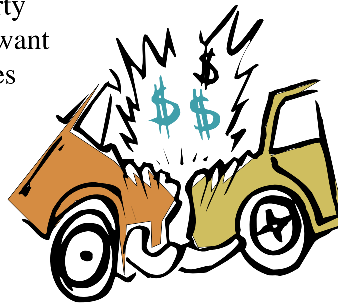
THE REGULATOR™
INSURANCE REGULATORY EXAMINERS SOCIETY

Third-party loss evaluators drawing more scrutiny

By Scott Hoober
REGULATOR staff writer

Americans all like a good deal, whether it's clipping coupons, winning a lottery or getting a generous check from their insurance company after a total loss.

In the ongoing tug of war between hopeful consumers and cautious insurers, in many cases, stand third-party loss evaluators. It makes perfectly good sense when you think about it for insurers to delegate valuation of property claims to a third party. Who wouldn't want to bring in, say, an authority on antiques when a burned-down home was filled with irreplaceable 18th century furnishings?



A lot of the recent publicity in the *Wall Street Journal* and on TV news shows has surrounded valuation of auto claims, where the venerable books of auto valuations — such as those published by National Automobile Dealers Association, which have been around for nearly seven decades — now have to compete with computerized databases.

The best known of the computerized evaluators are CCC Information Services Inc. (an information technology firm that dates back to 1978) and ADP (Automatic Data Processing Inc., the venerable payroll and benefits firm).

Few regulators or consumer groups seem to be challenging the idea that companies may delegate the valuation process, only their choice of vendor.

Under vs. Over

Since not many consumers call to complain when they receive too much cash for their wreck, the core of the allegations usually is that one or the other of the evaluators — usually CCC, ADP or their smaller brother, Mitchell — is consistently undervaluing.

Not a chance, says Kansas City attorney Art Chartrand, long-time outside counsel for CCC. After all, he says, the same evaluator is frequently called on by both sides.

"When a car's involved in a wreck, there are usually two insurance companies involved, and one or both of them will often request

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'Bancassurance' financial revolution has yet to arrive

By Ray Soifer
Soifer Consulting, LLC

A year after the enactment of Gramm-Leach-Bliley, "bancassurance" in the United States has made very little progress. With the conspicuous exception of Citigroup, whose formation of course predated the act, no significant mergers have yet taken place between banks and insurance companies. Moreover, even though hundreds of financial holding companies have been approved by the Federal Reserve, no U.S. insurance companies other than Citigroup have obtained such status.

S.900 Update

An Unpromising Outlook

To this point at least, the U.S. banking industry's response to bancassurance was probably best stated by Dick Kovacevich, chairman of Wells Fargo: "We don't have to own the factory to sell the product." Even

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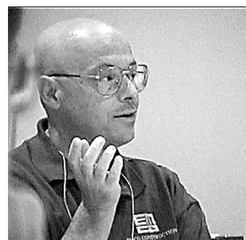
From the President

Reading the Fine Print

I hope you enjoyed the holiday season. It's hard to believe that another year has passed. It isn't too early to start making plans to attend our 2001 Career Development Seminar in Baltimore. Please note that the dates for the seminar have been changed to July 29-31, 2001. Our Executive Committee agreed to this change (without the benefit of a recount) in exchange for some favorable concessions from our hotel. Topics and speakers are being finalized and we hope to have another record turnout. I look forward to seeing all of you.



With reference to the Gramm-Leach-Bliley Act, as one of my co-workers likes to say, "the clock is ticking." One year down and two to go on the issue of agent licensing. I am sure that some of you are currently involved in drafting regulations that will be presented to your legislatures in the upcoming sessions. Of course, speed-to-market initiatives are also changing the way many of us conduct business.

