right to regulate an industry where the public good was involved. While this could have paved the way for some form of federal regulation, the states still controlled. Policyowners at the time, however, were wise to limit their business among century old companies like Lloyds of London or deal only with fraternal organizations who offered protection for members only. In 1905, Congressional began an investigation of the life insurance industry (**The Armstrong Report**) due to some serious financial reporting abuses with no resulting legislation. A related audit of nonlife insurers in 1910 (**The Merrit Committee**) found unchecked price competition abuses among fire and casualty companies. Inadequate rates, in turn, resulted in many insurer insolvencies. Still, however, the prevailing sentiment was that state administrators should be responsible for fair competition and public protection in the affairs of insurance. Each state went about establishing its own system of licensing insurers.

In the years preceding **the Great Depression**, financial conditions of insurance companies improved, primarily because the investments backing insurers prospered by huge leaps in value. Starting in the late 1920s, however, the effects of depressed conditions and declining security values started taking their toll. Insurance companies, particularly in the fire and casualty area, were failing at unprecedented rates. Life insurers, with their assets invested primarily in bonds and mortgages, were less affected by the rapid decline in security prices. Concerned state regulators, at a 1932 National Convention of Insurance Commissioners, recommended that companies set up voluntary "contingency reserves". Despite a general acceptance of this idea by individual companies, failures continued. Fortunately, recovery of the market in late 1932, afforded new assurances to regulators and the public. It was about this same time that multi-state insurance companies became more prevalent. These and other major insurers had avoided closure, and proved able to absorb the adverse effects of deflation, at least for limited time frame. Insurance managers of this era, hopefully realized their mistakes, due largely to an inflation psychology. State regulators narrowly escaped widespread collapse and gained a degree of confidence in their ability to garnish industry support for some form of solvency standards. Bolstered by their ability to handle these early brushes with insolvency, state regulators maintained a front seat in controlling the industry. This position was not questioned again until 1944. Though previous Supreme Court decisions repeatedly held that regulation of insurance was not within the power of the federal government because insurance was NOT commerce, on June 5th of that year, the Court reversed itself (**United States v. South-Eastern Underwriters Association**), declared insurance to be commerce and therefore subject to federal regulation to the extent that it was interstate in character. While ALL members of the Supreme Court agreed that insurance was subject to regulation under the commerce clause of the Constitution, a majority decided that the **Sherman Act**, non-insurance related legislation already on the statute books, was more applicable. The Sherman Act established that the making or setting of prices, premium rates in the case of insurance, was illegal and since this was a function fundamental to the operation of most insurance companies. With the Supreme Court again decided, Congress showed no desire to takeover regulation and, in fact, passed the **McCarran-Ferguson Act in 1945** which, in effect, formally invited the states to preempt the federal antitrust laws by regulating the business of insurance. In response to this Congressional invitation, individual states again prevailed as the responsible regulator for insurance business within their own jurisdictions. The result is that each state now maintains its own insurance department organized under the supervision of a commissioner, director or superintendent who is appointed or elected. Currently, twelve insurance regulators are elected.

Throughout much of the 1950s, 60s and 70s it appeared that the insurance industry was not a major legislative subject, although the business of insurance continued to grow more complex. However, as the 1980s beget progressive "*interest sensitive*" products as well as an aggressive tort system, the strain on the industry began taking its toll. Insurer safety and solvency regulation became morning news again. No doubt, history will also view the late 1980s and early 1990s as watershed years in solvency regulation. This experience, however, is easily surpassed by the disturbing upheaval in other financial services institutions, regulated by the federal government. Namely, the number of bank failures during this time frame climbed to between 200 to 300 annually! This compares to only 80 to 90 insurance company failures during the same time frame.

## ## THE OBJECTIVES OF INSURANCE REGULATION

The regulation of the business of insurance is fundamentally a task of consumer protection. The **primary goal of the regulator is to protect the interest of consumers** -- whether as policy holders, potential insurance claimants, or taxpayers -- **from the financial loss associated with insolvency**. This means that regulators must closely monitor companies and, where possible, take action designed to prevent an insurance company's insolvency. It may also mean, where an insolvency is unavoidable, as is sometimes the case in a competitive free economy such as ours, regulators must take action to assure that losses to consumers resulting from the insolvency are minimized. Another objective of regulation is **to assure the sense of fair play**. Many people mistakenly interpret this to mean the control of free competition. Actually, it involves systems to be sure that insurance is available to the public on a fair and even basis. Inner city applicants should not be denied access to insurance or be "redlined" for simply living in a higher risk area. Another more recent example of fair play regulation is the State of Florida's moratorium to keep insurers from canceling homeowner policies en masse or hiking rates to recoup major losses experienced from Hurricane Andrew. Regulators are also around to **assure equity**. This refers to policy holder fairplay regarding equal treatment between one policy holder and another as well as equal treatment where participating policies must impartially distribute earnings back to policy holders without discrimination of any kind.

## ## THE ROLE AND PROCESS OF STATE REGULATION

**Court cases** have established that the federal government has the power to regulate insurance but has elected to remain silent. Over a period of 100 years, ending in 1945, there have been many pieces of legislation (discussed above) leading to the current day presumption that the regulation and taxation of insurance is, for now, the domain of the states. Congress has let it be known, however, that if state regulation becomes ineffective or deficient in serving the public, the federal government maintains the right to takeover. During times of great economic stress and larger than normal insurance company failures, such as that experienced in the early 1990s, the threat of the federal intervention is routinely revived.

Regulation of insurance was at first the duty of **state legislators**. Their **role** was to help control insurer solvency, regulate rates, apply rules of fair play, oversee agent licensing, supervise company reporting and evaluate insurer finances in the areas of valuation of assets, investments, surplus, etc, as well as assume the prominent role as "executor" in the liquidation of troubled companies. However, because many of these areas require specialized knowledge, most states have found it necessary to establish their own departments of insurance. **Insurance laws are still the jurisdiction of state legislators** who depend on their respective departments of insurance to develop and evaluate proposed laws which are typically drafted with the aid of the state attorney general. The **official** in charge of insurance regulation is the commissioner, superintendent or director. He is usually appointed by the governor and is considered a powerful force in determining the direction and intensity of insurance regulation. Insurance departments have the authority to make and enforce rules. The authority to make these rules is known as **administrative law**. However, rules of the commissioner can be challenged or regulated through state judicial review or state insurance authority. Also, court rulings will reinforce or change state

insurance regulations.

Today, it is staggering to learn, there are almost 6,000 different insurance companies being regulated in the United States, collecting over \$600 BILLION in premium per year (Insurance Information Institute). According to author Wesley Smith "...This amounts to 12 percent of the disposable income in the United States. Americans pay more for insurance (direct and indirect) than they pay for federal income taxes, not counting Social Security. Obviously, the task of regulation is a mammoth undertaking. Yet, the size of state insurance departments' staffs varies from a dozen to over 1,300, with a national aggregate staff of just under 9,000 (1990). Similarly, the budgets for these departments cover a range from a low \$750,000 to \$67,000,000, with a national budget of over \$458 million (Government Accounting Office report to the Senate Subcommittee on Policy Research and Insurance, July 29, 1991).

## **## OTHER REGULATORY EFFORTS**

Like other systems of authority, the regulation of the insurance business by states agencies has been the subject of criticism. The issues include poor enforcement, lack of attention, lack of uniformity between states. Early attempts to create uniformity were primarily undertaken by private industry groups like the ***South-Eastern Underwriters Association (SEUA)***. At one time, this organization controlled 90 percent of the fire insurance within its stated jurisdiction. The SEUA established underwriting guidelines, agent requirements and other strict procedures until in 1942, the U.S. attorney general accused it of violating the Sherman Antitrust Act. Among other charges, the SEUA was eventually indicted for restraining interstate trade and monopolizing insurance business.

The longest surviving organization for promoting universal standards is the ***National Association of Insurance Commissioners***. The remaining portion of this chapter is dedicated to the efforts and inner workings of this group and its attempt to create a "model system" among all state departments of insurance. Suffice to say, the group's efforts have been more successful than any agency in unifying state cooperation. In spite of this, however, model laws are still not in force in every state. Specific "model laws" that are working in many states are generally believed to be effective. Further, non-participating states, under recent threat of federal intervention, are under more pressure than ever to comply with NAIC "model acts". Examples of the type of NAIC model acts in wide use include standards and rules concerning standard annual reports, uniform liquidation procedures, product improvements such as easy to read policies, indexes for price comparing insurance rates, model laws for regulating insurance rates and the availability of coverage, authority to revoke licensing of unauthorized insurers, risk based capital requirements, proposed model investment laws, etc. Still at discretion for state regulators are the rules and business procedures such as: agent licensing and continuing education, agent rebating, agent misrepresentation, agent discrimination, unlicensed insurers (nonadmitted companies), capital and surplus requirements, loss reserve ratios, policy owner dividends and state guaranty funds.

## **## THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS & INSURANCE REGULATION**

### **# A Brief History of NAIC**

The National Association of Insurance Commissioners is a voluntary organization composed of the insurance commissioners from each state. Its primary purpose is to create uniformity in state insurance laws. The organization has grown from a simple advisory role into a constructive participant in legislative issues and major creator of "model laws" now in use by a majority of states. The National Association of Insurance Commissioners' involvement in solvency regulation dates back to its formation 120 years ago. In fact, the ***NAIC was created*** specifically to address a series of insurance company insolvencies in the late 1860s and early 1870s.

Since then, state regulators have worked together, through the NAIC, to coordinate protection of the consumer from financial and personal loss that can result of the insolvency of an insurance company. The resulting system of insurance regulation provides a high degree of uniformity in the supervision of interstate companies, yet is sufficiently decentralized to provide responsiveness to insurance consumers and a sensitivity to the regulatory needs of a diverse nation.

In 1875, the NAIC adopted the predecessor the **Annual Statement Blank** which, since then, has served as the uniform financial reporting form for all insurance companies. Thirty-four years later, in 1909, when changing, and sometimes fraudulent, investment practices by insurers threatened the stability of the industry, the NAIC established the Securities Valuation Office (SVO) to provide uniform valuations of insurers' securities.

In the 1930s and 1940s, multi-state insurance companies became more prevalent. The NAIC responded, first by establishing the "zone examination system" for the regional examination of multi-state companies, then by publishing the NAIC **Examiners Handbook** to standardize zone examination procedures.

During the 1960s and 1970s, as the business of insurance continued to grow more complex, the NAIC responded with a host of improvements in solvency regulation. These enhancements included the adoption of model guaranty association acts and the institution of a centralized database and **Early Warning System** to help identify and prioritize troubled companies. This system was later expanded to become what is now known as the **Insurance Regulatory Information System (IRIS)**. Further standardization of solvency regulation was achieved with the release of the statutory accounting manuals for life and property/casualty companies and the **Troubled Companies Handbook**.

## # What Does NAIC Do?

The NAIC plays an integral role in the insurance regulatory framework, a role which is being significantly enhanced as increasing demands are placed on state regulators. **NAIC coordinates and assists state solvency efforts** in a number of ways, including: maintaining an extensive insurance database and computer network linking all insurance departments; analyzing and informing regulators as to the financial condition of insurance companies; coordinating examinations and regulatory actions with respect to troubled companies; establishing and certifying states' compliance with minimum financial regulation standards; providing financial, reinsurance, actuarial, legal and computer and economic expertise to insurance departments; valuing securities held by insurers; analyzing and listing non-admitted alien insurers; developing uniform statutory financial statements and accounting rules for insurers; conducting education and training programs for insurance department staff; developing model laws and coordinating regulatory policy on significant insurance issues; and conducting research and providing information on insurance and its regulation to Congress, government agencies and the general public. These activities facilitate state regulators' oversight of a complex industry extending across state and national boundaries while also enabling them to better respond to the concerns and unique aspects of their particular jurisdictions.

The NAIC has grown rapidly in recent years to be able to expand its services to state regulators and the general public. The NAIC currently has a highly trained, professional staff of 142, representing a 240 percent increase since 1982. The NAIC's budget has grown almost four-fold over the last ten years to \$16.2 million to support increases in staff, new programs and maintenance and enhancement of its expanded information systems.

To talk about all of the NAIC's activities in depth would take several chapters, but it is useful to outline several of those activities in greater detail.

**1. DATABASES & INFORMATION SYSTEMS** -- The NAIC has amassed the most extensive financial database

available on insurance companies accessible to state insurance departments through an advanced computer information network. The **NAIC database** contains five years of detailed annual and quarterly financial information on-line for approximately 5,400 insurance companies, in addition to data maintained off-line to the mid-1970s. The current database, systems and technology reflect a four-year \$17.6 million investment to provide state regulators and NAIC staff with a "state-of-the-art" information facility. The processing of annual statement data alone for 5,000 plus companies is a massive effort as each filing runs a gauntlet of 13,000 cross-check edits and careful review by a team of data quality specialists. Development of the database is closely integrated with the NAIC's development of the annual statement blank and accounting rules as well as the related specifications for diskette filings, which now comprise 90 percent of all filings.

The NAIC database serves as the core of the solvency surveillance and other analysis activities of state insurance regulators and the NAIC. State regulators and NAIC staff access the database through a variety of sophisticated application systems which allow them to access data on specific companies, generate "canned" reports on a group of companies, or generate custom reports to suit their specific needs. Every state department has at least one personal computer, provided by the NAIC, plugged into the NAIC network and 19 states have host-to-host connections allowing them to tie in other terminals. More than 500 insurance department users have direct access to the NAIC system and the number continues to grow. This national insurance database also has been provided to the GAO, federal agencies, academics, rating organizations and various other users. In addition, the information contained in the database is made available to the public in a variety of statistical reports and special studies.

The NAIC maintains a number of other databases which state regulators and NAIC staff utilize for financial analysis and other regulatory functions. The **Alien Reporting Information System (ARIS)** provides financial reports that show reinsurance ceded to alien insurers, along with identifying any invalid federal employer identification numbers (FEINs), alien numbers or company locations.

The on-line **Valuation of Securities (VOS)** system provides a complete VOS manual listing of securities held by insurers, along with historical data beginning with 1989, for financial review purposes. This database also contains individual portfolios of the 275 subscribing companies that maintain their stock/bond portfolio on the NAIC computer system.

The Omnibus Budget Reconciliation Act (OBRA) reporting system permits states to satisfy Medicare supplement insurance reporting requirements. Companies that write Medicare supplement insurance are instructed to send a completed OBRA reporting form to the NAIC. The NAIC then produces the required reports on behalf of each state and files them with the Health Care Financing Administration (HCFA).

The NAIC maintains other special databases containing information on regulatory actions against insurers and agents, the **Regulatory Information Retrieval System (RIRS)**, and information on entities of regulatory concern, the **Special Activities Database (SAD)**. RIRS, in existence since 1983, and SAD, initiated in 1990, greatly enhance regulator's ability to share information on individuals or companies possibly involved in illegal or questionable activities and prevent their infiltration into new areas. The RIRS database contains information on more than 49,000 agents and companies against which some regulatory action has been taken. State regulators and NAIC staff also use an electronic mail system on the NAIC's computer network to communicate rapidly and coordinate with each other on examinations, regulatory actions, troubled companies, entities of regulatory concern and a variety of other matters.

In addition to maintaining databases and systems, NAIC staff frequently provide consulting services to state insurance departments seeking assistance in enhancing their information systems.

**2. FINANCIAL ANALYSIS & SOLVENCY SURVEILLANCE** -- Financial analysis and other solvency surveillance are also major areas of activity for the NAIC. The NAIC has long served a vital coordinating function in the event that a single large, multi-state company experiences financial difficulty. Since the early 1970s, the **Insurance Regulatory Information System (IRIS)** has served as the **NAIC's baseline system** for monitoring insurers' financial condition at a national level and identifying those insurers requiring further regulatory attention. Companies are first processed through a statistical phase consisting of a series of eleven financial ratios followed by a series of additional screening criteria. Companies showing unusual results are then analyzed further by a select team of state financial examiners who recommend further investigation by the companies' domiciliary regulators, if necessary. Companies deemed to be "high priority" are followed up by the NAIC's Examination Oversight Task Force which takes action if the domiciliary state fails to do so. Insurers' IRIS ratio results also are available to regulators over the NAIC network and to the public in a hard copy report.

Although the IRIS has and will continue to be an important financial analysis tool for regulators, as explained earlier, the NAIC is constantly developing new solvency analysis systems. NAIC will use these systems and other kinds of quantitative and qualitative information to identify companies which may be in financial difficulty.

**3. OTHER NAIC FUNCTIONS** -- The NAIC supports the insurance regulatory process in a number of other ways. In the financial area, the NAIC's reinsurance experts advise state regulators on reinsurance transactions and contracts and reinsurance reporting issues. These experts also develop reference manuals that will assist regulatory examiners and analysts in evaluating reinsurance agreements. This section also operates ARIS and produces a series of special reports on companies' reinsurance activities and problems.

The NAIC's **Computer Audit Specialist** assists insurance examiners in using special audit software and automated procedures to perform more comprehensive and efficient examinations. A number of special examination routines have been developed including analysis of insurers' securities, reinsurance ceded and assumed and loss reserves. In 1987, the NAIC purchased a master license for several audit software products which are now being used by 35 states. To further facilitate this activity, the NAIC's computer audit specialist has developed an Automated Examination Procedures Manual, publishes a quarterly newsletter, and conducts several regional training sessions each year to increase regulators' knowledge of the audit software and automated techniques.

The NAIC's **Securities Valuation Office (SVO)** determines uniform accounting values of insurers' securities investments which include government, municipal and corporate bonds, and common and preferred stocks. The SVO database contains approximately 185,000 securities for almost 32,000 issuers. Each security in the database is reviewed and valued annually and published in the Valuation of Securities Manual.

The **Non-Admitted Insurers Information Office (NAIIO)** maintains a Quarterly Listing of Alien Insurers which states may utilize to determine surplus lines carriers eligible or approved to operate in their jurisdictions. To qualify for the listing, an alien must submit financial information, pass a financial and operational review, meet certain capital and surplus requirements and establish a U.S. trust fund.

The NAIC's **Special Services Coordinator** tracks and advises regulators concerning the activities of individuals, agencies and companies that are causing or have the potential to cause regulatory problems within their jurisdictions. He also assists regulators in investigating and coordinating insurance fraud cases with local, state and federal law enforcement authorities. In addition, the Special Coordinator publishes **Special Report**, a bimonthly newsletter to provide information on companies, individuals and practices that could affect insurers' financial stability.

Market conduct activities also have expanded significantly at the NAIC to better support the states' extensive



activities in this area. In addition to maintaining the RIRS and SAD system, the **Market Conduct Coordinator** is supporting the development of a new nationwide complaint database and a system for tracking basic profile data on entities involved in the insurance business. Information from the complaint database will be used to target companies for market conduct and financial examinations. These systems will further enhance state regulators' efforts to ensure that consumers are treated fairly in the insurance marketplace and that their claims are handled properly.

The **NAIC's Education and Training Department** conducts programs, workshops, seminars and other educational activities that deal with insurance issues and regulation for commissioners, their professional regulatory staff members and others concerned about the regulatory aspects of insurance. In addition to regular commissioner and staff programs, a special program developed for financial examiners has won a national award and other workshops have been conducted on solvency, health insurance and legal issues.

Finally, the NAIC serves an important research and information function for state regulators, Congress, federal agencies, the industry and the general public. The **NAIC's Research Division** and other divisions generate a number of standard, as well as custom, statistical reports and conduct special studies on industry investments, competition and profitability. The NAIC's Research Library maintains an 8,000 volume specialized insurance regulatory collection, conducts research for state insurance departments and answers numerous questions about insurance and insurance regulation from a variety of sources.

## # **Recent NAIC Accomplishments**

There are several key areas where NAIC has taken an active role in solvency regulation. These efforts culminated in the 1989 NAIC Solvency Policy Agenda which has five main components:

- ! The Financial Regulation Standards
- ! Improved reinsurance evaluation
- ! A more effective financial examination process
- ! Improved solvency analysis support
- ! Enhanced capital analysis & requirements

**1. FINANCIAL REGULATION STANDARDS** -- In this environment, in which troubles in the federally regulated financial institutions have shaken consumer confidence in all financial institutions, the NAIC has moved aggressively to enhance what has long been a sound system of insurance regulation by beginning the process which led to the 1989 adoption of the Financial Regulation Standards. These minimum standards establish **bottom line requirements for state solvency** regulation in three areas: **laws and regulations, regulatory practices and procedures, and organizational and personnel practices.**

In order to provide guidance to the states regarding the minimum standards and an incentive to put them in place, the NAIC adopted a formal certification program in June 1990. Under this plan, each state's insurance department will be reviewed by an independent review team whose job it is to assess that department's compliance with the NAIC's Financial Regulation Standards. Departments meeting the NAIC Standards will be publicly acknowledged, while departments not in compliance will be given guidance by the NAIC on how to bring the department into compliance. Furthermore, beginning in January 1994, accredited states will not accept reports of examination from non accredited states, providing further impetus for states to adopt the minimum standards. We expect that, as the standards are enhanced and more states enact them, greater pressure will be placed on other states to become accredited.

In fact, the NAIC Executive Committee has endorsed a Model Act which would provide a powerful incentive

for adoption of the NAIC's minimum standards. The Model Act, which is still under consideration, would sanction companies domiciled in non accredited states by requiring them to meet the solvency regulations of every accredited state in which they do business, as "designated by the department in a regulation adopted pursuant" to the Act. As a result of these and other contemplated sanctions, being domiciled in a non accredited state will increasingly become a liability, inducing states to meet the standards or witness the redomestication of their companies. Furthermore, the heightened scrutiny of such companies by the accredited states will provide added protection for insurance consumers.

Another element of the Financial Regulation Standards looks at the resources available to state insurance departments to enforce the laws and regulations imposed on insurance companies. The last several years has witnessed a dramatic increase in resources, both economic and human, that states have brought to bear upon insurance regulation. From 1985 to 1990, funding for state insurance departments increased by 96.7 percent. Similarly, from 1986 to 1989, the aggregate staffs for state insurance departments increased by 23.2 percent. This growth in personnel and resources has resulted in a 12.4 percent increase in the number of insurance department staff per company. Finally, one reason that total department funding has increased faster than staff levels is that insurance departments are making substantial investments in computer technology for improved solvency surveillance.

**2. IMPROVED REINSURANCE REGULATION** -- Regulation of reinsurance activity, by which insurers spread their own risk to other companies, is of particular importance to state regulators. In order for insurance consumers to be confident that their own insurance companies can make good on their promises, consumers must be confident that their insurer's reinsurer is willing and able to keep its promises. The regulatory challenge posed by reinsurance is made more complex by the fact that many reinsurers are based overseas and, therefore, are not subject to the direct regulation of either the state or federal governments.

Several decades ago, state regulators devised a method of protecting U.S. insureds by regulating the degree to which the primary insurer may reduce the liabilities on its balance sheet by taking credit for the reinsurance ceded by the insurer. In 1984, this concept was codified in the **Model Credit for Reinsurance Act**, which allows such a reduction of liabilities only if the reinsurer is licensed in the state, is accredited, qualifies under either the so-called Lloyd's or ILU provisions, or establishes either an acceptable trust, letter of credit, or cash deposit. Through the direct impact this treatment has upon the balance sheet of the primary carrier (the "ceding insurers"), state regulators can exercise a formidable influence over reinsurers, whether licensed to do business in a state or not.

Perhaps the most dramatic changes in the regulation of reinsurance have come about in the area of reporting requirements. The most notable of these is a new detailed requirement which gives primary carriers a financial incentive to assure that their reinsurance companies pay promptly. Furthermore, by incorporating the rule into the **NAIC Annual Statement Blank**, it has become a uniform reporting requirement in every state. Finally, the rule allows regulators across the nation to quantify the extent of overdue reinsurance and identify slow-paying reinsurers.

Another important development in the realm of reporting requirements is the creation of a more refined, computerized NAIC reinsurance data base. Beginning with the 1989 Annual Statement, reinsurers are now identified with a unique identification number. As a result, regulators can track the reinsurance operations of all companies in the U.S., including reinsurance ceded to virtually any company worldwide, and thus are able to evaluate the ripple effect of potential reinsurance insolvencies upon the rest of the industry. This ability to spot potential land mines that lie in the path of an insurer's financial health will better equip regulators to avoid or minimize solvency problems. Also, regulators are able to quantify reinsurance ceded to alien reinsurers and identify insurers which are highly leveraged by reinsurance transactions.

For some time, American regulators have been concerned about their lack of authority over reinsurance intermediaries and brokers. The potentially dangerous practice by some insurers of turning over critical management decisions to intermediaries, and the resulting improprieties encouraged by this practice, led the NAIC to craft the **Reinsurance Intermediary Model Act**. This act mandates licensing for brokers and managers of reinsurance and establishes minimum requirements for the relationship between ceding insurers, intermediaries and reinsurers.

For similar reasons, the role of managing general agents has come under scrutiny leading to the September 1989 adoption by the NAIC of the **Model Managing General Agents Act**. A managing general agent is an agent who either handles the reinsurance contracts for an insurer or manages all or part of its insurance business, and underwrites premiums in the amount of at least five percent of the company's net worth. Like the Intermediaries Model, the MGA Act prescribes limitations on the relationship between insurers and MGAs. These limitations are designed to weed out the improprieties that led to the abuse of the MGA function in some of the more conspicuous insolvencies of recent times. Both of these models are included in the NAIC's solvency standards and will be necessary for accreditation.

Furthermore, the National Association of Insurance Commissioners are allocating additional resources within the NAIC to assist state insurance departments in interpreting reinsurance contracts and evaluating reinsurance companies. When combined with our recent creation of a reinsurance database, this will do much to strengthen the ability of regulators to regulate this important sector of the industry.

**3. MORE EFFECTIVE EXAMINATIONS** -- Another key component of the NAIC Solvency Policing Agenda for 1990 was an overall assessment of examination processes. The concept of effective regulatory examination involves several components: (1) a system by which regulators are warned in a timely fashion that an examination of a particular company is called for, allowing for a targeted allocation of examination resources, (2) a financial reporting system upon which regulators can place substantial reliance, (3) on-site examinations that are timely and targeted toward those companies most in need of examination, and (4) high quality examinations. While state regulators and the NAIC have operated under an examination system that has proven over time to be quite effective, there has been substantial activity to improve that system.

The NAIC is dedicated to improving the system by which regulatory efforts are focused on those companies most in need of close scrutiny. They have created a centralized financial analysis unit within the NAIC which is developing additional statistical measures to the IRIS financial ratios so that they continue to be useful to insurance consumers, regulators and others. This unit also is developing a series of computerized analytical routines which will be utilized by state insurance departments to enhance their financial analysis and solvency monitoring activities.

Furthermore, they also have developed computerized and other financial analysis techniques to support the activities of the Potentially Troubled Companies Working Group in its oversight role. Additionally, the NAIC will continue to assist states in developing and improving financial statement analysis capabilities and techniques.

Of the various planks of the solvency platform adopted in December 1990, one of the most important was the requirement that insurance company financial statements be subject to an **annual audit by a Certified Public Accountant (CPA)**. This requirement was adopted both as a Model Regulation and as an amendment to the Annual Statement Instructions. The significance of the incorporation of the CPA audit requirement into the instructions is that it takes effect immediately in all 55 jurisdictions.

The NAIC also adopted a multi-faceted proposal which requires that the mandatory actuarial opinions regarding the adequacy of a property/casualty insurer's reserves comment specifically upon items which might materially

affect reserves, such as discounting, reinsurance collectibility, financial reinsurance, loss portfolio transfer, and salvage/subrogation. Perhaps as important a change was the requirement that the actuarial opinion address both gross and net reserves, a modification that will give regulators a clearer picture of a company's total potential liability, if reinsurance agreements were to fail.

Recently, the NAIC adopted a **Model Law on Examinations** which represents a conceptual change with respect to the frequency and scope of on-site financial examinations of insurers. By authorizing the Commissioner to conduct examinations whenever it is deemed necessary, and no less frequently than every five years, it is designed to direct department resources toward the examination of companies most likely to encounter financial trouble. This conceptual change can be accomplished because of the recent addition of new financial regulatory tools -- such as independent CPA audits, opinions on insurance reserves by actuaries, computerized annual financial statement analyses, and quarterly reporting by insurers, among others -- which mitigate the need for frequent comprehensive periodic examinations of all companies.

At the 1990 Winter National Meeting, the NAIC also received a report from the Examination Processes Committee which included 17 recommendations regarding the examination process. One of the more important recommendations involves improving the **Examiners Handbook**, incorporating the American Institute of Certified Public Accountants' generally accepted auditing standards, tailored where appropriate for the regulatory perspective, and establishing a system for annual review.

Other recommendations of the Examination Process Committee involve the creation of an NAIC Education and Research Foundation and the upgrading of qualifications of financial examiners. One of the challenges facing regulators is expanding the pool of financial examiners, auditors, and regulators with the necessary knowledge to perform complex insurance regulatory activities.

**4. IMPROVED SOLVENCY ANALYSIS SUPPORT** -- In recognition of the need to enhance the NAIC's solvency analysis support to the states, the NAIC has bolstered its budget. The NAIC's staff of financial analysts has been increased in order to better track insurance department handling of companies that are facing solvency problems. Analysts also have developed an additional computer based financial solvency analysis system.

The NAIC serves a vital coordinating function in the event that a single large, multi-state company experiences financial difficulty. The **NAIC's approach** to such situations is based upon two fundamental premises: **(1) that a smooth flow of information, always important to the effective regulation of the industry, is even more critical when a company gets into trouble, and (2) that a peer review process involving independent state regulators with common and interdependent interests can provide greater protection for consumers than is available from unitary systems of regulation.**

This philosophy can be seen in the operation of the **NAIC's Potentially Troubled Companies Working Group**. Created two years ago to deal specifically with large, potentially financially troubled insurance companies, the Working Group is a multi-state committee of state regulators supported by the staff of the NAIC's Division of Financial Analysts. When the Working Group identifies, through a sophisticated form of financial analysis based on the results of key financial ratios, a company that may be facing difficulties, the NAIC Member in whose state the company is domiciled is contacted by the NAIC and asked to report on that state's regulatory responses to the difficulty. Should the NAIC Member refuse to respond or provide a response that, in the opinion of the Working Group, is an inadequate regulatory response to the company's predicament, the Working Group prepares a coordinated interstate plan of action for implementation by the non-domiciliary states most likely to be affected by any problems that might arise.

**5. ENHANCED CAPITAL ANALYSIS & REQUIREMENTS** -- For nearly four decades, state regulators have

utilized a form of risk based capital regulation for stocks and bonds held by insurers. Life and health companies are required to establish reserves for their investments in securities, the size of which are based upon the quality of the assets. For example, a low grade bond in an insurer's portfolio might require the establishment of a reserve that is twenty times higher than that required for a high quality bond. Similarly, property/casualty companies may carry high grade bonds on their books at their amortized value, but must carry their lower grade bonds at the lesser of market value or amortized cost.

However, like their counterparts in the banking regulatory community, state insurance regulators realize that a more comprehensive risk based approach to capital requirements -- one that addresses asset risk for all assets, e.g., insurance risk, interest rate risk, and business risk -- will improve solvency regulation. The NAIC charged two working groups to develop the now enacted **Model Act on Risk Based Capital**.

The NAIC also has drafted a **Model Investments in Medium Grade and Lower Grade Obligations Act** to establish an aggregate cap of 20 percent on medium and lower grade obligations, with a graded system of caps based upon the quality of the obligations. The purpose of this regulation is to allow insurers some flexibility to invest company assets in medium to lower grade bonds, while at the same time assuring that the special risks associated with such bonds are mitigated in terms of the overall solvency of the company. These limitations will help to prevent a recurrence of the recent problems encountered by Executive Life and other insurers heavily invested in medium to lower grade bonds.

The NAIC is also working on a proposal to conform preferred stock ratings to the same categories used for bonds. The regulators are evaluating the impact of the proposed benchmarks, dictating which stocks would be carried at cost and which would be carried at market value and are expected to develop a proposal for action this year. Additionally, a task force of the NAIC is surveying all insurers to develop more detailed information on their investments in real estate, mortgages, and other assets with real estate related exposure. This information will ultimately be used to further improve the reporting of and establishment of valuation reserves for these investments.

## # NAIC & Proposed Federal/State Regulation

Conditions of the market have launched a flurry of proposals to improve regulation. Proponents have authored suggestions ranging from complete abandonment of state regulators to a co-op of state **and** federal agencies. The NAIC has long opposed the expansion of federal involvement in insurance regulation with the exception of a few areas. A highranking NAIC official put it this way: "We have done this, not out of a sense that our "turf" must be preserved, but because of our frequent experience that, more often than not, such involvement (by the federal government) hinders the resolution of the very problems it is intended to solve". An example is the Employee Retirement Income Security Act (ERISA) and its unfortunate consequences for the states which now must resolve the questions about whether certain health and welfare plans, specifically Multiple Employer Welfare Arrangements (MEWAs), are exempt from state insurance laws. Other examples include the federal laws authorizing risk retention groups and purchasing groups. These regulations have done little but promote entanglements between federal and state jurisdiction. In summation, the National Association of Insurance Commissioners states: "We approach the prospect of federal involvement in what historically has been our responsibility with caution, and base our evaluation on a case-by-case analysis. We are certain that overly broad involvement by the federal government poses great risks to the protection of the American insurance consumer".

The NAIC does, however, concede that in the federal government can be of great **assistance** to state regulators in two primary areas: **Fraud and Crime Statutes**. All regulators, have seen the damage that can be suffered by consumers at the hands of unscrupulous operators -- con artists who ply their trade from board room, office penthouse or agency. In addressing these problems, state insurance regulators usually have only two options --

criminal remedies and civil remedies. Federal assistance, according to the NAIC, could be most helpful on the following issues:

! **Interstate Statutes** -- States have power to deter and punish fraud and other corrupt activities in insurance companies in criminal actions. Additionally, the NAIC has recently created the Special Activities Database to help state regulators track individuals who have a history of involvement in insurance insolvencies. Given the existence of these state remedies and NAIC tools, why, then, is a federal criminal statute necessary? The answer to this question lies in the interstate and sometimes international nature of many insurance fraud schemes.

In some cases, prosecution of anyone responsible for a company's downfall in a state court would require extradition on a massive scale and could fail, due to jurisdictional problems. In other cases, not a single witness or piece of paper relating to the fraudulent transactions can be found in the state of domicile of the insurance company. A federal network could help remedy this situation.

! **Federal Fraud Statutes** -- Federal prohibitions of mail fraud and wire fraud are available criminal remedies for prosecutors seeking to punish those who would raid the coffers of an insurance company. However, these statutes have an important limitations. First, the requirement of the use of the mail can be avoided by perpetrators of fraud with relative ease. In the case of the filing of fraudulent financial reports with the state insurance regulator, some unprincipled thieves have been known to hand deliver financial reports to regulators simply to avoid the reach of mail fraud statutes. Requiring that all insurers mail their reports and applications will raise the specter of federal prosecution in the event those reports have been falsified. Second, there is a five-year statute of limitations found in federal mail and wire fraud. This imposes a constraint on the usefulness in prosecuting insurance fraud because the detection and investigation of complex multi-state insurance schemes easily can exceed this five-year time period.

In essence, NAIC believes there is a need for federal which:

- ! Specifically addresses insurance fraud,
- ! Prescribes strong criminal penalties
- ! Can be used in multi-state schemes
- ! Provides investigators and prosecutors with a statute of limitations which provides enough time for the preparation of a solid case.

In recent hearings before Congress, the NAIC did set forth proposals which, if approved, could address many of these deficiencies, improve multi-state coordination and make efficient use of federal and state cooperative regulation. Following is a discussion of the most valuable offerings.

### # **The NAIC Proposal for a Federal Criminal Statute**

The National Association of Insurance Commissioners proposal to establish federal crime statutes to aid insurance regulation consists of a set of amendments to Title 18 of the U.S. Code. This section is currently dedicated to federal provisions covering crimes regarding financial institutions.

The NAIC's proposed statute is designed to reach criminal activity affecting "the business of insurance", as defined in the McCarran-Ferguson Act. This broad definition is used to encompass activity by the full array of individuals whose fraud might harm insurance consumers, including any acting as or on behalf of an insurer, reinsurer, producer, reinsurance intermediary, broker, insurance consultant or adjustor.

The federal statute proposed would specifically establish four federal offenses regarding **insurance fraud**. First,

it would make it a crime to knowingly file with a state insurance regulator fraudulent financial statements. Second, it would ban embezzlement and theft of insurance company money, funds, premiums or credits. Third, the bill would prohibit the falsification of company records with the intent to defraud the company or its policy holders and creditors. Further, the proposal would outlaw the criminal obstruction of proceedings before state insurance regulatory authorities. Finally, the fourth proposal would also make conviction under the statute a predicate offense with respect to a federal civil RICO action.

The NAIC proposal calls for stiff **penalties**, appropriate to the seriousness of the harm that can be caused by the perpetrators of insurance fraud. For the most serious offenses, maximum penalties are as high as \$1,000,000 and/or 30 years imprisonment. Perhaps, as important is a prohibition, absent specific approval by the authorized state insurance regulatory official, of insurance related activity by a person who has been convicted of any criminal offenses involving dishonesty or a breach of trust or any of the offenses described in this statute. This is particularly important to the prevention of repeated abuses by previously convicted charlatans who would evade scrutiny by changing jurisdiction after conviction in one state.

The proposal also establishes a **Ten-year statute of limitations** for the offenses proscribed under the act. This is a straightforward recognition that crimes of this sort can take years to detect and investigate, a reality that is reflected in the similar federal statutes dealing with crimes against other financial institutions.

A federal statute with significant "punch" that NAIC proposes to access is the **RICO Act**. In 1970, the Congress enacted The Racketeer Influenced and Corrupt Organization Act (RICO) to curb crime and its spreading influence, particularly in the arena of American business. The RICO Act goes about this task with both criminal and civil provisions. In the 21 years the statute has been in place, federal prosecutors have used the criminal sanctions of the bill with increasing frequency and increasing success. The civil provisions of RICO, which allow actual damages to be trebled, have been used not only by the federal government, but by state government and private plaintiffs as well. The **advantages** of these civil remedies over RICO's criminal sanctions are several. First, the criminal justice system is confined in its ability to reach some of the subtler forms of fraud. Limitations on law enforcement resources, the cumbersome nature of criminal proceedings, and the higher standard of proof, all combine to restrict the use of RICO's criminal penalties to only a fraction of the instances of fraud that the Congress targeted by enacting RICO 21 years ago. A second advantage of the civil proceedings provided by the RICO Act is that they extract a very real financial penalty against corporate thieves. The powerful economic deterrent created by the prospect of damages in the amount of three times the actual damages caused by fraud says, loudly and clearly, that this crime will not pay. Third, an injured plaintiff facing the daunting legal costs of a civil RICO action will find that potential burden less intimidating when balanced against the prospects of treble damages. Furthermore, unlike the criminal penalties, RICO's civil damage provisions offer an injured party a very real prospect of being made whole.

Too often, regulators and the NAIC claim to have witnessed people entrusted with the health of an insurance company exploit that trust to gut the company and leave its carcass for the insurance commissioner to revive or bury, usually the latter. Because of the limitations posed by existing law -- both state and federal -- to state insurance regulators, the civil provisions of RICO would be a most potent weapon in the arsenal against these types of conspiracies. When financially impaired, an insurance company may be taken over at the direction of the state insurance department under a court order for the purpose of accumulating company assets, paying policy holder claims, and winding up the business affairs of the company. The liquidator or rehabilitator of an impaired or insolvent company, in most cases a state insurance regulator, can bring a federal civil RICO action against persons or companies who, through fraudulent activity, contributed to the financial decline of the company. Today, many state regulators are in the midst of such civil suits.

It is no accident that RICO is a favorite remedy for the most serious instances of insurance fraud -- the Act was

tailor-made for the kinds of abuses that can be found in the insurance industry. As a cash-intensive business that involves the receipt of premiums in exchange for little more than a promise of future payment, insurance acts as a magnet for con artists. As often as not, the fraud connected with the practice of looting an insurance company into insolvency involves a number of people -- corporate executives, agents, brokers, and employees -- engaged in a common scheme involving multiple criminal activities. This is exactly the type of criminal involvement in American business that RICO was intended to address.

Furthermore, a civil RICO action is particularly useful to a state insurance regulator trying to minimize losses to insurance consumers and taxpayers alike. Most every state has a property-casualty insurance guaranty fund and a life insurance guaranty fund which are designed to pay the claims of policy holders and other claimants of an insolvent company. State guaranty funds are financed by assessments made against the other insurers doing business in the state, which assessments are often passed on, market conditions allowing, to the healthy companies' policy holders and/or the state's taxpayers. A chief objective of a state regulator in charge of an insolvent insurer is the minimization of guaranty fund costs resulting from the insolvency. When a conspiracy to defraud an insurer contributes to an insolvency and thereby creates the need for such assessments, the policy holders and taxpayers of a state may reap substantial benefits from an insurance regulator's use of civil RICO to recoup at least a portion of the losses to the guaranty fund. In other words, civil RICO is an invaluable means of assuring that the costs of insurance fraud fall upon the culprits instead of the general public.

In recent years, there have been efforts in the Congress to limit the use of the civil provisions of the RICO Act. The most recent effort is found in H.R. 1717, currently pending in the House Judiciary Committee. While it is a major improvement over previous versions, the bill would still inhibit the ability of state insurance regulators to pursue the ill gotten booty of insurance fraud. Because of this defect, NAIC continues to oppose this and any other Congressional effort to hamstring any efforts to bring the perpetration of insurance fraud to justice.

The National Association of Insurance Commissioners proposal concerning assistance also focuses on **federal regulation of non-U.S. Insurers**. The NAIC is considering offering a draft proposal which would expand the function of the NAIC's Non Admitted Insurers Information Office (NAIIO) to include the approval of all non-U.S. insurers doing business in the United States. Currently, the NAIIO, established nearly 30 years ago, maintains the "Quarterly Listing of Alien Insurers," the so called "**white list**", an advisory listing of alien insurers approved as surplus lines carriers. Under the draft proposal, the NAIIO would also approve non-U.S. reinsurers.

The federal bill envisioned by the draft would not create a new federal agency, nor would it require an expenditure of federal funds. Rather, the bill would require that all non-U.S. insurers engaged in insurance in the United States meet the requirements detailed in the legislation. Direct writers would be required to be on the NAIC eligible list to do business in any state. Further, in order for an insurer to take credit for reinsurance ceded to a non-U.S. reinsurer on its Annual Statement, the reinsurer similarly must be eligible. Additionally, the proposal would require the establishment of trust funds for the protection of U.S. policy holders, claimants and cedents.

In concept, this proposal represents an excellent blend of the strengths of state regulation -- the nearly 30 years of experience of evaluating alien insurers for financial strength, the NAIC reinsurance database, and its pool of technical expertise, with a key strength of federal law -- uniformity of regulations affecting non-U.S. companies.

The guaranty fund system, which protects policy holders and claimants from the most serious harms arising from an insurer's insolvency, is also a potential candidate for federal intervention. Historically, the state-based guaranty fund system has performed quite well. There is substantial, although not complete, uniformity among the various funds, and adoption of guaranty associations acts based on the NAIC model laws on the subject has been nearly universal. Furthermore, to date, the guaranty funds have proven to be adequately designed to



provide sufficient funding to meet all the needs of policy holders and claimants of insolvent companies.

Yet, state regulators have expressed some concern in recent years that the guaranty system, now 20 years old, should be revised in light of recent increases in numbers of insolvencies and the increasing complexity of those insolvencies. The Guaranty Fund Task Force is holding a series of hearings to determine what, if any, changes need to be made to the system, including the possibility of federal involvement in the system.

## # **Why NAIC Believes Federal Intervention Should be Limited**

As we have just learned, the National Association of Insurance Commissioners feels, the federal government **does** have a constructive role to play in the regulation of insurance. However, in their opinion, it is essential for the protection of consumers that this **role be carefully limited**. There are several important reasons why this is so.

In the 1980s, state insurance regulators were faced with a dramatically changing regulatory environment which featured an explosion of new insurance products, dramatic changes in investment strategies by insurers, and sometimes striking changes in insurers' marketing practices. At the same time, the budgets of state governments across the nation increasingly felt the effects of the collision between a rising need for state government services and a declining capacity to increase state revenue. In fact, much of this budgetary crisis in the states was exacerbated by a sharp increase in federal delegation of program funding to the states.

