

Old asbestos claims never die; they just go on and on

by Scott Hooper
Special to *The Regulator*

Some of our grandparents or great-grandparents probably can remember back when we had a four-term president (and one who, incidentally, was not photographed in a wheelchair).

Those who reached adulthood the following decade have probably regaled you with stories of their first home in suburbia, and how they paid \$11,000 for it.

For those of us in the insurance game, though, grey hair might just correlate with the first time we heard that there was an asbestos crisis. But you don't have to be more than middle-aged to recall the first time you heard the crisis had been solved — seems so long ago, doesn't it?

The crisis never really did go away, though. And despite nearly two dozen unsuccessful bills at the federal level, plus legislation in a number of states, we're loath to proclaim that this time it looks like it might finally be ready to fade away. Perhaps it's safe to say is that we *hope* the asbestos issue is finally starting to fade as a threat to the companies that manufactured and used asbestos, and to the companies that insured them.

Asbestosis

Ironically, the ongoing threat to workers, the underlying issue, is for the most part a thing of the past.

We'd been using asbestos for nearly a century before its risks became clear, and by the '60s a cancer link was publicly known (though, as with tobacco, it's clear that asbestos manufacturers knew of the health risks long before the rest of us did).

It wasn't until the 1970s that the use of asbestos — in home and business insulation, fireproofing, vehicle brakes, floor tiles and more — tapered off sharply (at least in this country; in the third world, asbestos is still used extensively — and 30 million pounds are imported to the U.S. every year in foreign-made products).

An estimated 9 million Americans who mined asbestos, or who pro-

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The Look of Lloyd's — ten years after

by Vincent Laurenzano

Editor's Note: *It's been over a decade since Lloyd's of London's precarious financial condition threatened the stability of the U.S. insurance industry. The following article looks back on the events that triggered the crisis, the agreement that was reached, and the subsequent impact of that agreement on Lloyd's and the U.S. insurance industry.*

Lloyd's of London began over 300 years ago in Edward Lloyd's London coffee house where merchants and shipowners gathered to insure ships and their cargo. From its humble origins, Lloyd's developed into an insurance marketplace known worldwide for its expertise and innovation in all

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From the President

Looking to the Future

As the year of my presidency comes to a close, I would like to use this final column to express my appreciation to those who have made this such a successful year for IRES and to share thoughts on the future of our organization and insurance regulation.



If there is one thing I have learned this year, it is that the President of this organization is entirely dependent upon key people to keep the organization running and to achieve its goals. In that effort, the members of the Executive Committee consisting of Stephen King, Doug Freeman, Bruce Ramage, Jo LeDuc, Polly Chan and Katie Johnson were invaluable. Each took on the responsibilities of running their committees and keeping the organization on track. Come August, I will hand the reigns over to Stephen King who will, I'm sure, make an exceptional President.

As with past years, David Chartrand and staff have worked tirelessly to assure the success of the upcoming CDS, to keep the organization running and offer ongoing guidance. Special recognition also should be given to Wayne Cotter, whose editorial work behind the scenes for *The Regulator* results in a professional presentation that puts a public face on our organization.

I also would like to offer a special "thank you" to the NAIC and its staff, particularly Executive Director, Cathy Weatherford, who provided guidance and insight at the beginning of my year as President.

As I look to the upcoming years, I see great challenges for IRES and for insurance regulators.

As an organization, IRES must be able to adapt and seize opportunities to grow in new directions. In particular, IRES and its membership must determine what the membership base of the future should be. IRES must grow in membership to survive as a meaningful entity.

Many important questions must be answered to address this, such as, should we reach out to other state agencies involved in regulation of the business of insurance? Should we attempt to gain membership of insurance regulators employed by federal agencies? How else can we expand membership? Are there opportunities to “partner” with other similar organizations?

Looking to the future, the organization must hold to key principles of accountability and integrity. IRES must continually question how it can provide the greatest value to its members and to follow that in setting goals and objectives for each year.

As the regulatory landscape becomes more dynamic, it is essential that IRES continue to provide the highest-level education and training for regulators and to focus on providing the “cutting edge” information necessary for regulators to perform in an ever-changing workplace. The certification program that is currently in development is an example of IRES’ commitment to such education and training.

While challenges for the organization are great, our ability to meet the challenges already exists. The current family of IRES members continually surprises me with their creativity and common sense. You are the future of the organization and of insurance regulation.



Kirk R. Yeager, CIE
IRES President



SAN ANTONIO — Dennis Shoop (center) of the Pennsylvania Insurance Department is the 2005 recipient of the Paul L. DeAngelo Memorial Teaching Award from the IRES Foundation. The award was presented in May by Foundation board members Carol Newman (left) and John Mancini (right), during the Foundation’s annual Market Regulation School in San Antonio.

Welcome, new members

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Christian Ulmann, AK
Cynthia J. Williamson, NE

Is there any end to the asbestos saga?

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cessed it or worked with it, are still suffering from their long-ago exposure.

The teeny particles that cause asbestosis (a specific form of fibrosis) and in some cases other conditions, including broncogenic carcinomas and mesothelioma, are very persistent. That's why workers' families are also prone to health problems, usually from fibers accidentally brought home on clothing.

If you look at the population as a whole, asbestosis is quite rare. But among those exposed to asbestos — including vehicle mechanics, construction workers, shipyard workers, electricians and others in the building trades, and those who encounter old asbestos while refurbishing or demolishing old buildings — it's relatively common.

In a well-known Finnish study, 22% of men who'd either worked in construction for ten years or in shipyards for one year showed signs of asbestosis.

There's no cure for the disease. Once the little particles, known as amphiboles, get into the lung, they cause irreversible scarring of the alveoli, the little sacs where the actual work of the lung gets done.

Indeed, even with treatment, victims are likely to get worse, albeit slowly. Those who continue to work with asbestos, and those who smoke, get worse more quickly. Since it can take 20 to 40 years for symptoms to appear, and though many of the symptoms can have other causes, new asbestos-related cases are still being diagnosed.

Why so much detail about the disease itself? Because one of the big issues in the financial and insurance side of the asbestos debate is whether cash should go to anyone who fears disease because of long-ago exposure, or only to those with an actual diagnosis.

Paying the bills

It's not as simple as that may sound. The main reason is that the trial lawyers, smelling blood in the water, have trolled for clients. Potential litigants were invited to mass screenings, where the majority of those signed up actually showed no symptoms. A federal court judge in Texas and a New York grand jury are currently looking into the mass screenings and the ac-

tions of so-called "screening doctors," who diagnosed thousands of questionable cases; the Texas judge has said their actions raise "great red flags of fraud."

To date, of the millions paid out, more money has gone to the symptomless than to those with a debilitating asbestos-related condition.

Current legislation mostly aims at rectifying that obvious wrong, though law firms continue to troll for business.

Some of their pitches have become more responsible, such as the Web site that asks, "Do I have legal rights?" The answer: "If you have been exposed to asbestos at work or at home and are suffering from mesothelioma, you have specific legal rights. Consult with an experienced asbestos lawyer to determine the next step."

Another, however, still aims at those who may simply have been in the presence of the fibers: "An asbestos attorney that is aware of the trends and developments with asbestos litigation and legislation will be able to build a strong case for asbestos exposure victims."

Despite the flaws in the nation's tort liability system, many legitimate victims did go through the courts in the beginning of the asbestos crisis. But the number of claims quickly overwhelmed the system, and manufacturers began to seek bankruptcy protection.

As Michelle J. White, professor of economics at the University of California-San Diego, put it in a 2002 paper: "At least 500,000 individuals have filed claims related to asbestos exposure and, because a typical claimant files claims against approximately 20 defendants, as many as 10 million claims may have been filed.

"Over 75 firms have filed for bankruptcy due to asbestos liabilities, and estimates of the total cost of the asbestos mass tort range up to \$275 billion — larger than Superfund!