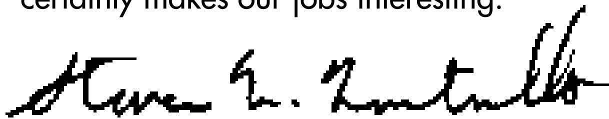
I was reading some quotations in my appointment book and came across one that caught my interest:

"Education is when you read the fine print. Experience is what you get if you don't."
— Pete Seeger

I still remember when I began working in the Consumer Services Bureau and had to deal with an irate consumer who was lamenting how his claim had been denied by his small mutual insurer based on a technical interpretation of policy provisions. He told me the president of the insurance company had told him, "We got you by the fine print."

In my years as a regulator, one of the first questions I pose to new examiners seeking advice on coverage and denial of claim issues is: "What does the contract say?" We as regulators have an obligation to see that the contracts we approve must conform to state insurance laws and be understood by the consumers who purchase them. A lofty goal. However, as the courts have affirmed, policy language interpretations will vary. At the same time we cannot ignore the concerns of the insurer with regard to competitive market forces, costs of duplicated effort and delays encountered in bringing products to market.

Our ability to protect the public will be greatly tested in the upcoming years, but I am confident that workable solutions will be achieved in meeting our new mandates. It certainly makes our jobs interesting.



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C.E. News

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May, 2001
Look for a CE transcript to be mailed to your preferred address on file with IRES.

April 8 – 10, 2001
IRES Foundation Market Conduct Regulation School in Savannah, Ga. Regulators may attend to receive a maximum of 12 CE credits.

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IRES CDS in Baltimore, MD. *(Automatic 15 credits if you pick up your attendance certificate, otherwise, you must report your hours to the IRES CE office and will receive a maximum of 12 CE credits.)*

September 1, 2001
The current compliance period is September 1, 2000 to September 1, 2001. The annual requirement is 15 CE credits. All courses must be completed by Sept. 1. *(NOTE: All qualifying CE hours must be at least 50% or more directly related to insurance principals.)*

Anyone unable to complete the CE hours by the Sept. 1 deadline may file a one-year extension. The extension request form must be in the IRES CE office by Sept. 1.

October 1, 2001
Reports received within 30 days of the Oct. 1 deadline will be accepted as long as the courses were completed during the current compliance period. A $30 late fee will be required.

More questions? Call us at 913-768-NICE

N · I · C · E

More scrutiny of third-party loss services

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CCC to value it," he said. "With these competing interests, CCC has no motivation but to get the value fair and correct every time."

It should be easy to compare the different evaluators on this point, since in one form or another all the data are publicly available. A direct comparison should demonstrate whether the Blue Book tracks with ADP's data, for instance. If the numbers were comparable, you'd expect each outfit to be high or low roughly half the time.

In fact, the last two times that states compared CCC's data to NADA's, Chartrand said, CCC's values were higher than NADA's on as many as 40% of all the vehicles valued.

But that level of comparability isn't enough for West Virginia, where Commissioner Hanley C. Clark has banned all but NADA as of Jan. 1, 2001.

The issue, Clark said, isn't whether one evaluator is fairer than another, but that they vary at all.

It is very difficult to explain to the consumer why the same vehicle can be given three different values.

— Commissioner Hanley C. Clark

"It is very difficult to explain to the consumer why the same vehicle can be given three different values," he said.

When his consumer-services people took a look, the difference wasn't always in the same direction, he added, though some evaluators did tend to come in lower the majority of the time. The problem was the lack of transparency and credibility of the computer-based systems altogether.

"I cannot think of any reason that we should have three or four different methodologies used in this state," Clark said.

The greatest source of complaints filed with the West Virginia department has long been from auto claims. And sure enough, since Clark announced his decision and companies began changing their practices in anticipation of the Jan. 1 deadline, complaints started declining.

NADA or nada

On top of that, state statutes talk about a "published guide." Plus the longest-standing guides, the ones published by NADA, already were being used to value cars for bank loans and by the state motor vehicle people to figure taxes.