Yet, despite these fiscal pressures on state budgets, state insurance regulators never lost sight of the importance of strong regulations, unlike their federal counterparts, and continued to strengthen solvency efforts throughout the last decade while federal regulators stepped backward. State expenditures for insurance regulation has grown far more rapidly than expenditures of commercial banks and thrifts. Similarly, states have made a significantly stronger commitment to expanding the human resources needed for sound regulation than their federal counterparts.

Not only have states increased their commitment to regulations more rapidly than has the federal government, but they have also devoted more resources, when measured against the size of the insurance industry, than their federal counterparts. While the relationship between industry size and the resultant regulatory burden is difficult to compare among the various financial services industry, one measure of the relationship is the regulatory budget as a percent of insurance industry premiums and bank and thrift deposits. When looked at this way, state insurance departments devote significantly more resources to the regulation of the insurance industry than their federal counterparts devote to the regulation of banks and thrifts. As these figures suggest, those who would argue that the federal government is more likely to provide a stronger commitment to solid regulation than the states simply have ignored the lessons of recent history.

It is not simply a commitment of resources by the statistics, however, that provides insurance consumers with solid protection against the pitfalls of insolvency. The very **structure of state regulation offers several advantages** over unitary regulatory structures.

One such advantage is the two layers of regulatory protection for insurance consumers: (1) regulation by the state of domicile of the insurer, and (2) regulation by the states in which the company is doing business. If regulation in the domiciliary state is inadequate, regulators in other states can still take action to protect their policy holders. The NAIC's primary focus is on strengthening the first layer of protection, but some of its efforts also strengthen the second layer. Federal preemption of state regulation could undermine this second layer, which could be disastrous if federal regulation proved to be inadequate, as it did over the last decade for other financial institutions.

Even short of complete preemption by the federal government is the possibility of federal involvement which could weaken this two-tiered system. A classic example of such a weakening of the second tier by federal involvement can be found in the **Liability Risk Retention Act of 1986 (LRRRA)**. Under this act, liability risk retention groups that are licensed in one state can escape the bulk of normal regulatory scrutiny in any other state in which they operate. This aspect of LRRRA has created a number of problems for state insurance regulators and the consumers they are pledged to protect, problems that were the subject of a hearing before a Senate Subcommittee.

Yet another structural strength of state regulation can be found in the integration of insurance solvency regulation with other aspects of the regulation of the industry. These functions include company and agent licensing, regulation of policy forms and rates, policing insurers' and agents' marketing practices and claims handling, investigating fraud, conducting legislative and policy research, providing consumer information and handling complaints, monitoring competition, addressing availability problems with special market assistance plans, and collecting premium taxes. These activities are critical to protecting the interests of consumers and ensuring that the promises of insurance contracts are fulfilled.

The integration of these responsibilities in one agency in each state offers tremendous advantages in coordinating public policy toward insurance and preventing conflicting regulatory actions. Adequate rates do not ensure that a company will remain solvent, but inadequate rates will ultimately bring it down. Vesting these responsibilities in one entity helps to ensure that rates will not be allowed to fall to a level that would endanger an insurer's solvency. In addition, by monitoring and regulating all insurer operations, state insurance departments are able to take actions more quickly to prevent solvency problems from occurring.

A further advantage of state regulation is one that has been portrayed by critics as a weakness: the incremental nature of change under state regulation. This advantage has two primary aspects. First, novel approaches to regulation in a changing economic environment may be tried by a state without committing the entire regulatory system to those new approaches. Thus, by utilizing the Jeffersonian concept of the states as "laboratories of democracy," state regulation is better suited to innovation than a unitary national system.

Second, the incremental nature of change in state regulation protects the national system of insurance supervision from sudden and sometimes radical swings in regulatory philosophy. Perhaps if federal and state regulators of the savings and loan industry had not moved a decade ago in lock-step toward deregulation of the industry, American taxpayers would not be looking at a potential cost of a half-trillion dollar price tag for that policy blunder.

## **## AN ASSESSMENT OF THE NAIC AS "THE" NATIONAL REGULATOR**

Having detailed the role and importance that the National Association of Insurance Commissioners plays in the regulation of insurance and its desire to maintain solvency authority at the State level, it is important to present an assessment of their effectiveness. In 1991, at the request of Congress, the U.S. Government Accounting Office (GAO) presented such an assessment -- a critical one at that. It is also appropriate to mention that the NAIC responded to this criticism by firing back at the GAO's methodology and study procedures. This response is discussed in the section that follows.

### **# The Government Accounting Office Study**

In their assessment of the effectiveness of the National Association of Insurance Commissioner's present and future role in handling national insurance issues, the GAO first identified important principles that underlie effective regulation. To effectively create and maintain a national system of insurance regulation, the GAO

recommends a regulatory organization would need authority to perform several essential functions, including the authority to: (1) establish rules for the safe and sound operation of insurers, (2) establish minimum standards for effective solvency regulation by state insurance departments, (3) monitor the functions of state insurance departments, and (4) compel the enforcement by state regulators of the rules for safe and sound operation, and the adoption and application by states of minimum standards for effective solvency regulation.

While recognizing NAIC's good intentions, the GAO does not believe that NAIC can successfully establish a national system of uniform insurance regulation because it does not currently have the authority necessary to require states to adopt and enforce its standards. Furthermore, GAO does not believe that NAIC can be effectively empowered either by the states or by the federal government to exercise the necessary authority. Empowerment by the states would require that each state legislatively cede part of its authority to NAIC. However, even if each state chose to do this, ceded authority would be subject to revocation at any time by each state's legislature. In effect, NAIC would regulate at the pleasure of those it regulates.

Empowerment by the federal government is also undesirable. NAIC is composed of state insurance commissioners. Those commissioners are accountable to their states and should not be made accountable to federal authority as well, since this would create an irreconcilable conflict of interest. Moreover, given NAIC's organizational structure, congressional delegation of the regulatory authority necessary to establish NAIC as an effective public regulator could raise constitutional questions.

GAO has identified problems in the state-by-state system of insurance regulation. Even though the responsibility for regulating insurance companies rests with each state individually under the state-by-state system, NAIC has attempted to address some of these problems by assisting or in some cases, overseeing the states as they carry out their activities in attempts to strengthen state-by-state regulation. For example, GAO found that NAIC: (1) has improved the credibility of insurers' reported financial information, (2) is attempting to improve capital standards through the promulgation of risk based capital requirements, (3) is attempting to improve its monitoring systems to better identify troubled companies, (4) has established a peer review process to better ensure that troubled companies are more effectively dealt with, and (5) is providing the states with a variety of automated data bases and tools to facilitate their oversight of companies. These and other efforts are steps in the right direction, though all of them leave room for further improvement.

NAIC's plan to create a national regulatory system consistent across all the states rests in large part on the success of its program to accredit state insurance departments that satisfy a set of minimum standards for solvency regulation. For several reasons, GAO questions whether NAIC's accreditation program can achieve its goal.

In conclusion, the GAO feels that NAIC's efforts to strengthen insurance regulation are laudable. However, NAIC does not have the authority necessary to fulfill its assumed role as a national regulator. As a result, NAIC is unlikely to achieve its stated goal of establishing a national insurance regulatory system. It can neither compel state actions necessary for effective regulation nor, in the long run, can it sustain its reforms. Following are areas of concern:

## **# NAIC Funding**

There is doubt that NAIC's current system funding would permit a large, federal authority. State insurance commissioners created NAIC, in part, to help address the problems that differing state-by-state authorities and regulatory tools caused as the states regulated multi-state insurers. NAIC's annual revenue is currently about \$16 million. While NAIC serves state regulators, assessments on the states on the basis of premium volume of their domestic insurers represent about five percent of NAIC's revenue. Other than education and training, which represent one percent of NAIC's revenues, NAIC's services and publications are available to the states at no cost.

NAIC relies on the insurance industry for most of its revenue. Database filing fees -- which represent 46 percent of NAIC's revenue -- are mandatory fees on insurance companies that are required by their states to file with NAIC. The insurance industry also purchases NAIC publications and the services of NAIC's Securities Valuation Office (SVO) and the Non-Admitted Insurers Information Office. Finally, only industry representatives pay to attend NAIC's meetings. Concerning expenses, nearly one third of its \$15.5 million expense budget is spent on its executive office and operations to support the NAIC committee system. This also includes overhead costs, such as rent and equipment depreciation, for the entire support office. The other major expenses in 1991 are NAIC's information systems (\$3.7 million), Securities Valuation Office (\$1.7 million), and financial services (\$1.7 million).

Further, since 1987, NAIC's support office has grown rapidly. NAIC's budget has increased over two and a half times, from \$5.9 million in 1987 to \$15.5 million in 1991. The number of employees has about doubled from 72 in 1987 to 142 in 1991. NAIC's employment growth reflects its efforts to provide more service to state regulators. Much of this staffing growth occurred in the information systems department. NAIC operates a \$4.5 million computer system and telecommunications network for states to share information and have on-line access to NAIC's financial, legal, and regulatory databases. Computer support staff grew from 17 percent in 1987 to 51 percent in 1991.

### **# Alleged Deficiencies in Goals**

NAIC has recently stated the goal of creating a "national" regulatory system. Beyond funding limitations, detailed above, the GAO does not believe that NAIC can successfully attain that goal for many reasons.

To effectively create and maintain a national system of insurance regulation, the GAO feels that a regulatory organization would need authority to: (1) establish uniform accounting and timely reporting requirements for insurers, (2) establish uniform rules defining safe and sound operation of insurers, (3) establish minimum capital standards commensurate with the risks inherent in an insurer's operations, (4) establish minimum standards for effective solvency regulation by state insurance departments, (5) monitor the supervisory and regulatory functions of state insurance departments, (6) compel state regulators to enforce the rules for safe and sound insurer operations, including the minimum capital requirements, and to take appropriate actions to resolve or close troubled insurers, and (7) levy assessments to cover the costs of oversight and supervision and maintain sufficient staff and resources to adequately oversee the industry.

Furthermore, like any public regulator, a national insurance regulator would be subject to statutory and constitutional constraints, including appropriate oversight. A public regulator, for example, must often comply with disclosure requirements, restrictions on employee activities, conflict of interest laws, and mandatory decision making procedures such as those contained in federal or state administrative procedures acts. Public regulators are subject to constitutional restrictions -- they may not deprive any person of property without due process of law.

GAO does not believe NAIC can effectively carry out all the functions necessary for effective solvency regulation, nor is it subject to the appropriate statutory and constitutional constraints. Although NAIC can and does establish voluntary standards for insurers and state regulators, the states have conferred no governmental power on NAIC, and it does not have the authority to enforce its standards. In the state-by-state system of solvency regulation, NAIC cannot compel states to accept and implement its standards. Because Congress has allocated authority to regulate the business of insurance to the states, each state has exclusive authority to establish and implement solvency regulation within its jurisdiction. However, each state could legislatively cede some of its authority to NAIC. Even if each state volunteered to do this, NAIC's standing as a regulator would always be weak because its authority would be subject to revocation at any time by each state's legislature. In effect,

NAIC would regulate at the pleasure of those it regulated.

Furthermore, because NAIC is a private organization controlled by state insurance commissioners, it does not appear that NAIC should be delegated federal authority to regulate state insurance departments for at least two policy reasons. First, state insurance commissioners are accountable to their states and should not be accountable to federal authority as well, since this would create an irreconcilable conflict of interest. Second, congressional delegation of the regulatory authority necessary to establish NAIC as an effective public regulator could raise constitutional questions.

## **# Alleged Deficiencies in Accounting Standards**

To effectively monitor solvency and identify troubled insurers, regulators need accurate and timely information. In addition, the financial reports that regulators need should be prepared under consistent accounting and reporting rules that result in the fair presentation of an insurer's true financial condition. Although NAIC is working to address these needs, GAO identified a number of areas where improvements are needed.

First, a lack of uniformity in the statutory accounting practices (SAP) of the states may hinder effective monitoring of a multi-state insurer's financial condition. Although each state requires most domiciled and licensed insurance companies to use and file the annual financial statement that NAIC developed, individual states may allow accounting practices that differ from those codified in NAIC's practices and procedures manuals. Since a multi-state insurer generally prepares its annual statement in accordance with the SAP of its state of domicile, that annual statement filed in other states may not be consistent with or comparable to the SAP of those states. Other states where the insurer is licensed may require the company to refile or file supplements in accordance with their SAP. In this case, the states would be using different financial data to evaluate the same insurer.

In an effort to encourage greater consistency in accounting practices, NAIC plans to revise its accounting manuals to unify existing statutory practices. However, even if NAIC adopts more uniform statutory accounting principles, each state could interpret or modify those accounting principles. Second, certain requirements of SAP may result in an insurer not fairly reflecting its true financial condition. For example, SAP requires insurers to reduce their surplus by 20 percent of certain reinsurance amounts overdue by more than 90 days. In contrast, Generally Accepted Accounting Principles -- used by insurance companies for other-than-regulatory reporting -- require an evaluation and could require as much as a 100 percent write-down. This GAAP requirement would result in the insurer's annual statement reflecting the amount of reinsurance ultimately expected to be collected, a better measurement than the arbitrary percentage required by SAP.

Third, false and misleading financial statements have contributed to insurer insolvencies. Many states had been relying on unverified insurer-reported financial data. NAIC now requires both actuarial certification of loss reserves for property/casualty insurers and, beginning this year, annual audits by independent Certified Public Accountants (CPAs) as part of its annual financial statement which every state uses. In this instance, NAIC has succeeded in using its authority to prescribe reporting requirements to try to improve the credibility of insurer reported data. But, problems persist despite NAIC's improvements. For example:

! The annual independent audit requirement is a definite improvement. But, the basis of the audit opinion still varies from state to state. This is because the CPA audit opinion is based on those statutory accounting practices prescribed or permitted by the state where an insurer is headquartered. Attempts by NAIC to unify statutory practices could facilitate comparisons of insurers, but differing state laws or prescriptions would still take precedence over NAIC's accounting guidance.

! The actuarial certification of loss reserves is not necessarily credible. NAIC allows states the option of accepting certification by insurance company employees. GAO believes loss reserves should be independently verified and certified.

Fourth, even when insurers correctly report their financial information, regulators are not getting it soon enough to identify troubled insurers. As we have previously reported, annual statements do not give regulators an indication of problems occurring early in a calendar year until between March and May of the following year. That means a lag of between 15 and 18 months from when the problem started and when the annual statement is reviewed. Because a financial entity can fail quickly, we believe quarterly reporting is necessary. NAIC said that, as of February 1991, 21 states required their companies to file quarterly statements, and another 16 states asked insurers to file on a quarterly basis. NAIC cannot require states to adopt quarterly reporting, but it has started to capture quarterly filings that are required by the states. These data are now available on-line to the states and will be used in NAIC's solvency analysis.

Fifth, current capital and surplus requirements, which vary widely from state to state, are not meaningfully related to the risk an insurer accepts. For example, minimum statutory surplus requirements for a life insurer range from \$200,000 in Colorado to \$2 million in Connecticut. Likewise, minimum statutory surplus requirements for a property/casualty insurer range from \$300,000 in the District of Columbia to \$2.9 million in New Jersey. NAIC is developing risk based capital requirements to be determined by the nature and riskiness of a company's assets and insurance business. It plans to incorporate formulas for calculating capital needs into the annual statement. This would have the effect of requiring all companies to report their risk based capital target as well as their existing capital. NAIC is also working on a model policy for states' consideration to encourage uniform state action against insurers that do not meet the new capital requirements. To be effective, the model would have to be adopted without modification by all states.

#### **# Alleged Deficiencies in the NAIC Database**

Without early identification of troubled companies, state regulators cannot reverse the affairs of troubled companies or act to minimize the damage resulting from insolvency. As previously reported, regulators have been relying on delayed and unverified insurer reported financial data and infrequent field examinations to detect solvency problems. NAIC has a number of initiatives underway to help remedy deficiencies in timely identification of troubled insurers.

Since 1988, NAIC has increased its support staff and computer facilities to improve collection and analysis of financial and other data on insurance companies. Through NAIC's telecommunications network, states have on-line access to NAIC's database of annual financial statements. The most recent six years of financial data for about 5,200 insurance companies are maintained on-line for regulatory analysis, with tapes available back to 1979. However, NAIC's financial database is only as good as the insurer reported data its actions to improve data quality, according to GAO, have not been sufficient to ensure that outcome.

NAIC has also developed legal and regulatory databases to help state regulators share information about troubled multi-state insurers. This way, states can get a better picture of the complete activities of a troubled multi-state insurer and prevent suspicious operations from spreading. Among these databases, NAIC's Regulatory Information Retrieval System gave states on-line access to the names of more than 49,000 insurance companies, agencies and agents, as of 1991, that have been subject to some type of formal regulatory or disciplinary action. Its new Special Activities Database, which has been operating since June 1990, is a clearinghouse for information on companies and individuals that may be involved in questionable or fraudulent activities.

NAIC also is developing a national complaint database that will help each state assess policy holder complaints from other states about multi-state insurers and agencies. Complaint information, which can give states indications of solvency and other problems, is now maintained only state-by-state.

NAIC's databases are important steps in the right direction, says GAO, but their ultimate success depends on the quality of insurer reported financial data and the willingness of state regulators to volunteer information and use the databases.

### **# Alleged Deficiencies in NAIC's Solvency Analysis**

State regulators generally focus their resources on insurers domiciled in their state. NAIC independently operates two solvency analysis programs to help states identify potentially troubled multi-state insurers operating in their state, but domiciled in another state. This is an important service because only a few states routinely provide others with regular updates on financially trouble insurers. Although state regulators are still ultimately responsible for determining an insurer's true financial condition, NAIC's solvency analysis is intended to be an important supplement to the states' overall solvency monitoring.

The first of NAIC's solvency analysis programs -- the Insurance Regulatory Information System (IRIS) -- is intended to help states focus their examination resources on potentially troubled companies. NAIC also makes preliminary IRIS results available to the public. GAO's concern is that IRIS' effectiveness and usefulness as a regulatory tool is limited by certain deficiencies: (1) it relies on insurer-prepared annual statements that previously were not always independently verified and are subject to significant time lags, (2) its financial ratios have a limited scope and may not identify all troubled insurers, (3) it is not equally effective in assessing different types and sizes of insurers, (4) it does not adequately address some important aspects of insurer operations, (5) it does not consider some readily available sources of solvency information, and (6) it is identifying an increasing number of companies, some of which may not warrant immediate regulatory attention.

In 1990, NAIC developed a new computer-based financial analysis system to identify potentially troubled companies requiring state action. The Solvency Surveillance Analysis System appears to address a number of weaknesses we identified with IRIS. However, it is too soon to assess how well it will identify potentially troubled companies or whether it will identify them early enough for effective state action.

In addition to NAIC's database and analysis systems to identify troubled insurers, the support office has developed automated tools to help state regulators more efficiently analyze financial statements and examine insurance companies. NAIC also purchased audit software and offered it to state insurance departments at no charge; 35 states had obtained the software. Of particular note, NAIC has developed new tools to help states assess reinsurance collectibility. Uncollectible reinsurance has contributed to several large property/casualty insurer failures. NAIC now requires insurers to disclose overdue amounts recoverable from reinsurers and has automated these data. State regulators can use NAIC's reinsurance database to quantify overdue reinsurance and identify slow paying reinsurers. NAIC acknowledges that its reinsurance database is only as good as insurer reported financial data, and it is working to identify insurers who report incorrect or incomplete information.

### **# Alleged Deficiencies in Resolving Troubled Companies**

Once regulators decide that an insurer is troubled, they must be able and willing to take timely and effective actions to resolve problems that may otherwise result in insurer insolvency. When problems cannot be resolved, regulators must be willing and able to close failed companies in time to reduce costs to state guaranty funds and protect policy holders.

In a recent report, GAO analyzed the timing of state regulatory action against financially troubled or insolvent property/casualty insurers. Regulators in 46 states and the District of Columbia reported to us the dates of insolvency for 122 insurers and the dates on which formal regulatory action was initially taken against those insurers. In 71 percent of those cases, the states did not take formal action until after the insurer was already insolvent. We also found that states delayed liquidating insolvent insurers under state rehabilitation.

Delays in regulatory action against financially troubled or failed property/casualty insurers increased costs for state guaranty funds and delayed payment of policy holder claims. In 36 failed insurer cases where financial data were available, the company increased its sales of insurance policies, even after state regulators identified financial trouble. This obviously increases the burden on state guaranty funds. In 47 cases where liquidation was delayed, policy holders with claims did not get paid promptly because claim payments were suspended.

GAO found many reasons for regulatory delay in dealing with troubled or insolvent insurers. In addition to relying on inaccurate and untimely data reported by insurers, states also generally lacked legal or regulatory standards for defining a troubled insurer, and vague statutory language made establishing insolvency difficult. Actions that are needed to correct these problems include developing a single uniform standard for determining if an insurer is financially troubled, requirements that certain actions be taken when specific hazardous conditions are present, and a single uniform legal definition of insolvency based on loss reserves and capital adequacy. Such action would improve protection of policy holders and state guaranty funds.

In 1989, NAIC created a new multi-state peer review committee -- the Potentially Troubled Companies Working Group -- to track how states are handling problem companies. The group looks at the companies that NAIC's independent financial analysis identifies as potentially troubled and selects certain companies for special attention. It requests states to respond in writing to its questions about those companies. State commissioners also are asked to appear before the NAIC commissioner committee that oversees the working group to discuss how they are handling potentially troubled insurers. According to NAIC, regulators are to, at a minimum, (1) demonstrate an understanding of both the nature and extent of the company's problem, (2) establish that the state has a sufficient plan of action to assist in correcting or stabilizing the company or that the state has an orderly process to withdraw the company from the marketplace, (3) establish that the state has the laws, regulations, and personnel to effectively carry out the necessary regulatory actions, and (4) establish that the state has effectively communicated its concerns to other regulators in states with policy holders who are at risk.

NAIC follows up on potentially troubled insurers and, if necessary, may form a special group of state regulators to oversee regulatory activities for a troubled company. According to NAIC, peer review helps to ensure that individual states are promptly addressing problems and keeping other states informed about troubled multi-state insurers.

GAO does not know whether this peer review system will prompt individual states to take more timely action to deal with troubled insurers or the extent to which it will enhance coordination of supervision of troubled multi-state insurers. Whatever the influence of peer pressure, supervisory actions to address problems of a trouble insurer remain the primary responsibility of the domiciliary state regulator, and the coordination of such actions involving multi-state insurers is a matter of negotiation among all involved states. NAIC has no enforcement power to compel a state to take action against a troubled insurer.

## **# NAIC Deficiencies in Controlling Holding Companies and Foreign Reinsurers**

To effectively monitor insurer solvency, regulators must be able to routinely oversee insurance holding companies. Inter-affiliate transactions are common in the insurance industry and are not necessarily detrimental. However, such transactions are subject to manipulation and may be used to obscure an insurer's true financial



condition. Abusive inter-affiliate transactions caused the Baldwin-United failure -- the largest life insurance failure in history.

States do not regulate insurance holding companies and cannot regulate the non-insurance affiliates or subsidiaries of an insurance company. Consolidated statements for insurers and affiliates might help states evaluate the overall financial condition of a holding company, but, according to NAIC, only 13 states require some form of consolidated reporting. NAIC has adopted model laws on holding companies to emphasize the need to regulate these transactions and encourage uniform state regulation. However, not all states have adopted NAIC's current model laws.

GAO points out that states have no authority to monitor the financial condition of reinsurers in other countries that do business with U.S. insurers. To effectively monitor insurer solvency, regulators need this authority. Foreign reinsurers provide more than one-third of the reinsurance written in the United States. While many foreign reinsurers are responsible and reliable institutions, some foreign reinsurers have failed to pay claims. Uncollectible reinsurance has contributed to several large insurer failures.

NAIC has tried to help state regulators monitor foreign reinsurers operating in the United States by providing to them a database of reinsurance activity reported by U.S. insurers. State regulators can now quantify amounts reported as ceded to any reinsurer worldwide and totals ceded by country. However, NAIC has made little progress, says GAO, in helping states evaluate the financial condition of foreign reinsurers. While NAIC maintains a so-called white list of acceptable foreign insurers, it specifically excludes foreign reinsurers. NAIC cannot require foreign companies to submit financial reports. Thus, its authority to evaluate either foreign insurers or reinsurers is no greater than a private rating organization's. NAIC believes that federal legislation is necessary to empower it to require foreign insurers and reinsurers to submit to monitoring as a condition for doing business in the United States and to require the states to use NAIC's listing.

## **# Alleged Deficiencies in State Solvency Laws**

Without uniformity in solvency laws and regulations, the state-by-state regulatory system is only as strong as the weakest link. Because insurers operate in many states, lack of uniformity in state solvency regulation provides opportunities for unsafe and unsound operations while it complicates regulatory detection of those activities.

Over the years, NAIC has developed and proposed for states' consideration about 200 model laws and regulations designed to foster state acceptance of the legal and regulatory authorities necessary to effectively regulate insurance. However, NAIC has no authority to require states to adopt or implement its model policies. Before this year, NAIC had only limited success in getting states to adopt its model laws and regulations. Moreover, states that do adopt model laws can -- and do -- modify them to fit their situations. For example, every state has a property/casualty guaranty fund to pay policy holders of failed insurers. Although most guaranty funds are patterned after the NAIC model, significant differences between state laws result in some funds offering less protection than others. This undermines NAIC's efforts to achieve uniformity. Another impediment to uniformity is the uneven adoption by states of NAIC amendments to its model laws and regulations.

Frustrated by the difficulty of getting states to enact model policies and provide sufficient regulatory resources, NAIC adopted a set of financial regulation standards for state insurance departments in June 1989. These standards identified 16 model laws and regulations, as well as various regulatory, personnel, and organizational practices and procedures, that NAIC believes are the minimum for effective solvency regulation.

NAIC must rely on state insurance commissioners to introduce the models in their various state legislatures and work for their passage. Individual states, in turn, may modify NAIC models depending on local needs and

circumstances.

Using NAIC's *Model Laws, Regulations and Guideline* publication service, GAO tabulated states' adoption of 14 model laws and regulations referenced in NAIC's financial regulation standards. The figures show, adoption of NAIC models varies widely. For example, only two of the four NAIC models adopted before 1980 -- the Standard Valuation Law and the Insurance Holding Company System Regulatory Act -- have been substantially enacted in all states. NAIC's Insurers Rehabilitation and Liquidation Act, or legislation that NAIC identified as substantially similar, has been enacted in 24 states, while 27 other states have legislation or regulations related to the subject, but not the same or substantially similar to NAIC's model.

While the original insurance holding company model was enacted in virtually every state, most states have not adopted key provisions that NAIC added in 1984 to control abusive inter-affiliate transactions. In this regard, only seven states adopted expanded authority to issue cease and desist orders and to impose civil penalties, while only six have added a provision allowing a receiver to recover funds from an affiliate. Additionally, NAIC's model regulation to supplement its holding company model act still has not been adopted in nine states.

Of the models proposed by NAIC since 1980, only the Model Risk Retention Act has been adopted in more than half of the states. In contrast, the Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Condition has been adopted by only four states since its adoption in 1985.

NAIC recommended independent annual audits by Certified Public Accountants in 1980. However, by the end of the 1980s, only 15 states had adopted this requirement. NAIC effectively abandoned the model law process as a means to get states to require this important regulatory tool. Instead, NAIC used its authority to prescribe annual statement reporting to require independent annual audits for insurers. This requirement now applies to all states.

Since January 1991, the National Conference of State Legislatures and the National Conference of Insurance Legislators have called on the states to comply with NAIC's standards. Likewise, the National Governors' Association has endorsed NAIC's efforts.

### **# Alleged Deficiencies in NAIC's Accreditation Program**

In June 1990, NAIC adopted an accreditation program to encourage state insurance departments to comply with its new financial regulation standards. According to NAIC, its new accreditation program has the effect of establishing a national system of solvency regulation consistent across all states.

However, GAO questions whether NAIC's accreditation program can achieve this goal. "First, even if the standards were implemented by all of the states, they would provide little more than an appearance of uniformity. The standards, for the most part, are general, and their implementation can vary widely. Second, the accreditation review process has significant shortcomings that cast doubt upon the credibility of NAIC's program. Third, even if the first two problems were solved, NAIC remains in the position of attempting to regulate the state regulators with no authority to compel their compliance."

Overview of the Accreditation Program: To become accredited, a state must submit to an independent review of its compliance with NAIC's financial regulation standards. An accreditation team is to review laws and regulations, past insurance company examination reports, and organizational and personnel policies; interview key department personnel regarding how legal provisions and regulatory practices are implemented; and assess the department's levels of reporting and supervisory review. The team is to report its recommendation as to

whether or not a state meets the standards to the NAIC Committee on Financial Regulation Standards and Accreditation.

This committee of state insurance commissioners decides whether or not a state becomes accredited. To avoid a direct conflict of interest, the commissioner from a state applying for accreditation cannot vote on that state's accreditation. Nevertheless, since each state ultimately will undergo an accreditation review, a commissioner voting to deny accreditation to another state may be subject to retaliation. Likewise, according to GAO, commissioners could engage in "backscratching", trading an affirmative vote for their own state accreditation. While GAO has no evidence that this has occurred, they note that the committee process is not sufficiently devoid of potential conflicts of interest to preclude the opportunity.

States that satisfy NAIC's financial regulation standards will be publicly recognized by NAIC as "accredited", while departments not in compliance will receive guidance on how to comply. Accreditation is for a five-year period; to be reaccredited, a state must undergo an independent review. NAIC is developing procedures for maintaining accreditation during this five-year period and decertifying states no longer in compliance.

NAIC plans to have accredited states penalize insurers domiciled in states that do not become accredited. Among the planned restrictions, which began in January 1994, an accredited state would not license an insurer domiciled in an unaccredited state unless the insurer agrees to submit to the accredited state's solvency laws and regulations and associated oversight. Whereas the home state usually has primary responsibility for solvency monitoring and regulation, this penalty would subject a multi-state insurer domiciled in an unaccredited state to regulation in every accredited state in which it is licensed. Given the varying state solvency laws and regulations, NAIC's penalties would be onerous for insurers domiciled in unaccredited states. If the accredited states carry out the penalties, according to NAIC, this would give insurers the incentive to lobby for the increased authority and resources their home state needs for accreditation.

NAIC's standards, says GAO, may not achieve uniformity since they do not set specific criteria or practices for the states to meet. This is why even universal adoption of the standards would provide little more than the appearance of uniformity. For example, NAIC's current capital and surplus standard requires, in part, that a state have a law that establishes minimum capital and surplus requirements. However, the standard does not specify what those minimum requirements should be. NAIC has said that this standard will be replaced when NAIC completes its new risk based capital requirements.

Another example is the standard for investment regulation. NAIC's standard is that a state should require insurance companies to have a diversified investment portfolio, but the term "diversified" is not defined. Other important terms -- "sufficient staff" and "competitively based" pay, for example -- in the standards are similarly vague.

Furthermore, GAO believes that some of the standards, in addition to being nonspecific, are inadequate to address regulatory problems that we have identified. For example, the model regulation underlying NAIC's standard for corrective action against troubled insurers is qualitative even when dealing with quantifiable conditions. NAIC's standard does not set a uniform measure for determining if an insurer is financially troubled or prescribe regulatory actions to be taken when specific hazardous conditions are present. As previously mentioned, lack of such regulatory guidance causes delay in states' handling of troubled insurers.

GAO feels that NAIC's accreditation review process suffers from two serious shortcomings. First, because the standards are not specific, there are no criteria for the accreditation teams to use in assessing compliance with the financial regulation standards. Second, the lack of documentation and procedural requirements for the team review has, to date, made it impossible to independently decide whether a team's work was sufficient to justify

a recommendation for or against accreditation.

To evaluate compliance with NAIC's standards, each accreditation team has to develop its own criteria for what constitutes acceptable compliance. To define terms and set more specific criteria for its standards, NAIC plans to have future review teams keep records of the criteria they use in assessing compliance with NAIC's standards. They will document the criteria in their review to the NAIC accreditation committee. NAIC said all criteria will be shared with the states in an effort to achieve greater consistency in the process and so that individual states can better prepare for accreditation.

Due to the lack of documentation, GAO does not know the basis for the findings of the accreditation team in Florida and New York. The review reports for the two states -- each about one-half page in length -- recommended that the state insurance department be accredited "based upon this evaluation effort and the knowledge and experience of the evaluation team". While the four-page report for the Illinois accreditation better documented what work the review team did, the report still did not document the basis for the team's findings or recommendations. Without such documentation or elaboration, it is impossible to independently verify that the team's analysis was sufficient to support its recommendation. NAIC's accreditation committee required the Illinois review team to submit an additional summary of its findings to support the team's conclusions that the state complied with each standard.

Based on lessons learned in Florida and New York, NAIC developed a more detailed work plan for use in subsequent accreditation reviews. The expanded work plan is a good starting point, but it will still be necessary to develop more detailed procedures and documentation requirements to ensure consistency between review teams and support for findings in the future. GAO bases this conclusion on their observations of an accreditation review team planning session in March 1991 and the team's visit to the Illinois Insurance Department in April 1991. GAO questions whether NAIC's work plan for the Illinois review was sufficient to ensure accreditation reviews that are consistent and sufficiently documented. NAIC's only quality control over the team's analysis has been to have an observer from the support office on each review.

A final problem with the accreditation review work plan is that coverage of work does not seem to have been sufficient to assess how well a state implements NAIC's standards. GAO questions, for example, how the accreditation team assessed implementation of Florida's regulations, given that several key provisions were adopted through emergency rule-making only weeks before the review. Although the standards called for the review team GAO observed to assess whether Illinois had implemented NAIC's guidance on handling troubled insurers, the team did not. Team members said that they assumed Illinois had followed NAIC's procedures because Illinois helped write the handbook.

## **# GAO Conclusions About NAIC As A National Regulator**

Although insurance is a national market, the state-by-state system of insurance solvency regulation is characterized by varying regulatory capacities and a lack of uniformity.

NAIC has taken a number of steps toward strengthening the state-by-state regulatory system and addressing a variety of problems. It has been successful in using its authority to prescribe reporting requirements to achieve uniformity in some aspects of state solvency regulation. NAIC has not been as successful with its model laws, which must be adopted by each state.

NAIC is trying to establish a national system of effective solvency regulation through its accreditation program. In effect, NAIC has assumed the role of a regulator of state insurance regulators. However, GAO does not believe that state adoption of NAIC's current standards will achieve a consistent and effective system of solvency

regulation. The underlying standards for accreditation are often undemanding and, in some cases, inadequate.

Even if NAIC devised sufficiently stringent standards for effective solvency regulation, however, GAO does not believe that NAIC can surmount the fundamental barriers to its long-term effectiveness as a regulator. Most importantly, NAIC lacks authority to enforce its standards. NAIC is dependent on consensus -- indeed unanimity -- among state insurance commissioners and legislatures to enact and implement its policy recommendations in a manner that achieves consistency in state-by-state regulation. Progress toward such consensus and unanimity appears to be occurring presently under the glare of intensified public scrutiny of the insurance industry and its regulators. Given NAIC's historical lack of success in securing state adoption of its model policies, it is highly questionable whether such progress will be sustained over the long run as interest in the industry's condition wanes.

## **## NAIC'S RESPONSE TO GAO CRITICISM**

Once testimony before Congress was made public, the National Association of Insurance Commissioners was quick to respond to its critics. Following is their defense and reasons they believe that NAIC is still a credible choice for a National Insurance Regulator:

### **# Incorrect Legal Conclusions**

The GAO claims that it would be unconstitutional for Congress to delegate national regulatory authority to the NAIC. The GAO made no attempt to outline the basis for this legal conclusion. While there are limitations to any delegation of authority Congress may make, a thorough review of the cases does not reveal any impediment to federal delegation drafted to come within these limitations. Indeed, such delegation is quite commonplace and, in fact, there are numerous references to the NAIC throughout federal statutes and regulations.

### **# Lack of Analysis or Explanation**

GAO asserts that one of the three fundamental weaknesses of state regulation is that: States vary widely in the quality of their solvency regulation. There are differences in regulatory workload, such as the number, size, and type of companies domiciled or licensed in a state; the available resources in a state; and each state's "regulatory philosophy".

It is a truism that there are differences in regulatory workload, number and size of companies domiciled and licensed in a state, resources and regulatory philosophy. The NAIC does not concede, however, that any of these factors is an indicator of "quality". The difference in workload caused by the differences in company numbers and size result in a rational difference in the amount of resources that should be properly available to handle the workload. A comparison of states for quality of regulation must take into consideration a number of factors not mentioned by the GAO but considered by the NAIC in its accreditation review. These include not only the numbers of staff, their qualifications and training, but also the amount of outside resources that may be available to the department from various sources.

Similarly, regulatory approaches may differ from state to state just as regulatory philosophies may differ with each presidential administration and even with one administration. But, clearly, the potential damage that may be caused to the insurance business as a result of an approach taken by one or more states, however, is held in check by the approaches taken by other states. The likelihood of significant negative effect on the insurance business of radical changes of philosophy among insurance regulators is therefore minimal. On the other hand, the same cannot be said of the federal regulatory system, as exemplified in the savings and loan and banking industries.

## **# Lack of Understanding of the Regulation of Insurance**

The GAO describes a third "weakness" of state regulation: State regulators do not oversee holding companies and foreign reinsurers. In part, these blind spots may have prevented regulators from acting to forestall large insurer failures.

In light of the fact that the Model Insurance Holding Company System Act is the law in virtually every state jurisdiction, the GAO is simply wrong, says NAIC. Or, perhaps the GAO is making the suggestion that a weakness of state regulation is that insurance departments do not regulate non insurer corporations such as General Motors and ITT, both of which have insurance subsidiaries. The fact is that transactions between affiliates are regulated and it is these transactions which relate to the insurer's solvency.

Further, while non-U.S. reinsurers are not directly regulated, their impact on U.S. reinsurers is. Incredibly, the GAO testimony totally omits any mention of the NAIC Model Credit for Reinsurance Act or its inclusion in the requirements for accreditation. The Act determines when a U.S. insurer may take credit for its reinsurance and assures that adequate security is in place to guarantee the obligation of the non-U.S. insurer. Day-by-day regulation of non-U.S. corporations is impractical whether done by the state or by a federal authority. The NAIC is considering a proposal, however, that would establish minimum requirements for non-U.S. reinsurers which would add an extra layer of protection to the safeguards contained in the Model Credit for Reinsurance Act. The proposal has not yet been ratified and further study must weigh the benefits to be derived from the extra layer of protection against the possible effects on capacity/availability and international trade.

Similarly, the GAO's lack of understanding of the complex world of insurance regulation is also revealed in the somewhat naive insistence upon development of a "single uniform standard for determining if an insurer is financially troubled". Insurer solvency is dependent upon a huge number of variables not present in other financial institutions such as banks and savings and loans, and therefore insurer solvency regulation is many times more complex than the regulation of other institutions. Simple principles applying to these other financial institutions are simply not transferable to the insurance industry.

## **# Unfair Comparisons**

The GAO has analyzed and reanalyzed the regulation, or lack thereof, of thrifts and banks. The NAIC is puzzled by the fact that, possessing as it does all the resources needed to compare state regulation of insurance to various regulatory structures of other financial institutions, including federal regulation and dual regulation, it declined to do so. This is unfortunate. The NAIC believes that state regulation of the business of insurance compares remarkably well to federal regulation of financial institutions and to a dual federal-state regulatory structure.

It is, of course, true that there are problems at the state level. Prompt communication or action does not always occur in state insurance regulation. Only in an ideal system does it always occur. Our goal is to improve the system to the point that it comes as close as possible to perfection. However, for the GAO to characterize the lack of perfection in the current system as a major inherent weakness is simply absurd.

These are but a few examples of a flawed analytical approach that pervades the GAO testimony. However, the NAIC is even more disappointed with the GAO's testimony on a broader, more basic ground: the GAO's testimony is grounded in a strong and rigid bias against state government. This bias is most clearly revealed in the fundamental conclusion of the document that, the "road to effective insurance regulation does not pass through the NAIC."

This bias against state government runs directly counter to fundamental principles of American government which vest basic powers of government in the states. The NAIC believes that solvency regulation should meet national minimum standards, but not only need not, but should not, be uniform in all respects. The ability of states to experiment with new forms of solvency regulation is one of the strengths of state regulation.

In sum, the GAO testimony is based more on bias than fact; more on unsupported conclusions than on audit findings; more on simple errors than on simple truths. It is that aspect of the GAO testimony, and not the testimony's conclusions, that disappoints the National Association of Insurance Commissioners most.

### **# NAIC's Conclusion**

Overall, the NAIC believes that the long standing tradition and operation of state regulation of the business of insurance have served consumers well. Certainly, they say, state regulation of the insurance industry fares better in a comparison with federal regulation of other financial institutions. State regulators are responding through the NAIC to the changing and challenging environment of the insurance industry.

"We believe the NAIC's Financial Regulation Standards and Accreditation Program will succeed in strengthening the state regulatory system", states the NAIC. "Other improvements," (discussed above) "from strengthened solvency analysis support, to enhanced capital analysis and requirements to improved examinations and more, will provide needed enhancement to a regulatory system that has been successful, but could be more so, particularly, as we enter the next century."

# COMPANY SAFETY

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## ## OVERVIEW

At one time, the topic of insurance company safety was discussed among a tight circle of professional industry groups and regulators. Today, however, potential trouble spots and ideas for constructing new regulations to protect consumers are being unveiled at a fast and furious pace. The suggestions hail from consumer coalitions, industry groups, auditors, state regulators and some members of Congress who continue to press for some form of uniform federal supervision of the entire insurance industry. So great has the call been, that at the outset of the final decade of the twentieth century, an industry that has flourished in this century is now struggling to redefine itself. At the center of attention are the issues of **safety, solvency and agent due care**: how to regulate, who will regulate, what the consumer will be promised and whose going to pay if something goes wrong. Clearly, the insurance professional is at risk to know as much about his product and company than ever before.

Recent problems are complex and visible and not limited to insurance companies. Most financial markets and many industries have changed dramatically especially through the 1980s. Changes in financial institutions have resulted from events like information and communication technologies -- making the world smaller and competition greater within a chosen financial services industry -- to spectacular financial disasters, e.g., the '87 stock collapse, the junk bond fiasco, the Executive Life / Mutual Benefit Life debacles, national catastrophes (Hurricanes Andrew Hugo, the midwest floods and California earthquakes). Geographic and product boundaries for financial markets . . . traditionally, not a factor for insurance companies . . . have faded, and new products and services have blurred the distinctions between bank or thrift institutions, security brokers and insurance agents. A place once reserved to buy groceries, for example, may now be a convenient spot to deposit or cash a pay check. And who would have thought banks and insurances agent would market and control "managed asset" mutual fund accounts? Further, with news of innovations like the "Information Superhighway" beaming financial and educational services to anyone who owns a telephone, there is no indication that this era of change is over. On the contrary, financial markets and institutions will continue to evolve.

The need to adapt to the increasingly competitive environment, new products, financial "heart attacks" and more has presented problems for many types of financial institutions . . . commercial banks, savings and loans, securities firms . . . and insurance companies. As always, when things change or require restructuring, there is a period of adjustment accompanied by trial and error, financial stress and an increased likelihood of less than top performance or the threat of complete collapse. It happens to many kinds of companies . . . including property/casualty and life/health insurers. It is a fact of doing business and part of any free-market system.

Multiple and prolonged insolvencies, however, take their toll. The insurance industry becomes tarnished, and new consumer/political pressures expound. This, in turn, expands the burden on regulators, industry groups and the insurance professionals to correct the potential effects a major insurance failure may have against the public and the economy. In some cases, over-regulation and speculation result in panic or perhaps a "light trigger" that could catapult a seemingly secure company into the solvency spot light. During the 1980s, solvency paranoia was focused on the banking industry. Volumes of information documented faulty and fraudulent investments



by banks and savings and loans. Managers were branded as criminals and regulators clamped down like a proverbial ton of bricks. Of course, the insurance industry has had its bout with solvency wars. In fact, just the cast or suspicion of problems or a drop in bond ratings has put companies at bay or, in some cases, out of business.

With rare exception, the insurance industry has enjoyed the comfort of consumer and regulator confidence throughout its history. Conservative marketing and investment practices in the industry scored high marks with a remarkably low rate of failure. Performance has periodically fallen below adequate levels, but generally not to a point that would jeopardize solvency. In the few episodes that varied this trend . . . the dangerous securities practices after the turn of the century and the substandard writers in automobile insurance markets of the 1960s . . . insurance regulators, aligning insurance companies and industry groups like the National Association of Insurance Commissioners have appeared to provide appropriate regulatory responses. Recent episodes are no exception. Most of the major insurers that went insolvent are in the process of being rehabilitated by state regulators or private investors. It is doubtful that policy owners will incur material losses.