"Five corporations have spent more than \$1 billion each on asbestos litigation, and U.S.-based insurers of asbestos defendants have paid out over \$20 billion to date."

But to paraphrase the title of White's paper, the asbestos genie wouldn't stay in the bankruptcy bottle.

The federal bankruptcy code established special provisions for asbestos claims, but those claims kept exceeding the amounts set aside.

For instance, in the first big asbestos bankruptcy, against predecessors to the Manville Corp. (which owned asbestos mines and produced products containing the mineral), six years of negotiation ended in a 1988 settlement.

“All tort claims . . . were discharged, and personal injury claims were channeled to the Manville Personal Injury Settlement Trust (MPIST),” wrote White. “MPIST was financed by bonds with a face value of \$1.8 billion, 80% of the equity of the reorganized Manville Corporation, and the right to receive 20% of the Manville Corporation’s profits for 25 years.”

The settlement established a schedule of payouts, from \$12,000 for bilateral pleural disease to \$60,000-90,000 for lung cancer to \$200,000 for malignant mesothelioma. Yet even at those relatively modest rates, it soon became apparent that everyone had underestimated the number of claims.

Payments eventually had to be slashed, to the detriment of injured workers, but not until before at-risk corporations, realizing how rational bankruptcy protection now was, filed for it themselves.

Meanwhile, seriously ill former asbestos workers continued to die without seeing a dime, and others began to wonder whether they’d ever see justice.

Pros and cons

The stage was set for federal legislation. Yet despite a seeming consensus that manufacturers and insurers should be shielded from lawsuits if, in exchange, victims would have access to a generous trust fund, 21 previous bills have died, and this year’s effort — though likely to pass in some form — is highly controversial.

If, as the cliché says, you’re doing something right when everyone hates you, the backers of this year’s asbestos bill are champs.

The Fairness in Asbestos Injury Resolution Act of 2005 has made it out of the Senate Judiciary Committee by a 13-5 vote, but both Republicans and Demo-

crats say they’ll fight on the floor to amend it or kill it.

“As currently written, I could not support the bill on the floor if it does not change,” Sen. John Cornyn, R-Texas, told the Associated Press. Added Sen. Jon Kyl, R-Arizona: “It does need substantial work.”

Even Sen. Arlen Specter, R-Pennsylvania, the committee’s chairman (and sponsor of the bill), said, “We will do our best to make further accommodations and improve the bill.”

Democrats, including Sen. Russ Feingold of Wisconsin and Sen. Joseph Biden of Delaware, also are preparing to fight the bill. Those two voted against the legislation in committee, along with three other Democrats: Ted Kennedy of Massachusetts, Charles Schumer of New York and Richard Durbin of Illinois.

“The mere fact that you spent a large amount of time on it doesn’t justify preempting people’s rights in court,” Feingold said.

The bill would require insurers and business groups to put \$140 billion into a trust fund. Victims of asbestos-related illnesses would surrender their right to

sue unless the fund runs out of money.

On the House side of Congress is H.R. 1957, which would establish medical criteria that victims of asbestos and silica exposure would have to meet before they could sue for damages. Those who don’t meet the criteria, which are based on American Medical Association recommendations, would be placed in an inactive docket until they do.

This seemingly obvious aspect of the bill is similar to legislation recently passed in Ohio, Georgia, Florida and Texas, according to the Insurance Information Institute, and pending in several other states.

The obvious wrong of trial lawyers trolling for potential litigants and then clogging up the courts with marginal but profitable lawsuits has led one law professor — Lester Brickman of the Benjamin N. Cardozo School of Law — to term the enterprise a “massively fraudulent enterprise” (although, to avoid being sued

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If, as the cliché says, you’re doing something right when everyone hates you, the backers of this year’s asbestos bill are champs.”

Will we ever see the end of asbestos claims?

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for defamation, he has since renamed it a “massive specious claiming”).

At this writing, it’s hard to predict whether either the House or Senate asbestos bill will pass, and if so, whether they can be reconciled into workable legislation.

Both the insurance industry and organized labor are hoping not, for the most part because they feel the fund, and the new restrictions on payouts, won’t be sufficient to end the crisis once and for all.

A letter signed by officials of the American Insurance Association, the Reinsurance Association of America and the National Association of Mutual Insurance Companies told Congress that “it is imperative that any trust fund provide insurers with both certainty and finality for our asbestos exposure.”

Carl Parks, senior vice president for government affairs at the Property Casualty Insurers Association of America, was even harsher. “The costs of this legislation to the industry are potentially devastating and are unacceptable to our members,” he wrote, warning that “unless substantial changes are made, we will strongly oppose it.”

AFL-CIO president John Sweeney wrote to the Judiciary Committee to say that the latest draft included some important improvements, such as increases in award levels for some disease categories and a bar against any liens on workers’ compensation awards. But, he wrote, it leaves “a number of serious deficiencies that must be corrected. . . . In addition, there are a set of issues, such as the statute of limitations, preemption and the treatment of claims if the fund sunsets, that will determine whether the compensation system works as intended for deserving claimants.”

Some of the issues Sweeney cited, such as elimination of compensation for a large group of lung cancer victims, are also supported by the insurance industry.

What’s next?

Despite amendments to the Senate bill that address a few of the industry’s issues, the bill — even if it does eventually pass — faces one other potentially big hurdle.

Though no one has made any overt threats, it seems likely that the legislation would be challenged in court. Two big unresolved issues are how much each insurer would be required to contribute to the \$140-billion trust fund (left up to a five-member Asbestos Insurers Commission) and what happens to the existing trusts, created as part of bankruptcy settlements. (The Senate bill would require that their nearly \$7.6 billion in assets roll over into the new federal trust, prompting several

of the major trusts to retain former U.S. Solicitor General Theodore B. Olson to represent them in a suit charging violations of the takings and due-process clauses.)

Perhaps the solution lies in examining the joint-and-several liability standard that’s prevailed so long in mass torts, and what role reallocation of liability among defendants played in driving more than 70 companies to bankruptcy.

In a new paper, Charles Mullin, a Vanderbilt University economist, and Anup Malani of the University of Virginia Law School estimate that each dollar that asbestos victims received under the joint-and-several tort system produced 23-66 cents of asbestos-related bankruptcy expenses.

They write that of the \$53.3 billion paid to asbestos claimants between 1994 and 2002, \$6.5-11 billion was reallocated from companies like Raybestos, Eagle Picher Industries, Celotex, Keene Corp. and National Gypsum, which went bankrupt in an initial wave from 1989 to ‘93.

Reallocation of those liabilities helped create what they termed a “contagion” that sparked an even larger round of bankruptcies from 2000 through ‘02, claiming companies like Armstrong World Industries, USG, Babcock & Wilcox, W.R. Grace, GAF Corp., AC&S

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However effective the legislation now before Congress may turn out to be, its fate will have a big impact on U.S. insurers.

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Will we ever see the end of asbestos claims?

and Owens Corning/Fibreboard — and costing between \$2.6 and \$4.3 billion.

The alternative the two researchers see having the greatest potential is a joint-and-several standard that eliminates reallocation, but in a bankruptcy proceeding would raise the priority of tort claims to be equal or even greater than secured creditors. Their thinking is that secured creditors can more easily bear the risk of a defendant company's bankruptcy than codefendants. As Malani and Mullin see it, once the defendant company's resources are exhausted, liability would not be allowed to pass on to other defendant companies.

In another study, Tillinghast-Towers Perrin recently estimated that U.S. insurers and reinsurers will ulti-

mately lose \$55-65 billion, with cumulative liability of \$200 billion — not far from the amount provided by the proposed trust fund.

In the absence of something like the proposed trust fund, insurers would be liable for 61% of that amount, Tillinghast says (with the risk split about evenly between U.S. and foreign insurers).