"With the great number of complaints that we in the insurance department have received and that I have personally encountered at the supermarket, dry cleaners, soccer games and calls at my home, I made the decision that we would go with one.

"And so I notified all companies in October that as of Jan. 1, 2001, West Virginia would approve only NADA."

CCC's Chartrand said the West Virginia Legislature disagreed with the commissioner, removing all references to NADA in a bill passed this past session.

"Clark is simply turning the clock backwards and is out of step with his own legislature on this issue," he said. "We will stick with the West Virginia Legislature and the data for now — data is very nonpartisan.

"I think the legislature will be wise to step in again and overrule Clark on this one."

The evaluators may not have taken Clark seriously, since he said they passed up several opportunities to submit details about their methods of valuing motor vehicles. It's safe to say they are not happy at the precedent West Virginia may be setting.

"They're very unhappy with my decision. And it was my decision," Clark stressed. "They've all threatened to sue me, and I've said, come on, boys."

West Virginia may be unique for banning the new computer-based evaluators, but they aren't alone when it comes to taking a hard look at the process of valuing auto claims.

In New York, for instance, the department formally allowed third-party evaluators five years ago, complete with standards for the number of vehicles that should be looked at and how far afield the firms may go in looking for comparable cars.

That state requires, as an alternative, averaging of data from two sources, one that's perceived by insurers as being a bit high, the other that consumer groups perceive as low. In certain circumstances, they also

More scrunity of third-party loss services

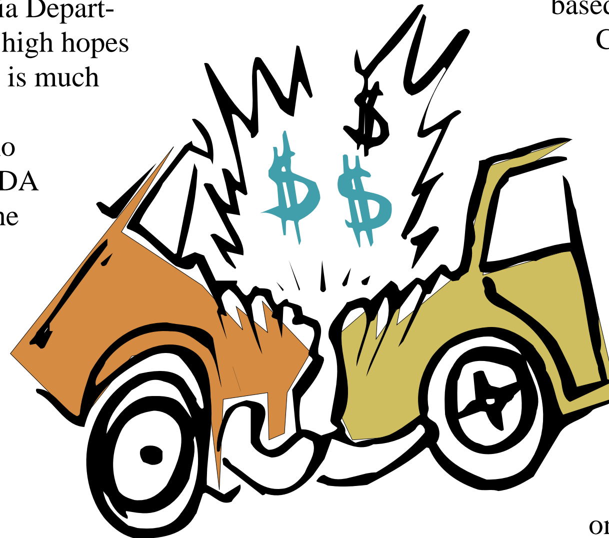
allow newspaper ads within a certain radius of the claimant's community.

California attempted to pass a regulation last year that would have effectively prohibited valuation companies from considering the condition of vehicle when establishing market value — meaning that the owner of a mint-condition '68 Mustang would get paid the same on a total loss as the owner of rusted-out junker '68 Mustang.

"That was the old California Department," Chartrand said, "I have high hopes the new California Department is much brighter than that."

But to Chartrand, those who make distinctions between NADA ard CCC misunderstand how the process works.

In the first place, the two majors, ADP and CCC, do much the same thing as the old-line Blue Books, at least on newer cars: They survey and check data from major auto dealers.



Value is value

"CCC didn't invent any new data — the data has always been the same — they just automated it and made it available quickly," he said.

Secondly, Chartrand added, CCC doesn't just work for insurance companies. Its information systems are also used in auto collision estimating and available directly to consumers.

"Most all body shops nowadays use one of basically three platforms," Chartrand said. "Basically, they're just automated versions of the old books. You used to go into a body shop and they'd pull a couple of books off the shelf and do all the estimating, from parts to labor. CCC and ADP simply automated that process."

If the data are pretty much the same, then how do they persuade insurers to hire them?

"The value that information technology companies add is that they can provide instant valuation," he explained. "They lower the administrative time. They lower the loss-adjustment expense, the LAE. This reduces time and gets the insured taken care of in a fast, fair and consistent manner. They have nothing at all to do with the values.