## ## THE FAILURE RATE

It is true that the decade of the 1980s and the early 1990s subjected the industry to higher levels of financial and market **trauma** than ever before. This period was marked by new records in sales and innovations. Fierce **competition and increasing cost pressures** became new problems in addition to outside influences like federal **deregulation of financial services, higher interest rates, new financial instruments, expansion of tort liability, soaring medical costs, catastrophic claims, the entry of some inexperienced, small insurers and relatively poor investment results**. In a rather short time frame, the industry evolved from a conservative, mature business with stable elements and generous profit margins, to a business marked by higher risks and narrowing profit margins.

A combination of these factors has also brought media and political attention and a definite erosion in consumer confidence. As this confidence declined, redemptions increased dramatically. At the same time, a major recession created financial havoc via junk bonds and plummeting commercial real estate values. The result: insurer failures. The additional toll of many years of "rate wars" and dramatic natural disasters created even greater pressures on the property/casualty side of the industry.

Just how bad is it out there? The answer depends on the source. The federal government has published volumes on insurance industry abuses and made scathing comparisons of insurer problems and the huge banking debacle of the late 1980s. Actual statistics, however, tell a somewhat different story. For example, in 1989, the peak of the bank and thrift controversy, failures in that industry numbered over 500 institutions involving some \$130 BILLION in assisted mergers or closures. In the same year, which coincidentally seems to be the peak year for insurance company problems, the number of failed companies numbered about 40 property-casualty insurers and about 40 life companies with a combined total bailout of less than \$1 BILLION. While no one should be happy with these results, it is clear that insurance industry failures have and will not likely become another savings and loan fiasco -- especially, since recent information seems to indicate a cycle of declining failures. This is indeed good news. But, this should not diminish the severity of recent failures -- more than the industry has seen since the great depression. These failures have given the industry a "black eye" which will take many years to heal. In a like manner, agents will bear the brunt of new client doubts and increased responsibility, both ethical and legal, to present financially secure companies.

## ## INDUSTRY TROUBLESPOTS

### # Life Company Problems

During the 1980s, life insurance companies scrambled to satisfy a longstanding customer who **transformed from a "saver" into an "investor"**. As much as life insurers wanted to please, their historically conservative investment practices would not allow them to quickly offer products with returns competitive with high yield products offered by financial institutions and security products. The fact that the high rates offered by banks and thrifts were federally insured put life insurance companies at a further disadvantage. Eventually responding to the pressure, life companies began undertaking new types of risks designed to support more competitive products. Marketing shifted from selling "**security**" to selling "**rate of return**".

Companies were forced to achieve a greater return on their assets by assuming **higher risk** in their investment portfolios. Others chose a strategy of increasing cash flow by mismatching assets and liabilities. Still others engaged in new forms of reinsurance arrangements which were intended to ease the strain on their surplus. As mentioned, asset mix is a current problem among life insurers. Although mixing moderate amounts of well diversified higher risk assets in an insurer's portfolio can be an acceptable strategy, concentrations in high risk assets can put policy holders in jeopardy. In some insurer failures, it is specifically the crisis of confidence surrounding these investments, not their liquidation, that created the failure. A recent example was Mutual Benefit Life. A downgrading of bonds in their portfolio triggered a run on the insurer they could not control. For this reason, some state regulators, like New York State, are placing aggregate caps on most types of investments that a life insurer may invest in -- these include stocks, subsidiaries and investment real estate. In the mid 1980s, the spotlight was on "junk bonds". Because original issues were relatively new, it wasn't until 1990 that a more appropriate disclosure system and accelerated reserve system for insurer held "junk bond assets" was adopted by the National Association of Insurance Commissioners. New models and systems are also coming forth that will develop risk reserve coverage for all classes of assets, including real estate mortgages. Another problem area among life insurers has been **asset/liability matching**. The mismatching of cash flows generated from assets and the cash flows required to cover liabilities can provide a competitive advantage to an insurer but places the insurer's policy holders at risk. New regulations are forthcoming that would require all life companies writing interest sensitive products to closely "match" their assets and liabilities.

**Reinsurance** is yet another area of concern. A life insurance company is somewhat unique, in that, due to the conservative nature of statutory accounting, the writing of new business results in a decrease in the company's statutory capital. This, in combination with the fact that all expenses for new business are charged up front created a greater strain on insurer "surplus". In the early to mid 1980s a new type of surplus relief reinsurance called "**financial reinsurance**" was developed to bolster the surplus of life insurers. The reinsurer placed a block of the ceding company's business on its books but did not assume the primary risks of the business. The ceding company decreased its liabilities, thereby increasing its surplus, without having transferred the real risk of the business. It is said by some that the use of financial reinsurance seriously distorts an insurer's financial statements, and at times, masks real problems. Again, new regulations are being created to deal with this problem.

**Holding company** abuse of insurers is another area of risk for the industry at whole. The failure of some life insurers can be directly tied to a systematic "milking" of these companies by a non insurance parent. Strong holding company laws and aggressive enforcement are essential ingredients to effective regulation of the industry. Again, some model laws were adopted by the National Association of Insurance Commissioners in late 1986. Finally, in an effort to "squeeze" more capital out of the balance sheet, there has been an assault on statutory insurance accounting. For the protection of policy holders, statutory accounting results in a forced conservatism in preparing an insurer's financial statement. Insurers, in a desperate effort to show more surplus, have waged

a campaign to recognize all the values in the assets on their books, as well as values in some assets not on their books, and to reduce their liabilities below the conservative levels set by regulation. Many elaborate schemes including sale and leaseback arrangements and the securitization of future revenues have been tried. Regulators expect this to continue where companies must see their profitability restored to a level at which they can attract real capital.

In terms of actual performance, life insurers, through significant efforts to cut product and management costs and liquidate certain assets, are posting "profits". According to A.M. Best, a major downsizing has trimmed expense growth and discipline pricing and effective interest rate management, along with dividend reductions, have "shored-up" insurer earnings -- return on equity for the industry is about 9.5 percent. It is significant to note, however, that while earnings are positive, the 1993 performance marks the third year of **decline in operating profits**. In a similar vein, the industry has suffered from major realized capital losses, exceeding \$500 million in 1993 compared with a \$2 billion gain a year earlier (A.M. Best). A bit of good news is the increase in net business written. Net premiums in 1993 grew by 9.9 percent. This is 3.5 percentage points higher than the 6.0 percent return posted for 1992. Much of this growing demand is an offshoot of the increasing popularity and competitiveness of annuities and variable annuities meeting the needs of consumers disappointed with their low-yielding CDs.

## # Health & Worker Comp Troubles

The health care industry has been a particularly vulnerable target for reform during the past decade. Never before have Congress and an Administration pursued change. At the root of the problem are three unrefutable facts: **1) health care costs are rising far faster than the Consumer Price Index, 2) worker's compensation claims, fraud and tort injustices (medical lawsuits) are higher than at any time in history and 3) long-term care is a burgeoning problem as major portions of the population near retirement age**. At the same time, government tinkering and political "showboating" on the health care "crisis" have done nothing but add salt to the wound. The industry is definitely in the grip of a blemished image, as stories of \$5 tongue depressors and the plight of the poor uninsured are aired nightly. Needless to say, Congress will leave NO stone unturned in an effort to completely reinvent health care.

The thought of government managed competition has sent many companies running. While large companies continue to dominate the field, smaller, more mobile insurers who have less invested in a health system infrastructure have and are making adjustments, including divestitures. For example, ITT Hartford, in 1993 announced agreements to transfer its major group medical business to Mass Mutual. Other carriers are simply exiting markets that are or no longer perceived to be profitable. The survivors are choosing to stand their ground and develop their own managed care capability or focus on specific geographic markets. Concurrently, however, many states are enacting their own reforms to hopefully ward off a full federal intervention. As of 1993, for example, almost 30 states have passed some form of health care reform involving employer mandates and matters such as guaranteed issue and guaranteed renewability. The industry's most significant challenge from the legislative area will be surviving government rate controls. Experts believe that such controls are unavoidable with either state or federal jurisdiction. Facing this prospect, health providers will need to push for significant cost containments, probably through the use of group or "pooled risk" groups and/or managed care relationships. Most observers agree that managed care is expected to expand under the Clinton proposal. Large carriers, like Aetna, Travelers, Prudential and Blue Cross/Blue Shield should be benefactors of this trend. The "Blues" are currently under extreme pressure to keep their low cost image. As a result, some consolidations have taken place. Given their longstanding presence in the marketplace and assuming they do not lose their non-profit status, they should maintain a significant advantage over other commercial carriers.

The workers' compensation carrier is another insurer facing major claim restructuring. Actual medical costs

associated with a workers' compensation claim have historically represented about 30 percent of the total claim costs with a factor of 70 percent attributed to salary reimbursement or payroll indemnities. Following today's trend in higher medical costs, these ratios have shifted to 40 percent of all claim payouts going to cover medical costs with 60 percent handling indemnities for lost payroll. Industry experts now believe, the system is on a fast track to a 50/50 proposition. The reason that this has become so costly for workers' compensation carriers has to do with the laws regarding payment of medical cost claims. Medical costs for the injured worker MUST cover medical costs from the first dollar and is typically unlimited in overall costs. The health managed care approach, by contrast, usually involves deductibles and copayments. Since patients are far less likely to seek discretionary medical services if they are footing part of the bill, medical costs under worker compensation are more costly than health insurance claims. In addition, the disabled workers' compensation patient has many more options available with less supervision. Chiropractic care, for example, which has been a substantial contributor in driving up medical costs, is legally provided to worker compensation claimants without much restriction in many states. Health maintenance organizations, on the other hand, typically exclude the use of chiropractors. Further, it is not mandatory, in most states to seek the attention of a single medical facility where a record of treatment and results can be tracked. Some states make employers provide a list of a few providers or only require the employer to direct medical supervision for a limited period of time (say the first 30 days). Thus, claimants are free to select and move from provider to provider. A worker with little motivation to return to work could use one provider's opinion against another to delay his recovery for an extended period of time. Another problem for the workers' compensation carrier is trying to control the costs involved with disability payments (salary reimbursement), worker fraud, rehabilitation and prevention programs designed to eliminate or reduce workplace accidents or illnesses at the source. Costs associated with these programs and general liability defense against worthless claims are creating extreme financial pressures of unprecedented size. Liability claims, in particular, are a major part of costs since damages from general liability typically include medical costs which are usually awarded for extended periods of recovery.

Many companies have decided to move away from the workers liability and health markets and focus on less regulated and potentially more profitable venues: **Long term care and Medicare supplement** lines. These specialty areas are expected to experience little disruption from proposed health care reform. The long term care market is a relatively new entry for insurers. And, for the most part, carriers have been very conservative in coverage. However, now that there are more than 100 companies offering long term care insurance and over 1 million policies written, regulatory intervention is a whisper away. Accusations against long term carriers include policy violations such as: unrealistic benefits, illusory benefits, misleading sales presentations, high premiums which buyers could not possibly continue, absence of non forfeiture values, rising premiums but level benefits, inadequate inflation protection and inadequate disclosures about solvency standards of the insurer. Already, the National Association of Insurance Commissioners has adopted a Model Act and Regulation for Long Term Care Insurance with many consumer protections including: prohibition of preexisting condition exclusion periods longer than six months, policies must not be canceled due to age or diminishing health status, 30-day free look, policies may not exclude coverage for Alzheimer's disease, policies may not limit coverage to skilled nursing care only, prior hospitalization requirements are prohibited, policies must be guaranteed renewable, inflation options must be provided, new claims protections, policies must meet a 60 percent loss ratio and detailed outlines of coverage must be provided to all prospective applicants at the time of solicitation. On top of these types of requirements, the care provided must contend with a real possibility that long term care could end as an actuarial nightmare. Factors that make it somewhat experimental include: medicines and technology that could greatly extend life could result in long term care being something close to "permanent care" -- the absence of an experience factor, the absence of any way to determine how the courts will interpret specific language incorporated in policies, uncertainties with respect to federal income taxation and the long run risks of changes in the supply of nursing homes.

## # **The Trouble in Property/Casualty**

In addition to enduring some of the greatest natural disasters of modern times, property/casualty insurers are still paying the price for some heavy price competition during the late 1970s and early 1980s. At the same time, liberal tort liability concepts have expanded and claim costs related to environmental issues (asbestos, toxic, etc) have soared beyond all previous levels. In order to remain "head above water", property and casualty companies, who had previously limited themselves to more conservative lines of liability insurance, entered **markets with higher risks and greater underwriting uncertainty**. In some cases, these changes were made with inadequate expertise, utilizing marketing techniques that inappropriately relinquished underwriting authority. **Some insurers severely underestimated their reserves and underpriced their policies with disastrous consequences.**

Far and away, the casualty losses of mega events like Hurricanes Andrew and Hugo, the Midwest floods and the California earthquakes, one right after another, will prove to be the losses hardest to recoup. Hurricane Andrew alone amounted to losses almost 20 times greater than the premiums paid by all Florida homeowners in that year and approximately equal to all homeowner premiums written countrywide for the same period. Unfortunately, rate regulations prohibit setting off losses in one state with gains from another. So, raising rates in all states to cover extraordinary costs resulting from problems in one state is not possible. Allowable rate increases are also inadequate. It is estimated, for example, that Florida insurers would have to increase their premiums by 25 percent, each year for the next 15 years to recover recent hurricane losses! Obviously, the State of Florida will not allow such an increase.

Since many property/casualty companies are reinsured, the reinsurance industry has felt the brunt of the impact. As a result, **reinsurers have substantially withdrawn from the marketplace**. Industry experts worry that this could create a capacity shortage. For the meantime, however, things appear stabilized for property/casualty insurers simply because they have been able to reap major capital gains from recent bond sales and the stock market has been very supportive in raising capital as investors needed higher paying issues. As mentioned, these two events have softened the blow of reinsurance withdrawals. The bad news is that the industry and reinsurers alike are now reinvested at much lower yields than before so there will be less net income available to relieve future underwriting losses. Further, if major catastrophes continue in a period where interest rates are rising, it is doubtful, that the insurers/reinsurers will be able to turn to bond sales to offset losses since rising interest rates cause bond portfolios to lose value. In addition, it is not sure how much help the securities industry could be during a period of rising rates since investors may lean toward more conservative "insured" issues like municipals. The bottom line of these events could mean that the property/casualty business will have less access to reinsurers and could experience more insolvencies in the years ahead when major claim events occur.

A 1992 survey of the top 100 casualty companies by A.M. Best documents recent financial changes. "Assets for these 100 insurers, which totalled \$533.8 billion in 1992, collectively represent nearly 85 percent of the property/casualty industry's assets. In line with the industry's growth, admitted assets of the top 100 grew 5.8 percent in 1992, slowing from 7.9 percent growth in 1991. The diminished growth occurred because of reduced growth of invested assets. In three of the past five years, the top 100 groups increased their invested assets by about \$35 billion, dipping to the \$20 billion level in 1990 and 1992 when the industry was hit by heavy catastrophe losses. Operating cash flow declined 35 percent to \$14.5 billion in 1992. This reflects continued growth in negative underwriting cash flows, which culminated in substantial Hurricane Andrew claims payments and a decline in cash flow from investment income -- the first decline in 50 years for the property/casualty industry. Declining investment yields and diminishing cash flows reinvested in the industry's portfolio combined in 1992 to cause a decline in net investment income. Consistent with A.M. Best Co's earlier projection, the industry's investment yield declined an additional 55 basis points to 5.95 percent as of September 30, 1993. Had it not been for additional funds from significant realized capital gains and capital contributed, growth in invested assets would have been a meager 2.5 percent instead of 4.4 percent for the top 100 groups".

## **## WHAT DO THE PROBLEMS MEAN**

Many of the pressures described above have already "vented" in the form of a rise, in the latter half of the 1980s, in a number of insurance companies failing, at least by certain regulatory standards, and those requiring formal action. Most of the underperforming activity, until only recently, was confined to companies writing between \$6 million and \$12 million in premiums per year and assets of between \$20 and \$40 million . . . small companies in the world of insurance. According to many industry professionals, however, the typical American insurance company, is in no way facing the kinds of risks faced by major company breakdowns like Executive Life, Mutual Benefit Life and others. In their opinion, the bulk of the industry has pulled through a tough economic environment and remains financially responsible. Most insurers are generally well capitalized, relative to other financial institutions, and are restructuring assets to meet new solvency standards, merging with stronger insurance and non-insurance companies and still conservative. Whether these measures are enough to weather the economic storms and other natural disasters of the 1990s remains to be seen.

As between property casualty companies and life/health companies, it appears that the casualty carriers continue to maintain greater liquidity -- about 77 percent of their assets are liquid vs. 56 percent for life companies (A.M. Best 1992 Survey). The life industry's affliction to real estate, mortgages and non investment grade bonds account for its low liquidity ratio. In contrast, property/casualty carriers have invested primarily in stocks, a trend they have maintained for the past five years. One must wonder, however, if the potential for loss in the casualty industry greatly offsets this liquidity edge. On the other hand, it has been principally life companies that have experienced the most serious failures.

Despite these statistics, the industry is, nonetheless optimistic. The independent agent, however, continues to walk a tightrope between clients who demand a "close to perfect" recommendation, an industry that is reeling from some major restructuring, aggressive competition and regulators who seem to have their own agenda. Through it all, no one has decided on a uniform system to determine safety and solvency and what role the agent will play. Any practicing agent should obviously stay close to this developing arena.

## • • COMPANY SAFETY IN THE YEARS AHEAD

During the last half of the 1980s and into the 1990s, industry failures and regulatory focus catapulted the issue of solvency to the front line. While in the spotlight, other problems in the industry were brought to surface like deceptive sales practices, misleading illustrations, national health care, asset risks, the adequacy of the state guaranty system, private rating service deficiencies and certain industry tactics used to "shore up" balance sheets. This negative exposure accelerated political investigations which have and will continue to result in new regulatory pressures. For the meantime, most insurers have been fairly successful in stabilizing their financials -- particularly capital surplus -- through aggressive cost containments and the "bulk sale" of selected assets.

Some experts believe that company managers are overcompensating, building surplus beyond reasonable levels in response to new or proposed risk based capital rules. While this will help companies meet new regulatory quotas, future earnings will decline, as potentially profitable acquisitions are by passed and the development of new product lines is placed on the back burner. This, in combination with proposals like the model investment law, render industry managers some complex limitations. Some believe, in the long run, insurers will be legislated out of their ability to make any investment risks. Since investment profits play a major role in surplus, this could leave the industry at a major disadvantage to cover future liquidity problems. A major turn of events or more catastrophic hurricanes or floods could again push many insurers over the brink. Further, the insurance industry position as a major source of capital for real estate and bond markets will be diminished or lost.

## ## FUTURE OPERATIONAL CHANGES

The biggest challenge facing insurance companies is how to balance *profits and solvency*. The industry is

entering a period of higher regulatory action and reaction. But what standards will they have to meet and who will regulate them? Further, will complying with new surplus and investment standards jeopardize an insurer's ability to satisfy shareholders and meet its own financial goals? These questions will probably NOT be answered for many years. In the meantime, insurance companies will likely be taking a "double books" approach of testing for regulatory reporting on one side, while the other side is testing for investment strategies and new products. Blending the two together will not be easy. While insurers have improved their monitoring of cash flows and asset/liability matching, the danger of interest rate fluctuations is now a substantial risk. If rates edge upward, carriers risk disintermediation, or a major outflow of funds, if they are unable to keep pace with consumer demands for higher rates. A concern shared by industry groups is that this condition, or additional casualty catastrophes (hurricanes, floods, earthquakes) might strain carriers beyond their resources. And, even though their liquidity level may be higher, under new risk based capital rules where future investment returns might be less, there will not be large "profit pools" to draw on for contingencies and as emergency claim funds. As a result, insurers may be forced to raise mortality and/or premium rates at a time when the forces of competition, regulatory pressures and consumer demand can least tolerate it. Aside from slim profit margins, other factors which could influence future solvency include changing demographics which have reduced the demand for life insurance; increased competition for savings dollars / insurance products from the banking and mutual fund industry and the ever present threat of potential loss of insurance tax advantaged status. On the casualty side, the industry is still suffering from past baggage in the form of liability suits and environmental claims (asbestos, toxic, etc). And, of course, no one knows what mother nature is likely to dish out.

## ## POSSIBLE REGULATORY CHANGES

In recent years, the industry has experienced a small taste of the new regulatory "bite". Despite huge insurer losses from hurricane and Midwest flood claims, regulators in these states prohibited major rate hikes and required companies to continue providing coverage. In Florida, consumer outcries prompted the state legislature to initiate a moratorium on "non-renewals" and limit annual rate increases to five percent when an increase of 20 percent is needed to recoup from hurricane losses. The liquidity problems of life insurers are also a definite target for regulators. So great is the pressure and so many are the proposals that life companies are totally consumed with restructuring for regulatory solvency to the detriment, some say, of passing on investment opportunities that could mean substantial earnings in years ahead. The management of profitability under these conditions runs a clear second to solvency issues. This could place life companies at a competitive disadvantage to banks and other financial services industries, where solvency issues have improved and profitability is again the first priority. The end result is still anybody's guess. What is certain is that new regulatory laws and proposals will proliferate. Here are a few that are already on the books or in motion:

### # Risked Based Capital

Guidelines for this new regulation will take effect in 1994 for life and health companies and 1995 for property/casualty insurers. **Risk Based Capital** is the "brainchild" of the National Association of Insurance Commissioners. Since its inception, the National Association of Insurance Commissioners has strived to create a "national regulatory system" by the passage of "**model acts**", or policies designed to standardize accounting and solvency methods from state to state. Risk Based Capital is one of many "model acts" recently adopted by the National Association of Insurance Commissioners. While the jury is still out on the effectiveness of Risk Based Capital, no one can argue that any attempt to establish a universal form of solvency regulation is attractive, and quite possibly mandatory in light of recent pressure by Congress and consumers. The National Association of Insurance Commissioners can be considered a logical conduit for national regulation, since its members are the insurance commissioners of each state and at present, the authority of states to regulate the insurance industry is allocated to the states under the 1945 McCarran-Ferguson Act.

The **Risk Based Capital Model Act** defines acceptable levels of risk that insurance companies may incur with regards to their assets, insurance products, investments and other business operations. Insurers will be required, at the request of each state insurance department, to annually report and fill out Risk Based Capital forms created by the National Association of Insurance Commissioners. Formulas, under Risk Based Capital, will test capitalization thresholds that insurers must maintain to avoid regulatory action; recalculate how reserves are used; reduce capitalization required for ownership of affiliated alien insurers and non insurance assets; and allow single state insurers to qualify for exemption from reinsurance capitalization if their reinsurance doesn't exceed five percent of total business written. The Risked Based Capital system will set minimum surplus capital amounts that companies must meet to support underwriting and other business activities. Because the standards will be different for each company, the guidelines run counter to existing state-by-state regulations that require one minimum capitalization requirement for all insurers regardless of their individual styles of business or levels of risk.

Insurers reporting Risk Based Capital levels of say less than 70 percent to 100 percent may be subject to strict regulatory control. Scores from 100 percent to 150 percent might be issued regulatory orders requiring specific action to cure deficiencies. Higher scores might receive regulatory warnings and corrective action stipulations. Attaining 250 percent or more, would relieve an insurer from any further Risk Based Capital requirements in a given year.

It is clear that Risked Based Capital encourages certain classes of investment over others. For example, an **asset-default test** under Risked Based Capital, called C-1, establishes varying reserve accounts be established for various classes of investments based on their default risk. These amounts could be as much as 30 percent for stocks and low quality bonds and 15 percent for real estate owned as a result of foreclosed mortgages. Industry critics say that the **C-1 surplus requirements** alone could be far greater than all other categories of Risked Based Capital like mortality risk assumptions, interest rate risks and other unexpected business risks. Since the 1994 Risked Based Capital reports will be based on 1993 financial conditions, many insurers have already started to restructure their portfolios to avoid as many C-1 assignments as possible. This has included the wide scale disposition of real estate and real estate mortgages, the repackaging of real estate products into securities and large reductions in "junk bond" holdings. Despite these efforts, C-1-rated classes of assets continue to represent a sizeable share of insurer portfolios. In many cases, companies have very few options to unload foreclosed real estate as long as the market continues soft. A Saloman Brothers Inc study of almost 500 insurance companies clarifies the problem. Using 1992 financial reports for these insurers, the median level of surplus capital was found to be at 189 percent of their respective risked based capital levels. Even though, a majority of companies exceeded the 150 percent threshold--thus, not requiring regulatory correction--the results indicate that hundreds of companies did not measure up. The concern by industry groups is that when risked based capital is enacted, the results could generate significant "bad press" which could weaken demand for individual company and industry products. There is also speculation that companies will change investment portfolios to achieve higher Risked Based Capital ratios. This may critically hamper real estate investing for a some time to come.

On the surface, Risk Based Capital seems to solve many regulatory concerns. Solvency rulings are standardized from state-to-state and specific action is mandated across the board. This would appear to be acceptable by insurance companies who could now predict regulatory response in any state. However, as we have seen, Risked Based Capital could also adversely affect financially sound companies simply because they own more real estate -- performing or not.

Risked based capital also scores low among insurers for another very important reason--Risk Based Capital Reports can be disclosed and misunderstood by the public, despite National Association of Insurance Commissioners' confidentiality promises. It is easy to realize that disclosure concerning a low scoring company could damage or cause a "run" on the insurer. The National Association of Insurance Commissioners feels it has



adequately provided for confidentiality within the Risk Based Capital Act. Specifically, the Model prohibits anyone in the insurance industry from using Risk Based Capital data and analysis in any public statement. There is even a provision recommending that state legislatures **exempt Risk Based Capital** information received from the National Association of Insurance Commissioners **from state "freedom of information" laws**. Insurers doubt that any such exemption from disclosure will suffice, since few states have adopted any exemption legislation, and there is history that pressure from public, political and judicial arenas ultimately lead to access by anyone for any reason.

In fact, there may be reason for insurance company concern about disclosure of Risk Based Capital data. Recently, there has been attempts to retrieve information similar to Risk Based Capital data by an insurance journalist/analyst using "freedom of information" statutes. Many states denied these requests for reports, called IRIS ratios (Insurance Regulatory Information System reports) since this data is considered confidential by state financial examiners. Yet, in some states, the same requests for information had mixed success via direct court action. In response, the National Association of Insurance Commissioners adopted a policy to withhold IRIS report information from states that could not assure confidentiality. Under court order, however, they later agreed to disclose the actual IRIS ratio themselves but not the analysis of their examiners that usually accompany IRIS reports. The court argued that even though the National Association of Insurance Commissioners is considered to be a private organization of government officials, rather than a government agency, IRIS ratios eventually became the exclusive property of state insurance departments and thus subject to public access under freedom of information. In another state, the courts rendered a different decision and granted an exemption under freedom statutes thus asserting the state regulator's right to withhold IRIS reports. They concluded that the privacy rights of the insurance company outweighed the merits of public disclosure.

Indeed, insurance companies have reason to remain uncomfortable about disclosure of confidential information like IRIS and Risk Based Capital reports. In fact, they might be uneasy to learn that efforts to win access to even more sensitive information, like minutes of insurance company board meetings, has been met with some success. Once information is demanded and then delivered to state regulators it becomes potentially fair game under freedom of information statutes. In a similar vein, there is concern that federal political pressure to subpoena confidential records of an insurer would allow even greater access since federal "freedom of information" statutes are typically more liberal than individual states. Safeguards proposed by the National Association of Insurance Commissioners and state regulators may help forestall public access, but it may be optimistic to think that a foolproof method to avoid disclosure is possible. Troubled insurers, may well brace themselves for the likelihood that data on their Risk Based Capital could make national news or influence their ratings.

Some, in the industry, also feel that the Risk Based Capital rules are simply too restrictive, subjecting many of the best known insurers to immediate regulatory action and/or "bad press". This, in turn might lead to a "run on the bank" that could tip these insurers into worse condition. The concern of these parties is that the risk based capital system doesn't falsely identify adequate capitalized insurance companies and undercapitalized ones as being adequately capitalized. Too much is concerned with the type of investment, rather than its quality. Just how companies react to these guidelines remain to be seen. As mentioned, many life and health insurers have already changed their investment strategies to more favorably align with Risk Based Capital guidelines by selling their large scale real estate investments and junk bonds.

## **# Solvency & Financial Enforcement Trust (Safe-T)**

In the search for a solvency "cure", it is possible that simple is better. Nothing could be simpler than a proposal called "**Solvency & Financial Enforcement Trust**" or SAFE-T for short. SAFE-T is considered a simple, straightforward solution because it eliminates the complex formulas proposed by many other plans, such as the National Association of Insurance Commissioners "Risk Based Capital" plan.

Developed years ago by State Farm for use by property/casualty companies, the SAFE-T method would require each insurer to fund a **custodial account** at an institution that is not related or affiliated with the insurer. The funding of this account would be accomplished using real, liquid assets. The amount of assets in the account would be sufficient to cover loss reserves and loss adjustment expenses. To facilitate claim payments from an insolvent insurer, the guaranty fund for a particular state has, in essence, a lien against the SAFE-T trust account. The value of assets in the custodial account would be verified annually by a Certified Public Accountant along with a certification of loss reserves. More recent amendments to the proposal allow the insurer to retain all ownership rights to the assets in the custodial account, as well as the rights to sell and trade them, so long as any securities meet qualifying standards under the act. Only cash, cash equivalents, publicly traded securities classified by the National Association of Insurance Commissioners as medium or high quality would be accepted. Also, an insurer could submit an approved letter of credit to meet assets requirements. The amount of this letter of credit, however, could not exceed 15 percent of the amount required to be on deposit in the SAFE-T account. Further, an insurer would be provided some leeway if the value of the assets in the account dropped during the year. So long as assets maintained 80 percent of the required value, the insurer would not be required to add more assets in the middle of the year. If, however, the value drops below 80 percent of the required amount, the insurer must immediately respond with additional asset deposits or risk a "cease and desist" order restricting the company from writing any new business. Custodians of the SAFE-T accounts would be responsible for reporting to the respective insurance commissioners the activity and value of the insurer's account. In the event an insolvency was eminent, the SAFE-T account would be available to make prompt claims or to reimburse the state guaranty fund.

The advantages of the Solvency & Financial Enforcement Trust are many. First, many of the standards, such as the use of Certified Public Accountants and certification of loss reserves, are already in place. This will enable easier set up and enforcement. Second, SAFE-T is based on the use of assets considered by many, including the National Association of Insurance Commissioners, to be the most valuable to an insurer's ability to meet its obligations to its policy holders. Third, the requirements of SAFE-T seem to align with the needs of state regulators looking for an improved "early warning" system that could be enforced without the need to apply complicated formulas and legal hoops. And, fourth, the number of insolvencies may be minimized, since liquid assets of the company will be "marshalled" by the custodian. In past cases, by the time an insurer faced insolvency, most of the liquid assets had already been sold, leaving less valuable and illiquid ones to the liquidator, state guaranty fund and policy owners.

## # **The Compact Approach**

Another approach to solvency regulation is to improve the existing state guaranty system. One proposal by the National Conference of Insurance Legislators seeks to provide a uniform set of standards for all state guaranty fund regulators. This would be accomplished by creating an **interstate "compact" or agreement** among all states to standardize the protection provided by guaranty funds, as well as procedures to rehabilitate and/or liquidate an insolvent insurer. The idea of a "compact" between states is nothing new. Article 10 of the Constitution provides for a mechanism for states to make agreements among themselves in order that fair treatment of the citizens be served. This has resulted in over 100 interstate compacts over the years on issues like taxes, vehicle laws and crime. There is no reason this wouldn't work to overhaul the current state guaranty systems which are riddled with loopholes, exclusions and diverse protection limits. It is common knowledge in the industry and among regulators that improvements to the system are needed, especially in the aftermath of public hearings presented to members of Congress in 1991 and 1992. Significant weaknesses in the guaranty fund system were discussed, and the fear among industry leaders and regulators alike is that a lack of action to respond with corrective action may result in efforts to replace the state guaranty system with a federal mandate.

State fund problems aired in the public hearings include guaranty limits, insurer and policyowner residency and

specific product exclusions. Guaranty fund limits vary widely between states. In Kansas, life and health benefits are covered up to \$100,000. The limits are \$500,000 in New York. Utah includes a \$500 deductible others do not. Michigan guarantees 1/20 of one percent of all property/casualty premiums while New York stands behind a whopping \$1 million. Some funds will only cover residents of their state, others will back anyone insured by a company that is domiciled in the state. Additional variations include service and product coverage. Some funds guarantee all annuities written by domiciled companies while others exclude variable type policies. Some cover HMOs and Blue Cross/Shield plans, while others do not.

The National Association of Insurance Commissioners developed "model acts" which it hoped most states would follow -- ***The Post-Assessment Property and Liability Insurance Guaranty Association Model Act (1969) and the Life and Health Insurance Guaranty Association Model Act (1970)***. The property/casualty model sets maximum limits at \$300,000 for any claim with unlimited coverage for workers' compensation. The life/health model includes maximum benefits of \$100,000 in cash values of life, annuity and health contracts and \$300,000 in death benefits. To date, not all states have followed these guidelines. On the property/casualty side, about 14 states meet or exceed the NAIC limits. The remaining follow some, but not all standards. In life/health, only 15 states limit guaranty funds in line with the Model Act.

The interstate "compact" proposed by the National Conference of Insurance Legislators could potentially smooth out the differences among states and bring about a set procedure for handling insurance company insolvencies. The proposal suggests this could be accomplished by creating a commission, called the ***Insurance Claimant Protection Commission***, to coordinate the activities of all state funds participating in the compact and act as the receiver of insurers placed in rehabilitation or liquidation. The commission would be comprised of the commissioner of each state. Each state would have one "member vote", as well as a designated number of "premium votes", based on the state's total premium volume. Any decision by the commission would require a majority of BOTH member and premium votes. Commission meetings would be public, unless a majority of members agreed that subjects discussed would reveal trade secrets or confidential information. Funding of the commission would be through assessments of insurance companies doing business in the compact states. Reports would be made annually to the governor and legislature of each state as well as the National Conference of Insurance Legislators. Regulations and statutes approved by the commission would be binding on all state funds in the compact. As an escape measure, each state's legislature could vote to reject a commission statute. If a majority of states follow suit, the specific regulation would have no force and effect on any compact participant.

Under the threat of federal intervention, it is likely that the interstate compact should attract major attention. Already, insurance departments of several states are amenable to working on a compact plan and the National Conference of Insurance Legislators is in process of contacting state legislators, policymakers and industry trade groups. The fact that the interstate compact was conceived by state legislators with technical assistance from one of the nation's top insurance law firms give it a greater chance of success than many other solvency proposals.

## **# Federal/State Co-Regulation**

On the heels of several large insolvencies, a flood of regulatory initiatives have emerged. Critics of the new proposals say there is no panacea for the problem of insolvencies. Even federal intervention will not bring an end to insolvencies, since they are inevitable in a free market. Then, too, the federal government does not have a stellar record in the area of efficiency and regulatory success. Others, however, believe that federal involvement in the regulation of insurance is necessary to industry stability and the centralization of authority. While there is cause to doubt this last proclamation, it is possible that some form of federal and state system of regulation will be attempted. The ***Federal Insurance Solvency Act of 1992*** is one such example. Under this proposed act, a solvency commission would be established to regulate all insurers. Insurance companies and reinsurers would receive the equivalent of a "solvency certificate" which would permit them to do business

anywhere in the United States. The bill also creates a protection or guaranty fund to cover any insolvency losses. As good as all this sounds, it would undoubtedly come with a hefty price tag and since it leaves rate regulation with each state, it establishes a system of "dual control". One can only imagine the regulatory hurdles and snafus that could surface under this proposal.

Some believe that a slightly different "two-tiered" system can work. Federally licensed companies could do business alongside state licensed insurers much like they do in the banking industry where some institutions are federally chartered while others operate solely under the jurisdiction of the state. Insurers, both large and small, could have the choice to be federal or state licensed and limits on guaranty funds could be standardized. Additionally, an insurer could and should be totally regulated by either the federal or state system, not partially regulated by both. The advantages of such a system key on uniformity for the insurer wishing to do business on a nationwide scale. Policy owners would also know that guaranty fund limits are the same from state to state. One would wonder, however, if such a system would favor federally licensed companies where policy owners might feel a federally backed guaranty fund is safer than a state fund. It is suggested, then, that for a successful federal-state system to exist, competition must be eliminated: This could be difficult, if not impossible to accomplish. That is why many industry regulators and players believe that a new, untried federal system is not practical. They argue that in place of scrapping state systems of regulation, a major restructuring of existing state guaranty funds and universal solvency rules would have greater value. Thus, proposals like Risk Based Capital, SAFE-T and the Interstate Compact must be seriously considered to "head off" federal intervention.

### **# Model Investment Laws**

The National Association of Insurance Commissioners has also made headlines for its proposal of Model Investment Laws. The purpose of these regulations would be to prevent insurance companies from concentrating too much cash in too few types of assets. Critics feel the National Association of Insurance Commissioners' guidelines rely too heavily on classifying by type of investment and risk and setting percentage maximums. This, they say, will leave regulators with little opportunity to use their own judgement.

### **# National Catastrophe Fund**

Although it may be years in the making, a National Catastrophe Fund is also being considered. During hearings before the Senate Commerce, Science and Transportation Committee, details indicate that this fund would reinsure existing companies to ease the impact of major disasters. A company with losses that exceeded 20 percent of its surplus would qualify for assistance. Because only regional and small companies are likely to collect from such a federal fund, the current thinking is that the amount of losses would not be large enough to seriously strain the fund.

### **# State Catastrophe Funds**

Regulators have and will be influential in convincing state legislatures to establish catastrophe funds. These funds may start out to be permanent solutions only to fizzle out within months or years after the disaster has struck--like the earthquake fund in California. Current efforts include Hawaii and Florida, where major hurricanes have hit in the 1990s. In Hawaii, the state hurricane fund is the exclusive provider of hurricane insurance. The program is financed through a variety of real estate fees, premium taxes and assessments. The system functions as a reinsurer to companies writing within the catastrophe zone. Florida's hurricane trust fund will reimburse insurers for 75 percent of their losses once claims surpass two times the amount of the company's annual premium. Financing of the program will be through surcharges on policies, a percentage of premiums written, emergency assessments and state guaranteed bonds.

## ## RATING CHANGES

For now, while interest rates and mother nature is lying low, insolvencies are down. Agents should, however, be prepared for the very minimum expectation -- the new regulatory environment coupled with diminished profits and the need for rating agencies to clamp down will affect ratings. The major **rating services expect downgrades to outpace upgrades** for many years to come. As case in point, during 1993, A.M. Best issued life companies 172 downgrades and only 56 upgrades. While this is not the same as widescale insolvencies, it is a deteriorating condition that could affect client confidence. Marketing products and services in the face of reduced ratings will test agent due diligence and company selection skills beyond any previous limits.

In a period following major company failures it is logical that the rating agencies will emerge with new, tighter criteria. They must also adapt to changing regulatory laws and formulas. Needless to say, major changes are going to occur. A preview of the intensity and breadth of change possible took place in July 1993 when A.M. Best shocked the insurance world by downgrading over half of the life companies who previously held A+ or A++ ratings to A. Before this, in late 1992, Best added six new letter ratings (A++, B++, C++, D, E and F). This increased the ratings of this firm from 9 to 15. It also brought to light the huge differentiation the company anticipates in company ratings. Further, it could be a indication that the company will no longer be timid in swiftly downgrading a company . . . perhaps to as low as D and F (liquidation). In a recent article, Best explains its rating modifications . . . "The purpose of these changes was to enhance the usefulness and clarity of our rating system . . . More important than the structural changes to Best's rating classification has been the continuing evolution of our analytical review. Specifically, qualitative considerations have become increasingly important in Best's rating system". Some feel that the Best downgrades are tied to size of company. One company's analysis showed that 77 percent of the 71 companies adjusted downward had assets less than \$600 million. Best contends that its rating framework is the same for all companies, regardless of size. They do admit, however, that there are advantages to size in certain lines of business. According to the company . . . "Administrative capabilities, technological advantages, lower unit costs and management depth can provide competitive strengths that contribute to market penetration and presence difficult to achieve in highly competitive businesses on a relatively small scale. Though such advantages may be reflected in rating assignments, smaller companies that remain highly focused and maintain sustainable and defensible strengths also fare favorably in Best's rating assignments".

Other rating services will also recognize the need to adapt their solvency formulas. In the past, some of these companies, namely Standard & Poors and Weiss, have based their analyses primarily on quantitative issues such as the insurer's claims-paying ability based on statistics generated from statutory filings with individual state insurance departments or the National Association of Insurance Commissioners. With new risks of regulatory violations, competition from new entrants, banks, thrifts, etc, and the delicate line insurers must walk between solvency and profit, it is likely these agencies will add fresh information to modify their approach. Few raters, with the exception of Moody's, have focused on the breadth of such issues. This is likely to change in the years ahead with the inevitable result being lower ratings.

# WHEN INSURANCE FAILS TO INSURE

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Insurance can fail to insure in many ways. The source can be an agent's negligence in providing coverage or it can involve deeper issues such as inadequate or defective protection, coverage disputes, or the clear inability to protect, e.g. insolvency of the insurer. In any instance, the result is bound to disappoint a client and cause potentially harmful exposure to personal assets as well as liability for the agent.

## • • WHAT GOES WRONG WITH INSURANCE

### • Coverage Shortfalls

Many Americans consider themselves dutiful to purchase and maintain insurance. Using rules of thumb they buy multiple policies with varying features and limits. Occasionally, these people find themselves in situations where a problem or liability arises from an unanticipated source, beyond the scope of these features and limits, resulting in ***an insurance shortfall***. Such is the case where a breadwinner dies prematurely or is permanently disabled in his prime, or consider a high wage earner who is the cause of a serious auto accident that disables a neurosurgeon for life. In the latter case it is obvious that his \$300,000 policy limit may not satisfy the surgeon's family and their attorney. When events like this occur the agent may find himself in the position of breaking the bad news or worse, explaining why he did not recommend better coverage.

Certain insurance shortfalls cannot be helped. After all, nothing in life is guaranteed to work out right everytime. Unfortunately, there are also instances where the coverage provided by an agent was significantly less than needed or, the coverage provided exceeded what was needed in one type of insurance at the expense of another. Where clients depend on an agent for multiple lines of insurance or simply because it's right to do so, agents need to consider these shortfalls to avoid possible exposure to negligence actions.

### • Coverage Disputes

In the midst of the litigation explosion, the stakes are high. Insurers are offering increasingly high policy limits, and insureds, who cannot secure coverage or who fail to be awarded coverage, risk losing a lifetime of assets. With this tension, conflicts between insureds and insurers and agents must gather additional consideration. To further confuse the issue, the courts are constantly "bending" statutes while public attitudes produce more and larger plaintiff verdicts, this despite the fact that the industry operates under fairly standard contracts. In essence, there has never been a time for greater disputes in coverage.

One form of coverage dispute results when the agent fails to secure the promised coverage (**Bell vs. O'Leary - 1984**). The courts have found that when an insurance broker agrees to obtain insurance for a client, with a view to earning a commission, the broker becomes the client's agent and owes a duty to the client to act with

reasonable care, skill and diligence. Agents have been sued for neglecting to secure the requested coverage, failure to notify the client that the insurance is not available, failure to forward premiums on policies which then lapsed, unintentionally omitting a specific type of coverage, providing unsuitable coverage, failure to properly bind the client and much more!

A more common form of dispute occurs when the insured and the insurance company simply do not agree on the interpretation of coverage provided. In practice, insurance coverage cases can be extremely complex. It is not unusual for these cases to involve numerous parties on both sides of the litigation. And, since policyholders usually buy insurance in many layers of coverage, i.e., life, health, casualty, excess, umbrella, from many different insurance companies over many years, the number of companies brought into one insurance coverage case can be quite large. Coverage cases are also being consolidated by the courts where numerous policy holders and insurance companies have been found to be litigating coverage for the same underlying claims or addressing the same coverage issues. In one instance, a group of independent environmental coverage actions were ordered to collectively resolve many common contract issues and cooperate in case management and discovery procedures simply because they were similar.

Where coverage disagreements persist beyond an initial settlement, policy holders or their attorneys must begin the tedious task of processing documents and information relating to the insurance companies' interpretations and meanings of their policies. This often leads to a **drafting history**. The drafting history contains detailed records of the insurance industry's deliberations regarding policies and seeks the original meaning of policy terms and the manner in which they were intended to apply. Courts have found such histories to be relevant and material, as well as filings made by insurance industry organizations on behalf of their members to state insurance departments and insurance regulatory agencies.