Even if those numbers are a little off, it's pretty obvious that the asbestos crisis is far from over. But, however effective the legislation now before Congress may turn out to be, its fate will have a big impact on U.S. insurers.

So keep your eye on the national news in your local newspaper. ■

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Quotes of the Month

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“The burden of having to comply with rules from fifty-six separate insurance regulators is too inefficient for companies, agents and consumers to manage, especially those whose interests are national in scope.”

— From a June 14 letter to the U.S. Senate Banking Committee from 135 insurers, producers, banks and financial services trade groups advocating an optional federal charter for insurance regulation.

“While the letter leaves the impression that many insurance companies support federal regulation, it has been our experience that the vast majority of insurance companies, and an overwhelming number of agents and brokers, oppose an optional federal charter for the insurance marketplace.”

— Charles E. Symington, Jr., Big “I” Senior Vice President for Government Affairs and Federal Relations, responding to the letter

The look of Lloyd's, ten years later

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kinds of insurance and for its financial strength.

In the 1990s, however, Lloyd's stellar reputation became tarnished. From 1982 to 1992 Lloyd's suffered approximately £8 billion in net losses, primarily due to asbestos and environmental claims as well as natural and man-made disasters. By the mid 1990s Lloyd's was teetering on the verge of collapse with many of its underwriting members facing financial ruin. In addition, Lloyd's members were levying charges against Lloyd's underwriters and other insiders of incompetent underwriting, misrepresentation and fraud.

Lloyd's, the Marketplace

Lloyd's is not an insurance company but rather an insurance marketplace, which, up until the 1990s, consisted solely of unincorporated individual members (Names) who provided capital to assume insurance and reinsurance risk. Each Name is a sole trader who trades with unlimited liability and therefore is liable for losses to the full extent of his or her personal wealth. Names severally but not jointly subscribe to policies through groupings known as Syndicates. In 1994, Lloyd's expanded its underwriting membership to include corporate entities. Today the vast majority of Lloyd's underwriting capacity is provided by corporate Names as a result of a large-scale withdrawal of individuals from the organization due, in large part, to its unlimited liability stipulations.

Lloyd's United States Trust Funds

In 1939, with war raging in Europe, Lloyd's established the Lloyd's American Trust Fund (LATF) in New York in what is now Citibank,

N.A. to ensure that the pending World War would not prevent Lloyd's from meeting its United States obligations were its assets to be seized. The purpose of the LATF was to secure Lloyd's obligations as a reinsurer and/or excess and surplus lines insurer on all United States dollar-denominated insurance and reinsurance contracts.

In the late 1970s Lloyd's United States representatives petitioned the New York Insurance Department (Department) to recognize Lloyd's as an accredited reinsurer by virtue of the fact that it had deposited in the LATF assets equal to its total United States dollar obligations. An accredited reinsurer is not authorized to write direct business in New York, rather the designation indicates that the reinsurer meets certain solvency standards that allow a ceding authorized insurer to claim credit on its Annual Statement for reinsurance

placed with them.

In 1977, the Department granted Lloyd's accredited reinsurance status when it amended Regulation 20 (11 NYCRR Part 125), which established requirements for the accreditation of a group located outside the United States whose members consist of individual unincorporated assuming insurers. At that time any such group seeking accreditation had to deposit and maintain with one or more banks located in New York State a trust fund having a surplus of not less than \$100 million, for the protection of United States ceding insurers and United States beneficiaries under policies of reinsurance.

As a result of that Amendment to Regulation 20, Lloyd's was issued a Certificate of Recognition as an Accredited Reinsurer on April 22, 1977. Lloyd's accredited reinsurer status meant that any

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From 1982 to 1992 Lloyd's suffered approximately £8 billion in net losses, primarily due to asbestos and environmental claims as well as natural and man-made disasters.

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reinsurance recoverable from Lloyd's would be allowed as an admitted asset in determining the financial condition of any New York-licensed insurance company.

On July 17, 1992, Lloyd's established a second trust at Citibank, known as the Lloyd's Central Fund United States Trust Fund (CFUSTF). The CFUSTF, patterned after Lloyd's Central Fund (Guaranty Fund), was established to meet the United States obligations of defaulting Names. The CFUSTF was initially funded with \$700 million.

On September 15, 1993, at the Department's direction, Lloyd's established two additional trusts in the United States: (i), the Lloyd's American Credit for Reinsurance Joint Asset Trust Fund (JATFRI); and (ii) the Lloyd's American Surplus and Excess Lines Insurance Joint Asset Trust Fund (JATFSL). These trust funds, operated on a joint and several basis, are funded with \$100 million to meet Department requirements that Lloyd's maintain a \$100 million surplus with respect to reinsurance liabilities and \$100 million surplus with respect to its excess and surplus lines liabilities.

Names Revolt

During this time, Lloyd's Names were becoming increasingly restless. They were now fully aware of the implications of Lloyd's unlimited liability provisions. Prior to this time, a Lloyd's membership was considered prestigious and relatively risk free. The unlimited liability provisions were seen by many Names as mere technicalities and not likely to be evoked.

It wasn't long, however, before the concept of unlimited liability was fully appreciated by Lloyd's Names. They realized that not only their investments in Lloyd's but their personal fortunes and homes could be at risk as a result of unfunded

liabilities associated with environmental and asbestos-related claims they little understood. The Names, however, weren't going down without a fight.

Some of the Names that had recently joined accused Lloyd's of fraud, of soliciting them to become Syndicate members only *after* the organization became aware that it would soon be awash in red ink. Moreover, American Names unsuccessfully attempted to convince the courts to attach U.S. trust funds in order to fund their individual losses. These actions by U.S. names occurred at a particularly inopportune time, a time during which the Department was seeking to convince Lloyd's to bolster its U.S. trust funds.

New York Insurance Department Exam

In 1994, amidst concerns over the crisis arising from asbestos and environmental liabilities, the financial condition of Lloyd's and the adequacy of the LATF, the Department — in its role as the domiciliary regulator with respect to the Lloyd's trust funds — conducted a limited examination to determine whether the LATF was in compliance with New York's regulations.

New York Insurance Regulation 20 required Lloyd's to maintain in the LATF assets equal to its gross United States liabilities plus a surplus of \$100 million. In May 1995, the Department issued a report indicating that Lloyd's was not in compliance with Regulation 20 because the LATF was, on a net-of-reinsurance basis, underfunded by approximately \$7 billion and, on a gross-of-reinsurance basis, by approximately \$18 billion. Therefore, total Lloyd's United States dollar liabilities exceeded the LATF assets by approximately \$18 billion and the Department had to seriously consider revoking Lloyd's' accredited reinsurer status.

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The Look of Lloyd's

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In response to its financial crisis, Lloyd's initiated a capital-raising effort through its "Reconstruction and Renewal" project. (See next section for more detail.) The Department realized that revoking Lloyd's accredited reinsurance status would have jeopardized the successful completion of the Reconstruction and Renewal process and threatened the financial viability of Lloyd's. Moreover, a large number of United States property and casualty insurers had significant reinsurance recoverables due from Lloyd's and revoking Lloyd's accreditation would also have adversely affected the financial condition of these insurers.

The Department therefore concluded that revoking Lloyd's accreditation was an untenable option, and that securing additional capital to restore Lloyd's to sound financial condition was of paramount importance. Accordingly, the Department supported the development of the Reconstruction and Renewal project and worked closely with Lloyd's and the United Kingdom's Department of Trade and Industry (DTI) to ensure the success of the project. Simultaneously the Department engaged in extended negotiations with Lloyd's and the DTI to seek a solution to the U.S. trust funding crisis that would provide adequate protection to United States policyholders of Lloyd's.