Policy holders and their attorneys also seek **underwriting and claims handling manuals** written by insurance company experts that are used to provide guidance to insurance company employees. These manuals may demonstrate how the insurance company interpreted their policies. In addition, they may contain the company's official position on coverage, claims and loss control. Many courts have ordered the production of such manuals and guidelines in the early stages of coverage cases.

Another valuable source used by attorneys is **reinsurance documents**. Communications between an insurance company and its reinsurer can provide information on whether and how policies may apply to underlying claims and may offer assessment of the insurance company's coverage obligations. Access to reinsurance documents is a hotly contested issue in insurance litigation discovery, and some courts have refused access to such documents.

Disputes also lead to discovery of **insurance company marketing policies** by documenting company advertising and agent/broker representations, as well as how the insurer has handled other policy holders with similar coverage claims. Also investigated is the possible cause and effect of the insurance company's involvement in other coverage litigation.

Insurance coverage disputes more than occasionally disintegrate into protracted and unnecessary litigation. Some areas of specific conflict include the following:

- **Trigger of Coverage:**

The term "trigger" is merely a label for the event or events that, under the terms of an insurance policy, determine whether a policy must respond to a claim in a given set of circumstances. While this definition seems clear, "trigger of coverage" disputes have been raging for decades and have been the source of much confusion.

In a life policy, the trigger seems clear: death. Disability and health policies, however, have a higher propensity for dispute: What is a permanent disability? Are there waivers and if so, how long? What is a major illness? Has the deductible been met? Are there additional policy exclusions? In long term care policies, trigger of coverage is even more acute where a written declaration by a physician may be required to solidify a patient's inability to care for himself: the prerequisite for insurance benefits.

Policy language in most commercial policies center around **three primary "trigger of coverage" issues**. First, the carrier agrees to provide coverage for "all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies, caused by an occurrence." Second, an "occurrence" is defined in the policies as "an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected or intended from the standpoint of the insured..." Third, "bodily injury" is defined as "bodily injury, sickness or disease sustained by any person which occurs during the policy period", and "property damage" is defined as "injury to property which occurs during the policy period..."

The "trigger" is plain under these three policy provisions when property damage or bodily injury "occurs" during the policy period. But, the trigger question becomes somewhat complicated when a long period of time has elapsed between the act giving rise to liability. Examples include a leak or spill involving hazardous waste or exposure to asbestos which may result in problems years later.

Most of the litigation concerning coverage for latent injuries have raised at least four different explanations of when damage "occurs" and thus "triggers" coverage. 1) The date of exposure to the toxic substance (**the "exposure" theory**); 2) the years in which the claimant incurred tangible injury (**"injury in fact" theory**); 3) the date of manifestation of injury (**the "manifestation" theory**) and 4) all year in which damage "occurs" or "could have occurred (**the "continuous trigger" theory**). The "continuous trigger" theory has received considerable attention during the past twenty years surrounding property damage or bodily injury due to hazardous waste/environmental contamination. In essence, the courts have generally ruled that commercial insurance policies are "triggered continuously" from the initial exposure to the contamination to the manifestation of any injury, disease or damage of property. By far, most policy holders adopt a "continuous trigger" approach to litigation. Insurance companies continue to argue, sometimes to no avail, that insurance policies cover an "occurrence" and NOT A "REOCCURRENCE".

- **Definitions:** The following are terms that often become the focus of coverage disputes:

**Bodily Injury** - bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time.

**Property Damage** - physical injury to or destruction of tangible property which occurs during the policy period. Loss of use of tangible property which has not been physically injured or destroyed, provided such loss of use is caused by an occurrence during the policy period.

**Occurrence** - an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.

- **Conditions:**

In addition to standard provisions and definitions, coverage is further defined in a "conditions" section where the duties and legal requirements of the insured and insurer are established. Typical conditions are the insurer's right to inspect, and the insured's duty to cooperate with the insurer and the notice provision.



The notice provision is the most frequently litigated condition. A sample notice provision might include the following language: "In the event of an occurrence, written notice containing particulars sufficient to identify the insured, the time, the place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the insured to the company".

Some courts have relieved the insured of its notice of obligation unless the insured was in some way prejudiced or harmed by the insured's delay in providing notice. The insurance company usually has the burden to prove that it was harmed by the insured's failure to comply with the notice requirement.

- **Exclusions:**

There are many standard policy exclusions as well as those relating to high risk issues such as partial disability, pollution, nuclear attack, "owned property", aircraft and liquor liability. The purpose of these types of exclusions is to limit the policy coverage to contemplated risks only. The burden of proving that an exclusion applies generally falls on the insurer in coverage disputes.

- **Named Insured:**

The definition of a "named insured" varies from policy to policy. Some define it in broad terms, while others insist on a more narrow description. Often, standard policy formats will provide a "listing" which has resulted in legal conflicts where coverage was denied a party on the listing who is no longer associated with the primary insured. The burden to prove continued association is with the insured.

- **Assignments:**

Conditions of most standard policies prohibit assignments without written consent of the insurer. Such provisions are enforceable because they ensure that the risk the insurance company agreed to insure remains the same. In fact, the majority of courts have refused to hold an insurer liable for an occurrence derived from a risk not contemplated by the insurer at the time the policy was issued. It is important to note, however, that prohibiting assignments does not bar the assignment of insurance proceeds.

- **Rules of Construction:**

The rules governing the construction of insurance contracts are usually the same as those for other contracts -- the policy language is to be interpreted given its plain and ordinary meaning. If a court determines that an ambiguity exists in an insurance policy, it will look to any outside factors or evidence that may help determine the parties' intentions. Where an ambiguity is not capable of resolution, most courts have construed the ambiguity in favor of the insured. Other courts have applied a "reasonable expectations" test and construed ambiguous policy language based on what a reasonable person in the position of the insured would understand the language to mean.

- **Duty to Defend:**

The prevalent view by the courts is that an insurer has the duty to defend an insured where the policy language gives the insured a reasonable expectation that the insurer will provide a defense. Standard policies employ language reading: "the company shall have the right and duty to defend any suit against the insured seeking damages on the account of bodily injury or property damage even if the allegations of the suit are groundless, false, or fraudulent". Insurers maintain the position that they may be contractually bound to defend, but may NOT be bound to pay, either because its insured is not factually or legally liable or because the occurrence is later proven to be outside the policy's coverage.

Coverage disputes are likely to develop and do, when an insurance company attempts to shield itself from any defense of an insured whatsoever, or when it withdraws from an action after it determines there is no basis for recovery. Other conflicts center around whether an insurer must defend only against an action that is a actual

lawsuit seeking damages or be required to defend against all claims which may result in liability. In general, courts assume a connection between the filing of a complaint and the triggering of a duty to defend by an insurer. A **PRP letter (Potentially Responsible Party)**, although not an actual claim, has also been interpreted by the courts to be a serious event that could, in fact, represent a new legal action against the insured. The duty to defend is typically established here, but not in the case of a simple **demand letter** which only exposes one to a potential threat of future litigation.

If there is **any doubt as to whether the facts give rise to a duty to defend, it is usually resolved in favor of the insured, but it is the insured's burden to show that the claims come within the coverage.** Claims related to acts of an insured in the area of crime, sexual misconduct, wrongful termination, contractual obligation, loss of profits or goodwill etc, have been ruled unacceptable ways to force an insurer's duty to defend.

- **Breach of Contract / Refusal of Coverage:** Breach of contract claims typically allege that an insurance company failed to defend or indemnify the policy holder under terms of the insurance contract. To a great extent, public policy supports the policy holder in most breach of contract allegations in an effort to solidify the "strict enforcement of insurance contracts". This is why state insurance regulators will typically be involved or called upon to rule on an insurer's potential or actual violation of codes.

Many times, an insured is denied protection because the insurer knows facts which would defeat coverage. A majority of different courts have ruled that under such conditions, an insurance company is not bound to "defend" such claims simply because it cannot be bound to indemnify -- in essence, the duty to defend can be disputed. Here, the insurer has the burden to prove that the facts of the insured's claim fall squarely within a policy exclusion.

- **Bad Faith:**

There is increasing judicial recognition that the relationship between an insurer and its policy holder is fiduciary in nature. Courts have compared the relationship of an insurance company to its policy holder to that of a "trustee for the benefit of its insured". Where an insurance company allegedly has violated its fiduciary duties owed its policy holders a bad faith claim could be appropriate in addition to any breach of contract action.

- **Choice of Law / Venue:**

Choice of law and venue, where to bring a suit, have become integrally tied together in coverage cases. There is general agreement that insurance coverage issues are **state law questions** even though most insurance policies do not contain any choice of law provisions. Courts, however, have also made venue decisions based on issues such as 1) the place where policies were contracted; 2) the location of the damage and/or 3) the principal place of business/residence of the policy holder.

- **Lost Policies:**

Some claims between insureds and insurance companies have developed over the inability of the policy holder to prove coverage by producing an executed insurance policy. If a policy has been lost or destroyed, the policy holder must satisfy two requirements to prove coverage. First, the policy holder must prove that the policy was, in fact, lost or otherwise unavailable by showing that he made a diligent search for the policy in all places where it can likely be found. Second, the policy holder must prove the existence and the contents of the policy by identifying the parties to the contract, the policy period and the subject matter of the policy. Secondary evidence includes any correspondence, certificates of insurance, claim files, management reports, corporate records, ledger entries, receipts, licenses and agent files and agent testimony.

Coverage disputes also evolve around the nature of damages or hidden exposures such as:

- **Environmental Litigation:**

There are numerous actions pending in state and federal court concerning the interpretation of commercial liability policies and environmental claims. Much of the confusion was started by the insurance companies themselves when they first marketed the 1966 standard form **Comprehensive General Liability (CGL)** policy which represented coverage for environmental hazards. Some companies went so far as to refer to environmental problems, in their sales literature and presentations, as a "hidden exposure" that policy holders should consider. Agents were instructed to sell the new policy on the basis of its broadened coverage in the area of pollution which was then only a growing, but minor exposure.

Since the 1960s, the Environmental Protection Agency (EPA) has contended with almost 300 million tons of hazardous industrial chemical waste leading to passage of the Superfund legislation which has obtained almost \$4 billion in settlements from waste generators, disposers and transporters of hazardous materials. Similar pending litigation involves other forms of mass tort liability, including asbestos, DES and other substances. The generators, disposers and transporters of hazardous waste and product manufacturers, installers and sellers faced with mass tort claims all turned to their insurance companies for coverage, and insurance coverage litigation often followed.

In response to a flood of litigation, the insurance industry began making adjustments. In 1973, certain terms in the CGL policy were revised. For example, the 1973 CGL policy defines "occurrence" as "an accident, including continuous and repeated exposure to conditions, which results in bodily injury or property damage neither expected or intended from the standpoint of the insured." Obviously, an occurrence under the 1973 definition required exposure to conditions over a period of time. "Property damage" was also changed to read "physical injury to or destruction of tangible property which occurs during the policy period . . . or, the loss of use of tangible property which has not been physically injured or destroyed, provided such loss of use is caused by an occurrence during the policy period." Thus, compared to the pre-1973 contracts, "property damage" now requires **physical injury** to tangible property. This distinction may be critical in certain hazardous waste cases and in asbestos property damage cases. In fact, courts have held that some insurers are not required to provide a defense in suits where there was no covered "occurrence" or "property damage" as defined in the CGL.

In the late 1970s and early 1980s, a number of carriers made even more dramatic moves by changing the "pollution exclusion" clause in their policies from the "sudden and accidental" variety to what is called the "absolute pollution exclusion". Although there are several versions of this exclusion, the basic thrust of each is to exclude coverage if the emission or discharge was accidental or sudden. Since most hazardous waste problems are sudden and accidental, the absolute exclusion appears to exclude most pollution incidents. A growing number of courts are siding with insurers where the absolute exclusion is in place. In these cases, most environmental exposure falls back to the insured and his own ability to cure the problem. The results can be devastating to a company, its owners and their respective estates.

- **Excess Insurance Claims:**

With the increase in mass tort litigation, environmental litigation and substantial jury awards, excess insurance policies and the role of excess insurance carriers have received increased scrutiny. In general, the fact that a primary carrier owes duty to its insured is well known. With respect to an excess insurer, the courts continue to struggle with the origin of duty.

In coverage disputes where the insured is bringing action against BOTH a primary and excess insurer, the excess carrier sometimes moves to dismiss the lawsuit on the basis that the actual exhaustion of the underlying primary liability limits is a prerequisite to a claim under the excess policy. Policy holders, on the other hand, argue that the mere potential that the underlying insurance will be exhausted is enough to justify a coverage dispute against the excess carrier. The courts have sided with each.

Another area of dispute is the **drop down** -- where an excess insurer "drops down" to provide insurance when the primary insurer has become insolvent. Courts are split on this issue, although a majority currently feel that an excess insurer is NOT OBLIGATED to drop down and provide coverage to an insured. The court's determination is usually based upon the language of both the primary and excess insurance policies.

In yet another decision, the courts have determined that the "trigger" of excess coverage is the amount "indemnified", not the additional costs involved in defense nor punitive damages. In **Harnischfeger v. Harbor**, for example, the fact that the insured paid \$3 million in defense and indemnity expenses could not yet trigger the \$3 million excess policy limits because the legal expenses incurred were not a factor.

- **Business Insurance Disputes:**

In recent years, the number and variety of claims brought against business has increase significantly. In spite of this fact, many businesses have not given adequate consideration to the potential insurance coverage for these claims. As an example, businesses which face claims only against their directors and officers, might tend to ignore the possibility of comprehensive general liability (CGL) insurance coverage. Likewise, when companies face claims of unfair business practices or statutory violations, they consider the bodily injury and property damage portions of their CGL policies only, failing to consider the advertsing injury and personal injury provisions, which may provide broader coverage.

In one advertising coverage dispute, the court held that the insured was NOT covered by its CGL policy because the insured failed to establish that its advertising activity **caused** the alleged injuries. The insured was selling a product that "infringed" on a competitor suggesting that the relationship of selling and advertsing were the same thing. Another court's rejection of coverage involved copyright infringement. Here, an insured distributed brochures that merely advertised copyrighted material for sale.

**Directors and officers liability** coverage typically insures the directors and officers directly and provides that the insurer will pay on behalf of or reimburse the directors and officers for "loss" arising from claims alleging "wrongful acts". Coverage is NOT afforded under this insuring agreement if the corporation is required or permitted to indemnify the directors and officers. Coverage has also been denied for claims involving dishonest conduct, claims in connection with the Employee Retirement Income Security Act (ERISA), claims involving bodily injury, personal injury and property damage as well as claims involving seepage, pollution and hazardous waste.

In a "**wrongful entry**" claim, the courts first rejected the insured's coverage under his CGL because the insured trespassed AND committed battery against a tenant. The courts ruled that actual damages resulted from the battery only. Later, on appeal, the court reversed its decision since it was determined that the battery could not have taken place if the insured had not trespassed. The trespass made the battery possible.

Other, **business insurance coverage exclusions** occur under the following conditions:

Liability under contract, willful violation of a penal statute, offenses relating to employment, libel and slander made prior to effective date of insurance or with knowledge that it is false.

- **Defenses of the Insurer**

Much attention is devoted to the "rights" of policy holders. Insurance companies, however, have their own safeguards, which help protect their interests, but add to to the growing list of things that can go wrong with insurance. Depending on the issue at hand, the result of having these "built-in" protections can completely void a policy or greatly limit its scope of coverage. Defenses consist of legal tools and techniques that help an insurer

initially determine pertinent aspects of the insurance risk for purposes of deciding whether to issue the policy and at what premium. After a policy is committed, additional policy conditions help the insurer "contain" the risk within the intended bounds of the contract. Over the years, a series of standard defense devices have evolved. These can be categorized as concealment, representations of the insured, conditions, warranties and limitations to coverage.

- **Concealment:**

The insured has the duty to disclose to the insurer all material facts that might influence a decision to issue a policy of insurance at all, or issue it at a particular level of premium. The holding back of information can, in some cases, constitute fraud by the insured and can render a policy **void**. In general, the rule on determining when a policy is voided lies in the issue of "bad faith". If the insured withholds information that he knows would be necessary to the insurer in evaluating risk, the insurer has grounds to void the contract. Examples might include an life insurance policy where an insured has agreed to an examination by the insurer's physician but still fails to still to disclose a medical condition that is critical to the insurer's risk decision.

The burden of proof as to fraud in concealment falls on the insurance company. In some cases, courts have sided with the insurer in establishing fraud by "inference". An example might be discovered evidence that the insured had made a previous attempt to destroy the covered building. On occasion, the insured has won based on the argument that facts uncovered by the insurer were not material because it was NOT made a subject by the questions asked on the application even though most applications include a provision requiring the insured to represent that he or she has disclosed all material information. Again, the issue of bad faith enters the picture. Only when the insured conceals a fact in bad faith, **knowing the fact to be material**, will the policy be voidable. An example is a life insurance application which contains a question as to how many times the insured has been hospitalized and for what causes. If the insurer describes one hospitalization but fails to mention a second, the incomplete answer is considered **material** and grounds for avoidance of the policy. However, if the insured had left the answer blank or merely given a date without specifying the cause, the incompleteness would be obvious and NOT grounds for avoidance. The test is whether or not the reasonable insurer would be misled.

Once a contract of insurance becomes binding, the insured ceases to be obligated to disclose any material information. In the case of life insurance, for example, where there is an appreciable period of time between the submission of the completed application and the issuance of the policy, the duty of the insured to disclose new or forgotten material information continues. The duty to disclose applies only to **facts, and not to mere fears or concerns** of the insured about his health or the subject matter of the policy. There is also no requirement that the insured disclose facts that the insurance company already knows, or which the insurer has waived. Nor, is the insured required to communicate events that are a matter of public record such as earthquakes, forest fires, etc.

- **Misrepresentations:**

A representation by the insured that is **untrue or misleading, material** to the risk, and is **relied** upon by the insurer in issuing the policy at a specific premium is considered a misrepresentation and grounds for avoidance of the policy, unless the policy is beyond the incontestable period. This is true even if the misrepresentation was made by the insured innocently, with no intent to defraud. A minority of courts, however, take a somewhat less severe position limiting or prohibiting avoidance where the insured's misrepresentation was NOT an intent to deceive the insurer.

Representations by an insured to an agent bind a contract because they are considered to be made to the insurer itself. However, a policy refusal or avoidance could occur when the insured has reason to believe that the agent will not pass information on to the insurance company.

The insurer cannot void a policy based on a representation by an insured regarding an intention or future conduct unless it is made a condition of the contract. An example here would be an oral statement by an insured that he will install a fire alarm at the premises. The insurer relies on this representation and reduces the premium but does not include an express term in the contract regarding the alarm. On the other hand, a written commitment by an insured to install an alarm that is not followed can jeopardize the policy.

Many insurance conflicts center around materiality. A representation is considered material if it served to induce an insurer to enter into a contract that would otherwise be refused or issued at a different premium. The point where representations by an insured cause coverage problems is where such representations are made with the intent to deceive and defraud. The burden of proving a representation **to be material** falls on the insurance company. If a material representation is found to be substantially correct, or believed to be correct by the insured, the courts have not permitted a voidance or limitation of coverage. An example might be an insured indicating he has not seen a physician within the past five years when he has been to a doctor for treatment of minor and passing ailments.

- **Warranties & Conditions:**

The terms warranty and condition are generally used to mean the same thing -- a representation or promise by the insured incorporated into the contract. A warranty or condition statement that is untrue and relied upon by the insurer at the inception of the policy can void the contract. A possible exception to this rule occurs in life insurance where an "incontestable clause" prohibits the insurer from voiding a policy after the insured has survived a given period of time -- usually two years. Thus, a valid warranty/condition is a powerful tool for insurers.

In recent years, the effectiveness of warranties and conditions have come under fire. In fact, many statutes now place stiff definitions and limitations on warranties. One statute, for example, provides that all statements made by the insured will be considered to be a "representation" rather than a warranty unless fraudulently made. As previously discussed, it is much harder to void a policy for misrepresentation than for a violation of a warranty or condition. Another statute requires that the breach of warranty is a defense for the insurer ONLY if it actually contributed to causing the loss, as opposed to simply increasing the risk. This is the most severe type of statute for the insurer, since even in cases in which the breach caused the loss, it is frequently impossible to prove the cause, e.g., a fire completely destroys a portion of a building.

- **Limitations on Coverage:**

Insurers over the years have attempted to control their exposure by tightening terms of the insurance contract. Adding personalized warranties and conditions is cumbersome and not always useful as a defense for insurers (see warranties and conditions above). Some courts, however, believe that insurers have side-stepped warranties and conditions by creating numerous clauses that served, instead, to limit coverage. The reason insurers have done this is because many of the statutes which commonly limit warranty defenses, such as incontestability, "contribute to loss" statutes and "increase the risk" statutes, do not apply to limitations to coverage.

There are several types of limitations that insurance companies can and do employ:

**Limitations of Policy Subject Matter** -- A homeowner's policy may cover most household possessions in general, but specifically exclude from coverage particular items like cash or coin collections.

**Limitations by Type of Peril** -- A fire policy may except from coverage any loss caused by a fire resulting from lightning or earthquake.

**Limitations on Proceeds Paid** -- Fire insurance policies frequently specify an upper limit of proceeds payable

for any loss, as well as limiting the payment to the value of the insured's interest in the property damaged. Automobile policies generally fix the upper limit of coverage both in terms of maximum proceeds per person and maximum proceeds per accident.

**Limitations on Period Covered** -- Every policy will be specific as to the date of expiration, and in some cases, as with life insurance, will also specify a grace period beyond the date of expiration that insureds may make a premium payment. Also, the date of inception of a policy can be specified on the policy or can be subject to the occurrence of some event such as the payment of the first premium or delivery of the policy to the insured.

A limitation on coverage can cause considerable conflict between insurer and insured. One reason is the fact that in some instances, it is nearly impossible to determine from the wording of a clause whether it is a warranty or limitation. In response, the courts have developed two tests to distinguish the two.

In one test, if the circumstance which is the subject of the clause is **discoverable** by the insurer at the time of inception of the policy, the clause will be classified as a warranty rather than a limitation. An example might be a policy condition that obligates the insurer when the policy is delivered to the insured "in good health" when, in fact, the insured is suffering from a discoverable disease.

Another test deals with risk. If a clause refers to a fact which potentially affects risk, but necessarily causes the loss, it is considered to be a warranty not a limitation. An example is a life insurance policy with a provision that excludes a death benefit WHILE the insured is flying in a private plane. The insured can bring action to force payment of such a claim, EVEN if the insured died of a heart attack while in a private plane. The flying merely increased the risk, but need not be the actual cause of death. Such a clause is considered a warranty. On the other hand, if flying in the plane was the cause of death, it could be interpreted to be a limitation that is better defended by the insurance company.

- **Settlement Disputes**

Some forms of insurance, like life insurance, are generally settled with ease since the amount paid in the event of loss is fixed by the contract. Similarly, in the case of accident insurance, the proceeds are measured by a specific amount agreed to be paid for loss of a particular limb or faculty, or, as in the case of health insurance, by the medical expenses actually incurred. By far, most settlement disputes occur over property/casualty policies where the payment in the event of loss is determined by an amount up to the "actual cash value" of the property at the time of loss. There are two basic approaches which insurance companies use in an attempt to arrive at a mutually agreeable value -- **reproduction costs less depreciation and market value**.

- **Reproduction Cost Less Depreciation:**

This measure is aimed at determining the cost of replacing the exact depreciated property that was lost. If this were the only option for insureds, it would represent an extreme hardship where, for example, the owner of a fifty-year old home that is destroyed would have great difficulty replacing it with a new building on the depreciated settlement. For this reason, **replacement cost insurance** is offered. Here, depending on the wording of the contract, the insured may be required to actually repair or replace the building in order to collect full payment. The most pressing problem for insureds is to keep policy limits above the 80% of market value requirement. Insurance companies require policy limits above this level to assure adequate coverage and keep premium levels high. Insureds may lose, however, if inflation and rising house prices cause the limit of coverage to wind up below the 80% figure at the time of loss, thereby nullifying the replacement cost provision.

- **Market Value:**

Items of commerce that are readily replaceable in kind, e.g., a warehouse full of books, shipments of grain, etc., have a market value that is relatively easy to establish. In the case of income producing property such as office buildings, apartments or commercial buildings, market value is determined by a more detailed method using the capitalization of earnings. Disputes in this area usually require testimony of an expert witness who determines the rate of return on investment that a reasonable investor would require in investing in this type of property.



# THE RATING SERVICES

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The activities of insurance company rating agencies have become increasingly prominent with the industry's recent financial difficulties and the well-publicized failures of several large life insurers. The ratings issued by these agencies represent their opinions of the insurers' financial conditions and their ability to meet their obligations to policy holders. Rating downgrades are watched closely and can significantly affect an insurer's ability to attract and retain business. Even the rumor of a downgrade may precipitate a "run on the bank", as in the case of Mutual Benefit, and seriously exacerbate an insurer's financial problems. There is little doubt that rating organizations play a significant role in the insurance marketplace.

Some have expressed concerns about the potential adverse effect of ratings on particular insurers and consumer confidence in the insurance industry in general. Once the province of only one organization, A.M. Best, a number of new raters emerged during the 1980s. Questions have been raised about the motivations and methods of the raters in light of the recent sensitivity regarding insurers' financial conditions and what some perceive to be a rash of arbitrary downgrades. On the one hand, insurer ratings historically have been criticized for being inflated or overly positive. On the other side, there are concerns that raters, in an effort to regain credibility, have lowered their ratings arbitrarily in reaction to recent declines in the junk bond and real estate markets and the resulting insurer failures and diminished consumer confidence.

Of particular concern to some regulators and the industry are the practices of Weiss Research and Standard & Poor's (S&P) publications of qualified solvency ratings. Both the Weiss "safety" ratings and the S&P "qualified solvency" ratings are based on a strictly quantitative analysis of financial data. While there has been a concern about inflated ratings historically, Weiss has been criticized for marketing bad news to consumers, i.e. ratings that are skewed to the negative. S&P's qualified solvency ratings also have been criticized for utilizing a scale that appears to be lower than their claims paying ability ratings. Some have accused S&P of using the qualified solvency ratings to "extort" insurers to pay a \$22,000 - \$28,000 fee to obtain a higher claims paying ability rating. S&P strongly denies these allegations and believes that consumers and agents properly understand the meaning of the qualified solvency ratings. Both S&P and Weiss contend that their quantitative ratings provide valuable, unbiased information to consumers.

The influence of the rating agencies and the practices of Weiss and S&P have prompted some regulators and insurers to suggest that the states and others should limit access to their database, which is utilized by these raters. There also have been calls for regulators and the NAIC to evaluate and certify rating agencies to ensure that their methods and practices meet certain established standards. However, other regulators have questioned whether it is appropriate and practical for regulators to withhold data or regulate rating agencies. These regulators suggest that a more appropriate regulatory role is to improve consumers' understanding of the rating process and allow them to decide how to use the information raters provide.

This discussion of the rating agencies presents certain factual information relating to the structure and activities of the five most prominent rating agencies -- A.M. Best, Standard & Poor's, Moody's, Duff and Phelps and Weiss Research. A summary of their rating classifications is shown on the next page. The philosophy, scope, fees, resources, process, methodology and classification scheme of each of these agencies is described below.

While issues relating to certain practices of the raters is discussed, this is not an attempt to evaluate the

validity of the raters' methods or practices. Also, there is no information provided on other insurer rating agencies which has not received as much attention as the five agencies listed above, such as Demotech, Fitch Investors Service and Thompson Bankwatch, Conning & Company, Thompson & Schupp and/or other organizations that provide financial analysis of insurers but not ratings per se, such as Ward Financial Group.

### **INSURANCE COMPANY RATING CLASSIFICATIONS**

<b>RATING</b>	<b>AM BEST</b>	<b>S&amp;P</b>	<b>MOODY</b>	<b>WEISS</b>	<b>DUFF &amp; PHELPS</b>
<b>Superior</b>	<b>A+ +</b>	<b>AAA</b>	<b>Aaa</b>	<b>A+</b>	<b>AAA</b>
<b>Excellent</b>	<b>A</b>	<b>AA+</b>	<b>Aa1</b>	<b>A</b>	<b>AA+</b>
	<b>A-</b>	<b>AA</b>	<b>Aa2</b>	<b>A-</b>	<b>AA</b>
		<b>AA-</b>	<b>Aa3</b>	<b>B+</b>	<b>AA-</b>
<b>Very Good</b>	<b>B+ +</b>	<b>A+</b>	<b>A1</b>	<b>B</b>	<b>A+</b>
	<b>B</b>	<b>A</b>	<b>A2</b>	<b>B-</b>	<b>A</b>
		<b>A-</b>	<b>A3</b>	<b>C+</b>	<b>A-</b>
<b>Good</b>	<b>B</b>	<b>BBB+</b>	<b>Baa1</b>	<b>C</b>	<b>BBB+</b>
	<b>B-</b>	<b>BBB</b>	<b>Baa2</b>	<b>C-</b>	<b>BBB</b>
		<b>BBB-</b>	<b>Baa3</b>	<b>D+</b>	<b>BBB-</b>
<b>Fair</b>	<b>C+ +</b>	<b>BB+</b>	<b>Ba1</b>	<b>D</b>	<b>BB+</b>
	<b>C+</b>	<b>BB</b>	<b>Ba2</b>	<b>D-</b>	<b>BB</b>
		<b>BB-</b>	<b>Ba3</b>	<b>E+</b>	<b>BB-</b>
<b>Marginal</b>	<b>C</b>	<b>B+</b>	<b>B1</b>	<b>E</b>	<b>B+</b>
	<b>C-</b>	<b>B</b>	<b>B2</b>	<b>E-</b>	<b>B</b>
		<b>B-</b>	<b>B3</b>		<b>B-</b>
<b>Below</b>	<b>D</b>	<b>CCC</b>	<b>Caa</b>	<b>F</b>	<b>CCC+</b>
<b>Standards</b>	<b>E</b>	<b>CC</b>	<b>Ca</b>		<b>CCC</b>
	<b>F</b>	<b>C,D</b>	<b>C</b>		<b>CCC-</b>

\* Under state supervision

\*\* In liquidation

## ## A.M. BEST COMPANY

The A.M. Best Company has been rating insurance companies since 1906 and its long association with the industry is important to understanding its philosophy and approach. Its **stated mission** is "to perform a constructive and objective role in the insurance industry towards the **prevention of insurer insolvencies**". Best views its ratings as an inducement for insurers to operate in a prudent manner and maintain strong financial health. It actively consults with and advises companies on the basis for their rating and what actions a company must take to maintain its rating or improve it.

The **objective** of Best's rating system is to evaluate the factors affecting the overall performance of an insurance company and to provide its opinion as to the company's relative financial strength and ability to meet its contractual obligations. Best conducts an extensive quantitative and qualitative evaluation of rated insurers based on various sources of information and knowledge of the company accumulated over a long period of time. This knowledge is acquired through frequent contacts with company officials as well as statutory financial statements, special questionnaires and a variety of other sources. Typically, there will be meetings once a year with company management at Best's headquarters in Oldwick, New Jersey. There may be more meetings, if necessary, but Best attempts to meet at least once with a company over a two-year period, in addition to telephone contacts and correspondence.

If adverse developments occur that may affect a company's financial condition, Best will discuss the situation with management. If the company can present an effective plan to resolve the problem, Best may not immediately downgrade the company. The company's situation would continue to be monitored to ensure that the corrective action was implemented.

To **obtain an alphabetical Best's rating**, an insurer must have been in existence for at least five consecutive years of representative operating experience, have net premiums in excess of \$1.5 million for a life/health insurer, \$1.5 million in surplus for a property/casualty insurer, submit the requested financial information and pay a \$500 fee. In the 1991 edition of **Best Insurance Reports**, 811 life/health insurers and 1,513 property/casualty insurers received an alphabetical rating. An additional 530 life/health insurers and 970 property/casualty insurers received rating "not assigned" (NA) classifications which explains why they did not meet Best's eligibility requirements. Of these non-rated companies, 291 life/health insurers and 597 property/casualty insurers received a Financial Performance Index (FPI) assignment, introduced in 1990. Insurers are required to have at least three consecutive years of representative operating experience to obtain an FPI rating. The \$500 fee does not apply to companies receiving a "not assigned" rating classification or an FPI assignment.

Insurers can **elect to not have their rating published**. If that happens, a company receives an NA-9 "Company Request" designation. In this instance, Best normally requires a minimum of two years to elapse before the company is again eligible for the assignment of a rating.

Best's 1991 alphabetical rating consisted of nine categories, ranging from A+ (Superior) to C- (Fair). On January 13, 1992, A.M. Best announced that it will expand its alphabetical categories to fifteen effective with its assignment of 1992 Best's ratings. The 1992 alphabetical ratings will range from A++ (Superior) to F (In Liquidation). The stated purpose of this expansion is to add finer distinctions among rated companies. In addition, Best announced that it will eliminate its "Contingent Rating" modifier and the rating categories of NA-7 (Below Minimum Standards) and NA-10 (Under State Supervision). Also, a new category NA-11 (Rating Suspended) will be added. Best's classification system is described in greater detail later in this section.

A.M. Best employs 360 full-time employees, of which 210 directly support its rating activity in addition to 125 temporary employees hired each spring to assist in processing insurer filings and data compilation. Of the 210 full-time staff, more than 100 are analysts and supervisory personnel directly involved in analyzing and rating companies. Best's analysts typically possess significant experience with respect to financial analysis of insurance companies, acquired at Best as well as in the industry. The productivity of Best's analysts also is enhanced by sophisticated computer-based analytical tools and a large amount of information accumulated on each company. In addition, A.M. Best has ongoing consulting and educational arrangements with a professional reinsurer, an accounting firm and an actuarial firm to keep its analysis informed of current developments and industry issues.

A more detailed description of Best's rating process, methodology, rating classifications and distribution follows.

## # Rating Process

Best's annual rating process begins with the receipt of insurers' annual statements and other questionnaires between March 1 and April 15. The statements are checked and discretionary items and write-in items are adjusted and standardized to put insurers on a comparable basis. Data is loaded to the mainframe computer after statement errors are reconciled with the insurer. The data is then compiled and prepared to reflect groups, pools or other organizational structures to perform appropriate unit or group rating analysis.

Once the data is compiled and prepared, a series of worksheets are generated which begin the analysis process. Utilizing the worksheets, an analyst reviews various financial ratios and assigns points based on a company's results relative to industry, peer group and Best's financial norms as compiled through an algorithm. The rating worksheets are reviewed to identify an insurer's adequacy and reinsurance protection. Ultimately, a score is produced which serves as a starting point leading into extensive qualitative analysis to fully understand and assess the company's true financial condition.

The qualitative analysis involves review of the rating worksheets, supporting documentation and various other information sources. Supporting documentation includes supplemental and background questionnaire, company reports, examination reports, SEC filings, reinsurer audits, and actuarial reports. Other information sources include management meeting notes, business plans, previous year and quarterly rating remarks, the current first quarter results and statement interrogatories.

After evaluating the quantitative and qualitative information, the primary analyst assigned to the company submits a rating recommendation to a manager for review and discussion. The manager either accepts the analyst's recommendation as submitted or modifies it before sending it on to an executive rating committee for final approval. The company is notified of its rating and has the option of discussing it with Best's analysts and officers before its publication. The insurer may present additional information or agree to take actions (e.g. adding capital) that may result in a revised rating.

Insurers can elect to not have their rating published. In that event, they will receive an NA-9 "Company Request" designation, which also is assigned if a company fails to pay the \$500 rating fee. In a recent year, 37 life/health insurers, or 2.8 percent, and 8 property/casualty insurers, or 0.3 percent, had been assigned NA-9 classifications. Best officials estimate that about half of these instances involve rating disputes.

After this process is completed, the ratings are published, on a weekly basis beginning in April, in **Best's Rating Monitor**, a special supplement to **Best's Insurance Management Report**, and made available through BestLink, the on-line computer service, and BestLine, 900 phone service. Ratings are also reported in other Best publications, including **Best's Insurance Reports**, as they are released.

Companies continue to be monitored after their annual rating is assigned. Ratings are reviewed with receipt of the second- and third-quarter statements and changes are released through Best's Rating Monitor, BestLine and BestLink. Meetings are held with company officials throughout the year, and there may be other frequent contacts with the company, if necessary. Analysts also monitor a variety of information, such as press clippings and correspondence from agents and competitors, to keep tabs on companies and note any new developments with respect to their activities or the markets in which they operate. In addition, Best conducts impact studies on the companies it monitors following a major catastrophe or regulatory/legislative development, e.g. California Proposition 103, Hurricane Hugo.

## # Rating Methodology

The **objective** of Best's rating system, as described in its literature, is "to evaluate the factors affecting the overall performance of an insurance company in order to provide our opinion as to the company's relative financial strength and ability to meet contractual obligations." Best's ratings are based on a quantitative evaluation of a company's performance with respect to profitability, leverage and liquidity and a qualitative evaluation of its spread of risk, reinsurance program, investments, reserves and management.

The **quantitative evaluation** analyzes an insurer's reported financial condition and operating performance for at least the previous five years against industry peer group and Best's financial norms, utilizing more than 100 financial tests and supporting data. If a company has a relationship with an affiliate through an investment, reinsurance or pooling agreement, data is consolidated to reflect this affiliation.

Best views profit as a measure of the management's competence and ability to provide insurance at competitive prices and maintain a financially strong company. Best's profitability analysis reviews the degree, trends and components of earnings over the most recent five-year period. Net investment income, federal income taxes, expenses, mortality and persistency (life companies only), reinsurance, reserving practices and methods, statement versus market value of assets, regulatory constraints and underwriting experience are evaluated with regard to their relative effect on a company's earnings and capital and surplus. Also, the stability, trend, type and diversification of premium volume are evaluated as to their impact or potential impact on an insurer's reported statutory operating results.

Best is watchful of highly leveraged companies that are exposed to a high risk of instability and adverse changes in underwriting or economic conditions. Best reviews a number of leverage measures including the ratio of premium to capital and surplus, both gross and net of reinsurance. Affiliated investments are considered in the analysis of capital and surplus which also is adjusted to reflect the adequacy and equity of policy reserves, the market value of assets and potential default risk, market value fluctuation, nonperforming assets and reinsurance quality. For property/casualty companies, Best looks at the ratio of reinsurance premiums ceded and loss reserves to surplus to measure the companies' exposure and dependence on reinsurance. The leverage analysis evaluates the relationship of net liabilities to adjusted surplus, insurance and investment risk based capitalization and other tests which measure a company's surplus or its asset and insurance risks.

Best believes that insurers' liabilities should be supported by sound, diversified and liquid investments to meet unexpected needs for cash without the untimely sale of investments or fixed assets. Best measures an insurer's "quick liquidity" position -- the amount of cash and quickly convertible investments as a percentage of liabilities; "current liquidity" -- the amount of cash and unaffiliated invested assets as a percentage of liabilities; and its cash flow position. The assessment of an insurer's liquidity incorporates an evaluation of the quality, market value, and diversification of assets, cash flow and asset/liability matching programs. Best also considers exposures maintained in single large investments. Stress tests assess the surplus impact of a 20 percent decline in common stock prices and the reduction in market value of bonds, preferred stocks and mortgage loans caused by a two

percentage point increase in interest rates.

Best's **qualitative evaluation** looks at any items which cannot be totally reflected in the "numbers" that may have affected a company's performance or may potentially affect its long-term viability. The qualitative evaluation includes, but is not limited to the: 1) composition of a company's book of business, i.e. spread of risk; 2) adequacy of the reinsurance program; 3) quality, estimated market value and diversification of investments; 4) adequacy of reserves; 5) adequacy of surplus; 6) experience and competency of management; 7) asset/liability matching programs; and 8) the distribution and nature of liabilities structures. Also, Best recently instituted a "policy holder confidence factor" which measures a life insurer's relative vulnerability to all surrenderable liabilities in relation to its liquid assets.

To evaluate a company's spread of risk, Best analyzes its book of business on both a geographic basis and by line of business. Best also reviews a mix of a company's business relative to the distribution of its assets and their respective maturity and expected performance. Best looks for concentration in volatile lines of business or hazardous areas which can negatively affect an insurer's financial stability.

Best reviews each insurer's reinsurance program to determine whether coverage is adequate for the potential risks involved. If an insurer carries a large amount of reinsurance, Best evaluates the quality, diversification and purpose of the reinsurance. An insurer's rating may be adversely affected if it has a large amount of reinsurance or reinsurance recoverable, particularly if the financial condition of the reinsurer is unknown. Significant amounts of reinsurance undertaken primarily for financial reasons also may negatively affect an insurer's rating.

Best examines an insurer's marketable assets (common stocks, bonds, mortgage loans) to determine the potential impact on its surplus if an insurer had to sell assets unexpectedly. The liquidity, diversification and quality of assets are evaluated to assess the uncertainty of the value to be obtained on their sale.

The adequacy of an insurer's reserves is essential to Best's analysis of its profitability, leverage and liquidity. For life companies, reserve analysis involves examining the types of business written and the valuation bases and interest assumptions used. For property/casualty companies, Best evaluates the losses and loss adjustment expenses on an ultimate payout basis. Best also considers the magnitude of a company's loss reserve discount relative to its surplus. In addition, the degree of uncertainty in loss reserve, recognizing that they are only actuarial estimates of future events, is evaluated. If the degree of uncertainty exceeds any equity in the reserves and is large in relation to net income and policy holder's surplus, Best's assessment of a company's reported profitability and leverage performance may be adjusted accordingly for rating purposes.

Best assesses the adequacy of an insurer's surplus relative to the degree of risk associated with its book of business. Best's rating evaluation accounts for the fact that varying degrees of underwriting risk and volatility exist with certain lines of business, with lines of higher volatility requiring greater capital adequacy.

Best prides itself on close working relationships and frequent contacts with the managements of the companies it reports on and rates. Best's rating evaluation considers the character, objectives, experience and competence of an insurer's management.

Various other important factors may be considered in the qualitative analysis, particularly those which may significantly affect a company's ability to meet its contractual obligations. Best's research and analysis in other areas may identify market or economic trends that could affect an insurer's financial condition. A company's relative standing within a rating category can be weakened, maintained or strengthened, based on the qualitative analysis. In a few instances, an insurer may be precluded from a particular rating classification or downgraded because of severe qualitative concerns.

## # Rating Classifications

Best has several different rating classification systems. The majority of companies have received an alphabetical rating which, in 1991, ranged from A+ (Superior) to C- (Fair). Best recently announced an expansion of its alphabetical categories from nine to 15, effective for its 1992 ratings. The stated purpose of this expansion is to provide for finer distinction of financial strength among companies. Double-plus rating categories of A+ + , B+ + and C+ + will be added to the current A+ (Superior), B+ (Very Good) and C+ (Fair) rating categories. In addition, rating categories of D (Below Minimum Standards), E (Under State Supervision) and F (In Liquidation) are being added to complete a range that will now extend from A+ + through F.

Insurers that do not receive an alphabetical rating receive an NA classification for various reasons. The current rating categories NA-7 (Below Minimum Standards) and NA-10 (Under State Supervision) are being eliminated. Companies previously rated in these categories will be included in the expanded alphabetical ratings. Also, a new category NA-11 (Rating Suspended) will be added. A portion of the not assigned companies also receive an FPI rating. Best issues reports even for non-rated companies. Best's 1992 rating classifications are described below in abbreviated form.

**A+ + and A+ (Superior)** : Assigned to those companies which in Best's opinion have achieved superior overall performance when compared to Best's standards. According to Best, A+ + and A+ (Superior) rated insurers have a very strong ability to meet their policy holders and other contractual obligations over a long period of time.

**A and A- (Excellent)** : Assigned to those companies which, in Best's opinion, have achieved excellent overall performance when compared to Best's standards. According to Best, A and A- (Excellent) rated insurers have a strong ability to meet their policy holder and other contractual obligations over a long period of time.

**B+ + and B+ (Very Good)** : Assigned to those companies which in Best's opinion have achieved very good overall performance when compared to Best's standards. According to Best, B+ + and B+ (Very Good) rated insurers have a strong ability to meet their policy holder and other contractual obligations, but their financial strength may be susceptible to unfavorable changes in underwriting or economic conditions.

**B and B- (Good)** : Assigned to those companies which in Best's opinion have achieved good overall performance when compared to Best's standards. According to Best, B and B- (Good) rated insurers generally have an adequate ability to meet their policy holder and other contractual obligations, but their financial strength is susceptible to unfavorable changes in underwriting or economic conditions.

**C+ + and C+ (Fair)** : Assigned to those companies which, in Best's opinion, have achieved fair overall performance when compared to Best's standards. According to Best, C+ + and C+ (Fair) rated insurers generally have a reasonable ability to meet their policy holder and other contractual obligations, but their financial strength is vulnerable to unfavorable changes in underwriting or economic conditions.

**C and C- (Marginal)** : Assigned to those companies which, in Best's opinion, have achieved marginal overall performance when compared to Best's standards. According to Best, C and C- (Fair) rated insurers have a current ability to meet their policy holder and other contractual obligations, but their financial strength is very vulnerable to unfavorable changes in underwriting or economic conditions.

**D (Below Minimum Standards)** : Assigned to companies which meet Best's minimum size and experience



requirements, but do not meet Best's minimum standards for C- rating. Note: This rating category was formerly the NA-7 (Below Minimum Standards) Rating Not Assigned classification.

**E (Under State Supervision)** : Assigned to companies which are placed under any form of supervision, control or restraint by a state insurance regulatory authority such as conservatorship or rehabilitation, but does not include liquidation. May be assigned to a company under a cease and desist order issued by a regulator from a state other than its state of domicile. Note: This rating category was formerly the NA-10 (Under State Supervision) Rating Not Assigned classification.

**F (In Liquidation)** : Assigned to companies which have been placed under an order of liquidation or have voluntarily agreed to liquidate. Note: This was a new rating category in 1992 to distinguish between companies under state regulatory supervision and those in the process of liquidation.

## # Performance Modifiers

Best assigns **modifiers** to their alphabetical ratings to identify a company whose assigned rating has been modified because of performance, affiliation or contractual obligations. As part of its rating structure changes, Best is eliminating its "Contingent Rating Modifier" (c) because of the availability of finer distinctions within the new rating structures. The "Contingent Rating" modifier was applied to a company's current financial performance, but the decline was not significant enough to warrant an actual reduction in its assigned rating. The full list of modifiers are listed below:

**"q" Qualified Ratings** (property/casualty companies only): Indicates the company's assigned rating has been qualified to identify those insurers whose financial strength could be adversely affected by 1) existing or pending state legislation which mandates rate restrictions or surcharges that cannot be passed on to policy holders; or 2) having payments due from mandated state residual market programs or reinsurance facilities equal to, or in excess of, their policy holders' surplus. The company's current rating does not reflect the potential impact of these programs as they represent a future circumstance which could not be quantified when the rating was assigned.

**"w" Watch List** : Indicates the company was placed on Best's Rating "Watch List" during the year to advise its subscribers that the company is under close surveillance because it has experience a downward trend in its current financial performance or may be exposed to a possible legal, financial or market situation which could adversely affect its performance.

**"x" Revised Rating** : Indicates the rating shown was revised during the year.

## # Affiliation Modifiers

**"e" Parent Rating** : Indicates that the rating assigned is that of the parent of a domestic subsidiary in which ownership exceeds 50 percent. The rating is based on the consolidated performance of the parent and its subsidiaries. To qualify for a parent rating, the subsidiary must be eligible for rating based on its own performance after attaining five consecutive years of representative experience; have common management with its parent; underwrite similar lines of business; and have interim leverage and liquidity performance comparable to that of its parent.

**"g" Group Rating** (property/casualty companies only): Indicates the rating is assigned to an affiliated group of property/casualty companies. To qualify for a group rating, the companies in a group must be affiliated via common management and/or ownership; pool a substantial portion of their net business; and have only minor

differences in their underwriting and operating performance. All members are assigned the same rating and financial size category, based on the consolidated performance of the group.

**"p" Pooled Rating** : Indicates the rating assigned to companies under common management or ownership that pool 100 percent of their net business. All premiums, expenses and losses are prorated in accordance with specified percentages that reasonably relate to the distribution of the policy holders' surplus of each group member. All members participating in the pooling arrangement are assigned the same rating and financial size category, based on the consolidated performance of the group.

**"r" Reinsured Rating** : Indicates the rating and financial size category assigned to the company are those of an affiliated carrier that reinsures 100 percent of the company's net premiums written.

**"s" Consolidated Rating** (property/casualty companies only): Indicates the rating is assigned to a parent company and is based on the consolidated performance of the company and its domestic property/casualty subsidiaries in which ownership exceeds 50 percent. The rating applies only to the parent company because subsidiaries are normally rated on the basis of their own financial condition and performance.

A.M. Best does not assign an alphabetical rating to a number of insurers because they do not meet certain requirements such as size or sufficient operating experience. A list of these not assigned classifications is provided below with brief explanations.

**NA-1 Special Data Filing** : Assigned primarily to small mutual and stock companies that are exempt from the requirement to file the standard NAIC annual statement. These company reports are based on selected financial information requested by Best, and the majority are submitted via Best's Data Collector under a cooperative program with the National Association of Mutual Insurance Companies (NAMIC) and other supporting organizations.

**NA-2 Less than Minimum Size** : Assigned to companies that file the standard NAIC annual statement, but do not meet Best's minimum size requirement of writings of \$1.5 million for life/health insurers or \$1.5 million of surplus for property/casualty insurers.

**NA-3 Insufficient Operating Experience** : Assigned to a company which meets, or is anticipated to meet, Best's minimum size requirement, but has not accumulated at least five consecutive years of representative operating experience.

**NA-4 Rating Procedure Inapplicable** : Assigned to a company when the nature of its business and/or operations is such that the normal rating procedure for insurers does not properly apply. Examples are companies writing lines of business uncommon to the life/health or property/casualty field; companies not soliciting business in the United States; companies retaining only a small portion of their gross premium writings; companies which have discontinued writing new and renewal business and have a defined plan to run-off existing contractual obligations; or companies whose sole operation is accepting business written directly by a parent, subsidiary or affiliated insurance company.

**NA-5 Significant Change** : Assigned to a previously rated company which experienced a significant change in ownership, management or book of business whereby its operating experience may be interrupted or subject to change; or any other relevant event which has or may affect the general trend of a company's operations.

**NA-6 Reinsured by Unrated Reinsurer** : Assigned to a company which has a substantial portion of its book of business reinsured by unrated reinsurers and/or has reinsurance recoverables from unrated reinsurers which

represent a substantial portion of its policy holders' surplus. Exceptions are unrated foreign reinsurers that comply with Best's reporting requirements and satisfy its financial performance standards.

**NA-7 Below Minimum Standards** : Discontinued in 1992 and replaced by D rating.

**NA-8 Incomplete Financial Information** : Assigned to a company that is eligible for a rating, but fails to submit complete financial information for the current five-year period under review. This requirement includes all domestic subsidiaries in which the company's ownership exceeds 50 percent.

**NA-9 Company Request** : Assigned to a company that is eligible for a rating, but requests that the rating not be published. The majority of these companies, such as captives, operate in markets that do not require a rating, but cooperate with Best's request for financial information so that a report can be prepared and published on their company. The classification is also assigned to a company that requests its rating not be published because it disagrees with Best's rating assignment or payment of the \$500 rating fee. In this situation, Best's policy normally requires a minimum of two years to elapse before the company is again eligible for the assignment of a rating.

**NA-10 Under State Supervision** : Discontinued in 1992 and replaced by rating of either E or F.

**NA-11 Rating Suspended** : Assigned to a previously rated company which has experienced a sudden and significant event affecting the company's financial position and operating performance, of which the impact cannot be evaluated due to a lack of timely or appropriate information.

A recent sample distribution of insurers by Best ratings is shown on the next page. Of the total companies rated, 41.7 percent of life/health insurers and 52.6 percent of property/casualty insurers were assigned a "Superior" or "Excellent" rating. Of the companies receiving alphabetical or NA-7 (Below Minimum Standards) ratings, 68.8 percent of life/health and 82.9 percent of property/casualty insurers were assigned a "Superior" or "Excellent" rating.

## # Financial Performance Index (FPI)

In 1990, A.M. Best also instituted the **FPI rating** for companies not meeting the size and operating experience requirements for an alphabetical rating. The FPI is assigned to companies that have three years of representative operating experience, submit NAIC statements, complete a supplemental rating questionnaire and qualify or NA-2 or NA-3 categories. The assignment of the FPI involves the same notification and discussion process with company management as with alphabetically rated companies.

The FPI procedure includes both a quantitative and qualitative review of a company's operating and financial performance. The quantitative evaluation is based on an analysis of a company's financial performance, utilizing essentially the same key tests required for the alphabetical rating. The qualitative review for the FPI rating is not as extensive as that for an alphabetical rating, but it does include adjustments for adequacy of reinsurance protection, geographic spread of risk and loss exposure by product line. A company is assigned an index of from 1 to 9 based on the quantitative and qualitative review of its overall performance. The description and distribution of the FPI ratings are shown on the next page.

An FPI of 1 is assigned to a company that does not have three consecutive years of representative operating experience or, in a few cases, was assigned an FPI which was lower than it found acceptable and requested that it not be published.

## # Dissemination of Rating Information

Best disseminates company reports and ratings through various publications and information services. **Best's Insurance Report** are published annually and available to consumers through most public libraries and state insurance departments which receive complimentary copies. Updated year end ratings and interim rating changes are also made available through various subscription publications, weekly, monthly and quarterly; daily through BestLink, the on-line computer network service; and through BestLine, a direct dial 900 rating service. These publications and services are complimented by other Best reports and analyses that deal with industry issues and developments.

## ## STANDARD & POOR'S

Standard and Poor's (S&P) has emerged as the second leading insurer rating agency in terms of the number of domestic insurers rated, with virtually the same number of insurers assigned letter grade ratings as A.M. Best. It has been rating bonds since 1923 and insurance companies' **claims paying ability** since 1983. S&P's insurer rating activity draws from its experience and procedures in rating debt issues and utilizes a similar classification framework, but is conducted by professional analysts whose background, experience and/or training is focused on the insurance industry. S&P's philosophy and approach to rating the financial strength of insurers is more like that of Moody's and Duff & Phelps than like A.M. Best. S&P sees its role as one of providing risk assessment of insurers to insurance buyers rather than serving as an advisor to insurers to assist them in improving their financial condition and rating.

S&P's Insurance Rating Services is one of six departments within its Ratings Group which has a staff in excess of 700 located in offices in seven countries. S&P's Insurance Rating Services provides ratings on fixed income securities, including long-term debt, commercial paper and preferred stock issued by insurance companies, as well as claims paying ability ratings and qualified solvency ratings of the financial strength of insurers.

S&P's **claims paying ability rating** is an assessment of an operating insurance company's **financial capacity to meet its policy holder obligations** in accordance with their terms. Claims paying ability ratings are based on a comprehensive quantitative and qualitative financial analysis using various sources of information, including interviews with company management.

S&P introduced qualified solvency ratings in 1991, after two years of development, to extend its coverage of opinions on insurers in response to market demands for information on insurers for which it did not provide a claims paying ability rating. The qualified solvency ratings are based on a statistical analysis of statutory financial data filed with the NAIC and purchased by S&P. S&P's qualified solvency methodology provides a solely statistically based indication of financial strength among insurers and differentiates broadly between classes of risk to policy holders. S&P's insurer ratings are not recommendations to buy, retain or surrender a policy from any particular insurer.

Some regulators and insurers have questioned the fairness of qualified solvency ratings. Conversely, other insurers have referred to their qualified solvency rating, along with other agencies ratings, in sales material or have expressed disappointment in not receiving a qualified solvency rating. Some brokers and agents have expressed the view that qualified solvency ratings are not well understood in the market. S&P notes others have expressed the view that qualified solvency ratings add useful information to the market. A more detailed discussion of qualified solvency ratings is provided later in this section.

All claims paying ability **ratings are voluntary** and insurers pay a rating fee that typically ranges from \$15,000 to \$32,000 depending on size, number of affiliated insurers, and other factors. In connection with their initial

application for a claims paying ability rating, insurers have the option of not completing the process and/or not having a claims paying ability rating published.

Once a claims paying ability rating is published, the insurer can request that it be withdrawn, although this option has been very rarely

exercised. A statement of S&P's current opinion of the insurer's financial strength will be released at the time of the rating withdrawal. If an insurer requests that its claims paying ability rating be withdrawn because it anticipates that the rating will be lowered, S&P will complete its review process and if a rating downgrade is viewed as warranted, will announce it before withdrawing the rating.

S&P has assigned claims paying ability ratings to approximately 200 life/health insurers, 400 property/casualty insurers, 25 monoline financial guaranty insurers and 80 non-U.S. insurers. In addition, S&P has assigned "qualified solvency" ratings to approximately 750 life/health insurers and 1,230 property/casualty insurers. S&P also has a subsidiary, Insurance Solvency International (ISI), which has assigned ratings to approximately 900 alien property/casualty insurers and reinsurers. S&P also provides reports on Lloyd's syndicates and life insurers in the United Kingdom.

S&P's Insurance Rating Services has a staff of 80 in New York and London of which 25 are analysts who assign claims paying ability ratings and monitor insurers' claims paying ability. S&P indicates that its analysts generally have advanced business degrees as well as professional experience in financial analysis of the insurance industry. Each rating analyst is assigned to rate and monitor 20 companies on average. In addition to rating analysts, S&P employs 10 statistical and computer support personnel and other support staff to assist the analysts.

S&P distributes its ratings through several publications and over the telephone. S&P also publishes other insurance industry reports and analyses supporting its ratings and provides other information on market conditions. A more detailed description of S&P's insurer rating process, methodology and classification scheme follows.

## **# Rating Process**

S&P's claims paying ability rating process begins with an application and a commitment from an insurer to provide the necessary financial information for a full evaluation. A lead analyst is assigned to work with the company and obtain financial information including five years of statutory financial statements, GAAP financial statements (if available) information provided on special questionnaires dealing with debt securities, mortgage loans and real estate investments, and other company documents. Various spreadsheets, profiles and financial ratios are prepared to assist S&P analysts in forming an initial opinion about the financial condition of an insurer relative to Best's standards.

S&P analysts also meet with company management to discuss issues relating to the company's business goals and strategies, profitability, underwriting standards, reserving policy, leverage and use of debt, earnings outlook, accounting policies, targeted markets, acquisition and growth philosophy, planning processes, asset distribution and quality, and asset/liability management. In an initial rating, S&P prefers to meet with an insurer for a full day at its headquarters to have full access to the appropriate personnel. Subsequent meetings may be held at the company's location or at S&P.

Subsequent to the management interview, the lead analyst prepares a report and preliminary rating based on a quantitative and qualitative evaluation of all the information compiled. The report is presented to a rating

committee comprised of five or more senior insurance industry specialists and also including, when necessary, other S&P specialists in areas such as real estate, private placements and other investments. The rating committee scrutinizes the preliminary rating, questions the analyst's assumptions, verifies the material facts and challenges the analyst's conclusions. After this review, the rating committee makes a final determination on the rating that will be assigned to the insurer.

The insurer is informed of the committee's rating assignment and the basis for the rating. However, the nature of the rating committee's deliberations and the identity of its members are not disclosed to the insurer. If the company can provide additional information and/or demonstrate that the basis for the initial rating was incorrect, the committee may revise its rating decision. Otherwise, the rating stands.

An insurer does have the option of requesting that an initial claims paying ability rating not be published. S&P believes that this option is necessary to ensure that it receives the cooperation of insurers to provide the information that it needs to do a proper evaluation, not only with respect to the initial rating assignment, but in connection with S&P's ongoing rating surveillance as well. S&P indicates, however, that this is an option that has rarely been exercised, and that when exercised, has to date virtually always resulted in ratings in the AA, A or BBB categories not being published. Also, insurers that decline their claims paying ability rating will receive a qualified solvency rating.

Once assigned and approved, insurers' ratings are released through monthly and quarterly publications as well as made available to consumers over the telephone.

After a claims paying ability rating is assigned, S&P analysts continue to monitor an insurer's performance for new developments. The surveillance process involves reviewing the insurer's financial statements and reports each year, annual meetings with company management, and monitoring company, industry and market developments. Any rating may be reviewed at any time when new information suggests that the financial strength of the insurer may have changed. S&P will always notify a company when a rating change is contemplated, and will meet with the company as part of the process leading up to the potential change. S&P also may issue a general advisory, referred to as a "**CreditWatch**", if new developments may affect an insurer's claims paying ability rating. Insurers are always made aware of a rating change or a CreditWatch advisory prior to its release.

## # **Rating Methodology**

S&P conducts a comprehensive quantitative and qualitative evaluation in assessing an insurer's financial strength and ability to meet its future obligations to policy holders for the claims paying ability rating. S&P applies a common set of qualitative principles to every company regardless of its line of business, but then tailors its analytical approach to each of the **four primary insurance industry segments**: life/health insurers; property/casualty insurers; consolidated property/casualty groups; and professional reinsurers. Its rating methodology profile covers **eight basic areas**: 1) industry risk; 2) management and corporate strategy; 3) business review; 4) operational analysis; 5) investments; 6) capitalization; 7) liquidity; 8) financial flexibility. S&P also looks at interest rate management and asset/liability matching for life insurers and loss reserve adequacy for property/casualty insurers. Insurers are "benchmarked" against industry norms in the quantitative portion of the evaluation, but there is no specific formula or algorithm used to score companies based on their statistical results.

S&P's **industry risk** analysis looks at four competitive factors; 1) potential threat of new entrants; 2) threat of substitute products or services; 3) rivalry among existing firms; 4) bargaining power of buyers/suppliers. Industry sectors are defined largely by the type of insurance written. When a company does business in more

than one sector, a weighted average risk score is assigned based on premium revenue.

With respect to **management and corporate strategy**, S&P evaluates whether the strategy management has chosen is both consistent with the organization's capabilities and whether it makes sense in its marketplace. S&P also evaluates a company's operational skills, which essentially involves an assessment of a company's ability to execute its chosen strategy. S&P evaluates management's expertise in operating each of the company's lines of business as well as the adequacy of audit and control systems; its financial risk tolerance, which relates to the amount of debt in its capital structure and the level of operating leverage which a company is willing to accept; its organizational structure, and how it fits the company's strategy.

S&P's **business review** analysis identifies the company's fundamental characteristics and its source of competitive advantage or disadvantage. This includes a description of the portfolio of business units and/or product lines, distribution systems, and the degree of business diversification. The business review includes analysis of those aspects of the business that affect the absolute level, growth rate and quality of the revenue base and focuses on the long-term revenue generating capabilities of the insurer.

Through an analysis of operating results, S&P determines a company's ability to capitalize on its strategy and company strengths. **Operating results** are analyzed independently of the firm's operating leverage. S&P's analysis of an insurer's earnings performance focuses on its underlying economic profitability rather than its stated statutory net gain. If available, S&P will review a firm's GAAP financials in making its assessment, although it will rely on statutory figures if GAAP financials are unavailable. S&P focuses on the after-tax return on assets as the most comprehensive ratio not affected by leverage. For a life/health insurer, S&P's analysis includes a review of its persistency, expense structure, mortality/morbidity experience, effective tax ratio, pricing policies and actual performance versus pricing. For a property/casualty company, S&P examines underwriting performance including premium growth rates, loss ratios, expense ratios, combined ratio and loss reserve adequacy. The trend and stability of a company's earnings are also evaluated.

S&P's **analysis of an insurer's investments** considers the insurer's allocation of assets among investments such as bonds, mortgages, preferred stock, real estate, common stock and other invested assets. The assets are evaluated for credit quality and diversification. An insurer's asset allocation is also examined to determine how appropriate it is to support policy holder liabilities.

**Asset quality** is reviewed throughout the investment portfolio, and charges are applied against the insurer's capital for problem and risky assets to establish what S&P believes to be the appropriate level of investment reserves. Delinquencies on mortgage portfolios, restructured mortgage loans, loans in the process of foreclosure and foreclosed real estate are also assessed. S&P applies a default rate model, based on historical experience and current S&P projections, to determine the appropriate level of investment reserve needed for mortgages, bonds and other fixed income assets. Credit is given for existing investment reserves in the statutory balance sheet. Equity assets, including common stock, real estate, and schedule BA assets, are reviewed for appropriateness of valuation. S&P may adjust capital to reflect what it believes to be over valued assets or to incorporate hidden asset values.

S&P also evaluates how well an insurer manages its interest rate risk and asset/liability matching strategies relative to its product lines. S&P reviews an insurer's **asset/liability management** by identifying the specific asset and liability durations and cash flows of interest rate sensitive portfolios. Investment risk and the degree of mismatch between the maturity and duration of the investment portfolio with an insurer's liability structure is principal to S&P's evaluation of management's tolerance for risk.

S&P's analysis of insurers' **capitalization** incorporates financial leverage and fixed charge coverage concepts

as well as the degree of operating leverage. The ratios used by S&P for all insurers are total debt to capital; long-term debt to capital; short-term debt to capital; fixed charge coverage; preferred stock to capital; and fixed charge coverage of preferred dividends.

The analysis of **operating leverage** is analyzed in relation to the business lines of an insurer. For life/health insurers, operating leverage is defined as total liabilities to statutory capital, treating the mandatory securities valuation reserve (MSVR) as capital and excluding separate accounts from liabilities. For property/casualty insurers, the applicable ratios are net written premiums to surplus; loss reserves to surplus; loss reserves to earned premiums; ceded written premium to gross written premium; and investments in subsidiaries/affiliates to surplus.

Other risks inherent in an insurer's operations such as asset/liability mismatch are also examined in relation to the level of capital. In addition, the use and quality of reinsurance is analyzed. Finally, the **quality of capital** is analyzed in terms of the degree of exposure to reinsurers and equity assets such as common stocks, including investment in affiliates, real estate equities, and equity investments in partnerships relative to the capital base of the firm.

Property/casualty insurers' **loss reserves** are also evaluated for adequacy. S&P's loss reserve analysis looks at six lines individually and combined utilizing data filed on Schedule P: personal auto liability; commercial auto liability; other liability; medical malpractice; workers' compensation; and commercial multiperil. S&P utilizes several different standard techniques to arrive at a degree of confidence in the loss reserve for each line and to identify areas where management will be asked to explain deviations from expected results.

In evaluating **liquidity** for life insurers, S&P focuses on an insurer's ability to handle reasonable increases in cash outflows due to lapses, surrenders, policy holder loans or other cash withdrawals. S&P analyzes the nature of a company's policy holder liabilities and their associated surrender charges and/or market valuation charges in determining the susceptibility to increased cash outflows before policy maturity. In addition, it looks at the maturity structure of large dollar investment-oriented contracts such as guaranteed investment contracts (GICs) in evaluating a company's liquidity needs. The amount of liquid assets available to meet increased cash outflows and policy maturity are compared.

S&P defines liquid assets to include cash and short-term securities; government and government-backed securities; investment grade public bonds; private placements in NAIC categories 1 or 2 maturing in one year or less; and other liquid assets as determined by S&P through discussions with management. The liquidity ratios examined by S&P for life/health insurers include operating cash flow to benefits paid; operating cash flow to liabilities; and cash and short-term investments to invested assets. For property/casualty insurers, S&P looks at underwriting cash flow to sources/uses; total cash flow to sources/uses; and cash and short-term investments to invested assets.

Finally, S&P evaluates an insurer's financial flexibility in terms of its capital requirements and capital sources. Capital requirements refer to factors that may give rise to an exceptionally large need for either long-term capital or short-term liquidity. Capital sources involve an assessment of the extent to which a company has access to short and long-term capital beyond normal operating earnings and cash flow.

## # **Qualified Solvency Ratings**

S&P's qualified solvency ratings are based strictly on the application of statistical analysis to statutory financial data filed by insurers with the NAIC. The objective of the statistical analysis is to distinguish insurers that are financially weak or more likely to get into financial trouble from insurers that are financially strong or less likely to encounter financial difficulty. Multi-variate discriminant analysis is used to develop a model which assigns



a **numerical score (Z-score)** to each insurer based on its financial results. The financial ratios or variables which comprise the model are measured over a four-year period to incorporate trend. The model is tested using alternate data sets to affirm its stability and ability to predict failed insurers.

The analysis is conducted separately for the four different industry segments: consolidated property/casualty insurers; individual property/casualty insurers; professional reinsurers; and life/health insurers. The procedures used were reviewed by independent actuarial and accounting consultants. The models used are updated as new data become available and the characteristics of failed and solvent insurers change over time.

A sample summary of S&P's qualified solvency ratings is shown on page 20 with the relative importance or weight of each factor analyzed in terms of the degree of exposure to reinsurers and equity assets such as common stocks, including investment affiliates, real estate equities, and equity investments in partnerships relative to the capital base of the firm.

Insurers' **Z-scores** are divided into three broad groups. Insurers with the highest scores are assigned a BBBq rating indicating "adequate" financial security. Their scores most closely resemble those of financially strong insurers. The next segment of scores are assigned a BBq rating, indicating that financial security "may be adequate". Insurers receiving the lowest scores are rated Bq, indicating a "vulnerable" financial condition. Their scores most closely resemble those of insurers that have actually experienced financial difficulty.

## # **Rating Classifications And Distribution Claims paying Ability Ratings**

As indicated above, S&P provides either of **two types** of ratings of an insurer's financial strength: a **claims paying ability rating or a qualified solvency rating**. The claims paying ability rating is an opinion of an insurer's financial capacity to meet the obligations of its insurance policies in accordance with their terms. Claims paying ability ratings are further divided into two classifications: secure and vulnerable. Rating categories from "AAA" to "BBB" are classified as "secure" claims paying ability ratings and are used to indicate insurers whose financial capacity to meet policy holder obligations is viewed on balance as sound. Rating categories from "BB" to "D" are classified as "vulnerable" claims paying ability ratings and are used to indicate insurers whose financial capacity to meet policy holder obligations is viewed as vulnerable to adverse developments. In fact, the financial capacity of insurers rated "CC" to "C" may already be impaired, while insurers rated "D" are in liquidation. Ratings from "AA" to "CCC" may be modified by a plus or minus sign to show the relative standing of the insurer within those rating categories.

The specific claims paying ability ratings are further described below:

**AAA** : Insurers rated AAA offer superior financial security on both an absolute and relative basis. They possess the highest safety and have an overwhelming capacity to meet policy holder obligations.

**AA** : Insurers rated AA offer excellent financial security, and their capacity to meet policy holder obligations differs only in a small degree from insurers rated AAA.

**A** : Insurers rated A offer good financial security, but their capacity to meet policy holder obligations is somewhat more susceptible to adverse changes in economic or underwriting conditions than more highly rated insurers.

**BBB** : Insurers rated BBB offer adequate financial security, but their capacity to meet policy holder obligations is considered more vulnerable to adverse economic or underwriting conditions than that of more highly rated insurers.

**BB** : Insurers rated BB offer financial security that may be adequate but caution is indicated since their capacity to meet policy holder obligations is considered vulnerable to adverse economic or underwriting conditions and may not be adequate for "long-tail" or long-term policies.

**B** : Insurers rated B are currently able to meet policy holder obligations, but their vulnerability to adverse economic or underwriting conditions is considered high.

**CCC** : Insurers rated CCC are vulnerable to adverse economic or underwriting conditions to the extent that their continued capacity to meet policy holder obligations is highly questionable unless a favorable environment prevails.

**CC and C** : Insurers rated CC and C may not be meeting all policy holder obligations and may be operating under the jurisdiction of insurance regulators and are vulnerable to liquidation.

**D** : Insurers rated D have been placed under an order of liquidation.

### # **Qualified Solvency Ratings**

Insurers that do not voluntarily apply for a claims paying ability rating are assigned a qualified solvency rating based on a quantitative analysis of their statutory financial data. Qualified solvency ratings are computed for individual insurers on a stand alone basis, without consideration for strength or weakness that might be added by a parent or affiliated companies.

Qualified solvency rating designations range from BBBq to Bq. The "q" suffix indicates the qualified nature of the rating because it is based strictly on a statistical analysis. The definitions of the qualified solvency ratings are given below.

**BBBq** : Results of quantitative tests on the insurer's statutory financial results are consistent with those of insurers providing adequate or better financial security.

**BBq** : Results of quantitative tests on the insurer's statutory financial results are consistent with those of insurers providing financial security that may be adequate.

**Bq** : Results of quantitative tests on the insurer's statutory financial results are consistent with those of insurers providing vulnerable financial security.

S&P has been criticized by some insurers and regulators because the highest qualified solvency rating possible is BBBq which appears to be lower than the highest claims paying ability rating possible, AAA. However, S&P's rationale for the use of B-range symbols for qualified solvency ratings is that they are consistent with the definitions of S&P's claims paying ability ratings.

In S&P's *Insurer Solvency Review*, it points out that a BBB claims paying ability is considered secure, but not superior. Similarly, a BBBq rating is presumed to represent a secure insurer, although it is uncertain how secure based on its statistical analysis alone. S&P acknowledges, "It is possible that a more comprehensive evaluation would reveal that a BBBq-rated insurer could be rated BB or lower on the claims paying ability rating scale. It is most likely, however, that an insurer rated BBBq would be rated among the top four categories (AAA to BBB) for claims paying ability."

S&P describes insurers rated BB for claims paying ability as providing "financial security that may be adequate

but caution is indicated since their capacity to meet policy holder obligations is considered vulnerable to adverse economic or underwriting conditions..." S&P links that definition to its BBq qualified rating, indicating that insurers rated BBq appear weaker than insurers rated BBBq but, nonetheless, offer financial security that may be adequate. The most likely range of claims paying ability rating is A to B.

S&P's definition of a B claims paying ability rating says: "Vulnerability to adverse economic or underwriting conditions is considered high." A Bq rating is intended to convey a similar notion. Insurers rated Bq show material weaknesses according to the financial data, similar to insurers that have encountered financial difficulty in the past. However, just as some insurers rated BBBq in reality may be weaker than the data suggest, it is probable that some insurers rated Bq may in fact be stronger than the data suggest. For example, an apparently weak subsidiary can be bolstered by the firm support of a strong parent. Nevertheless, insurers with qualified solvency ratings of Bq would, on their own merits, be least likely to receive claims paying ability ratings in the "secure" range of BBB or higher.

S&P contends that consumers properly understand the distinction between the claims paying ability and qualified solvency ratings. However, some insurers and regulators believe that consumers tend to equate the two. No research has been conducted to determine whether consumers properly understand the difference between the two types of ratings. S&P bases its conclusions on telephone contacts with consumers.

Because of concerns about consumer misperceptions, some insurers and industry trade associations indicate that they feel coerced to "purchase" a claims paying ability rating the fee for which typically ranges from \$22,000-\$28,000 and which may be different than their qualified solvency rating. Some insurers have claimed that it is unfair to subject them involuntarily to a statistically based rating and to be confined to a qualified B-range rating because they have not paid for a more in-depth claims paying ability rating. Some smaller insurers express additional concerns that S&P's qualified solvency rating model tends to favor larger insurers.

However, S&P believes that the qualified solvency methodology provides an unbiased indication of insurers' financial strength and can differentiate broadly between classes of risk to policy holders. It further maintains that the classification framework used for the qualified solvency rating is appropriately conservative to protect consumers.

The tabel on the next page provides a recent sample distribution of claims paying ability and qualified solvency ratings. Of the total companies rated, 16 percent of life/health and 19 percent of property/casualty companies received an AAA (Superior) or AA (Excellent) rating. Of the companies receiving claims paying ability ratings, 78.1 percent of life/health and 75.6 percent of property/casualty insurers received an AAA or AA rating.

## # Dissemination of Rating Information

S&P disseminates its ratings and other financial information about insurers through several publications. **S&P's Insurance Book** is a quarterly looseleaf service providing comprehensive coverage of more than 500 insurance companies: property/casualty, life/health, reinsurance, bond insurance and mortgage insurance. **S&P's Insurer Solvency Rating** provides qualified solvency ratings for 1,600 insurers in addition to all of S&P's claims paying ability ratings. **S&P's Insurance Digests** are quarterly publications containing capsule reports on S&P-rated companies. **S&P's Insurers Ratings List** is a monthly publication listing all of S&P's insurer claims paying ability ratings by industry. **Select Reports** are four-page reports, excerpted from **S&P's Insurance Book**, containing a full, in-depth review of each company. Consumers also can obtain information on up to five insurers at a time, free of charge, by calling S&P's Rating Information Department.

## ## MOODY'S INVESTOR SERVICE

Moody's Investors Service was founded in 1900 by John Moody, who invented bond ratings in 1909. Today, Moody's rates securities of some 4,000 industrial companies, public utilities, banks and other financial institutions. In addition to bonds, Moody's rates the credit worthiness of a wide variety of financial obligations, such as commercial paper, bank deposits, money market funds and GICs. In the insurance sector, Moody's has been rating the debt securities of insurance companies since the mid-1970s. Moody's began assigning insurance company financial strength ratings in 1986. Although Moody's rates fewer insurers than A.M. Best or S&P, it has acquired a solid reputation for thoroughness and expertise in its insurer rating activities.

Moody's **financial strength ratings** reflect its opinion as to an insurer's ability to discharge senior policy holder obligations and claims. It seeks to measure "credit risk", i.e., the risk that an insurer will fail to honor its senior policy holder claims in full and on a timely basis. Moody's financial strength ratings are based on quantitative and qualitative analysis of the industry, regulatory trends and the business fundamentals of the insurer.

Insurers can apply to Moody's for a financial strength rating. There is a basic annual appraisal fee of \$25,000 for life insurance financial strength ratings and \$22,000 for property/casualty financial strength ratings. In addition, where Moody's believes there is sufficient policy holder and investor interest, Moody's is prepared to assign financial strength ratings to life companies that have not requested a rating. Although Moody's will generally solicit the company's cooperation under such circumstances, Moody's is prepared to go forward without company participation on the basis of publicly available information. Moody's will only do so if adequate information is available in the public domain to reach a credible rating conclusion. Moody's does not charge a fee, at least initially, to insurers that have not applied for a rating.

Moody's primary focus on the life side has been insurers that are large annuity writers, but it is expanding into other segments of the life industry and also has rated property/casualty insurers. Moody's currently has assigned financial strength ratings to approximately 80 domestic life insurers, 180 property/casualty insurers and reinsurers and 20 alien insurers. It also has assigned about 175 debt ratings for insurers. Moody's estimates that its rated life companies represent roughly 75 percent of industry assets and more than 90 percent of GIC assets. Moody's estimates that its rated property/casualty insurers represent 60 percent of net premium written for the domestic property/casualty industry and 50 percent of net written premiums for the domestic reinsurance industry.

Moody's financial strength ratings and debt ratings for insurers are produced by its Insurance Group, which is part of its Financial Institutions Group. The Insurance Group is composed of an associated director, eight senior analysts including two actuaries, and four support personnel. Moody's analysts generally have significant insurance industry experience. Moody's committee rating process also utilizes expertise of other Moody's staff and management in analyzing and rating insurers. A more detailed description of Moody's rating process, methodology and classification scheme follows.

## # Rating Process

In assigning financial strength ratings to insurers, Moody's employs a committee process that draws upon the perspective and expertise of a number of analysts, associate directors and directors. The lead analyst is responsible for analyzing the insurer and preparing a rating recommendation to Moody's Corporate Rating Committee. This committee is ultimately responsible for the final rating decision. Once a committee decision is reached, the insurer is informed of the decision, and the rating is usually released to the public shortly thereafter. Once a rating has been assigned, it is considered to be "**continuously under review**", and it can be changed if Moody's becomes aware of developments within the company, the industry, or any other general developments that Moody's believes could change the fundamental risk embodied in the rating. Moody's analysis typically, but not always, involves meeting with the company management.

Insurers are given the right to appeal first-time financial strength ratings and to meet with Moody's staff to disclose new information that may be relevant to the rating decision. However, since 1992, Moody's has reserved the right to disclose an insurer's rating, whether the insurer agrees with its rating or not. When entering new areas, Moody's has initially given insurers the option of not having their rating published until a "framework of comparability is achieved within the given sector". Recently, Moody's determined that its rating coverage of U.S. life insurers has met this standard and, therefore, it no longer offers the refusal option to life insurers. It does still offer the refusal option to property/casualty insurers.

## # Rating Methodology

Moody's financial strength ratings are based on industry analysis, regulatory trends, and an evaluation of an insurer's business fundamentals. Its **industry analysis** examines the structure of competition within the insurer's operating environment and its competitive position within that structure. The analysis of regulatory trends attempts to develop an understanding of potential changes in a particular country's regulatory system and tax structure. The analysis of a company's business fundamentals focuses primarily on financial factors, "franchise value", management and organizational structure/ownership.

In conducting its industry analysis, Moody's looks at a number of factors, including: the degree of concentration within the industry; the extent of inter-industry competition; the degree to which competition is likely to remain orderly; and the level of national protectionism, explicit or implicit. Moody's analysis of regulatory trends includes consideration of potential changes in regulations or taxation that could inhibit an insurer's competitive position or could lead to a significant restructuring of segments of the industry. Moody's also considers the failure-resolution practices of state regulators in its overall financial strength rating.

Moody's analysis of the **financial fundamentals** of a company encompasses capital adequacy, investment risk, profitability and liquidity. To assess capital adequacy, Moody's adjusts an insurer's statutory data to estimate its economic capital as a going concern. Adjustments include consideration of the conservatism in statutory reserves and asset valuation, acquisition costs recoverable from future earnings, hypothecation of future earnings through financial reinsurance, and investments in subsidiary companies. Moody's also employs a risk-based benchmark capital ratio to assess capital adequacy which recognizes an insurer's mix of lines of business and assets, each of which has varying risk characteristics, including asset default, pricing adequacy, and interest rate risk.

Moody's assesses a number of **factors** to reach conclusions about an insurer's expected long-run profitability and the risk that actual results may differ from expected profits. The factors assessed include 1) market focus of the insurer; 2) competitive dynamics in each market segment; 3) relative distribution costs; 4) underwriting record and outlook; 5) investment strategy.

Moody's **liquidity analysis** attempts to understand the liability structure of the company, the options that may exist in the liabilities, and the degree to which the company's liabilities are confidence-sensitive. For life companies, when there is a high proportion of confidence-sensitive policy holders, Moody's analyzes the company's assets. It considers an insurer's asset structure and its "cushion" of a large portfolio of liquid, marketable assets as well as alternative sources of liquidity for a company.

Moody's **qualitative evaluation** of an insurer also includes an assessment of its "franchise value", management and its organizational structure. In assessing an insurer's franchise value, Moody's looks at its competitive position in its marketplace. This involves assessing the quality of the company's products and distribution systems, and whether its product or service is essential. Moody's also will evaluate whether the company has sustainable competitive advantages in its key lines of business.

Moody's **evaluation of management** considers its financial track record in such areas as investment risk taking, profitability, and product innovation. Management's strategy, as measured by rapid growth or new business development, is also assessed.

Moody's also examines an insurer's **relationship to a parent**, to subsidiaries or affiliate companies to assess their impact on the financial strength of the insurer. If an insurer is part of a holding company structure, its financial strength rating will typically be constrained by the senior long-term debt rating of the holding company.

## # **Rating Classification & Distribution**

Moody's uses the same **symbols** for its insurer financial strength ratings and bond quality ratings. The rating gradations are broken down into nine symbols, each symbol representing a group of ratings in which the quality characteristics are considered to be broadly the same. Numeric qualifiers (1-3) further distinguish insurance within the rating symbol. The rating symbols are divided into two distinct segments: strong companies (Aaa-Baa) and weak companies (Ba-C). Moody's rating symbols and descriptions are listed below.

**Aaa** : Insurance companies rated Aaa offer exceptional financial security. While the financial strength of these companies is likely to change, such changes as can be visualized are mostly unlikely to impair their fundamentally strong position.

**Aa** : Insurance companies rated Aa offer excellent financial security. Together with the Aaa group, they constitute what are generally known as high-grade companies. They are rated lower than Aaa companies because long-term risks appear somewhat larger.

**A** : Insurance companies rated A offer good financial security. However, elements may be present which suggest a susceptibility to impairment sometime in the future.

**Baa** : Insurance companies rated Baa offer adequate financial security. However, certain protective elements may be lacking or may be characteristically unreliable over any great length of time.

**Ba** : Insurance companies rated Ba offer questionable financial security. Often the ability of these companies to meet policy holder obligations may be very moderate and thereby not well safeguarded in the future.

**B** : Insurance companies rated B offer poor financial security. Assurance of punctual payment of policy holder obligations over any long period of time is small.

**Caa** : Insurance companies rated Caa offer very poor financial security. They may be in default on their policy holder obligations or there may be present elements of danger with respect to punctual payment of policy holder obligations and claims.

**Ca** : Insurance companies rated Ca offer extremely poor financial security. Such companies are often in default on their policy holder obligations or have other marked shortcomings.

**C** : Insurance companies rated C are the lowest rated class of insurance company and can be regarded as having extremely poor prospects of ever offering financial security.

A recent sample distribution of Moody's ratings are shown on the next page.. Of companies rated, 58.3 percent of life companies and 77.4 percent of property/casualty companies were rated as Exceptional (Aaa) or Excellent

(Aa).

## # Dissemination of Rating Information

Moody's disseminates its ratings through various publications and over the telephone. The public can obtain Moody's ratings, free of charge, by calling its public ratings desk. Moody's Life Insurance Credit Research Service includes detailed reports on insurers, special comments on the industry, and access to analysts. Moody's **Life Insurance Handbook** contains summary credit opinions of all rated life insurers.

## ## DUFF & PHELPS

Duff and Phelps, located in Chicago, is another well-known rater of securities that branched into rating insurers' financial strengths. D&P has been providing investment research since 1932, public credit services since 1980, and claims paying ability ratings of insurers since 1986. D&P had been rating insurers debt issues since the early 1980s and expanded to claims paying ability ratings of insurers to respond to a growing demand for analyses of major pension contract carriers. D&P's philosophy and approach are similar to that of S&P and Moody's in terms of its risk assessment of insurers from the standpoint of insurance buyers. D&P emphasizes a very thorough **qualitative analysis along with quantitative analysis** in conducting its rating evaluation.

A D&P claims paying ability rating reflects D&P's opinion as to the likelihood of payment of policy holder and contract holder obligations in accordance with the terms of such obligations. Insurers apply to D&P to obtain a claims paying rating and are required to pay a \$17,000 annual fee, in addition to agreeing to supply the necessary financial and other information. However, D&P has rated three carriers that did not apply for a rating. Insurers also can opt not to have their rating published although no company is currently in that status.

Currently, D&P provides claims paying ability ratings for 91 life/health insurers, 7 property/casualty insurers and 6 bond insurers. Seven analysts, in addition to other staff financial analysts and experts, are primarily involved in developing claims paying ability ratings for insurers.

A more detailed summary of D&P's rating process, methodology and classification scheme follows.

## # Rating Process

Insurers are subject to a thorough quantitative and qualitative evaluation in D&P's rating process. The rating process starts with an application from the insurer. This is followed by a D&P request for financial information including:

- ! Current year budget covering expected statutory performance, and, if available, current five-year projections with assumptions.
- ! Materials that will help to illustrate the asset/liability matching process, including investment policy and methods for estimating asset and liability durations.
- ! Current New York Regulation 126 filing.
- ! Listings of problem loans/assets for each major asset class.
- ! Organizational charts covering corporate structure and principal executive reporting lines.
- ! Descriptive materials concerning key products.

- ! Strategy statement by product line.
- ! Distribution of bond assets by quality ranking, industry category and other categories perceived to be important.
- ! History of the company focusing on major milestones.
- ! Any available relative industry comparison statistics on investments, expenses, market share, etc.
- ! Long form (including all schedules) annual statements for most recent six years. Separate annual statements for subsidiary organizations for most recent year.
- ! Separate account statements for most recent two years. Separate account statements for subsidiaries for most recent year.
- ! Quarterly statutory statements for current and preceding year. Also, subsidiaries' quarterlies.
- ! Most recent insurance department triennial examination report.
- ! Annual shareholder reports, 10Ks (current and preceding year 100s) for most recent six years and current proxy and recent prospectus.
- ! Most recent two years audited SAP and GAAP financial statement for entity being rated.
- ! Annual policy holder reports for most recent two years.

After the information has been received, D&P representatives visit the insurance company for an initial on-site interview. During that meeting, D&P representatives talk with key management personnel including the chief executive officer, chief financial officer, chief investment officer, chief marketing officer and product managers. In special situations, company officials are also invited to D&P headquarters in Chicago to meet with members of the D&P rating committee.

Upon receiving the insurer's financial data, D&P analysts conduct a number of tests that include comparative analysis and financial ratios in areas such as profitability, operating efficiency, investment risk, leverage and liquidity. The analysts also conduct an extensive qualitative evaluation of the company's management, competitive position, economic fundamentals, ownership structure and asset/liability management practices. There also is considerable cross comparison of quantitative and qualitative factors to reach an analytical judgement as to the financial condition of the insurer.