Pursuant to an agreement reached in May 1995, Lloyd's agreed to immediately transfer \$500 million to the CFUSTF and cause each syndicate seeking to do business in the United States to establish a trust fund in New York to secure its liabilities on reinsurance policies insuring United States cedents *on or after August 1, 1995*. Lloyd's

agreed that the new syndicate trusts would hold assets to fund the syndicates' gross insurance liabilities in compliance with New York Insurance Regulations. Lloyd's agreed to additional measures to secure United States policyholder claims as detailed below.

Reconstruction and Renewal

Reconstruction and Renewal was designed to mutualize (*i.e.*, transfer all assets and liabilities to one fund, Equitas Reinsurance Limited) the liabilities on all policies of insurance and reinsurance issued by Lloyd's syndicates in 1992 and prior years and to resolve pending litigation by Names against Lloyd's, and various Lloyd's market participants.

The Lloyd's Reconstruction and Renewal project was implemented on September 4, 1996 when all Lloyd's members' 1992 and prior liabilities were reinsured by Equitas Reinsurance Limited (Equitas), a newly organized DTI-licensed reinsurer. Equitas was organized solely to run off the 1992 and prior claims of Lloyd's and was funded with a premium of £14.7 billion including £3.2 billion of new capital.

Names agreeing to the settlement of the litigation that is part of the Reconstruction and Renewal project were entitled to withdraw from Lloyd's provided they pay their "finality statement," which represented a portion of the £3.2 billion in additional premium required by Equitas to meet its obligations. By paying Equitas a designated sum, Names agreed that Equitas would assume their 1992 and prior claims. The agreement did not, however, absolve Names from any liability should Equitas assets ultimately be insufficient to meet its pre-1993 obligations. In other words, the agree-

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The agreement now appears to be working very much as envisioned ten years ago.

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ment did not represent a novation of the Names' policyholder obligations, but it was structured on an actuarially sound basis so as to minimize the chances of policyholder recourse against Names.

Although many Names objected to the conditions of the agreement, most paid their finality statements, dropped any pending lawsuits against Lloyd's, and hoped they had seen the last of unlimited liability with respect to their Lloyd's' investments.

With respect to funding Equitas, the Department approved the transfer of \$5 billion from the LATF as part of the premium to Equitas for assuming the 1992 and prior liabilities of the Names. The approval was conditioned on the following:

- Establishment of the Equitas American Trust Fund in New York with Equitas as the Grantor and the LATF as the sole beneficiary. A \$5 billion premium payment from the LATF was paid into the EATF. Thus the funds remained in the United States as security for U.S. policyholders.
- An additional \$1.2 billion contribution by Equitas to the EATF to support the United States liabilities.
- Assurance from Lloyd's and the DTI that United States policyholders from 1992 and prior would, in the event claims are not paid in full from the funds in the LATF and the EATF, have recourse to the JATFRI and JATFSL trust funds for the unpaid portion of claims.

This last condition is especially significant because, under New York's regulations, these trust funds must continually be maintained at \$100 million each for Lloyd's to retain its accredited reinsurance status and the ability to write surplus lines business in the United States. Thus in the event that the assets dedicated to support the 1992 and prior claims of Lloyd's United States policyholders prove insufficient, the ongoing Lloyd's market will need to fund the deficiency if it desires to continue

to do business in the United States under its current favorable terms.

The solutions reached by the New York Insurance Department in cooperation with Lloyd's and the Department of Trade and Industry in resolving a financial crisis that had the potential to cause serious disruption in the United States insurance market seems to have worked. Today, ten years later, Lloyd's appears to once again be financially sound and is providing insurance capacity to the United States. Equitas to date has met its obligations and although all its liabilities have not been resolved, appears to be capable of meeting the remainder.

Although many Names, particularly U.S. Names, may have been less than pleased with the final solution, the experience offers a good example of regulators working with industry to resolve problems with systemic implications. Reaching a satisfactory solution required a significant sacrifice from all the major players and the agreement now appears to be working very much as envisioned ten years ago. ■

Vincent Laurenzano is a former chief of the New York State Insurance Department's Financial Condition Property/Casualty Bureau and Assistant



Deputy Superintendent. Mr. Laurenzano is currently employed as an insurance finance consultant with the Manhattan-based Stroock & Stroock & Lavan LLP Insurance Practice Group.

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See related story, p. 23

Life Settlements: Pro and Con

EDITOR'S NOTE: *Life settlements allow relatively healthy individuals to sell their life insurance policies to unrelated investors. The Regulator recently asked Michael Freedman of Coventry First and John Skar of the Massachusetts Mutual Life Insurance Company to respond to the following question: Are life settlements good for consumers?*

YES: More choices for consumers

by Michael D. Freedman

Life insurance consumers have never had the degree of choice they enjoy today. An ever-growing array of insurance products gives policyowners new tools to meet their financial planning goals. Just as important are the choices now available for exiting life insurance policies that are no longer needed or affordable, or simply do not meet expectations.

While the rights of U.S. life insurance policyowners to sell their unwanted insurance to third parties was affirmed nearly 100 years ago, a lack of willing buyers effectively eliminated the secondary market value of life insurance. As a result, policyowners who wanted to exit a policy had only one option — surrendering the policy to the issuing life insurer.

The rise of a vital secondary market for life insurance has changed all that. The secondary market now gives life insurance policyowners the same economic freedoms and power as consumers with other financial assets.

First, and foremost, is the freedom to know what one's asset is worth. Prior to the rise of the secondary market, the value of an unwanted or unneeded policy was whatever the carrier offered. In the current free market environment, a policy's value is determined by independent market forces. As a result, life insurance

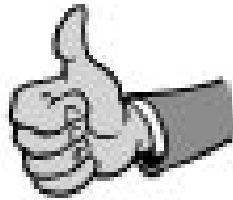
consumers are now empowered simply by having their insurance policies appraised. With a secondary market value in hand, policyowners are able to make better financial planning decisions -- whether or not they ultimately choose a life settlement.

Second, the competitive market provides life insurance consumers with the freedom of choice. Life insurance provides solutions to meet various financial needs. Over time however, circumstances change, and with them the need for insurance. Likewise, the evolution of underwriting means better, more efficient life insurance products are continuously entering the marketplace. The result is an ever-changing financial landscape that demands greater flexibility from consumers. Add the fact that a majority of universal life and term insurance policies never mature in a claim, and the

message is clear: life insurance is no longer a primarily "buy and hold" asset. It is a financial tool that is used in specific circumstances to address specific goals. The secondary market simply gives policyowners the freedom to respond to changing situations and manage their life insurance more effectively.

Third, and most tangible, is the fact that the secondary market ensures that consumers can obtain the best possible price for their qualifying policies, ranging from three- to ten-times the cash surrender value available under the policy. Coventry First has provided policyowners with more than \$500 million over cash surrender value in just over three years. In total, the life settlement market has paid an estimated \$1.6 billion over cash surrender value. Clearly, the market has presented consumers with a compelling alternative.

But the benefits of the market extend to the life insurance industry as a whole. A recent report from Bernstein Research, an international investment research firm, notes the increased liquidity provided by the secondary market may lead to an increase in sales of cash value life insurance, while carriers will be



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NO: Few policies & high costs

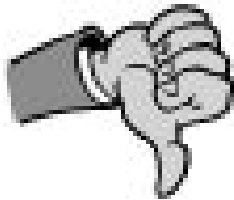
by John Skar

Life settlements are complex and extraordinarily expensive. It is estimated that less than 0.3% of individual life policies in the U.S. qualify for a life settlement offer. The rare policies that do qualify have intrinsic economic values that have appreciated enormously due to the poor health of the insured. Regardless of the current dividend or credited rate, these policies have high expected returns on future premium payments due to the increased likelihood of the insured's death. Obviously, finding those policies and convincing owners to sell them requires a lot of marketing effort.