Upon completing their evaluation, D&P analysts present a report and initial rating recommendation to the D&P rating committee. The rating committee, consisting of 11 senior credit rating company officers, reviews the analysts' report and recommendation and determines a rating. The rating and an analysis is presented to the insurance company. The company has the option of not having the rating published, but currently no companies are in that status. Insurer ratings are then disseminated over the telephone, through electronic mail, press releases and D&P publications. Insurers are also allowed to distribute their D&P rating and report.

After its initial rating is completed, insurers are subject to **ongoing review**. This includes obtaining quarterly updates of financial information as well as annual reviews. In addition, D&P insists on being informed of any



significant developments affecting the company to be able to assess their impact and support the rating.

## # Rating Methodology

Analysis of an insurance company's claims paying ability is "closely allied" to credit analysis at D&P. The process emphasizes analysis of the company's future ability to pay its policy and contract obligations when they are expected to come due. Confidence in an insurer's long-term solvency and its ability to maintain adequate liquidity are critical considerations in D&P's review.

D&P's assessment of an insurer's claims paying ability is based on both quantitative and qualitative analysis. Moreover, interaction between D&P analysts, senior credit rating committee members and senior management of the company being rated is central to the rating process. Critical areas of analysis are an assessment of the rated company's capital adequacy and the ability to maintain adequate capital in future years; review of investment returns; review of the liability structure (principally statutory reserves) with heavy emphasis on the inherent stability of such liabilities; an assessment of asset and liability management practices including scenario testing in connection with controlling interest rate risk over a range of possible interest rate scenarios; a detailed review of liquidity management and "worst case" scenario testing; analysis of profitability, tax issues, product line returns, reinsurance relationships and marketing strategy; and an actuarial review of product design, pricing and performance together with interest rate crediting practice. In addition, historical, current year-to-date and budgeted financial results are reviewed together with long-range strategic forecasts.

The purpose of this review and analysis is to develop a set of financial performance expectations for the company being rated reflecting the prospective nature of the rating. The subsequent monitoring of the assigned rating and a company's financial performance is a continuing process with actual financial performance regularly compared to expectations.

**Ratios** included in D&P's quantitative tests are:

- ! Return on Average Admitted Assets
- ! Return on Adjusted Surplus
- ! Net Investment Income Yield
- ! Combined Ratios
- ! Expense Ratios
- ! Surplus Formation
- ! Higher Risk Assets to Adjusted Surplus
- ! Investment in Affiliates to Adjusted Surplus
- ! Premiums to Adjusted Surplus
- ! Adjusted Liabilities to Adjusted Surplus

In determining **adjusted surplus**, D&P sums a company's reported surplus, mandatory securities valuation reserve, deficiency reserves, and other balance sheet items which it considers to represent "capital" employed. D&P's rationale on these adjustments is to identify and measure total capital employed and thus measure both profitability and operating leverage on a basis consistent with a company's economic reality.

**Surplus formation** measures growth in adjusted surplus relative to the growth in adjusted liabilities. A ratio of 1.00 indicates that adjusted surplus and adjusted liabilities are increasing at equivalent rates. A ratio of less than 1.00 implies increased use of operating leverage as the growth in liabilities exceeds the growth in adjusted surplus.

D&P rating evaluation also places considerable emphasis on **qualitative factors** including:

- ! Economic fundamentals of the company's principal insurance lines;
- ! Company's competitive position;
- ! Management capability;
- ! Relationship of the rated entity to either parent, affiliate, or subsidiary; and
- ! Asset and liability management practices.

Ultimately, D&P's rating conclusions rest on integration of the quantitative and qualitative factors in a company's picture. In D&P's view, the **critical consideration in rating** is the analytical judgement as to whether historical trends will persist or reverse themselves.

For example, a company with sharply declining profitability measures would normally have a lower claims paying ability rating than a company with either lower and stable or lower and increasing profitability measures. Conversely, a company with higher absolute but stable leverage could receive a higher claims paying ability rating than a company with lower but increasing leverage.

D&P also is very attentive to an insurer's sensitivity or exposure to both underwriting and business cycles. For example, it notes that the profitability of a life insurer's group accident and health business is typically very sensitive to competition induced rated inadequacy, inflation-driven increases in claim costs, and business cycle-related reductions in client company employment levels. Similarly, an insurer's assets and liabilities are highly sensitive to interest rate changes, which is the principal factor accounting for balance sheet volatility. Consequently, D&P focuses on asset and liability mismatches and management techniques to control interest rate risk. It also is concerned with measuring the adequacy of a company's adjusted surplus relative to the effects of this volatility.

Finally, D&P will weigh certain factors differently in making a rating judgement depending on the circumstances. For instance, for a company with either demonstrated significant parent support or well above average stability as gauged by trend and volatility, the absolute level of leverage would normally take on less importance in reaching a rating decision than for a company for which these circumstances were not present.

## # Rating Classification and Classification Distribution

The **rating scale** that D&P uses for its claims paying ability ratings is the same as the one it uses for bonds and preferred stock although different definitions of safety are used. D&P's claims paying ability rating concerns only the likelihood of timely payment of policy holder and contract holder obligations and is not intended to refer to the ability of either the rated company, or as the case may be, a parent, affiliate, subsidiary, etc., to pay non-policy/contract holder obligations. A scale from AAA to CCC is used with "+" to "-" signs to further delineate quality within the broad alphabetical categories. D&P's ratings and definitions are provided below.

**AAA** : Highest claims paying ability. Risk factors are negligible.

**AA** : Very high claims paying ability. Protection factors are strong. Risk is modest, but may vary slightly over time due to economic and/or underwriting conditions.

**A** : High claims paying ability. Protection factors are average, and there is an expectation of variability in risk

over time due to economic and/or underwriting conditions.

**BBB** : Below average claims paying ability. Protection factors are average. However, there is considerable variability in risk over time due to economic or underwriting conditions.

**BB** : Uncertain claims paying ability and less than investment grade quality. However, the company is deemed likely to meet these obligations when due. Protection factors will vary widely with changes in economic and/or underwriting conditions.

**B** : Possessing risk that policy holder and contract holder obligations will not be paid when due. Protection factors will vary widely with changes in economic and underwriting conditions or company fortunes.

**CCC** : There is substantial risk that policy holder and contract holder obligations will not be paid when due. Company has been or is likely to be placed under state insurance department supervision.

The next page shows a recent sample distribution of D&P ratings. Of the 77 life/health insurers rated, 68 or 88.4 percent received above an A+ rating. However, only two of the seven property/casualty insurers had a rating above A+ .

## # Dissemination of Rating Information

D&P disseminates financial and rating information on insurers through several means, including telephone inquiries, electronic transmission, press releases, company reports and two publications. The **Insurance Company Claims Paying Ability Rating Guide**, issued quarterly, contains detailed reports, financial information and ratings for all D&P rated insurers. There is also a monthly **Rating Guide** which provides claims paying ability ratings for insurers as well as ratings for long-term and short-term debt instruments and preferred stock. In addition, the public can telephone D&P free of charge to obtain insurer ratings and an explanation of what the ratings mean.

## ## WEISS RESEARCH

Weiss Research, located in West Palm Beach, Florida, is somewhat different from the other insurance company raters discussed in this paper in terms of its approach. Its founder, Martin D. Weiss, has been publishing newsletters about money markets, interest rates, bank safety and economic forecasting since 1971. In 1989, Weiss began publishing "safety ratings" of life, health and annuity insurers. Weiss' methodology and rating scale has generated some controversy within the industry.

Weiss' **safety rating** indicates its opinion regarding an insurer's ability to meet its commitments to its policy holders not only under current economic conditions, but also during a declining economy or in an environment of increased liquidity. A computer model comprised of some 200 financial ratios is used to determine an insurer's rating. The data for the model is obtained from statutory statements and other supplemental financial information provided by insurers.

Weiss stresses that it bases its analysis exclusively on **objective, quantifiable information**. It eschews interjecting subjective and unquantifiable judgement into the rating process. Consequently, unlike other raters, Weiss does not interview insurer's management nor utilize other subjective information. Weiss believes that good management will produce good results and that bad results cannot be explained away by management.

Weiss' ratings are essentially **involuntary**. Insurers do not apply to Weiss for a rating, nor do they pay a fee for

being rated. Weiss supports its insurer rating activities through the sale of its rating information to the public. Weiss believes that this approach allows it to be independent in its rating evaluation. Currently, Weiss rates more than 1,700 life, health and annuity insurers.

Weiss Research employs a total staff of 70, including analysts, programmers and technicians, clerks and customer service counselors who support all its services. Of these staff, seven analysts, including a consulting actuary, are directly involved in developing and running its computer model.

A more detailed description of Weiss' rating process, methodology and classification scheme follows.

## # Rating Process

Weiss follows a **five-step process** to arrive at a rating. The process begins with data collection. Weiss obtains quantitative information on insurers from several sources including 1) statutory data in computerized form from the NAIC; 2) statutory annual and quarterly data not provided by the NAIC; 3) supplemental data from surveys sent to the companies; and 4) additional data supplied by the companies.

The next step in the process is data validation. This involves running crosschecks on data to identify errors, which are corrected by reference to the hard copy statement or by contact with the company. Data is then mailed to the companies for validation.

The next steps are ratio analysis and modeling. The modeling procedure involves automated generation of ratings through a hierarchical series of calculations involving weighting, capping and filtering of the ratios. Weiss describes its rating system as a pyramid. At the top of the pyramid is the overall rating. This rating is composed of several indexes. Each index, in turn, is derived for a series of "components". The components are based upon several "subcomponents". The subcomponents are derived from the statutory data and data from the companies.

The last step is "reality checking". This involves manual verification of the results and modifications of the overall model so that all companies are affected fairly.

The results of Weiss' analysis and its ratings are sent to the companies with a request that the data be examined and verified. Some companies do not respond to these requests and others may object to the rating. Insurers are invited to visit Weiss Research to discuss the rating methodology and conclusions. Insurers are requested to provide new, objective and verifiable information, which will be put into the process and evaluated along with other data.

Once finalized, Weiss ratings are communicated over the telephone and through several publications and software to consumers, agents and others. Review of the insurer also continues. Weiss Research receives quarterly reports from the insurance companies. New information is added to the analytical process and is reported in quarterly updates.

## # Rating Methodology

Weiss' **rating model** utilizes five key indices: 1) risk adjusted capital; 2) profitability; 3) liquidity; 4) spread of risk; and 5) sources of capital. Weiss utilizes two risk-adjusted capital ratios to determine a company's exposure to investment liquidity and insurance risk in relation to the capital the company has to cover those risks. The first risk-adjusted capital ratio evaluates the company's ability to withstand a moderate economic decline. The second ratio evaluates the company's ability to withstand a severe economic decline.

To calculate these risk-adjusted capital ratios, Weiss sums all of the company's resources that could be used to cover

losses. These resources include capital, surplus, MSVR, and a portion of the provision for future policy holders' dividends, where appropriate. Additional credit may also be given for the use of conservative reserving assumptions and other "hidden capital" when applicable. Next, Weiss determines the company's target capital. This answers the question: Based on the company's level of risk in both its insurance business and its investment portfolio, how much capital would it need to cover potential losses during a moderate economic decline? For Weiss, an average recession is one in which the real gross national product (GNP) declines by about the same amount as it did in the postwar recessions of 1957-58, 1960, 1970, 1974-75, 1980 and 1981-82.

The first **risk-adjusted capital ratio** is equal to capital resources divided by target capital. If a company has a risk-adjusted capital ratio of 1.0 or more, it means the company has all of the capital Weiss believes that it requires to withstand potential losses which could be inflicted by a moderate economic decline. If the company has less than 1.0, it does not currently have all of the basic capital resources Weiss thinks that it needs.

Weiss notes that during times of financial distress, companies often have access to additional capital through contributions from a parent or holding company, current profits or reductions in policy holder dividends. Therefore, an allowance is made in the rating system for firms with somewhat less than 1.0 risk-adjusted capital.

The second risk-adjusted capital ratio is equal to capital resources divided by target capital calculated under conditions of severe economic decline. According to Weiss, a severe recession is a prolonged economic slowdown in which the single worst year of the postwar period is extended for a period of three years. This ratio is then converted into an index measured on a scale of zero to 10, with 10 being the best and seven or better considered strong. A company whose capital, surplus, MSVR and other capital reserves equal its target capital will have a risk-adjusted capital ratio of 1.0 and a risk-adjusted capital index of 7.0.

Weiss' **profitability index** also is a major factor in measuring the financial strength of an insurer and is derived from an analysis of the following five components: 1) the adequacy of investment income; 2) average and weighted average of net gain on operations over the past five years; 3) volatility of operating gains; 4) contribution of gains to capital growth; and 5) control over expenses, in relation to anticipated norms.

The **adequacy of investment income** to meet the interest requirements of policy reserves is measured in the same way as IRIS ratio 4. It compares the interest credited to life and annuity, health and deposit funds (such as GICs) with the company's investment income to determine whether the company's investment income adequately covers its needs. If income levels are inadequate, the rating will be adversely impacted. Significant margins above the break-even point have a positive impact on the profitability index.

The average and weighted gain on operations look at the overall profit levels of the company over a five-year period. They are measured in terms of return on assets and return on equity. Weiss looks for stable, consistent profits and does not give additional credit for return on equity figures above the 7.5 percent level. A subcomponent is the difference between the straight average and weighted average of net gains. This reveals the profit trend. If the weighted average is greater than the straight average, profits are generally improving. An up trend favorably affects the profitability index, helping to offset the negative impact of net loss in the current period. Conversely, a downtrend with marginal current profits may have a negative impact on the profitability index.

With respect to volatility of profits, credit is given for a low standard deviation. Conversely, large swings in operating results are viewed negatively. Additionally, volatile operating gains are viewed as a possible indicator of surplus relief insurance. Additional deductions are made for weighted aggregate operating losses over the last five-year period.

The sources of a company's capital are viewed as an important barometer of a company's financial health. Weiss

believes that a company should fund its growth internally from its profits. Contributions from stockholders and/or parent corporations and capital gains are also considered positive factors. However, gains from surrenders, large amounts or reinsurance with non-affiliates and changes in reserve valuation basis are viewed negatively. These and other sources of capital are weighted to produce an index that measures the quality of capital sources.

Weiss sees control over expenses as a key indicator of management's skill in controlling operations. In the Weiss analysis, based on studies by the Canadian Institute of Actuaries, average expenses are derived by function and by line of business. A mean cost figure is derived based on a series of unit costs. For each company, the number of units is multiplied by the average unit cost, which, in turn, is compared with that of all the other companies. If total expenses are more than 100 percent of the standard, it indicates a less than average efficiency of operations, negatively affecting the profitability index. If they are less than 100 percent, it indicates a greater than average efficiency positively affecting the index.

Weiss' **liquidity index** compares: 1) the company's liquid assets; 2) illiquid assets; 3) cash flows to its potential liquidity needs. The following are the subcomponents of each of these components:

! Liquid assets include cash and marketable securities, such as bonds with maturities of less than one year, publicly traded bonds of investment grade and common or preferred stock.

! Illiquid assets include items such as real estate, mortgages and investments in affiliates.

! Cash flow items include premiums and investment income less benefits and other expenses.

Subcomponents affecting potential liquidity needs include:

! Liability for interest sensitive products (e.g. GICs, deferred annuities and other deposit funds), depending on cash-out provisions;

! The company's surrender experience;

! Market value adjustments; and

! Surrender fees as disincentives for disintermediation.

The spread of risk factors utilized by Weiss include: size of investment portfolio; distribution of net premium and deposit funds by line of business; number of policies and contracts in force; and retention limits on ordinary and group life and use of reinsurance. Sources of earnings/capital include: operations (retained risk); reinsurance; investment earnings; realized capital gains; unrealized capital gains; capital infusions; paper adjustments (changes in MSVR, reserve valuation basis, etc.); and appropriateness of dividend levels (policy and stock).

Weiss' **investment safety index** utilizes risk and liquidity calculations separate from those used in the risk-adjusted capital ratios. Weiss' model considers investment yields, bond default rates, mortgage non-performance rates and portfolio diversification. The process evaluates the relative risks in each investment category and considers these in relation to a company's resources for dealing with them. Exceptional values are noted and analyzed to determine its relevance to a company's financial strength.

As indicated above, Weiss **does not allow subjective judgements** to alter a factual interpretation of the data. However, there are factors which other raters might treat as qualitative which are quantified in Weiss' system. For

example, the New York Regulation 126 filing is analyzed in terms of the severity of the underlying assumptions used and the results of the scenario testing in terms of their impact on profits and capitalization. These are then carried over to the interest-rate risk factors in the risk-adjusted capital equation and other equations. Another example is where the nature of the policy-loan provisions in each company's contracts is quantified in the risk factor associated with policy loans in the risk-adjusted capital calculation. Also, the impact of mergers, acquisitions and other special historical circumstances on mechanical ratios are factored out with filters tailored to the particular situation and then used for all companies falling into a similar category.

Weiss also measures the quality of management through quantitative analysis of historical data on past performance. Areas evaluated include: cost control skills; bond portfolio management skills; mortgage portfolio management skills; asset-liability management skills; and profitability management skills as measured by current and recent trends.

## # Rating Classifications and Distribution

In Weiss' view, the rating of an insurer's financial health should reflect the probability of that company meeting claims in the future as well as its **probability of insolvency**. Its objective is to place companies in a risk-class that accurately describes the likelihood of insolvency.

Weiss' basic rating scale ranges from A to F with "+" and "-" modifiers. A "+" sign indicates that, with new data, there is a modest possibility that this company could be upgraded. The A+ rating is an exception since no higher grade exists. A "-" sign indicates that, with new data, there is a modest possibility that the company could be downgraded.

In addition, companies with less than \$25 million in capital and surplus are designated with an S in front of their alphabetical rating. The S is simply a reminder that consumers may want to limit the size of their policy with this company so that the policy's maximum benefits do not exceed one percent of the company's capital and surplus. Also, companies receive an unrated classification U if: 1) total assets are less than \$1 million; 2) premium income for the current year is less than \$100,000; 3) the company functions almost exclusively as a holding company rather than as an underwriter.

Weiss' basic ratings are listed below with their definitions.

**A Excellent** : This company offers excellent financial security. It has maintained a conservative stance in its investment strategies, business operations and underwriting commitments. While the financial position of any company is subject to change, Weiss believes that this company has the resources necessary to deal with severe economic conditions.

**B Good** : This company offers good financial security and has the resources to deal with a variety of adverse economic conditions. However, in the event of a severe recession or major financial crisis, Weiss feels that this assessment should be reviewed to verify that the firm is maintaining adequate financial strength. Carriers with a rating of B+ or higher are included on Weiss' recommended list of companies.

**C Fair** : This company offers fair financial security and is currently stable. But, during an economic downturn or other financial pressures, Weiss feels that it may encounter difficulties in maintaining its financial stability.

**D Weak** : This company currently demonstrates what Weiss considers to be significant weaknesses that could negatively impact policy holders. In an unfavorable economic environment, these weaknesses could be magnified.

**E Very Weak** : This company demonstrates what Weiss considers to be significant weaknesses and has also failed

some of the basic tests used to identify fiscal stability. Therefore, even in a favorable economic environment, it is Weiss' opinion that policy holders could incur significant risks.

**F Failed** : Company is under the supervision of state insurance commissioners.

The distribution of Weiss' ratings tends to be more bell-shaped with more insurers receiving average or below average ratings than assigned by other raters. A recent sample distribution of Weiss' ratings are shown on the next page. Of the 1,470 insurers receiving a letter grade, only 3.8 percent received an A grade and only 15.2 percent received a B grade. Of the rated insurers, 48.2 percent received a C grade and 32.8 percent received less than a C rating.

## # Dissemination of Rating Information

Consumers and agents are able to obtain a verbal rating over the telephone from Weiss for a \$15 charge. A personal safety brief, which is a one-page summary of Weiss' rating for an individual company, is \$25, or three for \$55. For \$45, a consumer receives an 18-page in-depth analysis of a company, or three for \$95. Consumers also can order an **Insurance Safety Directory** issued quarterly for all life and health insurance companies. The Directory includes key financial data and ratios for each company and a list of recommended companies with a rating of B+ or higher.

## ## SUMMARY ON RATING SERVICES

There is a good deal of similarity among the rating agencies in terms of their basic objectives and approaches in evaluating the financial strengths of insurers. Their essential objective is to assess and offer an opinion as to the ability of an insurer to meet its obligations to policy holders. With the exception of S&P's qualified solvency ratings and the Weiss' safety ratings, the raters utilize both qualitative and quantitative analysis, apply certain basic principles, and follow similar rating processes.

At the same time, there are differences among the raters, and they sometimes issue different rating opinions of the same insurers. Rating the financial strength of an insurer is inherently a complex process, and there is considerable opportunity for variation. In terms of quantitative analysis, raters differ with respect to the specific financial ratios used; adjustments to data or ratios to reflect reserve adequacy, reinsurance quality, investment quality, ownership structures and other factors; the weights or significance attached to different financial ratios; and ultimately the way in which quantitative information is utilized in an insurer's overall evaluation.

Qualitative analysis provides even greater opportunity for different evaluations among the raters. Assessing the implication of qualitative factors for a company's financial strength, particularly over a long time horizon, inherently involves a considerable amount of subjective judgement. That subjectivity inevitably can result in at least marginally, and sometimes significantly, different rating conclusions.

Rating opinions are also affected by somewhat different rating philosophies. The securities rating firms -- Standard and Poor's, Moody's and Duff & Phelps -- essentially assess the risk that an insurer will not be able to meet its obligations to policy holders. Weiss also assesses an insurer's risk to policy holders but bases its assessment on more pessimistic economic scenarios than other raters. Alternatively, A.M. Best places greater emphasis on prevention than detection of insolvencies. For that reason, Best may exhibit greater patience than other raters in allowing a company to resolve its problems before downgrading it.

Insurance company ratings which are based strictly on statistical analysis -- S&P's qualified solvency ratings and Weiss Research's safety ratings -- fit into a special category. The primary advantages of quantitative ratings are that they cost less to perform and do not require the insurers being rated to cooperate. The agencies that issue quantitative ratings contend that they expand the availability of unbiased information to consumers. Critics complain that



quantitative ratings do not consider various qualitative factors that could explain adverse statistical results. Weiss responds that its approach avoids influence by company management to reach a more favorable rating determination than what the company's actual results suggest. However, in theory, qualitative considerations could also result in a less favorable rating. Indeed, it is difficult to argue with the fact that quantitative ratings are inherently more limited than ratings that consider qualitative information as well as quantitative information. From a public interest standpoint, the issue boils down to whether the benefits gained from having additional rating opinions available, albeit statistically based, outweigh any costs that inure from their limitations.

This analysis did not evaluate which rating philosophy or methodology was better or worse. Each rater offers support for its particular approach. We also did not attempt to assess the accuracy of ratings by looking retrospectively at how failed insurers had been graded by different raters prior to the insurer's failure. Ideally, such an assessment would consider accuracy in identifying financially strong insurers, as well as financially weak insurers. This is easier said than done because the fact that a low rated insurer has not failed does not necessarily mean that the low rating is not justified or that the insurer will not ultimately fail.

The emergence of additional raters during the 1980s responded to a perceived demand for more information and alternative opinions about insurers' financial strength. There seems to be fairly unanimous agreement that the availability of multiple rating opinions benefits consumers, even if there is disagreement about how these opinions should be formulated. There are also different opinions about the ability of the users of rating opinions to evaluate the validity of those opinions and to sort good methods from bad ones. Some believe that regulators should intervene to prevent the supply of misinformation while others would prefer to rely on the market, i.e., users of rating information, to sort good information from bad information.

# STATE GUARANTY FUNDS

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## **## PURPOSE OF GUARANTY ASSOCIATIONS**

The purpose of the state guaranty associations is to fully guaranty the reasonable expectations of the vast majority of individual policy and group insurance certificate holders. It is important to note that these associations DO NOT exist to underwrite any and all promises, no matter how large or reckless. In essence, state guaranty associations have limitations.

Guaranty associations are created by state law "to protect policy owners, insureds, beneficiaries, annuitants, payees and assignees against losses, both in terms of paying claims and continuing coverage, which might otherwise occur due to an impairment or insolvency of an insurer."

When an insurer becomes insolvent, it frequently exits the market with liabilities in excess of its assets. The ultimate questions to be answered is: who is going to bear the burden of this shortfall? To date, state legislators have used guaranty funds to shift most of the burden of the shortfall from the policy holders of the insolvent company back to insurers. Absent guaranty fund protection, the policy holders of the insolvent insurer would be forced to absorb the complete loss produced by the insolvent insurer. Guaranty funds provide policy holders and beneficiaries with an entity ready to absorb most of the losses left by the insolvent insurer.

Guaranty funds are able to provide protection to policy holders by assessing surviving insurers for amounts necessary to pay the claims of the insolvent insurer. Essentially, these funds shift the burden of the shortfall from policy holders to surviving insurers. Managers of the surviving insurers must then allocate the assessment. Groups that could be called upon to absorb the assessment include: equity holders, policy holders, employees, and taxpayers. Most states use premium tax credits to shift the shortfall to taxpayers.

The assessment paid by insurers can be viewed as an interest free loan to the state by way of the guaranty fund. The loan is partially repaid in the form of tax credits and deductions. Federal taxpayers also receive part of the burden as assessed insurers deduct their assessments from taxable income.

## **## THE NEED FOR A SAFETY NET**

In any competitive environment, even one as intensively regulated as insurance, insolvencies will occur. The proper role of insurance regulation is to avoid financial failure if possible, detect it as soon as possible when it cannot be prevented, and act promptly to contain its size and impact once the insolvency is known.

The vast majority of insurers failed because they priced their product too cheaply. They neglected to underwrite adequately by identifying the nature and extent of the insured risk. An in almost all these cases, the signals were disproportionate increases in premiums written; entry into new and exotic lines of business; risky investments; precipitous drops in surplus; reinsurance to temporarily bolster surplus; overly generous dividends to parent companies; and low claim reserves.

The comprehensive June 1991 **Best's Insolvency Study** confirms this conclusion. Of all property-casualty insolvencies since 1969, 28% were caused by inadequate pricing, which resulted in inadequate loss reserves; 21% by rapid growth; 10% by alleged fraud; 10% by overstated assets; 9% by significant change in business; 7% by reinsurance failure; 6% by catastrophic losses; and 9% by "miscellaneous".

Some believe that inadequate pricing and deficient loss reserves, rapid growth, overstated assets, and significant change in business should have been detected through regular examinations, market conduct exams, holding company reports, annual statements and CPA audited annual reports of non-insurers, as well as by just listening to street talk. It is true that a few insurers were known by general industry discussion to be in trouble long before regulators took action.

Reinsurance failure as a cause of insolvency can be prevented by exercise of the existing regulatory authority by the ceding insurer's domestic commissioners as to the granting or denial of credit for unauthorized reinsurance and by the regulation of the solvency of licensed reinsurers by their domestic commissioners. Moreover, "reinsurance failure" as it impacted on some ceding insurers can more appropriately be characterized as "poor management" by the ceding insurer because, as Best's stated, they "purchased the least expensive reinsurance protection without sufficient regard to the financial strength of the reinsurer."

Many insolvencies attributed to "reinsurance failure" are almost always the result of other causes, with reinsurance only becoming a factor after the ceding insurer has been declared insolvent, when the reinsurer disclaims its coverage, alleging fraud.

Whatever their cause, none of these insolvencies occurred overnight. Did they occur in states with modest resources and few or inexperienced personnel? The biggest states with larger department funding were those with the most insurer failures.

**Best's** also confirms this failure of the regulatory giants. Of the 372 property-casualty insurance insolvencies between 1969 and 1990, 187, or 50%, occurred in six states. These states, that domiciled only 34% of the insurers during the period, were Texas (47 insolvencies); California (35 insolvencies); Pennsylvania (35 insolvencies); New York (30 insolvencies); Illinois (22 insolvencies); and Florida (18 insolvencies).

Of these six states, four, California, New York, Texas and Florida, accounted for 48% of the \$429 million budgeted for all 50 state insurance departments (plus those of the District of Columbia and Puerto Rico), and the other two highest insolvency states, Illinois and Pennsylvania, with another 5.6%, were in the top 9 states with the highest regulatory budgets. It is unlikely that more money to these six states would have avoided any insolvencies.

Why do states so rich in funding and expertise permit so many large insolvencies to occur? Why don't they catch them sooner? One school of thought blames the political nature of insurance regulation and the very existence of guaranty funds.

As insurance has become a more public factor in our economy, insurance regulators have found themselves in an increasingly political arena. They have permitted or been forced to allow their focus to shift from the primary role of the regulator -- solvency -- to what has become the more visible issue of pricing.

Rate and policy form approval, particularly for commercial insurance where the buyer neither needs nor wants this layer of "protection", drains essential regulatory resources that could better be directed to the solvency of insurers.

Examinations of insurers that focus on trivia as much as essentials and that take up to three or more years to complete, being outdated by the time they are released, no longer perform the investigatory and preventive role that used to

spot trouble before it became fatal.

Like everyone, insurance commissioners do not like to admit failure, and many commissioners and their staff view the insolvency of a domiciled insurer as a personal and institutional failure. That, despite the fact that however intense and expert the regulation, some insolvencies will occur.

Thus, regulators welcome promises of cash infusion, assertions of improved payout patterns, claims of better quality of new business and investments, and the assertion that "things can't get any worse" -- anything to avoid or delay the admission that, despite their best efforts, a failure occurred.

Unfortunately, in too many cases these promises are unrealistic and are never fulfilled, and, during the period of regulatory indulgence, the insurer's financial condition rapidly deteriorates, new policy holders pay for coverage they will never receive, and, as a result, other insurers and taxpayers end up paying more to clean up the default.

Although the insolvency most likely was predetermined years earlier when bad business was written below cost or unrealized investments were made, the situation worsens as new business is written at even less adequate prices in desperation to maintain liquidity.

## **## HOW GUARANTY FUNDS STARTED**

The timing of regulatory action, in catching the insolvency early and cutting losses, is essential. This was one of the rationales for the creation of guaranty funds. It was believed that, in addition to the direct benefit of the funds providing compensation to policy holders and claimants, the fact that such compensation was available would encourage regulators to act promptly to take over insolvent insurers while the deficit was relatively small, and to liquidate them if they could not be rehabilitated.

It was expected that the relatively small automobile insurer insolvencies of the late 1960s, which resulted in property-casualty insurer guaranty fund legislation, would not impose an undue burden on either other insurers who initially provided the guaranty fund payments, or on taxpayers and policy holders who ultimately paid for the insolvent insurer's obligations.

The first state guaranty mechanism for life and health insurance and annuities was formed in 1941 in New York. The second such mechanism was created in Wisconsin in 1969. In 1970, the National Association of Insurance Commissioners (NAIC) adopted the Life and Health Insurance Guaranty Model Act. The NAIC has made several major revisions to the Model Act since its adoption, the most recent in 1987. At this point, all 50 states and Puerto Rico have created some form of guaranty mechanism.

## **## HAVE THE FUNDS ACCOMPLISHED THEIR GOAL?**

Some believe that while the guaranty funds have, for now, met the goal of compensating policy holders, they have not had the intended result of strengthening regulatory backbone. They have had exactly the opposite effect.

Confident that continued forbearance towards a financially troubled insurer will not embarrass them because most claims are likely to be paid by the guaranty funds, some feel that regulators have tended to procrastinate in the unfounded hope that somehow the insolvency will heal. It is alleged in congressional testimony that two major regulatory states delayed taking action against large financially hazardous or insolvent insurers until pending guaranty fund legislation was enacted.

It is unlikely that a single insurer backed up by a guaranty fund has been prematurely liquidated. Conversely, belated receivership, with escalating deficits during each day of continued operation, has become the rule.

Although it has become obvious in banking and savings and loan insolvencies, guaranty funds are not without cost. Whether a small auto insurance insolvency or a large commercial one is involved, the payments by guaranty funds are borne by the contributions of surviving insurers and, one way or another, are passed on to policy holders or taxpayers.

It is likely that the movement to restrict guaranty fund coverage to large commercial policy holders will be endorsed in a growing number of states, but for non-commercial insureds, guaranty funds are likely here to stay, regardless of unintended and anti-solvency results.

## **## STRUCTURE AND WORKINGS OF CURRENT FUND SYSTEMS**

The guaranty associations are non profit legal entities whose members comprise all insurance companies licensed to write insurance or annuities in the state. Each association is governed by a board of directors approved by the state's insurance commissioner.

### **# Exclusions**

In general, guaranty acts exclude from coverage policies issued by entities that are not regulated under the standards applicable to legal reserve carriers. Insurance exchanges, assessment companies, fraternal, HMOs and, in many cases, the Blues (Blue Cross and Blue Shield -- especially where they have not been converted to legal reserve carriers), are commonly excluded.

The guaranty laws also commonly exclude from coverage policies or portions of policies under which the risk is borne by the policy holder or which are not guaranteed by the insurer. Variable accounts in some life policies or annuity contracts are examples.

Significant variation does exist in the treatment of unallocated funding obligations (UFOs), including GICs, which are commonly purchased as pension plan assets on professional, sophisticated advice by pension plan trustees.

### **# Limits of Protection**

Most guaranty associations limit their protection to policy holders who are residents of their own state. (It does not matter where the policy owner's beneficiaries live.) The trend toward adopting such a residents only provision follows a major amendment to NAIC's model guaranty act adopted in 1985. Arizona, Virginia, West Virginia, Nevada, North Carolina and Oregon very recently amended their life-health guaranty laws to cover only their own residents.

However, if the insolvent insurer's domiciliary state follows the NAIC model, coverage would be extended by the domiciliary state to residents of another state if that state also has a similar guaranty act and the impaired company was not licensed there and the policy holder is not eligible for coverage there. An example of such a situation would be a New York resident who owns a policy of the Executive Life Insurance Company, which is domiciled (chartered) in California. Since New York has a life-health guaranty association but the company was not licensed to do business there, New York residents will be covered by the California Life Insurance Guaranty Association. However, residents of a jurisdiction such as the District of Columbia which does not have a life-health insurance guaranty association would have no guaranty association protection, even though Executive Life was licensed there.

Other states, like Alabama, still follow an older model act and guaranty benefits of impaired or insolvent insurers domiciled in their own state, no matter where the policy holders live, and they also cover their own residents who are policy holders of licensed companies domiciled in other states, unless coverage is provided by the state of domicile.

## # Dollar Limits

Typical payouts to policy holders who are victims of failed or financially strapped insurance companies might read as follows:

### ***Life and Health Guaranty Funds***

Maximum Death Benefit	\$300,000
Maximum Cash Value Covered	\$100,000
Maximum Annuities	\$100,000
Maximum Health and Disability	\$100,000
Maximum Aggregate Per Person	\$300,000

### ***Property/Casualty Guaranty Funds***

Maximum Claim            \$300,000 - \$500,000

Individuals who have several policies may have additional limits. For example, a person who owned a term life insurance for \$500,000, a whole life policy with cash values of \$150,000 and a single premium annuity with an accumulated value of \$200,000, will collect ONLY \$300,000 -- the maximum aggregate limit per person regardless of how many policies. The fact that these policies may be spread among three different insurers does not make any difference. There would still be a \$300,000 maximum in most states. The same is true for property/casualty claims. Regardless of the number of policies or how they are distributed among different insurance companies, the maximum claim that can be paid by a state guaranty fund is fixed at between \$300,000 and \$500,000 per individual. In addition to the individual annuity contract coverage provided, state life and health insurance guaranty associations generally cover individuals under group annuity certificates.

Where an individual has been issued evidence of insurance by or on behalf of the insurer, i.e., a "certificate", that individual is covered as though he had purchased an individual insurance policy. Coverage generally will be provided by the guaranty association of the state of residence.

## # Unallocated Funding Obligations

Unallocated funding obligations (UFOs) are group contracts that are not issued to and owned by an individual, and do not provide guarantees to any individual. They include unallocated annuities, funding agreements, guaranteed investment contracts (GICs), deposit administration contracts (DACs), and other arcane titles. As mentioned, employers often purchase such investment vehicles to fund retirement plans.

The types of UFOs ***not covered under the NAIC Model Act*** are referred to as "financials", a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery, and any unallocated annuity contract issued to an employee benefit plan protected under the Federal Pension Benefit Guaranty Corporation. However, when allocated annuities are purchased for pension plan participants in connection with a plan termination, normal guaranty association coverage then attaches.

Some states exclude all UFOs from coverage. The reason for this, and the reason for the limited, although high, coverage in the NAIC model act, is the moral hazard of unlimited coverage on giant contracts, under which investors could rely on outside guarantees instead of the financial strength of the issuer. This is the very problem that brought down so many Savings and Loans, swallowed the FSLIC, and that has also badly bitten the banks and FDIC.

## # Triggers

Generally, the guaranty associations provide coverage when the company has been declared financially impaired or has been ruled to be insolvent by a court of law. However, there are some situations preceding such a judicial action when many associations may take measures to cover the impaired insurer's policy holder obligations, particularly for health benefits, death benefits, and immediate annuity payments. However, since the primary purpose of the guaranty associations is to protect policy holders, and not to bail out impaired or insolvent insurers, most associations are reluctant to provide coverage before an order of liquidation, unless it is clearly demonstrated that to do so in a particular case will be less costly over time.

## # Coverage Options

Guaranty associations may provide coverage directly, or through outside administration or other insurance companies. In many cases, the guaranty association will continue coverage for the full policy period. It may do this directly or it may transfer the policy to another insurer or administrator.

In multi-state insolvencies, most guaranty associations work through NOLGHA to secure an assumption reinsurance agreement with another insurer or a claims servicing agreement with a third party administrator on a multi-state basis.

If the impaired or insolvent insurer is licensed in more than one state, as most are, NOLHGA's affected member associations try to work closely through our Disposition Committee with domestic receivers to protect policy holders and ensure early and equitable access of guaranty associations to the insolvent company's assets. On behalf of its participating member guaranty associations, NOLHGA's Disposition Committee expedites reinsurance assumptions, claims processing and audits.

## ## HOW DO LIFE/HEALTH GUARANTY ASSOCIATIONS DIFFER FROM PROPERTY/CASUALTY GUARANTY ASSOCIATIONS?

The NAIC Post-Assessment Property and Liability Insurance Guaranty Association Model Act limits the obligation of the association to covered claims unpaid prior to insolvency and to claims arising within 30 days after the insolvency, or until the policy is canceled or replaced by the insured, or it expires, whichever occurs earlier. There is no reason for the association to continue existing coverage since policy owners will be able to replace their property and liability policies. The function of the property/casualty association is to allow policy holders to make an orderly transition to other companies.

Unlike the property/casualty guaranty associations, life/health associations do not terminate coverage. The NAIC Model Act requires the associations to "guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer."

Life and annuity contracts are long-term obligations for which coverage must be continued. An insured may have impaired health or be at an advanced age so as to be unable to obtain new and similar life or health insurance coverage in the open marketplace.

Coverage may be continued directly by the guaranty association or, more often, by a new company to which the business is transferred. Guaranty associations generally avoid assuming the business of an insolvent company. They are not insurance companies and are not well equipped to track large numbers of long-term obligations. When possible, the policies and contracts of an insolvent company, with the help of an infusion of funds from the guaranty associations, will be reinsured with another company.

## **## OPERATING A GUARANTY ASSOCIATION**

The powers of the association are exercised through a board of directors selected by member insurers, subject to the approval of the commissioner. The directors are officers of insurance companies who serve on the board without remuneration. Expenses incurred in fulfilling the duties of a director may be reimbursed by the association.

The association fulfills its functions under a plan of operation developed by the association and submitted to the commissioner for approval within a period of time, typically 30 days, after the guaranty association is created. The **NAIC Model Act** requires the plan of operation to:

- ! establish procedures for handling the assets of the association
- ! establish the amount and method of reimbursing members of the board of directors for their expenses
- ! establish regular places and times for meetings of the board of directors
- ! establish procedures for records to be kept of all financial transactions of the association, its agents, and the board
- ! establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner
- ! establish any necessary additional procedures for assessments besides those set forth in the statute
- ! contain additional provisions necessary or proper for the execution of the powers and duties of the association

The NAIC Model Act also permits a board of directors, with the approval of the commissioner, to **delegate its powers or duties**, except its assessment power and its right of subrogation, to a corporation, association, or other organization that performs functions similar to those of those associations in two or more states. The association is also empowered to employ or retain such persons as are necessary to handle the financial transactions and other necessary and proper functions of the associations.

## **## WHO PAYS FOR GUARANTY ASSOCIATION PROTECTION & WHEN?**

The funds necessary to fulfill an insolvent insurer's obligations are obtained by **assessments levied against other insurance companies doing business in the state**. The amount each company must pay depends upon how much business that company writes in the state of the same type written by the insolvent company. Assessments are capped on an annual basis to ameliorate the adverse impact upon the insurer's financial stability. The limits range from 1% to 4%, with most states imposing an annual assessment limit of 2%. State law also provides that an assessment may



be waived for an individual insurer if the commissioner of that state determines that payment of the assessment would endanger the insurer's ability to meet its own obligations. Assessment waived for an individual insurer are paid by the remaining insurers doing business in the state.

Assessments are **levied when an insurer has been declared financially impaired or when the insurer has been declared insolvent by a court of law**. To enable a guaranty association to fulfill policy holder obligations quickly, state statutes permit the associations to borrow money. This enables an association to pay claims while work continues to determine the appropriate amount to be assessed.

Forty-two of the fifty-one jurisdictions with guaranty associations allow insurers to offset, against their premium or other tax liability to the state, all or part of the amount paid as assessments to the state guaranty association. These numbers illustrate the recognition by most state legislators of the soundness of allowing companies to offset assessments against premium taxes. A breakdown in the system resulting in the insolvency of the company is one of the costs that the state should bear as part of its responsibility for solvency regulation. The tax offset, therefore, acts as an incentive to effective solvency oversight by the state regulators.

To maintain a balanced budget, state governments face the choice of raising other state taxes, increasing borrowing or reducing services. For this reason, governmental interest in reducing the costs associated with insolvency is understandable. Yet, states seem unwilling to recognize the relationship between the funding of insurance regulatory oversight and the possibility that lower funding levels may mean a higher number of insolvencies. A higher number of insolvencies may cause a decline in available revenue through the tax consequences of guaranty fund assessments. The Government Accounting Office (GAO) implies such a linkage exists between regulatory resources and the number of insolvencies. In-depth audits of insurance departments nationwide determined that over 40 percent had difficulty in obtaining adequate funding that prevented them from hiring needed or qualified examiners. A specific example included one state where a staff of 29 was in charge of analyzing almost 6,500 annual statements.

The GAO and others have proposed regulatory improvements. Most of the improvements require additional regulatory funding. However, if regulatory improvements result in the earlier detection of troubled insurers, a situation exists

with the possibility of a gain for all parties. Because an improvement in regulatory oversight is likely to result in a reduction in the need for assessments, it is possible that the associated tax and insurance cost savings could more than offset the increased regulatory cost.

## **## THE CONSEQUENCES OF GUARANTY FUND PAY OFFS**

Two questions arise as a consequence of guaranty fund distributions:

- ! What are the implications of shifting the burden of the shortfall from the policy holders of the insolvent firm to assessed insurers?
- ! What are the implications of allowing assessed insurers to shift parts of the burden to taxpayers?

First, what is the impact of shifting the burden away from the policy holders of the insolvent insurers? ***The existence of guaranty funds reduces the incentive for consumers to review the financial strength of prospective insurers.*** Individual policy holders covered by guaranty funds do not typically bear losses beyond delays. Therefore, consumers may focus attention on price or interest rate without much regard to financial strength when selecting an insurer. This reduction in policy holder monitoring may cause insurers to seek higher rates of return by adopting

riskier investment strategies. With regard to insurance, the guarantees result in pressure for insurance managers to increase the risk level of their investments in order to lower the price of their products. The increased risk results in a general increase in the probability of insolvency.

Another incentive produced by the existence of guaranty funds involves regulator behavior. Because the cost of a shortfall in an insolvent insurer is initially borne by assessed insurers, with the state tax credits being spread over five years, and sometimes more, the effect of an insolvency is spread over time. In addition, the effect is spread over a larger constituency: taxpayers rather than just policy holders. Therefore, **guaranty funds** appear to reduce the incentive of consumers to shop based on the financial strength of the insurer. They **may also reduce the incentive for regulators to quickly remove a failing insurer from the market.**

The second issue was the implication of allowing assessed insurers to shift some of the burden of the assessment to taxpayers. Before addressing this issue, it may be helpful to remember what events cause a policy holder to rely on a guaranty fund for compensation. Ultimately, if the state regulator does not remove a failing insurer prior to it depleting its capital, then a shortfall is created. At present, the responsibility for removing failing insurers is the jurisdiction of the state governments. This does not imply that an insolvency is a failure on the part of state regulation. Failing insurers are evidence of a competitive market where some providers are driven out of business. However, some industry will argue that **because the state failed in its legislative and regulatory oversight, it should be the state government that bears the burden of the shortfall.**

Though the decision is ultimately a value judgement, there are some compelling reasons for providing state tax credits for assessments paid. These reasons include more appropriate cost sharing, and the effect on the incentive to regulate. There is some logic in spreading the burden in the broadest possible manner. For states, this means distributing costs through their general revenue systems. Using the broadest possible method to spread the burden appears appropriate when the potential payees are neither responsible, nor the primary beneficiaries of the payments. The equity holders, policy holders, and employees of the assessed insurers have as their greatest offense in this scenario, the decisions to affiliate with an insurer that was financially stronger than the insolvent insurer. Therefore, it seems to serve fairness to spread the costs as broadly as possible.

There is an additional reason for states to provide credits. Because the states have the primary responsibility for policing solvency, a **credit against assessments gives the states a financial interest in improving their regulatory effectiveness.** To this end, states would have the greatest incentive to regulate if the credits were applied as they are in South Carolina where assessed insurers are allowed a 100% tax credit. The South Carolina credit minimizes the impact of the insolvency on the federal revenue system. The credit provides for the broadest possible distribution of the burden of insolvency within the state. Short of a reason to penalize a particular group, such as policy holders of assessed insurers, it seems to be a fairer method of allocation. And finally, the state tax credit provides a financial incentive for regulators to be more effective in policing solvency.

## **## THE REASON GUARANTY FUNDS RECEIVE FEDERAL & STATE INCENTIVES**

Unless a benefit relationship exists that enables government to charge a price mimicking the market system, expenses are typically distributed in the broadest manner possible, that is, through the general revenue system. The market system allows the beneficiaries of a good or service to choose the product because they perceive the value of the benefits to be greater than the price. The structure of guaranty funds suggests that government does not expect a quid pro from the primary beneficiary of guaranty fund protection, in essence, insureds of the insolvent insurer. Instead, government attempts to finance guaranty protection by spreading costs broadly across the population.

Absent guaranty funds, an insolvency has a negative impact primarily on insureds of the insolvent company and third party claimants. **Government has deemed it socially desirable to minimize the negative impact on insureds of the**

***insolvent insurer by spreading the burden of insolvency to others.*** In effect, the existing set of laws relies on taxpayers through the general revenue system, owners and employees of insurance companies, and insurance consumers to pay the costs of insolvency. Additionally, government requires the insurance industry to finance the governments' portion.

Rather than rely exclusively on government revenues for funding, guaranty funds rely on insurers for short-term funding needs. That is, guaranty funds pay many of the claims of the insolvent insurer with monies obtained from the assessments on surviving insurers. Then, most states grant a tax credit against state taxes for assessments paid.

Essentially, ***guaranty funds allow the state to compensate victims of an insolvency without budgeting for the anticipated claims expense and without incurring an interest cost for borrowing the required funds.*** The "loan" made by insurers is repaid in the form of tax credits and deductions. The repayment reduces corporate taxes causing government to rely more heavily on other revenue sources than it would absent the insolvency. Hence, part of the cost of insolvency is shifted to taxpayers from customers of the insolvent insurer, but part is shifted to its former competitors. The distribution of the portion shifted to taxpayers is determined by the incidence of the federal and state revenue system.

The model state tax credit scheme is 20 percent of the assessment for each five years, beginning the year after the assessment. Because the credits are spread over five years after the assessment is paid, and because not all states grant tax credits that sum to 100 percent of the assessment, insurers incur opportunity costs, the so-called time value of money issue, and administrative costs of compliance that may not be shifted.

When a state does not offer a tax credit that sums to 100 percent of the assessment, additional offsets are available to insurers. A portion of assessments not offset by a state tax credit may be paid by insureds of the surviving insurer through recoupment provisions allowed under the guaranty fund acts of some states. Finally, of the assessments not recouped or offset by a state tax credit, insurers may offset 34 percent through the federal tax system because the assessment, as a business cost, is deductible from federal corporate income taxes.

Placing the focus of insolvency cost on guaranty fund assessments diverts attention from a number of other insolvency costs. For example, unless they have extracted their capital, the owners of the insolvent firm bear a loss of equity. Assessments also require the insurer to determine their correctness, at some positive cost, and to make the payment. Because the payment reduces surplus, the ability to write new business is inhibited. Insureds of the insolvent insurer and third party claimants also bear a cost because guaranty funds limit the amount of coverage with claim caps and deductibles.

The cost of insolvency remaining with surviving insurers is likely to have both direct and indirect effects. Among the direct effects, the profits of insurers may be reduced, the taxes paid by insurers will be reduced, and industry concentration may be increased. Among the indirect, or consequent effects, the availability of insurance may be impaired. That is, because the rate of growth of insurance company surplus is positively related to profits, a non-transferable guaranty fund assessment will reduce the profits and the rate of surplus growth. A reduction in the rate of growth of surplus will constrain the growth of insurance availability. Consequently, the quantity of risks undertaken might be reduced and society would suffer a loss of utility from the foregone consumption opportunities.

The general revenue system putatively distributes the cost of government in the broadest manner. The reasons a government might deviate from funding in the broadest manner include (1) the group targeted for heavier taxation disproportionately benefits from the activity being funded, (2) there is a desire to penalize the group for culpability in the insolvency, or (3) the distribution will be more/less progressive than the general revenue system and this result is deemed desirable.

With respect to the benefit argument, ***insurers may benefit from a higher level of consumer confidence because guaranty funds exist***, but the net benefits are uneven. The best and worst insurers benefit from consumer confidence created by reliance on the existence of a guaranty fund. Indeed, the incentive structure outlined below suggests that the ***benefits to weaker insurers are greater***. With a guaranty, consumers are less sensitive to financial strength, and they are more likely to shop on price alone. Consequently, weak insurers may attempt to cover losses through underpricing to attract revenue. The underpriced risks accepted increase the ultimate cost and likelihood of the insurers insolvency. It is possible that better insurers would benefit from the elimination of the guaranty fund because, while aggregate demand may be lower, consumers would be more likely to choose the products of fiscally sound insurers. It is not clear that the net benefit of guaranty funds to the industry is positive.

The culpability argument also seems unlikely to apply to surviving insurers. It is primarily governmental regulators rather than competing insurers, that have responsibility for ensuring the financial integrity of an insurer. It is similarly unlikely that the distribution of costs to shareholders and insurance consumers is a more progressive funding pattern than that incidence of the general revenue system. Because insurance is a normal good, the quantity purchased by consumers is a higher percentage of income for lower income individuals. Like any tax on a normal commodity, the incidence of the portion borne by consumers is regressive. Absent tax credits, the percentage of insolvency costs borne by consumers would increase. Some suggest that competition will cause the assessment to be paid from shareholders' equity, rather than by insurance consumers. This result would be more likely to occur if a subset of the industry were paying the assessment. Costs that are common to all firms in the industry are typically included in the price paid by consumers.

While the incentive structure of guaranty funds has been critiqued by many, a viable alternative has not yet surfaced. A number of commentators have suggested excluding large commercial insurance purchasers from guaranty fund protection. Some find this suggestion appealing because it is likely that the external benefits from the monitoring performed by these purchasers would accrue to individuals and small commercial purchasers.

## **## CAN GUARANTY ASSOCIATIONS HANDLE MAJOR INSOLVENCIES?**

The answer to this question depends on the authority asked. Following are some relevant issues:

### **# Industry Critics**

Association funds, according to the critics, are full of exclusions, qualifications and other stipulations that make it difficult to figure out exactly what is covered. For example, a group annuity purchased by a company pension does not individually name the employees covered under the plan. Although state guaranty fund limits may reach \$1 million to \$5 million for these group contracts, losses in excess would not cover individual employees. Further, once an insurance company takes over control of a group contract, protection by the Pension Benefit Guaranty Corporation is lost. Guaranteed Investment Contracts, GICs, have similar limitations.

Another limitation of the system, say the critics, is how money is raised. In the event of a major loss, most states can assess insurers an average of up to 2 percent of the amount of premiums written for the previous year. Some states may assess as much as 4 percent while others are currently limited to only 1 percent. Where a significant loss has occurred, the low level of these assessments might require several years for full coverage to occur. Further, an insurance company can appeal the amount of the assessment or defer making payment if it would put them at financial distress.

Congress has also raised doubts about the system based on recent Government Accounting Office (GAO) report specifically addressing health care reform. The GAO said its survey of insurance departments found wide variations in the way they "monitor insurance solvency and approve health insurance premium rates and respond to consumer

complaints. The consequences of an insurance company failure can be catastrophic for policy holders who may be left with millions in unpaid claims and without health insurance, and while states have guaranty funds to protect consumers when an insurance company goes broke, there are gaps in that safety net. Consumers may be left unprotected when an insurer with multi-state operations fails, and in 30 states, the guaranty funds do not cover Blue Cross or Blue Shield plans."

## # **Industry Supporters**

According to the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), the aggregate annual assessment capacity of the life/health guaranty associations is \$3.06 billion. This figure does not include the recently-enacted Colorado, Louisiana, or New Jersey guaranty association laws. Broken down by line, the aggregate annual assessment capacity is \$1.09 billion for life insurance, \$784 million for annuity contracts, and \$1.2 billion for accident and health insurance. This capacity far exceeds the obligations confronted by the state guaranty association system to date.

When considering the capacity of the current guaranty association system to handle a major insolvency, it is important to remember that, for many types of losses, guaranty association assessments can be made over many years. For life insurance contracts and annuities, the guaranty associations often simply continue in force or reinsure the business. Thus, the losses will be spread over a number of years as benefits are paid. Because losses are spread over a period of years, the one-year assessment capacity of the guaranty association system is not conclusive in determining the ability of the system to cope with losses from any major insolvencies that might occur.

The current system of post-insolvency assessment state guaranty associations has protected consumers well. State guaranty association laws have been easily adapted to changing circumstances over the past five years to ensure timely payment of policy holders' claims.

In 1990, the American Council of Life Insurance appointed a Study Group to consider alternatives and enhancements to the current guaranty association mechanism. The Study Group issued its final report in October, 1991. Members of the Study Group concluded that in order to buttress policy holder confidence in our industry in the current economic environment, a universal and more uniformed guaranty mechanism was needed, as well as a strengthened state regulatory system. The Study Group made the following specific recommendations:

- 1) The Study Group believes the capacity of the guaranty association system is more than adequate to handle insolvencies that may occur; however, if concerns regarding the capacity of the current system persist, the concept of a catastrophic insurance system should receive further consideration.
- 2) Enactment of the NAIC Life and Health Insurance Guaranty Association Model Act, modified in accordance with ACLI policy, should be sought in the District of Columbia.
- 3) Existing guaranty association laws should be amended, where appropriate, to provide for "residents only" coverage, including the exception for non-resident policy holders, consistent with the NAIC Life and Health Insurance Guaranty Association Model Act. Amendments should be sought only where it is possible to do so without jeopardizing existing premium tax offset provisions.
- 4) The current NAIC Model Act and existing guaranty association laws should be amended, where appropriate, to eliminate coverage for unallocated annuities. Amendments should be sought only where it is possible to do so without jeopardizing existing premium tax offset provisions.
- 5) Enactment of a full premium tax offset should be sought, where feasible, in all jurisdictions.

- 6) The NAIC should be encouraged to stipulate the provisions that must be included in a state's guaranty association law in order for that state to be accredited.
- 7) Enactment of the NAIC Insurers Rehabilitation and Liquidation Model Act and the NAIC Administrative Supervision Model Act should be sought, where appropriate, in all jurisdictions.
- 8) The NAIC should be encouraged to adopt standards to require receivers to (a) cooperate with guaranty associations to minimize the administrative costs of insolvencies, (b) utilize uniform automated reporting systems to minimize administrative costs, and (c) pursue recovery from affiliates under section 14.E of the NAIC Life and Health Insurance Guaranty Association Model Act. Adoption of these standards ought to be required for accreditation by the NAIC.
- 9) The legislative committee should appoint a Study Committee including public relations, marketing, actuarial, and legal experts, to re-examine the issue of advertising and disclosure of guaranty association coverage. The study should cover the questions of advertising and disclosure specifically in connection with marketing practices of agents.

# REINSURANCE

by Affordable Insurance Educators  
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In reading this chapter, it will become clear that reinsurance plays a vital role in helping all types of insurance companies meet their everyday commitments. The greater frequency of recent insurer downfalls and natural disasters, however, is creating a shakeout in the industry causing many longstanding reinsurers to exit the business. Some insurance companies who also sell reinsurance have suffered the hazards of double exposure by having to pay claims from BOTH their primary and reinsurance divisions. It is also the contention of some industry groups that abuse of the reinsurance system, including some questionable reinsurance schemes by depressed insurers and foreign reinsurers, has been a key factor in almost every insolvency. In response to many of these issues, reinsurance companies have reassessed their own risk/reward underwriting leading to higher prices and in some cases decisions to cease business altogether. Buyers of reinsurance, in turn, have been finding price increases difficult to handle and quality reinsurers harder to come by. Eventually, this has and will limit their ability to write policies causing what some believe to be a "capacity crunch". Given this scenario, it is understandable that reinsurance and insurer safety are closely related and important topics of study.

## ## PURPOSE & PRACTICES OF REINSURANCE

### # Reinsurance Defined

Reinsurance is often described as the *insurance of insurance* companies because it provides reimbursement for the insurer's losses under policies covered by the reinsurance contract. Insurance placed with the reinsurer is called the *ceded amount*, and the company that receives the benefit of the insurance is called the *ceding insurer*. Insurance purchased by reinsurers to cover their own losses is called *retrocession*. The process of reinsurance involves a transaction whereby the reinsurer, for a premium, agrees to indemnify the ceding insurer or reinsured against all or part of its losses under policies written. It is a transaction which does not involve the policy holder who looks only to his insurer for defense and indemnity against loss. Reinsurance is purchased by a primary or an excess ceding insurer for its own benefit so that it can *spread its risks and limit its own liability* from large or catastrophic losses.

Reinsurance is often confused with excess or surplus line insurance. However, the two are totally unrelated. Excess and surplus line insurers are primary companies providing direct coverage to insurance consumers. Their function is to supplement the standard admitted insurance markets. Excess and surplus line insurers are, in turn, large purchasers of reinsurance.

### # Sources & Reasons For Reinsurance

Reinsurance can be obtained through *three distinct sources*: professional reinsurers, reinsurance departments of primary insurance companies and unauthorized alien reinsurers. The insurance premium charged policy holders by insurers includes the cost of reinsuring the risk. In other words, there is *no added charge to the policy holder*. The primary company calculates the premium on a gross basis and all reinsurance expenses are incorporated in the premium. The insurer has the responsibility to evaluate the risk in its totality and to price the risk according to the potential loss exposures. The distribution of the *reinsurance premium between the insurer and the reinsurer* is a separate transaction which *does not involve the policy holder*.

There are many *reasons primary insurers purchase reinsurance*. The two most important are to limit their liabilities and to increase their capacity. An insurance company may wish to *cap its exposure* to losses in one or a

combination of three ways: *a per risk limitation, a catastrophic loss limitation or an aggregate of loss limitation.*

Prudent insurance management and certain insurance regulations demand that a company place a limitation commensurate with that company's surplus or equity on any one potential loss exposure, even though the company may provide coverage under an insurance policy in amounts considerably in excess of this prudent "retention". This is where reinsurance comes in. The individual company's retention may be anywhere from a few thousand dollars to several hundred thousand or even in the million dollar range. Whatever the loss exposure may be above the retention, up to the policy limits of the reinsurance contract, if any, becomes the responsibility of the reinsurer.

Most companies also seek to protect themselves from a disastrous accumulation of losses arising from a single event. For instance, a hurricane or an earthquake. No one single loss payment arising from the event might be beyond the company's individual risk retention level, but the accumulation of all the losses arising from the incident might be excessive for that company. Generally speaking, an insurer estimates the probable maximum loss to which it may be exposed, based on its business concentration in any particular geographical area, compares that exposure to its surplus and purchases reinsurance to cover the potential losses which exceed a prudent level of catastrophic retention.

Another approach often used by companies to limit their potential liabilities attempts to cap the aggregate losses which may be sustained over a specific period -- say one year -- either with respect to its total combined losses for the period or the combined losses for certain lines of insurance. The important reason an insurer may want to purchase aggregate loss reinsurance is to stabilize its operations from year to year.

By providing a mechanism whereby companies may limit their loss exposures to levels commensurate with their surplus, reinsurance allows those companies to offer coverage limits considerably in excess of what they could provide otherwise. This is a crucial function for small to medium size companies, allowing them to offer coverage limits which meet the needs of their policy holders. If only the larger insurers could do so, there would ensue considerably less competition and insurance capacity would be much more restricted than it is today.

Reinsurance further *enhances an enlarged capacity* by a variety of other approaches which are related to accounting procedures. When an insurance company issues a policy, the expenses associated with issuing the policy, such as taxes, agent commissions and administrative expenses, become a current charge on surplus, while the premium collected must be set aside as an unearned premium reserve. The premium can only be considered as earned by the company and available to it over the life of the policy. This mismatch in accounting between premium and expenses makes good sense from a regulatory standpoint in that it allows for a more conservative accounting, commensurate with regulation for solvency. But it penalizes insurers to the extent that the more business they write, the more they must draw down on their surplus, thus reducing their capacity. By reinsuring a part of the business written, an insurer is able to limit the impact of the mismatch since the reinsurer must reimburse its client company for its proportionate share of expenses. The reinsurer then is the one which must reduce its surplus by the expenses it absorbs from its reinsured.

Similarly, when a claim is presented to an insurance company, a loss reserve must be established for the amount of anticipated claim payment. The reserve also comes from the company's surplus. However, to the extent a reinsurance recovery is anticipated on the claim and the reinsurer qualifies under state regulation, the insurer may limit its loss reserve to the extent of its own estimated "out of pocket" liability.

There are other approaches to reinsurance as a mechanism to enhance capacity. One such approach which was used perhaps to excess in the past is known as a "loss portfolio transfer". Under this transaction, the insurer "sells" a portion of its loss reserves to the reinsurer which promises to pay the claims represented by these reserves when they are finally adjusted. Assuming that the loss reserves being transferred to the reinsurer exceed the payment which the insurer makes to the reinsurer, the difference may be added to the insurer's surplus, thus, enhancing its capacity.

Reinsurers provide *other services* besides financial transactions aimed at limiting an insurer's exposure to losses, stabilizing an insurer's operation or enhancing its surplus to increase capacity. Many reinsurers are equipped to provide guidance to insurers in underwriting, claims reserving and handling, investments and even general



management. These services are particularly important to smaller companies or to those which may wish to enter new lines of insurance.

## # Limitations of Reinsurance

First and foremost, *reinsurance does not change* the inherent nature of risk being insured. Thus, it does not make a bad risk insurable. Neither is reinsurance, nor can it be made to be, a subsidy allowing underpricing of risks. Finally, reinsurance does not make a risk exposure more predictable or desirable. While it may limit the exposure to a risk from the standpoint of the primary insurer, the total risk exposure is not altered through the presence of reinsurance.

## # Reinsurance Contracts

There are two basic types of reinsurance contracts. The first, called a "*treaty*", covers some portion of a particular class or classes of business, e.g., the insurer's entire workers' compensation business or its entire business covering exposures in a state. Treaties are usually expected to remain in force for long durations and are often renewed on a fairly automatic basis unless either party wishes to negotiate a change in terms. The second contract form is called a "*facultative agreement*". It allows an insurer to reinsure a specified risk under terms and conditions agreed upon between the insurer and reinsurer.

*Facultative reinsurance* contracts are used to supplement treaty arrangements. Treaties may, for instance, contain certain exposure exclusions such as exposure involving long haul trucking, munitions manufacturing, or environmental liability. Risks which are written by the insurer which may have such exposures are then covered separately under facultative reinsurance contracts. The reinsurer which provides the company's treaty coverage may not necessarily be the one providing the facultative reinsurance.

There may also be certain classes of risks which are anticipated to develop losses which may adversely affect the treaty experience which, although not excluded from a treaty, may be placed facultatively. A school bus might fit in this category.

Risks whose exposure may be catastrophic are often facultatively reinsured as are unusual risks. Prior to the 1950s, there was relatively little use made of facultative reinsurance in the U.S. Lloyd's of London was virtually the sole market. U.S. reinsurers began to compete for the business in the 1950s and today facultative reinsurance has assumed a major role in the domestic reinsurance market. In a survey conducted by the RAA for year end 1987, casualty reinsurance dominated the facultative business. Facultative reinsurance requires a technical expertise not available to all reinsurers. Since risks are reinsured on an individual basis, the reinsurer must have the necessary knowledge to underwrite and price exposures on an individual basis. This resembles, in many ways, the steps which an insurer must take in writing its direct business.

*Treaty reinsurance* underwriting is, on the other hand, very different. Keep in mind that reinsurance treaties automatically cover all risks written by the insured, unless they present exposures which have been specifically excluded. Although treaty reinsurance does not contemplate an individual underwriting risk review by the reinsurer, it demands a careful review of the underwriting philosophy, practice and historical experience of the insurer, a thoughtful evaluation of its management attitude toward claims and engineering control, as well as management's general background, expertise and planned objectives.

Both facultative and treaty contracts may be written on a prorata basis or an excess of loss basis and sometimes on a combination of both. A pro rata contact simply prorates all premium, losses and expenses between the insurer and the reinsurer on a pre agreed basis. Although reinsurers have, of late, avoided the prorata approach in casualty lines, it is still used extensively in property reinsurance.

*Excess of loss reinsurance* which also can be the base of either facultative or treaty reinsurance contracts requires

the primary company to assume all losses up to a predetermined amount, called *the retention*, and for the reinsurer to reimburse the ceding company for any excess over the retention, up to the limits of the reinsurance contract. This arrangement provides the reinsurer with an opportunity to develop a rate commensurate with its exposure and to bargain with the insurer for an adequate share of the total premium.

## # Reinsurance Marketing

Any insurance company may sell reinsurance. The insurance license issued by a state insurance department designates the lines of business a company may sell, i.e., automobile, workers compensation, etc. Once authorized to do business in a specific line in a state, the company may either provide insurance or reinsurance for that line. Some insurance companies, known as *professional reinsurers*, specialize in reinsurance. While U.S. licensed professional reinsurers provide approximately 52 percent of the U.S. insurance industry's reinsurance needs, many insurance companies sell reinsurance as an adjunct to their direct insurance activities through reinsurance departments. Approximately ten percent of the domestic reinsurance market is represented by reinsurance departments of U.S. direct insurers. The balance of the U.S. market reinsurance needs are provided by alien companies. It is of interest to note that after having remained stable at around 30 percent for ten or more years, the foreign share of the U.S. reinsurance market has substantially increased in recent years.

Reinsurance may be provided by companies either *directly or through reinsurance brokers*. A small number of larger reinsurers, called direct reinsurers, deal directly with their customers, insurance companies. Those companies provide direct customer assistance on underwriting, claims handling, and management service as well as reinsurance. U.S. direct writing companies write approximately 40 percent of the U.S. reinsurance premium. Other reinsurers deal through reinsurance brokers, known as intermediaries, who place the reinsurance coverage of insurance companies with reinsurers, which are often referred to as "broker reinsurers". Reinsurance brokers may also provide consultative services to insurers as is often done by the direct writing companies.

In the broker market, it is customary for the larger broker reinsurance companies to compete for a reinsurance contract and for the smaller broker companies to assume various shares of the contract. Since direct writing reinsurers are usually larger, they often keep large reinsurance contracts for their own accounts.

An insurance company will usually have in force *simultaneously several reinsurance contracts*. Some contracts may cover specific lines of insurance coverage at various limits of coverage. Others, through facultative reinsurance, may cover specific insurance policies. Since the primary purpose of reinsurance is to spread risk exposure to levels commensurate with the financial ability of insurers to pay losses, reinsurance relationships vary from insurer to insurer.

Reinsurers themselves purchase reinsurance called *retrocession*. As with reinsurance purchased by a direct insurer, the amount of retrocession purchased by a reinsurer depends on its capital base and the extent of the risk reinsured.

## # Reinsurance vs. Insurance

The traditional role of reinsurance has been to serve as the insurance industry "shock absorber". It exists to level individual companies' distortions in year to year operations that result from those relatively few losses larger than they can readily sustain financially.

The *premium distribution between insurance and reinsurance* has remained fairly stable over the past decade, hovering around ten to one. Of course, the relative premium share between insurance and reinsurance varies by line, with considerably greater reinsurance used in commercial exposure.

While it would be helpful to know the size of the capital surplus which supports the net reinsurance premium written in the U.S., this figure is, unfortunately, not available. This results for two major reasons. First, partly because some

alien markets do not release surplus information, and partly as a result of major differences in accounting conventions, the surplus supporting the 38 percent of the U.S. net reinsurance premium written by alien companies is unknown. Second, primary insurers assuming reinsurance through reinsurance departments are not required to segregate surplus, and their numbers are not available.

## # The Pricing of Reinsurance

Many students of insurance economics assume that insurance and reinsurance react similarly to the economic environment in which they operate. Actually, there are important distinctive characteristics which, over the long term, must accommodate reinsurance economic realities. Much of the *difference between insurance and reinsurance* can be ascribed to factors which must be considered in conjunction with rating and pricing the reinsurance product, particularly with respect to excess of loss reinsurance.

The pricing of reinsurance for life companies is quite a bit clearer than for casualty insurers. *Life insurance reinsurance* only insures the difference between net amount at risk and the net retention of the insurer. The net amount at risk is essentially the policy face amount less its terminal reserve. As the terminal reserve increases throughout the life of the policy, the amount of the policy reinsured continually decreases.

*Casualty reinsurance* pricing is quite similar to the pricing of primary insurance. Its elements must contain sufficient amounts to cover losses, expenses and profits. The most difficult of these elements to develop is "losses". To the extent credible and relevant data is available, ordinary actuarial rate making techniques can be used. The data must, of course, be adjusted to reflect changes which have taken place since the data was developed and the anticipated changes which will occur over time until the last claim on a contract is ultimately paid -- and for reinsurers, this could well be decades in the future.

Although this may sound simple, in practice the pricing of excess of loss reinsurance presents extraordinary problems. These stem from three basic facts:

1. Relevant and credible loss data is often unavailable.
2. Reinsurance losses take so long to develop that great reliance must be placed on incurred, but not reported, losses and their evaluations are extremely sensitive to changes in the environment in which the actual claims will be adjudicated.
3. Finally, the impact of inflation on future loss payment -- whether due to changes in the liability system, more generous jury awards, price level changes or whatever -- is more severely felt by reinsurers than insurers.

First, let's discuss relevant and credible loss data. Insurance and reinsurance loss costs are functions of a combination of frequency, how many claims per unit; severity, the average cost of each claim; and the total number of units to be insured. Generally speaking, the higher the number of similar units insured, the more reliable the data. Automobile property damage liability is a case in point. There are many automobiles to be insured, and the frequency of claims is relatively stable from year to year.

Reinsurance, on the other hand, is characterized by a relatively low and unstable frequency and a very high, but also unstable, severity. Thus, the law of large numbers upon which insurance pricing depends does not often apply to reinsurance. The reinsurance underwriter is much more dependent on judgement factors, based on experience, to develop an adequate price.

The second basic fact about pricing reinsurance is loss development. Because the traditional general liability insurance contract provides for coverage of any loss occurring during the policy, irrespective of when the loss is reported, it leaves the insurer exposed to claims which may be filed many years after the policy has expired. Certain exposures are particularly susceptible to this latency factor, referred to as the "long tail".

Although this delay in reporting creates serious problems for all insurers, there are marked differences in loss development patterns between reinsurers and primary insurers.

The major reason for these differences lies in the retention feature of excess of loss reinsurance. Since many claims are not valued at ultimate cost initially and the initial reserve is within the primary insurer's retention, the primary insurer may not report such claims to its reinsurer until considerable time has passed. The relative development can be much larger for the reinsurer than the primary insurer since the primary insurer's net loss on any particular claim is limited for annual statement purposes to its retention. In addition, the primary company's claims department has more direct control over the administration and adjudication of each claim.

The table on the next page will illustrate the point. Note, for instance, that in workers' compensation, a primary insurer is aware of 67 percent of the losses it will incur at the end of the first year of the insurance policy. The reinsurer only knows of nine percent of its losses by that time. After the fourth year, the primary company knows of all but five percent of the losses it will incur. The reinsurer still does not know 68 percent of its liability.

This delay creates major problems for reinsurers in the anticipation of losses and the consequent rating of future business on the basis of accurate loss information. For the past several years, the RAA conducted studies on reinsurance loss development trends. In recent years, loss development factors have become larger. With few exceptions, each year's additional information has proved previous loss development patterns to have been optimistic.

Assuming no change in the future loss development pattern, only a bare majority of losses on reinsurance contracts covering general liability exposures issued, say in 1990, will be known to the reinsurers by the end of the century. Keep in mind that these losses will be adjudicated in the social, judicial and economic environments which will then prevail, but the premiums to pay those losses must, nevertheless, be collected.

## # **IBNR Reserves**

Of course, all insurance companies, *insurers and reinsurers* must set aside *loss reserves* for claims which have not as yet, but are anticipated to be, reported. These *incurred, but not yet reported (IBNR)*, reserves are drawn down as losses develop. Companies use a variety of methods to establish IBNR and continuously review these reserves in light of current and anticipated changes. However, since these reserves represent loss payments to be made in the future, they are extremely sensitive to changes in social, economic or legal environments. In effect, they are a "*best guess*" expectation of future anticipated loss payments.

When IBNR reserves represent a small fraction of loss reserves, they may not have a significant influence on *total losses reported* on past policies, the single most important element used in rating current exposures. However, for reinsurers, particularly in general liability and workers' compensation lines, IBNR reserves are the major data available to rate current exposure.

The lack of reliability of this large IBNR reserve creates a major difficulty in rating exposure as environmental liability, some professional liability and others. For reinsurers, this is aggravated by the fact that reinsurance losses are so much slower to develop and, to the extent they are limited through retention, reinsurance losses are capped at amounts considerably in excess of primary company retentions.

Back in the early 1960s, for instance, it was common for a reinsured company to offer \$5 million or \$10 million coverage limits to a commercial policy holder, but retain only \$50,000 or \$100,000. All losses in excess of those retentions were then intended to be absorbed by reinsurers and retrocessionaries. However, since it was expected that the retention would suffice to cover the majority of losses, the reinsurance premium paid was relatively small.

What has, in fact, happened is that those contract retention limits today are being reached and pierced with unexpected frequency in just about all lines of a business as a direct consequence of the unexpected changes in the

civil justice system and inflation.

## # Tort Awards & Reinsurance

The Rand Corporation's Institute of Civil Justice's report, "Trends in Tort Litigation: The Story Behind the Statistics", confirms what reinsurers had suspected all along -- changes in jury award patterns have been concentrated in the excess limit coverage layers, those which so often reach into the reinsurance protection. This should come as no surprise since there appears to exist a general consensus that average awards in tort cases have increased significantly over the past few years. The dispute between consumer and insurance industry advocates is whether the proper measurement of jury liability should be "average" or "mean cost". If we assume that mean costs have remained relatively stable, as claimed by consumer spokesmen, but average costs have increased, it is obvious the coverage layers most affected by changing award patterns are the excess of loss layers -- those which directly impact on reinsurance.

## # Inflation & Reinsurance

The disproportionate effect of inflation on loss costs of reinsurance is made readily illustrated on the previous page.

As mentioned above, the reason for this skewed distribution between insurers and reinsurers inflation effect is the fixed retention limit which protects the ceding company's exposures on those contracts customarily used for casualty lines. That is, excess of loss contracts.

## ## REINSURANCE REGULATION

In a recent Subcommittee report to Congress, the following was said about the regulation of reinsurance, "Basically, reinsurers are not regulated directly because the focus of regulation is on the primary insurance company that writes a policy for a customer." This statement is incorrect with respect to the 62 percent of the reinsurance premium assumed by U.S. reinsurers.

Contrary to common belief, U.S. reinsurance companies are regulated. In fact, their **regulation is similar to that of primary insurers**. The driving force behind regulation of U.S. reinsurers is to safeguard reinsurance insolvency. Reinsurance purchased at the lowest price means nothing if the reinsurance company is no longer in business when the claim payment for indemnification comes due. Therefore, the primary focus of state insurance regulators, with respect to reinsurers, is to ensure that reinsurance companies are able to pay claims.

U.S. **reinsurers' filing requirements** are similar to primary companies', including the same voluminous annual Convention Statement and quarterly financial statements. Reinsurers are likewise subject to similar state and zone examinations. This, however, only applies to companies which are domiciled or licensed in the U.S.

As previously mentioned, a substantial share of U.S. reinsurance is written by unauthorized alien companies which are out of the reach of U.S. regulators. A simplistic approach to overcoming the jurisdictional limitation of state regulators would be to limit the U.S. reinsurance market to U.S. domestic or licensed companies. Traditionally, however, the international reinsurance markets have been the main source of retrocession insurance. The influence of the London markets, in particular Lloyd's of London, has been substantial. Unfortunately, recent shakeouts at Lloyds and other London suppliers have dramatically drained the coffers. As a matter of fact, the entire international reinsurance markets are not providing sufficient capacity to supply U.S. reinsurance buyers.

## # NAIC & Reinsurance

Regulation of reinsurance cannot be so restrictive as to preclude adequate capacity. Alternative, but indirect, regulatory controls over nonadmitted companies have been developed by the National Association of Insurance Commissioners (**NAIC**) **through a Model Act on Credit for Reinsurance**. This Model limits the extent to which

an insurer may consider reinsurance recoverables from unauthorized insurers to the amount of posted collateral, such as letters of credit, trust funds or funds withheld. Many states have adopted this Model or a version of it.

The NAIC has, over the past several years, substantially increased the information required to be reported both by insurers and reinsurers on reinsurance related matters. Beginning with 1987, for instance, all U.S. insurers assuming reinsurance became obligated to report in their Convention Statements the development of reinsurance losses, separately from insurance losses. Prior thereto, companies which wrote both direct and reinsurance premiums could commingle their loss data for financial statement purposes. Accordingly, it was impossible, other than through a case by case examination of a company's files, to determine the extent to which an insurer had recognized the high volatility of reinsurance in loss reserving. Some believe that such a procedure would have provided an early warning to California regulators of the Mission problems.

Following this, the NAIC adopted a further major change in its Convention Statement related to reinsurance. Beginning with year end 1989, all companies, insurers and reinsurers, were required to note reinsurance recoverables which are overdue as well as the identity of the responsible reinsurer. When these recoverables are more than 90 days past due, a surplus provision for past due reinsurance must be established segregated from the company's surplus and reported as such.

The NAIC has often been criticized for adopting model acts which are viewed with indifference by state legislators. However, the recent changes to reinsurance accounting procedures became effective nationwide because they affect the Convention Statement which has been adopted for use by all states for all U.S. insurers and reinsurers. These modifications will result in more and improved reinsurance data. They were fully supported by the **Reinsurance Association of America (RAA)** member companies which have concluded that the small additional expenses resulting from compliance will, over time, be well worth the cost, if such changes lead to a more secure and reliable reinsurance environment.

It is only recently that the NAIC recognized that reinsurance is different and considerably more volatile than insurance. The steps outlined above are a good beginning, but some feel more needs to be done. For instance, the NAIC long ago developed a series of solvency warning signals, the Insurance Regulatory Information System (IRIS), to assist in the early detection of a company's financial weaknesses. Today, the prevailing permissible leverage ratios under the IRIS program are identical for both insurers and reinsurers. This makes no sense, say the critics, in light of the greater volatility of reinsurance.

A study of the NAIC IRIS program, which the RAA conducted, found that many critical ratio results for reinsurers were distinctly different from those for the total industry. In addition, the results of reinsurers over time differed from those of the total industry. For example, the premium to surplus ratio for all companies was 152.0. For the 139 reinsurers in A.M. Best's data base, the ratio was 112.8. The respective medial values were 117.0 and 88.7.

## # U.S. vs. International Regulation

While a number of world reinsurance centers apply extensive regulatory controls over their domestic companies, nowhere in the world is reinsurance regulation similar to the U.S. The discounting of loss reserves, a practice generally prohibited in the U.S. under statutory accounting, is widely practiced in other parts of the world. On the other hand, many countries require the establishment of various additional reserve funds, such as catastrophe or tax equalization reserves, prohibited in the U.S. It is sobering to note that probably **ten percent** or more of the U.S. **reinsurance premium is written by alien companies** located in countries which are generally "**havens**" with lax regulation coupled with little or no taxes levied on domestic insurers.

Some industry experts feel this will change as higher financial and accounting standards are placed on U.S. Insurers. The National Association of Insurance Commissioners, Congress and the Reinsurance Association of America are examining solvency regulation imposed on alien reinsurers and the U.S. companies ceding business to them. Once determinations and agreement can be hammered out, "Made in the U.S.A." will take on new significance in buying reinsurance.

## # Letters of Credit

The reliance placed by U.S. regulators on **letters of credit (LOC)** is an adjunct to regulation. The major criticism is the dependency of the amount of the LOC on the adequacy of the insured's loss reserves. It takes decades for losses to emerge. So, IBNR reserves set today must attempt to identify the economic, judicial and legislative environments which will prevail at the time cases are actually disposed. No matter how refined a company's actuarial techniques are, this is, in some instances, a task beyond any reasonable controls.

A specific example will illustrate the problem. For years preceding the enactment of the Federal Superfund legislation, insurers had provided various liability coverages to hazardous waste handlers and disposers. Reinsurers, in turn, had provided substantial support to those policies, some of which provided coverage for "sudden and accidental" environmental accidents. IBNR reserves held by these insurers and reinsurers for environmental incidents were negligible. The Superfund law retroactively materially increased the liability of these handlers and disposers. Still, insurers and reinsurers did not increase their IBNR reserves in light of what they perceived to be a very limited extent of coverage for environmental losses, which, as noted, limited the policy protection to occurrence arising from sudden and accidental events. It was not until thereafter, following judicial interpretation of the policy language in ways never anticipated by insurers, that the significance of the Superfund law to insurers became apparent.

Even today, as state and federal courts dissent among themselves on the application to Superfund cleanup requirements of those insurance policies which were issued decades ago, insurers are uncertain as to the amount of reserves which should be established. If we were talking in terms of a few million dollars, the impact on the financial condition of insurers and reinsurers would not be significant. But, hundreds of billions of dollars are involved, amounts many times in excess of the combined insurance industry's capital and surplus.

To the extent these potential losses are covered by alien reinsurers, LOCs should be available to guarantee the reinsurance recoverables. However, the extent to which these losses have been adequately reflected in the industry's financial reports is questionable and, consequently, the **available LOCs supporting the alien reinsurance recoverables are probably inadequate.**

LOCs are NOT a substitute for sound regulation. When issued as security on behalf of well managed, sound alien reinsurers, they are probably not even needed. However, they do represent a minimum security of a guarantee against possible nonpayment due to insolvencies of companies which are not so well regulated or managed.

## # Alien Reinsurer Regulation

The availability of unregulated offshore reinsurance provided an opportunity for the implementation of questionable reinsurance schemes which ultimately led to many recent insolvencies.

The **U.S. is one of very few countries in which alien insurers may operate** either through wholly owned subsidiaries or through branches or, in fact, both. Those subsidiaries and branches are regulated as other U.S. insurers. They must file financial reports and are similarly examined. These foreign subsidiaries and branches provide substantial reinsurance capacity which is supported by trustee surplus funds located in the U.S. Furthermore, the NAIC Model Act on Credit for Reinsurance was recently amended to allow credit for reinsurance placed with accredited reinsurers. An insurer may qualify for accreditation by establishing a minimum trustee surplus in the U.S., by filing annual statements substantially similar to the Convention Statement, and by agreeing to be examined by a U.S. insurance regulator. Several state legislatures are considering adopting these amendments.

The NAIC has also recognized the need for higher capital and surplus to support reinsurance underwriting. Although some have questioned whether the new minimum surplus requirements provided in recently adopted Model legislation are adequate, the introduction of the concept is encouraging in itself.

The report notes the international nature of insurance and particularly reinsurance. The world distribution of the U.S. reinsurance premium underlines the easy access by alien reinsurers to the U.S. market. The reliability of this alien reinsurance support is very uneven. While it clearly would make sense to encourage the channeling of U.S. reinsurance premiums to the more secure markets, U.S. tax policy tends to defeat this objective.

Much of the recent expansion of the foreign penetration of the U.S. reinsurance market has come from countries which combine a relaxed regulatory climate with low or zero taxes on insurance activities. The only tax on U.S. reinsurance premiums ceded to companies domiciled in those countries is the U.S. excise tax, a one percent gross premium tax. U.S. reinsurers, on the other hand, pay income tax equivalent to 7.5 percent of premium. The resulting difference has placed ***U.S. reinsurers at a major competitive disadvantage*** which is very real indeed. In a recent press interview, when asked why Bermuda is such an important reinsurance center and whether it could maintain its preeminent position, one of the island's leading reinsurance brokers answered, "because freedom from corporation tax allows reinsurers to offer highly competitive prices".

Regulation cannot substitute for good management practices. The placement of reinsurance is a major responsibility of insurance management. It is a responsibility which cannot be substituted by regulation. There are many public and private resources available to check into the security and management of alien reinsurance companies.

It is ironic that, while there has been considerable improvement in the quality and quantity of information submitted through efforts like the Convention Statement, there have been very few instances of sanctions levied against executives filing, on behalf of their companies, inaccurate financial statements. A basic weakness of statutory accounting and reporting is the absence of individual and corporate liability for false, inaccurate and negligent compliance with insurance regulations.

The difficulties in regulating an international commodity such as insurance and reinsurance are, in part, due to the limited geographic reach of regulators, as noted in the report. However, the major difference is accounting conventions, country to country, are themselves major obstacles which would not disappear under a federal regulatory system. To establish minimum solvency standards for all companies doing business in the U.S. becomes a formidable task when these differences are taken into consideration.

As an example, the required valuation of assets by many Continental reinsurers results in a reported capitalization which would be grossly inadequate to sustain their net written premium, based on U.S. standards. Yet, many of these companies are solid, conservative entities. Currency fluctuation is another element which any international regulatory system must consider.

It is suggested that any consideration of the desirability of bilateral agreements to limit access to the U.S. market to companies based in countries where solvency is well regulated, as suggested by the report, be preceded by some attempt at developing a uniform insurance solvency accounting system among world insurance centers. This may yet prove to be an impossible task.

## **# Other Reinsurance Issues & Suggestions**

The investigation performed to date leaves little doubt that mismanagement or fraud, even when limited, can lead not only to massive financial losses, but also to a loss of confidence in the integrity of insurance and its regulatory structure. To prevent future similar occurrences without unduly stifling the insurance and reinsurance competitive environment is a challenge which, if successfully attained, will be of great public benefit. Clearly some compromise will need to be achieved between the need for regulation of a broader segment of the business serving the U.S. reinsurance needs and capacity.

In addition, all states today require ***reinsurance contracts*** to include certain clauses which are of overriding public policy. For instance, all contracts must ***contain an insolvency clause which requires the reinsurer to pay all reinsurance proceeds to the liquidator***, in the case of insolvency of the insurer, without diminution resulting from the insolvency.



While there is relatively little hands on direct regulation of reinsurance contracts and prices, any restriction of reinsurance contracts and rates has an effect on reinsurance. If, for instance, the rate allowed on primary business develops an inadequate premium, the premium paid the reinsurer will reflect some inadequacy.

Taken together, the direct and indirect regulation of U.S. reinsurers and reinsurance contracts is significant, but it is different from that imposed on the primary industry. Simply put, the major thrust of reinsurance regulation should be to influence primary insurers to do business with reinsurers which are well-funded, or which have posted sufficient collateral to ensure payment of claims when due.

# PROTECTING ASSETS

*by Affordable Insurance Educators 1995-1998*

The professional agent helps preserve client assets when he provides safe, appropriate and sufficient levels of coverage and diligently practices "loss prevention" or ways to help clients minimize liability or financial exposure that might exceed insurance coverage or push its limits. Few would argue that the insurance is the most effective asset protection tool . . . a first line of defense . . . a shock absorber against economic and legal catastrophe.