Recruiting life agents to help search for large policies on unhealthy seniors is essential. Usually, multiple agents and brokers are employed and commissions are generous. Once prospects are located, they must go through an expensive underwriting process to estimate life expectancy. Since this estimate of the investment's "maturity date" is inexact, investors are likely to set their offering price low enough to ensure a profit. Since investors pay required premiums until the insured dies, reinsurance is purchased to limit the tail risk of an insured living too long. Finally, most investors pay tax on the excess of the death benefit over their cost basis in the investment, which is yet another expense to build into the offering price.

A recent study by Deloitte and the University of Connecticut Actuarial Science Dept. (ref: www.lifesettlementseducation.com) estimates that between 50% and 75% of the intrinsic economic value of life settled policies is destroyed by these costs. This is astonishingly high when compared with the transaction costs associated with selling other financial assets. Significantly, all of these costs are avoided if the policy is retained in the insured's estate.

Therefore, the Study concludes that policies



eligible for life settlements should be retained, not sold, if the owner has any estate needs. If cash is needed, some other estate asset should be sold, rather than the life policy. The Study also determined that on average for every \$1 of life settlement proceeds paid out, up to \$2 of estate value is destroyed. For regulators and consumer advocates, the lack of disclosure regarding the costs involved in these transactions may be a source of concern.

Sell, Surrender or Keep?

Life settlement marketing is built on continuous repetition of a simple proposition: selling a policy is better than lapse or surrender. While true, this statement avoids the more important observation that, if you have any estate needs, retaining the policy is superior to either sale or lapse. Understandably, life settlement marketers do not mention the high cost of these transac-

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Defining Viatical and Life Settlements

Viatical settlements are sales of life insurance policies on terminally ill people to unrelated investors. Viaticals arose during the early years of the AIDS epidemic, but declined in popularity as new treatments extended life expectancies. The viatical industry was tainted with many instances of insurance and investor fraud.

Life settlements are structurally identical to viaticals, but target seniors (age 65+) who have had a negative change in health and with current life expectancies ranging from 2 to 12 years. While viaticals involve policies with relatively small death benefits, the average life settlement has a death benefit in excess of \$1 million. Despite their identical structure, life settlement brokers claim that their business model is different than the tainted viaticals.

— John Skar

Life Settlements: Pro and Con

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motivated to offer additional features such as expanded accelerated death benefits or increased guarantees of cash value, all of which will have the effect of driving new business. In addition, the investment community may see the increased activity in the industry as an opportunity for securitizations.

Likewise, a very recent study, conducted by Deloitte Consulting LLP and the University of Connecticut and paid for by MassMutual, emphasizes that “selling a life insurance contract in the secondary market always provides more liquidity than surrendering the contract.” Indeed, for policyowners who have no alternative but to lapse or surrender a policy, the study asserts “the existence of an efficient secondary market in the financial services industry could improve the economic welfare of consumers in general, as well as the value of the corresponding asset in the primary market.”

Of course, for the majority of policyowners, maintaining their policies continues to be the best course. But the mere presence of a viable secondary market gives these individuals the means to evaluate what the policy is worth. In cases where the policy is no longer performing up to expectations, the market provides new options.

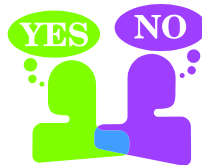
The secondary market also creates incentive for the primary life insurance market to adjust their surrender values to competitive levels, according to the seminal 2002 Wharton Financial Institutions Center study entitled “The Benefits of a Secondary Market For Life Insurance Policies.” This study estimated that the mature life settlement market could reach \$100 billion in the next few years, effectively transforming life insurance into a fully evolved asset to be actively managed, much like equities, bonds, and real estate. The same study goes on to compare the economic benefits of a

secondary market in life insurance with those of other secondary markets such as home loans and catastrophic risk insurance. By creating liquidity and an enhanced perceived value within the world of life insurance, the secondary market will, in its own way, enhance the health and vitality of the entire financial services sector. In fact, Standard & Poor’s and other leading ratings firms are now including secondary market participants in their rankings.

In sum, the advantages of a healthy secondary market are many. For consumers, the market has created a pro-competitive environment that is generating new value, fresh innovation and a dynamic level of activity in the life insurance sector. Life insurance is now more flexible, more powerful and more valuable than ever before.

For insurers, the secondary market value of life insurance will drive up the demand for life insurance. This increased demand, coupled with the enhanced value of the life insurance contract, will provide carriers and professional insurance advisors strong and valuable opportunities to meet the needs of financial consumers.

As such, it is in the interest of all members of the life insurance industry – regulators, carriers, professional advisors and secondary market participants – to work together to create a strong and vital market. A market that is pro-competitive and pro-consumer, where all parties are, indeed, winners. ■



Michael D. Freedman is Senior Vice President, Government Affairs at Coventry First. With his primary focus on the continued growth of the secondary market for life insurance in the United States, Mr. Freedman represents Coventry First and the secondary life insurance market before government officials.

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tions or the advantages of policy retention.

Rather, they invariably remind prospects of the many reasons one might want to get rid of a life policy: high premiums, poor policy performance, change in insurance needs, death of original beneficiary, etc. Next, they provide the good news that a life settlement is superior to lapsing or surrendering. Finally, prospects are reminded of all the things that this “unlocked” cash can be spent on. Ironically, many of these needs point right back to the insured’s estate, *e.g.*, gifts to children or grandchildren, gifts to charity, etc.

Marketing material aimed at life insurance agents or brokers points out three or more sources of compensation from a life settlement transaction: (a) renewal commissions from original policy; (b) direct commissions on the settlement transaction; and (c) commissions on sale of new insurance or investments with cash obtained from the settlement. Many life settlement companies claim that up to 70% of settlements result in sales of new life insurance. Many people have questioned whether life insurance replacement regulations should apply in these situations.

If there’s an Estate, Retain the Policy

What consumers, regulators and financial advisors should remember is that at least 99.7% of all life policies are not eligible for life settlements. This means that the overwhelming majority of lapsed or surrendered policies are not eligible for settlement. The few that are eligible have greatly appreciated in economic estate value due to the decline in health of the insured and should be retained. They are worth more than the surrender value because statutory mandated surrender values are based on average mortality, not unhealthy mortality.

Regardless of the original purpose of this insurance or its current policy performance, these highly appreciated policies should be retained, not sold or surrendered. As long as the insured has an estate need, the appreciated policy should

be part of the estate. Since so much of the policy’s estate value is destroyed by its sale, it makes more financial sense to meet liquidity needs with other assets, where transaction costs are many times lower.

This raises an interesting question: for the few policies eligible for life settlements, how many are owned by people with no estate needs? Common sense suggests that most owners of \$1 million policies who are age 65 or older have estate needs. This leaves a very small legitimate market for life settlements, hardly big enough to sustain an “industry.” Some of the leading life settlement firms seem to have recognized this problem and are taking steps to grow their own source of new policies to re-sell.

One such program utilizes non-recourse premium financing to pay premiums for the first 24 to 36 months, *i.e.*, the policy contestable period. A non-recourse loan is secured only by the value of the policy itself---no other asset is required as collateral. Wealthy, older people are approached with offers of virtually free coverage for two to three years. The ideal candidate has some medical problems, but can negotiate a “standard” offer from one of the more aggressive life underwriters. At the end of the period, the insured person can either pay off the loan and retain the policy, or walk away and turn the policy over to the settlement company. Since these loans are expensive and generally accumulate both principal and interest, they are designed to have the insured person walk away and turn the policy over for settlement.

Not a Financial Concern to Insurers

Life settlement firms portray life insurance companies’ opposition to settlements as based on financial self-interest, *i.e.*, they claim that life companies would rather have these policies lapse. This is a myth. Life companies already assume that lapse is anti-selective, *i.e.*, that unhealthy lives will keep their policies. Less than 0.3% of policies are even eligible for settlements. Of those, few would have lapsed or surrendered, certainly not enough to materially impact a life

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company's financial results. Most life companies simply do not want their agents involved in transactions that clearly are not in the client's best interest.