Indeed, the role of insurance is purposeful and necessary, but it is important to remember it is not the ONLY approach to protecting assets. Some legal techniques are proving to be valuable methods of supplementing insurance protection or useful where insurance coverage is simply not available. These are sufficient reasons for agents to learn about protecting assets beyond insurance. Of course, as the insurance professional refers a tax liability problem to a CPA, a trust question to an estate planning attorney, so he should advise the client needing asset protection to see a competent professional or team in the business of protecting assets.

IN NO EVENT, SHOULD THE AGENT DESIGN OR ADVISE A SPECIFIC COURSE OF ASSET PLANNING OUTSIDE INSURANCE LICENSING. THIS IS BEST LEFT TO AN ASSET PROTECTION PROFESSIONAL.

## • • THE NEED FOR AGENTS TO UNDERSTAND ASSET PROTECTION

Agents deal with many clients that they CANNOT FULLY INSURE. There are also occasions where insurance **fails to insure**. The professional agent should be alert to these situations and should advise the client accordingly. Following are points of concern where protecting assets goes **beyond insurance**.

- The need for a protection structure which can be used as a replacement to insurance when premiums rise beyond a client's ability to pay.
- The need for a protection system that can supplement current insurance, covering gaps in protection like punitive damages or an underinsured breadwinner.
- The need for a protection structure that will become a back up for times when, for whatever reason, a lapse in insurance coverage occurs.
- The need for a protection structure as back up when an insurer fails to pay or becomes insolvent
- When coordinated with estate planning, the need for a structure to protect inheritances and estates from frivolous claims and plaintiff attacks.
- The need for a structure to protect business and property owners from new and exotic environmental liability which may be excluded by insurance or entirely unknown by present standards.

## • • GETTING STARTED IN ASSET PROTECTION

Asset protection planing has no set procedure because the rules and individual state laws are in a constant flux. What works today will need adjustment down the road. Approaches will also vary with the personal and business exposure of each individual. Additional factors are the extent of client resources and his intentions concerning the preservation of assets today AND tomorrow.

### • Premises of Asset Protection

The following premises are basic to any protection plan:

- Asset protection should be regarded as a "vaccine, not a cure". And, like most vaccines, for best effect it should be started BEFORE the illness (lawsuit or claim) begins.
- Effective asset protection is measured by the legal assumption that "the whole is worth more than the sum of the parts". In essence, an estate that is divided into many sub entities is less attractive to pursue than a single, large estate.
- Insurance is critical defense against the loss of assets so long as the agent provides "insurance that insures". Agent due care in delivering adequate coverage and solvent carriers is essential.
- Risk is a fact of life that must be analyzed and constantly managed.

## • • **TITLING ASSETS**

Many people believe they are supplementing their coverage and legally protecting assets simply by transferring title to a less exposed family member or using a trust or corporation for business. While these methods may provide a modicum of asset protection, the alert agent should advise clients to seek the services of an attorney when asset protection is the primary motivation for transferring title.

Most attorneys will agree, that there is considerable confusion about how to hold title to assets for the best protection against lawsuits or a massive insurance claims. By far, the most popular means of holding title is joint tenancy. Most homes and possessions are owned in the following manner - "husband and wife as joint tenants". Whether this is the best method for asset protection purposes is discussed below. Other forms of ownership include Tenants in Common, Community Property, Partnership, Corporations, Limited Liability Corporations, Trusts, Land Trusts and, of course, Individually. It is doubtful that any single entity will suffice as an effective asset protection tool. Most likely, a **combination** of these titling methods is required to offer a higher level of protection.

## • **What Agents Can Do**

The nature of insurance applications makes it possible for an agent to learn about the titling or ownership of client assets. This is a valuable opportunity to uncover or correct ownership issues that might cause problems or additional exposure to claims. Some possible warnings signs or troublespots include:

- **Universal Titling:** Where everything owned by a client is titled the same, assets may be at risk. Depending on the size of the client's estate an asset protection attorney should be consulted.
- **Incomplete Titles:** This often occurs in trusts where the words "trustee" has been left out or the trust date is omitted. Improper titling can void trust protection.
- **Conflict in Title:** Clients will sometimes refer to ownership as "husband and wife as joint tenants" on one document and "community property" on another. To be effective, asset protection planning must be precise.
- **Joint Tenancy & Wills:** Few people know the relationship between property owned as joint tenants and their will. Properties that are titled as "joint tenants" typically transfer to the surviving joint tenant AND supersede the will. Thus, a client, who has willed a majority of an estate to his children, but owns all property as joint tenants with a spouse might be interested to learn that, in almost every situation, the property will go to the spouse at his death. As you can see, estate protection and asset protection go hand in hand.
- **Incidents of Ownership:** For years, advisors have recommended wives own their husbands' insurance and make the payments out of an account owned by the wife in order to remove all "incidents of ownership". Today, it may be more advisable to let a trust be the receiver of insurance proceeds to reinforce tax advantages where the insured is NOT the owner of his own policy.
- **Signatures:** Sometimes, it is critical that a specific person write the check for insurance coverage. This can occur in the case of medical reimbursement plans where the funds used to make insurance premiums should come from the spouse's private account and be reimbursed by the business account. A mistake here can cause the IRS to void all or certain deductions and create tax liabilities that could endanger assets.
- **Tax Effects:** If the agent is offering tax and estate planning advice, he should disclose the consequences of titling contracts such as life policies, variable policies, annuities, etc. As a general rule, the death of an owner or annuity triggers a death benefit which carries tax liability. In some contracts, tax and surrender charges can be

deferred where a "contingent owner" is allowed.

## • **Joint Tenancy**

In general, joint ownership of assets is the most popular form of family ownership. It is estimated, for example, that more than 80 percent of all real estate in the United States is held in joint tenancy. And, joint control is the ownership of choice for most bank accounts, stocks, bonds and safe deposit boxes. It is easy to see that this form of ownership is by far the prevalent form of holding title. Also of note is the fact that joint tenancy is NOT limited to husbands and wives. There are many homes, bank accounts, stocks, cars and more owned jointly by parents and children, business partners and friends.

### **HOW JOINT TENANCY IS CREATED**

Joint tenancy is created when property is owned by two or more people having equal shares. Two common ways that joint tenancy is created include:

1. A seller of property conveying the asset to two or more persons as joint tenants.
2. The owner of property conveying to himself and one or more persons as joint tenants.

Other factors establish the creation of joint tenancy include that the transfer must be "expressly declared" to be a joint tenancy. In other words, joint tenancy is not presumed. The title must express that the property is owned . . . "as joint tenants". The words "right of survivorship" are not required. The creation of joint tenancy must be by a will or single transfer. In other words, there is a "unity" associated with joint tenancy. It is an indivisible interest. In most jurisdictions, joint tenancy must be created by a written instrument and not by an oral agreement.

### **HOW JOINT TENANCY WORKS**

The single most prominent feature that distinguishes joint tenancy from other forms of ownership is that ***upon the death of one of the joint tenants, the surviving tenants become the sole owners of the entire property.***

The interests of joint tenants are always equal shares. Four joint tenants, for example, must each own a one-fourth interest. If one has 40 percent and the others share 60 percent, they are not joint tenants. If one joint tenant conveys his or her interest, the joint tenancy ends, and the parties become tenants in common.

In the event of simultaneous deaths of the joint tenants, the joint tenancy is canceled, and the undivided interest of each joint tenant is divided as if each had survived the other. For instance, the property of a husband and wife would be divided equally, so that one half passes through the husband's estate and the other half through the wife's estate.

Each joint tenant has rights to the possession of the whole, but NO right to exclude co-tenants, yet any joint tenant can demand a break-up and partition. Joint tenants can also be compensated for damage or waste caused by a co-tenant, reimbursed from co-tenants for expenses paid such as taxes or interest, and have the right to share in any income from an outside source attributable to the property.

Concerning bank accounts, the money belongs to the parties in proportion to the net contributions by each, unless there is clear and convincing evidence of a different intent. On the death of one of the parties, the account goes to the surviving parties unless evidence to the contrary is shown

A principal disadvantage of joint tenancy is its general inflexibility and the inability of the tenants to dispose of the property by will (only the survivor has this right).

### **JOINT TENANCY & CREDITORS**

There are many ways that creditors can reach a joint tenancy.

In the case of a dwelling, a creditor attempting to reach the interest of a joint tenant can cause ONLY the interest of the debtor to be sold. This compares with community property in that the creditor can force the sale of the entire dwelling to satisfy payment.

For most other property, the general rule is that **the creditor can acquire the interest of the debtor**. However, if the debtor is a joint tenant, the creditor forces an end to the joint tenancy and he or she becomes tenants in common with the remaining joint owners.

In essence, holding title as joint tenants carries little creditor protection since creditors can attach a jointly held interest and petition the court to "partition" or divide up the property. If it is property that cannot be divided, creditors can order it sold to receive the debtors share.

## • **Tenancy in Common**

### **HOW TENANCY IN COMMON IS CREATED**

Tenancy in common is a default title. If a transfer of property does not specify joint tenancy, the property is not acquired by partners for partnership purposes or by a husband and wife as community property, it is considered tenancy in common. Tenancy in common can also be created by express transfer and wording.

### **FEATURES OF A TENANCY IN COMMON**

Under a tenancy in common, each tenant owns a **divided interest** in the property. The interest DOES NOT have to be equal. As such, each tenant can sell or encumber his share of the property free from interference from co-tenants.

There is NO right of survivorship in tenancy in common

Concerning bank accounts, the money belongs to the parties in proportion to the net contributions by each unless there is clear and convincing evidence of a different intent. On the death of one of the parties, the account, or appropriate portion thereof, passes to the decedent's estate.

### **TENANT'S IN COMMON & CREDITOR'S**

In the case of a dwelling, a creditor attempting to reach the interest of a tenant in common can cause ONLY the interest of the debtor to be sold. This compares with community property in that the creditor can force the sale of the entire dwelling to satisfy payment.

For most other property, the general rule is that **the creditor can acquire the interest of the debtor**. And as a tenant in common, the creditor can force a sale of the common asset. For this reason, it is important to select co-tenants who appear to be relatively free from financial problems.

## • **Community Property**

### **HOW COMMUNITY PROPERTY IS CREATED**

The property acquired by the efforts of either a husband or wife, or by both a husband and wife, during marriage is community property unless it is acquired as the separate property of one of them.

Generally, property that one of the spouses brings to the marriage continues to be his or her separate property during marriage. Gifts or bequests of property to one spouse during the marriage are also the separate property of that spouse, as is inherited property.

Commingling of separate property usually converts it to community property.

Earnings of a spouse during the marriage are generally community property

In general, property cannot be both joint and community, or tenants in common and community property.

Income from appreciation of community property is community property, Income from and appreciation of separate property is separate property.

The contributions to a bank account owned by a husband and wife are presumed to be community property. However, unless the account is termed a "community property" account, the survivorship right is revocable by will of the first spouse to die.

Property acquired by a married person while living out of state, in a non community property state, is NOT community property.

Separate property can become community property by an express declaration that is made, joined in, consented to or accepted by the spouse whose interest in the separate property is most affected. Similarly, separate property can be created by a transmutation of community property.

### **HOW COMMUNITY PROPERTY WORKS**

Each spouse can leave his or her interest, by will, to whomever he or she chooses. In a transfer of community property realty, BOTH spouses must join in the transfer.

A gift of community property must be accompanied by a written consent by both parties. Either spouse has the management and control of the community property

Since a spouse does not have the right to withdraw his other interests in the community property, there is no right to have the community property partitioned or divided, other than in the case of divorce or separation.

### **COMMUNITY PROPERTY & CREDITORS**

The general rule is that community property is liable for debts of either spouse during the course of the marriage.

Obligations incurred prior to the marriage or after a separation or divorce are consistently treated as the separate obligation of the spouse incurring the debt.

Whether a spouse contracts for individual benefit or for the benefit of the community property is irrelevant. A creditor's ability to reach marital property is not effected by the purpose for which a spouse contracts.

If a debt that is a joint obligation of a husband and wife, the community property together with the separate property of each spouse will be liable for the debt.

A spouse who pays a single payment on behalf of the other spouse is said to have granted "apparent authority" to the other spouse to contract joint debts. The spouse who paid the bill may be held liable for subsequent debts incurred by the other spouse. A spouse who wishes to avoid such joint liability should make clear to the other spouse and any creditors that said spouse incurred this debt and acted without his or her authority or consent, or that the payment being made on behalf of the other spouse does not constitute authority for the other spouse to make future contracts that might obligate the paying spouse.

### **• Tenants by Entirety**

At present, about one-half the states (not California) recognize tenants by entirety. This type of ownership is a

special form of joint tenancy which may be used only by a husband and wife.

### **HOW TENANTS BY ENTIRETY IS CREATED**

In states that recognize this ownership, a presumption exists that when a husband and wife take property as joint tenants, they instead take ownership as tenants by entirety. To eliminate this presumption, title should read as "joint tenants and not as tenants by entirety"

Title of the husband and wife is in both as to the whole, rather than in undivided half interests. Under this concept, the property is owned not by two people, but rather by the "unity" or "entirety" created when the parties are married. On the death of either party, the survivor would own the whole property.

The tenancy by entirety operates until both parties agree to a transfer or until the marriage is dissolved by law or by the death of one of one of the parties.

### **HOW TENANTS BY ENTIRETY WORKS**

In many states, tenancy by entirety is recognized only for real estate, and it usually takes BOTH parties to convey clear title to a third party.

Under common law rights, the husband has sole right of possession and management and sole right to income, but cannot act in a manner to impair the wife's right of survivorship. In some states, the Married Women's Property Acts alter this common law theory, often giving the spouses equal rights of management and possession and equal rights to income.

### **TENANTS BY ENTIRETY & CREDITORS**

Where common law is observed, the husband's creditors can proceed against the husband's rights (to use, possession and control) to the asset and on the husband's right of survivorship, but CANNOT acquire the wife's estate in survivorship unless the wife is also a debtor. In essence, in some states the property stays relatively protected if the wife incurs the debt.

Any creditor protections of tenancy by entirety last as long as the parties are married. Divorce and death terminate a tenancy by entirety. If the spouse without liability protection dies before the other spouse, the estate can be exposed to claims of creditors.

## **• Partnerships**

Most people connect the formation of a partnership with the operation of a business interest. Yet, they are frequently used in personal and family settings, including home ownership. There are two major kinds of partnership -- general partnerships and limited partnerships.

### **HOW PARTNERSHIPS ARE CREATED**

There are no strict rules to follow to form a general partnership. For the most part, co-ownership as "partners" establishes a general partnership

Limited partnerships are formed by compliance with Corporation Code Sections at the state level.

### **HOW PARTNERSHIPS WORK**

Property must be owned by multiple persons in partnership "for partnership purposes".

Limited partners are not bound by the obligations of the partnership, provided they play no active role in the

management of the partnership.

## **PARTNERSHIPS & CREDITORS**

In general, the assets of a partnership are not available to a creditor of a partner on a personal debt of the partner. In practical terms, a creditor must only look to the debtor's share of partnership proceeds AFTER the partnership has been dissolved and debts of the partnership paid.

Alternatively, the creditor can look to attach the debtors profits and surplus from the partnership. This is called a **charging order**. It does NOT make the creditor a partner. The charging order is intended to protect partners of a partnership that having nothing to do with the claims of creditors of the individual partner.

A charging order is obtained by the creditor by making application to a court which then charges the interest of the debtor partner with payment of the unsatisfied amount of the judgment. The court may then or later appoint a receiver of the partner's share of the profits, and of any other money due or to be due him from the partnership. If a charging order fails to be an available remedy, the courts have allowed the foreclosure sale of a partner's interest. At a foreclosure sale, only the partner's interest, not specific assets of the partnership, are sold. It is unlikely, however, that a partnership interest will bring a high price from third parties. If the creditor becomes the purchaser, and until the dissolution of the partnership occurs, the creditor will still be entitled to only receive the partner's profits.

In many instances, the obstacles that must be hurdled to gain access to a debtors partnership interest help shield a partner from all but the most determined creditors.

## • **Corporations**

### **HOW CORPORATIONS ARE CREATED**

Corporations are formed under specific rules of each state.

### **HOW CORPORATIONS WORK**

A corporation is a distinct, legal entity separate and apart from its members, stockholders, directors or officers. Although it is a separate legal entity, it can only act through its members, officers or agents.

A corporation is considered to be a "citizen" of the state where it is created. It does not cease to be a citizen of the state in which it is incorporated simply because it engages in business or acquires property in another state.

The powers of a corporation are derived from the constitution and laws of the state in which it is incorporated.

A stockholder of a corporation is NOT the owner of corporate property. Further, the existence of the corporation is not affected by the death or bankruptcy of a shareholder or by the transfer of his shares. Therefore, the corporation has **continuous existence** as long as it complied with the annual requirements of the state in which it was formed.

### **CORPORATIONS & CREDITORS**

In general, creditors of the corporation can proceed only against the assets of the corporation and not ordinarily against the stockholders, officers, directors, agents or employees of the corporation.

Exceptions to the above rule include where parties in the corporation have personally guaranteed some form of corporate obligation; where employees of the corporation have been negligent or have committed a wrongful act; where officers have not paid withholding taxes or similar taxes; where specific fiduciary violations can be determined.



Legal advisors are split on the issue of creditor rights against an incorporated sole practitioner. Some assess the "key person" rule in support of complete liability. Others argue that many lawsuits are derailed simply by the existence of a corporation.

- **Limited Liability Company**

A limited liability company is an unincorporated entity that combines the tax and operational flexibility advantages of a partnership with a corporation's limitation on liability.

#### **HOW LLCs ARE CREATED**

An LLC is created by filing "Articles of Organization" with the state, usually the Secretary of State. A written agreement between the LLC members is not required, although it is good business practice to have one.

#### **HOW LLCs WORK**

There is no requirement for corporate formalities such as minutes, resolutions and annual meetings.

There is no "double taxation" like a corporation. An LLC is treated like a partnership for tax purposes

On the sale or exchange of an LLC interest or on the death of an LLC member, the tax basis in the LLC's assets are stepped up.

#### **LLCs & CREDITORS**

In an LLC, no one has personal liability for the debts of the partnership. All members of the LLC are liable to creditors ONLY to the extent of their investment in the company.

- **Trusts**

#### **HOW TRUSTS ARE CREATED**

Trusts are created by formal agreement using 1) a creator "settlor", 2) a trustee and 3) a beneficiary. Most trusts are more akin to a conveyance, rather than a contract

Consideration is not necessary to create a trust but there must be "delivery", intent to have the instrument take effect, to make it binding.

The subject matter of the trust must be definite and specific

A trust cannot be created of property not yet in existence or to be acquired at a later date.

#### **HOW TRUSTS WORK**

A Trustee may be anyone legally capable of dealing with property. A corporation may act as a trustee. Lack of a trustee will NOT destroy a trust since the courts will appoint one. Powers of the trustee are determined by 1) rules of law and 2) the authority granted by the settlor.

There are few restrictions on who may be a beneficiary.

Unless the power of revocation is reserved by the settlor, the general rule is that a trust, once validly created, is irrevocable. Normally, a trust has a termination date which may be specified by a certain number of years, or the settlor may provide that the trust shall continue for the life of the named individual. The death of the trustee or beneficiary does not terminate the trust if neither of their lives is the measure of the trust's duration.

There are hundreds of different trust relationships that may be created - each with characteristics of a special nature, e.g., domestic trusts, off shore trusts, trusts "implied" by law, charitable trusts, spendthrift trusts (where the beneficiary's principal and income are controlled and thereby protected from creditors) and precatory trusts (left for X in full confidence that he will care for Y)

## **TRUSTS & CREDITORS**

In general, unless there are restrictive provisions in the trust spendthrift verbiage, a beneficiary's interest may be attached by his creditors or the beneficiary may sell his interest.

Creditors have also gained access to trust assets when the following conditions exist:

- 1) The trust was funded as a result of a fraudulent conveyance
- 2) The settlor of the trust retained too much control over trust assets
- 3) The settlor retained too much of an interest in the trust
- 4) The trust is illusory (trust is non existent or a sham)

## **• • TRANSFERRING ASSETS**

### **• Fraudulent Conveyance**

People who are being pursued by a creditor or facing a large judgment often believe that transferring the title of their property to someone else might be a quick, sensible solution to protecting assets. Unfortunately, this rarely works, due to the volumes of law known as ***fraudulent conveyance***.

Broadly speaking, a ***fraudulent conveyance is defined as*** a transfer of property without adequate consideration and with the intent that the transferee will hold the property for the benefit of the transferor, returning it when requested, so as to defraud creditors who could otherwise seize the property in payment of their debts. If a transfer is found to be fraudulent, it can be made "null and void" by a court of law.

In essence, the law is not so naive that it will allow a person to avoid the payment of legal debts simply by making a "gift" of his property to another family member or a friend. ***Fraudulent conveyance laws protect present and future creditors against transfers of property made with the intent to hinder, delay or defraud them.***

The determination of whether a transfer of assets is "fraudulent" or lawful is a matter of a court's evaluating a number of factors including ***intent, timing of the claim, pendency of the threat of litigation, solvency of the debtor, consideration and the relationship between the transferor and transferee, concealing the transfer, the transfer of one's entire estate, and the transferor's retention or control of benefits.***

#### **• INTENT**

In general, if the courts determine that a debtor has a particular creditor or series of creditors in mind and is trying to remove his assets from their reach, his intent is "fraudulent" and could be grounds to allow a judgment to proceed or discharge a bankruptcy. If the debtor is merely looking to his future well being, the transfer would not be fraudulent

#### **• TIMING OF CLAIM**

Specific bankruptcy laws provide that every transfer made and every obligation incurred by a debtor ***within one year*** prior to the filing of bankruptcy is fraudulent.

#### **• FAIR CONSIDERATION**

In general, a transfer of property by a debtor is considered fraudulent if the conveyance is made without receiving reasonable consideration in exchange for the property. In essence, the transfer is a sham to avoid creditors.

- **THREAT OF CLAIM**

To constitute a fraudulent conveyance, there must be a creditor in existence or the debtor feels there is a threat of claim from a current or future creditor. However, where the creditor is not in existence at the time of the transfer there must be evidence presented by a damaged creditor that there was still fraudulent intent. An example might be the physician who systematically transferred assets out of his name because he was unable to secure malpractice insurance and, at the same time, restricted his practice to less risky medicine. Courts held that the doctor acted prudently to protect his assets from future, unforeseen adversity where malpractice insurance was not available. Here, future "victims" of the doctor's medical malpractice were not identifiable or known, individually or as a class. Further, as long as no evidence proved that the doctor intended to commit malpractice, the transfer of assets was NOT legal fraud.

- **DEBTOR SOLVENCY**

The solvency of a debtor is another factor used by the courts to determine fraudulent transfer of property. Cases where legal fraud were proved include situations where debtors were "head over heels" in debt just prior to transferring assets or where the debtor transferred assets knowing that the business venture he was starting or operating was highly speculative or financially hazardous. In other words, the courts will rule fraudulent conveyance where the debtor's objective is "If I succeed in business, I make a fortune . . . If I fail, my creditors will bear the loss".

Obviously, there are many facts that can determine the fraudulent nature of transferring assets. As a result, there has been significant federal and state legislation that control this area of law, each with corresponding criminal and civil penalties.

- **UNIFORM FRAUDULENT CONVEYANCE ACT (UFCA) - Early 1900s**

Adopted by 26 states, including California, but not Texas. This legislation was an early attempt to define specific situations where fraud was present in a transfer, regardless of the transferor's intent. Sections of this law define debt and discuss debtor insolvency rules. Also, it established specific remedies for creditors such as the right of attachment, restraint of debtor from transferring additional properties, the appointment of receivers for property and the right to sue a debtor who allowed transferred property to depreciate or physically damaged same out of spite.

- **UNIFORM FRAUDULENT TRANSFER ACT (UFTA) -- 1984**

Adopted by California and Texas, this legislation expanded the definitions of the Uniform Fraudulent Conveyance Act (UFCA) and added issues concerning "intent". To fall under the full extent of this act, ***an action against a debtor must be brought within four years after the "fraudulent transfer" was made.***

- **CRIMINAL CONTROL ACT -- 1990**

The Criminal Control Act assigns criminal penalties against debtors who use fraudulent transfers or conceal assets from lending institutions, federal lending agencies (FDIC, RTC, etc).

- **THE MONEY LAUNDERING CONTROL ACT -- 1986**

Used initially in the control of drug traffickers, this act was expanded in 1988 & 1990 to cover financial related crimes such as concealment of assets from a receiver, custodian, trustee or officer of the court or fraudulent transfers when contemplating bankruptcy. Penalties imposed include monetary fines of up to \$500,000 or twice the value of the property/funds involved in the transaction, or imprisonment for up to 20 years.

- **THE ANTI-MONEY LAUNDERING ACT -- 1992**

The significance of this act lies in the strengthening of reporting requirements by financial institutions (including banks, insurance companies). In essence, these financial institutions MUST identify any customer who maintains an account, report suspicious transactions, and maintain records pertaining to transfers of funds between different institutions (including transfers by wire, draft, etc),

- **Legitimate Property Transfers**

There are many reasons and situations where property transfers are considered legitimate, thus avoiding fraudulent conveyance issues. Simple estate planning techniques, for example, allow for systematic transfers of property to children or grandchildren. Significant and quick transfers to a spouse, however, can be suspicious and should be accomplished only with the aid of an attorney.

Other transfers that can be considered legitimate include transfers to family members as birthday gifts, i.e., the purpose of the giving is "innocent". Also, small periodic transfers or incremental transfers are less likely to be challenged than would transfers of one or two significant assets.

- • **ASSET PROTECTION PLANNING**

Beyond insurance, the process of asset protection planning can be complicated by exemption codes, the "encumbrance and/or transfer" of wealth, bankruptcy and a maze of various holding entities. The purpose of these legal tactics is to isolate liability in such a way as to limit anyone's ability and/or desire to pursue one's assets.

The aggressiveness of protection planning can vary based on the value of a client's assets and the extent to which he is exposed. In more complicated cases, using several techniques is the norm. Some work very effectively while others are meant to be potential obstacles designed to make a creditor or plaintiff stop and think about negotiating the sums owed first.

While these words make the process sound simple, it is NOT. Asset protection takes time and has its associated costs. Implementing plans can range from as little as \$1,000 to \$50,000. Once entities are created, they require annual maintenance consisting of legal and accounting fees

In all, protecting assets beyond insurance is the ultimate commitment of resources and patience. Following are some legal theories that focus on this ever changing area of law:

- **Exemptions**

Exemption planning takes advantage of known "safety nets" already built into the law to help place certain kinds of assets beyond the reach of creditors. Most exemptions must be filed or claimed. If not, they are considered waived.

- **STATE CIVIL CODES**

Certain civil code sections offer exemption protection from creditors. They might include payments made for child support, spousal support and family support.

- **HOMESTEAD**

Homesteads are claimed on the principal dwelling of the debtor or the debtor's spouse. A declaration of homestead can only be made for a residence that is real property, not a houseboat or mobile home. This exemption may also be carried over where the proceeds from a formerly homesteaded dwelling are used to purchase a new dwelling within six months. The amount of a homestead exemption is a minimum of \$50,000. This can be increased to \$75,000 for a family dwelling and up to \$100,000 for certain elderly, disabled or low income dwellers. An owner or his spouse may declare and record a homestead.

- **PERSONAL POSSESSIONS**

There are many articles of a personal and business nature that are exempt from creditors. A partial list includes:

- **Personal Property** -- Items such as health aids, jewelry (\$2,500), household furnishings (appliances, clothing and other items determined to be "ordinarily and reasonably necessary"), cemetery plots and motor vehicles (\$1,200).
- **Business Property** -- Tools, equipment and vehicles necessary to earn a living are exempt up to \$2,500 (\$5,000 for husband and wife).
- **Life Insurance & Annuities** -- Both are exempt without filing. This means a creditor cannot force a policy holder to cash-in his policy. However, a debtor can be forced to borrow against the policy. The first \$4,000 in loan value is exempt (\$8,000 for a husband and wife). If a policy matures, the proceeds are exempt to the extent that they are reasonably necessary for the support of the debtor, his spouse and dependents.
- **Health Insurance** -- Benefits from a disability or health insurance policy are exempt without filing (does not apply if the creditor is a health services provider).
- **Retirement Plans** -- Most private or public retirement plans, IRAs and Keoghs are exempt unless they have exceeded their contribution limit or are needed for child or spousal support.
- **Personal Injury or Wrongful Death Damage Awards** -- Most are exempt to the extent they are needed to support the debtor and his family.
- **Miscellaneous Exemptions** -- Paid earnings, Veteran's benefits, unemployment benefits, workers' compensation payments and college financial aid are exempt.

- **BANKRUPTCY**

Filing bankruptcy is another method of exempting assets from creditors when necessary. It is important to note that there are federal AND state bankruptcy codes. A federal filing alone may NOT exempt debtors from state creditors.

Well known types of bankruptcy filings include:

- **Chapter 13** --Chapter 13 allows an individual under court supervision and protection to develop and fulfill a plan to pay his or her debts in whole or in part over a three year period, but it can last another two years.
- **Chapter 11** -- Chapter 11 is a version of Chapter 13 for businesses
- **Chapter 7** -- Chapter 7 is a complete discharge of debts. Assets are liquidated to satisfy creditor claims.

- **Legal Theories Concerning Asset Protection**

There are many legal theories that form the basis of asset protection. Some are hard and fast principles while others are more abstract. In any event, the following are clear indications that there are many approaches and defenses in the world of asset protection.

- **FREE ALIENABILITY OF PROPERTY**

Our common law system favors the *free alienability of property*. In essence, this theory concludes that one who is free from creditor concerns is absolutely free to dispose of his property as he sees fit. This may include gifts to children, a spouse or a transfer to a trust. Clearly, asset protection planning is not an excuse to defraud creditors or evade taxes. Furthermore, fraudulent conveyance laws generally protect present and subsequent creditors from transfers of assets made by a person who is or foreseeably will become their debtor.

- **WHOLE vs SUM OF THE PARTS**

One of the basic premises of good asset protection is the legal assumption that "the whole is worth more than the sum of the parts". This issue takes on more meaning with the knowledge that most asset protection planning involves the intentional "breaking up" of large ownership blocks into much smaller blocks, each with its own title and life. The force and effect creates a smaller "target" for a plaintiff or large creditor to pursue.

It has long been a fundamental legal tenet that small, individual ownership can lead to better protection of assets because a third party interested in laying claim to a client's assets will consider a fractionalized interest to be worth far less than a whole. The common sense of this issue prevails: A creditor or high ticket insurance claimant, will factor in the cost, time and effort needed to force the sale of a single block of assets, under one ownership, in contrast to the much higher cost, time, effort and delay to retrieve multiple, variously titled assets. Further, in the case of some fractionalized assets that have been planned properly, there is no hope of the third party actually acquiring the asset. Rather, he would have to settle for the right to any income or benefits that might accrue from the fractionalized interest. For most, the thought of being in business with other fractionalized owners who are, for the most part, at "odds with the third party", will be a distressing issue to overcome. In such cases, third parties may be completely discouraged from pursuing such an action. This is an important element of asset protection to keep in mind when studying the forms of ownership that follow.

- **CHOICE OF GOVERNING LAW**

In the United States, individuals generally have the freedom to select the law that will govern a business transaction. Examples include the use of Delaware or Nevada corporate law by a company domiciled in California. Choice of law principles likewise allows a grantor of a trust to set up a trust that is governed by the laws of his or her home state or any other state. Taken further, there is no reason to limit one's choice of law to a particular state, the fifty states or any one foreign country when a world of governing laws is available.

Factors to consider when choosing a governing law include the tax laws of the jurisdiction, whether laws are more favorable and protective, the political and economic climate of the jurisdiction, language barriers, telecommunication facilities, etc.

- **OWNING "FREE & CLEAR" vs ENCUMBERING**

Using new asset protection methods, the old school thinking that the best way to own is "free and clear" is not the best way to protect assets. By owning property free and clear, one is exposed to the potential for a large loss. In the case of real estate, a large earthquake can demolish property. Similarly, a sizeable judgment from a lawsuit can take property away.

Some asset protection attorneys suggest encumbering or highly leveraging property (loans) to such an extent that a creditor will lose interest in pursuing it.

- **CONVENTIONAL FORMS OF PROTECTION ARE LOSING GROUND**

The new school of thinking is that traditional methods are not working like they used to. The corporate veil is seemingly more pierceable than ever. Further, the concerns with insurance coverage exist on three fronts: insolvency of the carrier, the willingness to continue coverage and exclusions such as punitive damages and gross negligence of associates.

- **EXPANDING LIABILITY THEORY**

Our court system makes legal decisions based on precedents. Most attorneys and students of law believe this is a system destined to expand liability because each decision in the chain sets the stage for the next step of expansion. This, coupled with the willingness of judges and juries to expand theories of liability leaves a tremendous amount of uncertainty and exposure for the person who has relied on traditional forms of planning.

Furthermore, our tort system does not favor defendants. It is said, "Once you have been sued, you've lost". A defendant can incur years of legal fees simply to respond to a suit -- even if he or she is found not liable. In his book *The Litigation Explosion*, Walter Olson argues that "A litigator can come around, dump a pile of papers on your front lawn and you can go literally broke trying to respond to it".

- **Holding Entities**

Most asset protection strategies involve the use of multiple and varied "holding entities" designed to isolate liability and thus contain exposure. These entities are typically trusts (domestic and foreign), partnerships (family and business), corporations (state domiciled or out-of-state) and limited liability companies.. We have presented a short discussion of each as follows:

- **FAMILY TRANSFERS**

A situation where a person hastily transfers title of a property to another family member to avoid creditors is not the ideal form of protecting assets. In fact it is called the "poor man's asset protection". Creditors are usually able to prove that a "fraudulent conveyance" occurred. Or, courts determine that the debtor failed to cut the strings by retaining benefits or control over the property. In either case, the creditor may proceed against the debtor and void the transfer of property.

For this method to have a chance, it must be used in the true context of "gifting" and be consistent with goals of the client (planning for college or an estate). The intent should be to have little control over the gifted asset.

- **PENSION PLANS**

Until recently, most qualified and private pension plans received preferential protection against creditors and claims. After all, that was the premise behind **alienation or assignment of benefits**. This provision was inserted in the interest of insulating assets of the plan from the claims of the participant's creditors. With a rise in liberal court decisions, however, several federal courts have begun making the assets of plans available to creditors for criminal acts, matters of divorce and bankruptcy, in total disregard of the alienation and assignment provisions. Courts have allowed payment from retirement plans for alimony and support of a child or spouse. The Retirement Equity Act of 1984 went a step further by requiring trustees of a plan to distribute or attach employee benefits once a domestic relations issue was awarded.

While penetration of a pension plan has been more difficult in bankruptcy situations, the trend may be reversing -- especially where the debtor has the right to amend or terminate his pension plan. Here the courts determined that he could NOT exclude them from bankruptcy assets. Worse yet, a Keogh plan was exposed to bankruptcy simply because the participant was self-employed and the only plan participant.

- **DOMESTIC TRUSTS**

A "**domestic trust**" is a trust established in the United States based on the laws of a particular state. While domestic trusts have been a longstanding tool for asset protection planners, they suffer from a number of disadvantages when compared to foreign trusts. In general, domestic trusts restrict the nature and extent of benefit or control that a trustor can retain.

- **Revocable Trusts**

The traditional role of living trusts is the avoidance of probate, publicity and the potential savings of estate taxes. Their use in asset protection is limited where the creditor proves that property was fraudulently conveyed into a trust in anticipation of debt problems or where the trustor (the person who established the trust) retained too much control or too much of an interest. Too much control can be construed to be the **power to revoke the trust or the power to appoint control over trust assets and the disposition of income**. Too much interest can be defined as having the right to encumber trust property or divert its income. A trust with a **spendthrift clause** helps limit a beneficiary's interest in a trust, thus limiting the creditor's interest as well.

Other applications of living trusts in asset protection have centered on the use of two trusts -- one for the husband and one for the wife. If the husband is the more vulnerable party, most of the assets would be put in the wife's revocable trust where creditors would have limited access.

Overall, the revocable trust has very limited asset protection qualities.

- **Irrevocable Trusts**

Irrevocable trusts have greater protection ability against creditors getting at the corpus of the trust if the trust was established with the following features in mind:

1. The trustee appointed is independent
2. The trustee does not have absolute discretion to distribute income and principal to the grantor
3. The trustee's power in relation to the grantor is tightly restricted
4. The trust had a legitimate reason to be established other than to protect assets from future creditors

As is the case with revocable trusts, however, where a trustor has too much interest or control, BOTH the corpus and income of the irrevocable trust can be penetrated.

- **FOREIGN TRUSTS a.k.a. ASSET PROTECTION TRUSTS**

A "**foreign trust**" (or foreign situs trust; off shore trust or asset protection trust) is defined as a trust established pursuant to the laws of a foreign country. Owners who need to protect assets can transfer those assets to the foreign trust. Or, the assets can remain in the United States but retitled in the name of the foreign trustee. The owner retains substantial control but the assets do not appear as part of the owner's net worth. The advantage of a foreign trust is that the trust laws and spendthrift provisions of some foreign jurisdictions are more protective than domestic trust law. Some foreign centers do not recognize judgments by U.S. Courts and do not permit contingency fees by attorneys. Additionally, some foreign jurisdictions have short statute of limitations regarding fraudulent conveyances, the practical effect of which is that by the time a plaintiff finds the country where the money is and files an action, the statute of limitations bars the suit. With these types of obstacles, plaintiffs, creditors and their attorneys are discouraged because it is difficult to make claims or judgments stick.. This alone is a substantial "lever" used to arbitrate settlements between creditors and debtors.

Potential uses of a foreign trust include:

- Advance planning for the protection of assets in general
- An alternative or supplement to traditional forms of liability insurance
- Diversion of business opportunity



- Strategic positioning in negotiating with present creditors
- Isolation of a portion of accumulated wealth so that not all is tied up when future loans are taken or guaranteed

Popular foreign trust centers include the Bahamas, Belize, Liechtenstein, the Cayman Islands, the Cook Islands, Cyprus, Gibraltar and the Turks & Caicos Islands, Guernsey (Channel Islands) and Isle of Man

Additional benefits to foreign trusts include probate avoidance, confidentiality, ease in transferring assets, avoidance of monetary exchange controls, vehicles for global investing and flexibility. From a tax standpoint, a properly structured foreign trust will be tax neutral, i.e., it will create no significant income, gift or estate tax gain to the grantor.

There are some associated risks. For one thing, instability of the foreign country might make it difficult or impossible to reclaim trust assets. In addition, the United States Government has worked to reduce the effectiveness of foreign trusts as tax havens and protected depositories by negotiating bilateral and multilateral treaties. The Caribbean Basin is one such example. Here, the U.S. traded custom exemptions for an exchange of information related to tax matters and civil/criminal issues. Similar agreements have been signed with a focus on criminal activities between the United States and dozens of countries. To combat these actions, some foreign trusts are established with provisions that allow the situs of the trust, or its trustees to change from one jurisdiction to another. This further shields the trust from the threat of expropriation and problems like instability of a country.

Likely candidates for foreign trusts are those with \$300,000 or more in cash and marketable securities; or persons with estates so large that they would consider it worthwhile having the highest level of creditor and plaintiff protection available; or persons who are at risk of future creditor problems and lawsuits due to the nature of their business. Agents working in advanced underwriting markets might find clients interested in off shore trusts, especially those involved in high risk businesses or professions like toxic wastes.

The market for offshore trusts may be narrowed somewhat by the cost, which can be as much as \$15,000 to set up and \$2,000 per year to maintain. While this seem high, the savings are obvious to someone like a physician paying \$50,000 in malpractice premiums per \$1 million coverage.

#### # FAMILY LIMITED PARTNERSHIPS

Family limited partnerships have been a popular tool for protecting accumulated wealth. An individual contributes assets to a family limited partnership in exchange for interest(s) in the partnership. In essence, the contributor no longer owns these assets. Instead, he or she owns a partnership interest. Control over assets is still managed by taking a general partner position. This, the contributor has successfully separated ownership from control.

Creditor and plaintiff protection inside a family limited partnership is afforded (under most state laws) where a creditor's only remedy against a limited partnership is to obtain a "**charging order**". A charging order only gives the creditor the right to receive distributions which otherwise might be made to the partner whose partnership interest is charged **if and when distributions are made**. In effect, the creditor could receive nothing if the partnership decides not to distribute. Further, the creditor assignee would receive a k-1 that would still make him responsible to pay tax on a distribution that he did not get. In years past, this feature has given the family limited partnership a decided edge as the premier form of asset protection.

Unfortunately, recent court actions have eroded some of the protection afforded by the charging order. The California Court of Appeal recently noted: ". . . The purpose of the charging order remedy was to prevent the unnecessary interruption of partnership business and to avoid adverse impact upon innocent, non-debtor partners, not to allow the avoidance of one's just debts."

Other concerns about the viability of family limited partnerships as an asset protection tool include:

- # The client is still subject to the whims of the domestic courts
- # If a charging is obtained by a creditor, the client is also limited in his or her ability to freely access partnership assets.

- # Courts are allowing foreclosure on family limited partnerships where the primary purpose of the partnership is to hold family assets like a home.
- # Courts are likely to continue to erode the protection of the charging order.

### # **CORPORATIONS**

For years, corporations have formed the foundation of asset protection because a corporation can reasonably protect its members, stockholders, directors and officers from liability and shield assets from creditors -- at least, far better than a general partnership or sole proprietorship.

Like any method of asset protection, the corporation is not fool proof. There is much written about “piercing the corporate veil”, especially where there is a single, key person running the corporation and state courts do not “guard” the veil. But asset protection professionals still believe that the corporation can serve as an initial “shock absorber” in any claim or plaintiff action. Further, there are many types of liability exposure that might not arise at all if a corporation were in place.

### # **Out-of-state Corporation**

To enhance on the liability protection of corporations, some have turned to their right to choose a different governing law. The State of Delaware and more recently Nevada, for example, appear to have legislation offering a much higher degree of protection than that available in remaining states.

Nevada, in particular, in 1991 passed on of the strongest laws in the nation concerning protection of personal property for individuals who control a corporation formed in that state. What makes this law so effective is the fact that the Nevada courts aggressively defend it. Other state courts have allowed the veil to be pierced for a multitude of reasons. In addition to this reason, there is no state income tax on a Nevada corporation and privacy is a high priority since Nevada is the only state that does NOT have a reciprocal taxpayer sharing agreement with the IRS.

Of course, every state has statutes that regulate the activities of their corporations, including corporations from other states -- called *foreign corporations*. For the most part, the type of business activity planned determines how much regulation will take place. If one is a resident of a state, he or she is free to be a stockholder, director, officer, agent or employee of a corporation in another state with no jurisdiction needed by the resident state. If, on the other hand, someone is planning to open a factory in his resident state, but operate through a foreign corporation, the foreign corporation would fall under the control of the resident’s state.

### # **Multiple Corporations**

Taking asset protection to even higher levels might involve using multiple corporations. Assets might be spread out and be better protected inside several different corporations instead of one. Examples include a small airline that incorporates each plane or the taxi cab company that formed a corporation for each taxi.

### # **LIMITED LIABILITY COMPANY**

A limited liability company (LLC) is an unincorporated entity that combines the advantages of a partnership flow-through tax treatment / operational flexibility with corporation’s limited liability.

Limited liability companies offer numerous advantages over existing forms of doing business, such as:

A single level of tax vs. The “double taxation” experienced by corporations -- once at the corporate level, and again after dividends.

LLC’s are not required to follow any corporate formalities. Unlike S-corporations, there are no restrictions on who can be an owner or member of an LLC. Unlike general and limited partnerships, the members of an LLC are not liable for its debts.

## # MULTI-FACTED APPROACH

Aggressive asset protection might utilize a combination of ALL or some of the above methods. For example, some high-risk professionals form one or more family limited partnerships and, when the legal waters are calm, gift some or all of the limited partnership interest to a foreign trust. The client still retains control over the family limited partnership assets as the general partner. If the legal waters become choppy, the actual assets can flow through to the foreign trust. As a fiduciary of the trust, the trustee of the foreign trust would likely reinvest the distributed assets out of the country. Other variations on this concept include using domestic corporations, foreign companies, or limited liability companies in combination with one or more family limited partnerships.

In the final analysis, the reader and the client must understand that the effectiveness of any asset protection plan is variable and subject to change with the tide of new and increasingly tougher property transfer rules and liability statutes. There is NO right approach. There is NO single approach that WORKS for sure. Rather, efforts should be spent on “*improving*” one’s situation to a level where he or she will weather the next legal storm better than before.

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