May be a Fiduciary Concern for Agents

Financial advisers should provide the best advice, not just "better than" advice. Saying that a life settlement is "better than" a lapse or surrender is not providing the best advice. When an adviser gets paid to facilitate a settlement, especially if the proceeds are then used to fund another insurance product or some other estate planning purpose, serious questions of fiduciary ethics may arise.

Given their high cost and the potential for misinformation, regulators may want to consider what requirements are appropriate in the area of consumer disclosure and agent education about life settlements. They may also monitor programs that abuse insurable interest statutes in order to grow pools of future life settlement candidates on behalf of third party investors.

If consumers receive appropriate financial advice, fully consider all their options and act rationally, the number of life settlement transactions will be very small. As agent and consumer education improves in this area, the number of life settlement companies should decline dramatically. There may also evolve less costly alternatives to life settlements, such as a line of credit secured by the death benefit, which will allow unhealthy seniors to retain ownership while still accessing some of the policy's increased value. ■

John Skar is Chief Actuary and Chief Risk Officer at Massachusetts Mutual Life Insurance Co. Mr.



Skar is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries. The views expressed in this article are his own, and do not necessarily reflect those of his employer.

C.E. News

If you are coming to the CDS in Tampa, note that in order to receive the full 15 CE attendance credits, you must stay until the end of the seminar and pick up your attendee certificate. Those who leave early will only receive credits for the time attended, or a maximum of 12 CE credits. If you don't pick up your certificate and want a copy, you can call the IRES office afterward to request a copy.

Your NICE transcripts went out in May showing the hours you have submitted so far for the 9/1/04-05 Compliance Year. If you find yourself short on hours, be sure and send us an extension form by 9/1/05. This will give you an extra year to comply.

Don't forget that you can check your credits online. Our Web site is www.go-ires.org. On the IRES home page click MY CREDITS, click logon, type in User ID (which is your name as it appears in your newsletter) and your password. If you forgot your password or need one, please contact us at 913-768-4700.

Members receiving an AIE or CIE designation during the time period 7/1/04-6/30/05 will be acknowledged at the Monday luncheon during the Tampa CDS, as well as during a private cocktail reception that evening. We hope you can attend. Registration information can be found on our Web site.

N · I · C · E

National IRES Continuing Education

LEARNING REGULATION — TEXAS STYLE

Compliance professionals — newcomers and veterans — gather in San Antonio for IRES Foundation's annual Market Regulation School

SAN ANTONIO — Nearly 300 industry compliance professionals gathered here May 1-3 to meet with state regulators about the latest trends in market regulation. The seminar at the Hyatt Regency Riverwalk was the 12th annual National Insurance School on Market Regulation, sponsored by the IRES Foundation.

The seminar, which opened with a "first-timers" reception at the historic Lone Star Palace overlooking the Alamo, included group sessions and private appointments covering all aspects of compliance with state statutes and regulations. The IRES Foundation annual school is nationally acclaimed for its unique format that focuses on personalized information briefings between regulators and industry.



Industry compliance staff at a "round robin" breakfast with state regulators



Insurers learn the "ABC's of Market Conduct Exams" during breakout sessions at the San Antonio School.



Kirk Yeager, IRES President and Colorado deputy commissioner, fields industry compliance questions



Texas Commissioner Jose Montemayor (middle) is flanked by Foundation board members John Mancini and Cynthia Davidson. Montemayor delivered the school's opening keynote address.

IMSA: Working with regulators for a more ethical market

by Brian Atchinson

It is an uncertain time for everyone associated with insurance – consumers, companies, producers, regulators and rating agencies. News reports outline alleged sales abuses targeting seniors and the military, and the complex and sometimes confusing relationships between insurers and reinsurers.

These misdeeds and allegations coupled with investigations initiated by New York Attorney General Eliot Spitzer, other state attorneys general, the Securities and Exchange Commission, the National Association of Securities Dealers and even the FBI have prompted a new examination of the role of ethical business practices within the insurance community. Ultimately, state and federal authorities will address any criminal activities.

The pressures of a highly competitive marketplace, unfortunately, have prompted some companies to engage in practices that, while not illegal, may be unethical. There has been plenty of lip service paid to ethical business conduct. But the true commitment of some companies to “walk the talk” has, in many instances, been lacking. There remain many who believe they can avoid the cost of creating a real “culture of compliance” if the only downside is the occasional lawsuit or regulatory fine.

The atmosphere today is reminiscent of the early 1990s for the insurance industry. During that time, many life insurers were the focus of intense regulatory scrutiny that forced corrective action as a result of widespread inappropriate marketing and sales practices. Many insurers also faced litigation charging that sales representatives were misrepresenting products.

During that period, industry leaders convened a group of experts to study the problem and consider solutions. The end result was the Insurance Marketplace Standards Association (IMSA), whose mission is to promote consumer protection through high ethical standards in the sales and service of individually sold life insurance, annuity and long-term care insurance products.

In order to qualify for IMSA membership, a company must establish, maintain and document its commitment to:

1. Conduct business according to high standards of honesty and fairness and to render that service to its customers which, in the same circumstances, it would apply to or demand for itself;
2. Provide competent and customer-focused sales and service; Engage in active and fair competition;
3. Provide advertising and sales materials that are clear as to purpose and honest and fair as to content;
4. Provide for fair, expeditious handling of customer complaints and disputes; and,
5. Maintain a system of supervision and review that is reasonably designed to achieve compliance with these Principles of Ethical Market Conduct.

IMSA was partially predicated on the Total Quality Management belief that “If you cannot measure it, you cannot manage it.” Companies must develop and maintain an infrastructure of policies, procedures and staff to detect and resolve questionable marketing, sales and distribution practices *before* they become systemic. As one rating agency analyst recently noted, IMSA is the only tangible manifestation of a company’s commitment to ethical business practices.

In short, IMSA offers a methodology and template to provide company managers with a new set of qualitative and quantitative tools to help manage their organizations in a way that would keep them compliant with laws and regulations and IMSA’s Principles and Code.

IMSA standards require a company to establish a sound market conduct infrastructure designed to identify possible market conduct problems early before they become widespread.

Through active data collection and monitoring, IMSA qualified companies are able to continuously improve their compliance practices. In 2002 and 2003, IMSA spent considerable time examining the independent assessment process based on feedback from regulators to ensure greater consistency and rigor within the program. This effort resulted in IMSA's Independent Assessment Manual that provides a common baseline standard of performance for independent assessment by following a list of specific test steps to be performed. The IMSA testing methods include documentation review, interview/field validation, direct observation, sampling and surveys.

As a result of these program improvements, an increasing number of regulators are recognizing IMSA's value as a tool to help them in market analysis and examination activities. Massachusetts recently joined New York and Texas in issuing a bulletin recognizing the value of IMSA. Reportedly, other states are asking about a company's IMSA qualification and using IMSA information in their work, recognizing that IMSA-qualified companies can provide valuable information to allow regulators to measure a company's commitment to sound market conduct practices.

IMSA continues to work with regulators to explore areas of mutual concern and cooperation. IMSA staff has visited 40 state insurance departments to learn about their issues and concerns and to discuss ways that IMSA qualification and documentation can be a tool in the market analysis and market conduct process.

The IMSA program, while rigorous, does not guarantee perfection. But the principles to which a company must adhere to maintain IMSA qualification create a structural and organizational imperative that promotes self-corrective action. IMSA-qualified companies that find problems as a part of their ongoing compliance processes are often self-reporting these issues to regulators. We see more and more examples of this kind of self-reporting from IMSA members, offering an additional layer of checks and balances that enhance consumer protections.

While IMSA is not an advocacy organization, it is gratifying to note increasing recognition by

state and federal officials in their initiatives to update and modernize insurance regulation. The NAIC's *Framework for a National System of State-Based Regulation*, issued in 2004, points out the significant role that best practices organizations such as IMSA can play in market regulation, and the Market Analysis Handbook specifically references IMSA as a valuable element in the market analysis process.

The Future of IMSA

What is in IMSA's future? Certainly the focus on high standards of compliance will continue and probably even intensify. Companies that focus on creating internal structures to ensure compliance – IMSA companies, for example – are well-positioned for that type of scrutiny. In addition, these companies have in place the necessary structures and have adequate resources to properly respond to regulators, either on their own by self-reporting or if a question arises.

IMSA will continue to examine and, if necessary, refine its policies and procedures to be sure they remain stringent and relevant.

Groucho Marx said, "The secret of life is honesty and fair dealing. If you can fake that, you've got it made!" In 2005, companies cannot fake it when it comes to ethical business practices. It's not enough to just talk about ethics. Companies need to show consumers and regulators a real, sustained commitment to high standards.

Regulators cannot be everywhere, nor should that be the expectation. Each company needs to dedicate itself to keeping the promises inherent in the insurance contract. Consumers expect nothing less. ■

Brian Atchinson is Executive Director of the Insurance Marketplace Standards Association. From 1992 to 1997, Mr. Atchinson served as Superintendent of the Maine Bureau of Insurance and served as NAIC President in 1996.



Regulatory Roundup

ARIZONA – Governor signs legislation allowing exclusion of fires caused by terrorism in the Arizona standard fire policy

On April 25, Arizona Governor Janet Napolitano signed into law House Bill 2192, which amends Arizona Insurance Code Section 20-1503 to permit a coverage exclusion in the Arizona standard fire policy of loss by fire or other perils insured against if the loss is caused directly or indirectly by terrorism and involves risks other than a loss involving certain types of residential property. The Bill was issued in response to an increase in insurance premiums that occurred following the enactment of the federal Terrorism Risk Insurance Act of 2002 (TRIA), which required insurers to offer insurance coverage for acts of terrorism to policyholders. According to an Arizona Senate “Fact Sheet” on the Bill, TRIA voided certain terrorism exclusions then in force to the extent an act was certified as a terrorist act in accordance with the provisions of TRIA. The Senate Fact Sheet further states that the current version of the Arizona standard fire policy insures direct loss by fire regardless of the cause of the fire and that the policy’s war exclusion clause does not extend to acts of terrorism. House Bill 2192 amends Arizona’s standard fire policy to permit an insured to elect to exclude from coverage losses from fires resulting from terrorism. The Bill will become effective on August 12, 2005. *To view House Bill 2192, visit www.azleg.state.az.us.*

NEVADA – Use of automobile electronic recording devices

Both houses of the Nevada Legislature recently passed Assembly Bill 315, which would regulate the installation of, and restrict the distribution of data produced by, an automobile event recording device (ERD). The Bill, if enacted, would require automobile manufactur-

by
**Stroock & Stroock &
Lavan LLP**

ers of a motor vehicle sold or leased in Nevada and equipped with an ERD to disclose the presence of the ERD in the owner’s manual. The disclosure must include a list of the kind of information recorded by the ERD. For example, the statement must indicate that the ERD records such information as the direction and rate of speed at which the motor vehicle travels, a history of where the vehicle travels, steering performance and break performance (including whether the brakes were applied before an accident), as applicable. Data recorded by an ERD generally may be retrieved only by the registered owner of the vehicle, subject to limited exceptions. For example, ERD data may be transmitted to third parties if the vehicle owner consents to retrieval of the data, if the data is retrieved by a new vehicle dealer or a garageman to diagnose, service or repair the vehicle, and pursuant to a subscription agreement for the provision of ERD recording services. Representatives of the insurance industry have criticized Assembly Bill 315 because it does not include insurers among the third parties to whom ERD data may be transmitted without the policyholder’s consent. These observers argue that ERD data helps insurers to fight fraud, to administer accident claims and to verify or disprove claimant witness accounts. Assembly Bill 315 has been approved by both houses of the Nevada Legislature and was delivered to Governor Kenny Guinn on June 3, 2005. *To view Assembly Bill 315, visit www.leg.state.nv.us.*

NEW JERSEY – Assembly proposes legislation regulating the use of after market collision parts in motor vehicle repairs

The New Jersey Assembly has proposed Assembly Bill 3682, which would regulate the use of after market collision parts for motor vehicles. An “after market collision part” is defined to mean any motor vehicle replacement part used to repair collision damage other than new parts manufactured by the original equipment manufacturer (OEM) or new parts bearing the trademark of the OEM. After market collision parts would include, but not be limited to, non-OEM sheet metal

The New York-based Stroock & Stroock & Lavan LLP Insurance Practice Group includes partners Donald D. Gabay, Martin Minkowitz, William D. Latza and William Rosenblatt. The Insurance Practice Group also includes insurance finance consultants Vincent Laurenzano and Charles Henricks. They gratefully acknowledge the assistance of Todd Zornik, an associate in the group, and Robert Fettman, a law clerk in the group. This column is intended for informational purposes only and does not constitute legal advice.

or plastic composite parts, salvage or used parts and nonmechanical remanufactured or rebuilt parts. The Bill would require any person proposing to make any physical damage repair to provide the vehicle owner with a written estimate of the cost of the repair, which must include a list and cost description of the parts to be used for each repair. If the repair shop proposes to use any after market collision part, the words “after market collision part” preceded by the type of part – “non-OEM,” “salvage,” “used,” “remanufactured,” “rebuilt” or other approved description – must be included in the estimate. Each written estimate including after market collision parts must also include a mandatory disclosure concerning the quality of after market collision parts in relation to original parts, which notice must be signed by the vehicle owner. Assembly Bill 3682 also prohibits an insurer from requiring a claimant to consent to the use of after market collision parts as a condition to payment under an insurance policy. During the model year and the four following years, if a vehicle is repaired using non-OEM parts, an insurer is required to reimburse the claimant for any additional charges incurred to install and finish the after market collision part in excess of the cost of installing and finishing the equivalent OEM part. Assembly Bill 3682 directs the Commissioner of Banking and Insurance to promulgate regulations necessary to implement the legislation. The Bill also allows the Commissioner to impose certain fines for violations of the provisions of the Bill. As of May 12, 2005, the Bill had been referred to the Assembly Transportation Committee without a recommendation. *To view Assembly Bill 3682, visit www.njleg.state.nj.us.*

PENNSYLVANIA – Viatical settlement broker license testing requirements for licensed life insurance producers

On March 25, 2005, the Pennsylvania Insurance Department issued Notice 2005-04 regarding viatical settlement broker testing requirements applicable to licensed life insurance producers. The Notice was issued in light of the NAIC’s June 2004 adoption of the Model Viatical Settlement Regulation. The Notice cites section 11(3) of the Pennsylvania Viatical Settlements Act, which authorizes the Department to establish appropriate licensing requirements, as the statutory authority for issuance of the Notice. The Notice exempts from the separate viatical settlement broker prelicensing exam requirement licensed Pennsylvania resident and nonresident life insurance producers who have been acting as licensed life insurance producers in Pennsylvania or in

any other state for at least one full year prior to applying for a viatical settlement broker license. Life insurance producers exempt from prelicensing testing continue, however, to be required to apply for and obtain a viatical settlement broker license before acting in that capacity. As of May 2005, viatical settlement broker license applications may be submitted electronically. Copies of the latest application containing a section for indicating the possession of a resident or nonresident life insurance producer license are available at www.sircon.com. Notice 2005-04 affects viatical settlement broker license applications received after April 1, 2005. *To view Notice 2005-04, visit www.pabulletin.com/secure/data/vol35/35-13/580.html.*

VERMONT – Insurance Department issues Bulletin on confidentiality requests in rate and form filings

The Vermont Insurance Department recently issued Bulletin 149 regarding confidentiality requests by insurers in connection with rate and form filings. The April 11, 2005 Bulletin reminds insurers that rate and form filings are generally treated as public records for public disclosure purposes, subject to limited exceptions. The Bulletin points out that “public record” or “public document” is defined broadly in Vermont Statutes Annotated (VSA) Section 317(b) to mean all documents “produced or acquired in the course of agency business.” This definition is limited by VSA Section 317(c), which sets forth a limited exemption from the public disclosure of certain classes of public records (*e.g.*, documents containing trade secrets and records which, if made public, would cause the custodian to violate any statutory or common law privilege or standards of ethics for any profession regulated by Vermont). Moreover, VSA Section 4688(e) subjects property/casualty rates and supporting information to public inspection immediately upon filing or after approval for items subject to prior regulatory review. The Bulletin notes that an insurer must designate as exempt from public disclosure any document that it claims to be exempt pursuant to VSA Section 317(c). Claims for exemption should be accompanied by a sufficiently detailed explanation supporting the claim, and the Bulletin warns that broad or blanket claims for exemption of entire documents are unlikely to provide the required level of detail needed to support a request for exemption. Records identified as confidential will not be disclosed to the public pending a determination by the Commissioner of Insurance of Vermont. *To view Bulletin 149, visit www.bishca.state.vt.us/RegsBulls/insbulls/BUL149.htm.*

Casual Observations

Lost your identity? Don't worry; you're covered

When it comes to identity theft, we're not sure if insurers are part of the solution or part of the problem.

Remember the federal Gramm-Leach-Bliley (GLB) Law? It was supposed to usher in a whole new world of one-stop financial shopping. Never mind that most consumers didn't give two figs about one-stop financial shopping — this was happening, this was third millennium, baby.

And don't forget those GLB privacy protections designed to guard against sales of your personal and financial information. "Protections," however, is surely a stretch here. In order to shield yourself from third-party data sharing under GLB, you have to wade through annual privacy notices, determine how to "opt-out" of information-sharing arrangements, and then convey your intentions to the appropriate financial services company.

And these actions would just protect you from data sharing with nonaffiliated third parties. Under GLB, financial services companies can share the data with affiliates in their financial holding company with or without your permission. We'd say that's pretty porous protection.

So with all this nonpublic data swirling about, is it any wonder that some managed to land in the wrong place? Earlier this year ChoicePoint, a data collection service, announced it had unknowingly sold nonpublic information on more than 100,000 individuals to a firm that turned out to be fraudulent, established simply to rip off consumer data. And who supplied a good deal of ChoicePoint's data? You guessed it, insurance companies.

But insurers have put their heads together and crafted the perfect solution — identity theft insurance. The good news is identity theft insurance is cheap (for now), \$25 to \$50 a year. The bad news is that it doesn't cover any fraudulent charges to your account, but does compensate for lost wages, legal fees and any medical expenses associated with your particular credit nightmare. (So if your credit troubles should lead to a nervous breakdown, relax, you're covered.)

An insurer selling us identity theft insurance is a bit like a restaurant offering us *Pepto-Bismol* following a meal. Wouldn't it have been simpler to just prepare the dish properly? Identity theft will continue to plague consumers until privacy concerns outweigh the financial incentives that drive the sharing of confidential information. That promises to be a long time coming. Until then, get used to the taste of *Pepto-Bismol*.

— W.C.



THANKS!

At its recent Insurance School on Market Regulation in San Antonio, the IRES Foundation paid tribute to the last three persons to serve as chair of its Board of Directors. Current Board Chair Carol Newman presented engraved desk clocks to past chairs David Abel (2002-02), Beth Stuchel (2003-04) and Bruce Foudree (1999-2000)

LEFT TO RIGHT: Dave Abel, Carol Newman and Beth Stuchel.
Not pictured: Bruce Foudree

Visiting Tampa, by the Bay

Long before Hernando de Soto sailed into the Tampa Bay area in 1539 searching for gold, Tampa was a thriving Indian fishing village. The native tribes, Calusa, Timucua and Seminole, named the village Tanpa, which means "sticks of fire," so-called because of the frequency and intensity of its lightning storms. On maps made by the early explorers, the spelling became Tampa.

Tampa has come a long way since then and — as part of the Tampa-St. Petersburg-Clearwater area — is now considered the modern metropolitan hub of Florida's west coast. In addition to a relatively temperate climate and 35 miles of white sandy beaches, it has much to offer visitors.

Tampa's diverse culture is reflected in its eclectic choice of cuisines that includes Spanish, Cuban and Italian influences. **The Columbia Restaurant** is among the oldest restaurants in the Florida and the largest Spanish restaurant in the world. The restaurant, which celebrates its 100th anniversary in 2005, encompasses an entire city block and includes 15 dining rooms and nearly 1,700 seats.

Bern's Steak House, a Tampa landmark, boasts one of the largest wine collections in the world, featuring about 6,500 labels, with a working wine cellar that holds about 90,000 individual bottles. The menu features cut-to-order steaks and two dozen different caviars. Its 65-page menu also offers fresh local fish and home-grown vegetables for those with a taste for healthier fare. Tampa is also the home of America's only authentic thatched-roof Irish pub. **Four Green Fields** offers both traditional and progressive Irish music and entertainment, fine pub grub and thickly accented bartenders.

Each of Tampa's "neighborhoods" offers distinctive sights and scenes. Ybor City's "Centro Ybor" is Tampa's Latin Quarter, attracting visitors with its unique history dating to the early 19th century, distinctive architecture and festive atmosphere. Vintage clothing stores, art galleries, coffee houses, cafes and

bistros can be found lining the red brick streets and hand-rolled cigars can still be found in this former "Cigar Capital of the World."

One of Tampa Bay's oldest and most glamorous neighborhoods, Hyde Park is an old-money district made up of multi-million dollar mansions and bungalow-style masterpieces where visitors will find high-end designer boutiques and one-of-a-kind local shops full of unique trinkets and treasures. Located in the heart of Tampa's Historic District, it reflects the architectural styles of the 19th century. For something more modern, Channelside, on Tampa's downtown waterfront, is home to live band music at **Stumpy's Supper Club**, a dueling piano bar, an upscale bowling and billiards lounge and Tampa Bay's official Visitors Information Center.

If sports is your passion, Tampa's right up your alley with trails for hiking, biking, jogging, walking and skating. There's horseback riding, dozens of golf courses and no shortage of tennis clubs. Or try your best bait and tackle on one of the more than 200 species of fish found in beautiful Tampa Bay. Although summer's not the time to catch the 2003 Super Bowl Champion Buccaneers or the 2004 Stanley Cup winners, the Tampa Bay Lightning ("sticks of fire"), the Tampa Bay Devil Rays are in town.

The Devil Rays, led by fiery manager Lou Piniella, will host the Kansas City Royals for a four-game series just prior to the start of the CDS. The series kicks off Thursday July 28 (7:15 pm), followed by two more evening contests on Friday (7:15 pm) and Saturday (6:15 pm). The series concludes with an afternoon game on Sunday, July 31 (2:15 pm). Early birds take note: The Devil Rays will take on the 2004 World Champion Boston Red Sox earlier that week.

Lastly, there's the Lowry Park Zoo, Busch Gardens, the Tampa Museum of Art, the Florida Aquariums and Kid City — the Children's Museum of Tampa, a miniature outdoor city offering hands-on activities.

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√ All members are welcome to attend the IRES Board of Directors meetings in Tampa. The Board meets at 4 p.m. Sunday, and again at 4 p.m. Tuesday. If you have items you'd like put on the discussion agenda, contact the IRES office at ireshq@swbell.net.

√ Interested in working on newsletters, seminars, web sites or budgets and finance? Now is the time to submit your name to the IRES office if you'd like to serve on any of our committees or subcommittees during the 2005-06 year, which begins immediately after the August CDS. Send an email to ireshq@swbell.net and let us know what committees or projects interest you the most.

In the next REGULATOR: Highlights of the Tampa CDS

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