"The values are what the values are what the values are," he said. "I often tell regulators, 'CCC just reports the news, they don't create it.'"

One of the advantages of a booklet, such as those published by NADA, is that anyone can go to a bookstore, library or the Web and take a look at the numbers listed there. The computerized databases, on the other hand, allow for more frequent updates — and for greater levels of detail — so Arkansans know they aren't having their vehicles valued based on data from, say, southern California.

"That's the hallmark of CCC's system," Chartrand said. "They monitor local marketplaces all over the country and do not aggregate multistate average data like most all guidebooks."

One of the highly publicized cases, reported last summer on the front page of *The Wall Street Journal,* involved a car in Oregon that was valued based on data from Alaska.

In theory, at least, that should never happen with the computerized databases. CCC starts with the ZIP code of the principal garage of the loss vehicle, and except for rare and exotic vehicles, which often have national values, and those metro areas that cross state lines, the data are supposed to be local.

(There are exceptions. State regulators in Nevada have requested the use of surrounding state data, and Chartrand said Alaska regulators asked CCC to consider Seattle values since that's where most used cars in Alaska come from.)

In Oregon, an administrative rule that went into effect as of Feb. 1, 1999, specifically authorizes companies to use electronic auto evaluation firms. Following the publicity in the Journal and elsewhere, the department began taking a look at whether new limitations are needed, although at last report the '99 rule is still in effect.

Old vs. new cars

There's one major difference between valuing newer vs. older automobiles.

Since most of the major evaluators get their data from large used car dealers — primarily new car

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dealerships that sell used vehicles on the side — they're pretty much limited to newer used cars.

"Cars that are over five years old are not maintained on franchised new-car dealer used car lots," said Chartrand. CCC will utilize large, reputable used car lots, but they don't use the Fast Freddie instant-credit lots to establish the value of used cars. Ditto with NADA, which as you recall is the association of large auto dealers.

Yet at least half the cars in America are older than '95 or '96 models, so all the evaluators, electronic or print, need to have a system for capturing valuation data.

"Anybody can go out and value cars one or two years old, because they're all over dealer lots," Chartrand said. "It's not too difficult to do. The trick is when you get into cars five years and older."

The two things that most affect car values are mileage and condition, both of which diverge as cars age.

The solution of course is to monitor newspaper ads, which is pretty much what all the evaluators do. Where an individual agent or adjuster used to be able to check out a few ads, the big companies peruse thousands, then throw out the high ones and the low ones and create their own database. Toss in mileage, aftermarket accessories and a judgment as to condition, and you've got a value.

Many complaints seem to arise from total losses on vehicles that the owner says isn't just old, but classic.

Chartrand said disagreements like that are between the companies, their agents and adjusters and their customers. CCC's job, he said, is simply to give a value on a car as described — not to describe it.

"It's up to the adjuster to report to CCC what they want valued," he insisted. "CCC simply says: If you report to us accurately, we will give you a fair local-market valuation."

In case the consumer disagrees with the official valuation, he or she may call the evaluator's 800-number and try to persuade them to take a second look. CCC also offers claimants free access to their AutoSearch to find them a comparable or better vehicle for the claim dollars they were paid.

Department's role

Even if the evaluators were perfect, there would always be disagreements. Should companies, as well as consumers, be taking those published values with a grain of salt?

"It depends on the state," said Chartrand.

"Every state's got different regulations. Some states would say that you just use it as a guide. But in some states, if the professional valuation company says it's worth X, you could violate the regulation by paying different from that. You can violate the regulation by paying more, and you could also be in trouble obviously if you paid a dime less.

"Twenty years ago they never would have gone after a company for paying too much, but commissioners are all worried about the cost of premium right now, and if companies are consistently paying more on their claims, that's as much of a violation as paying less."

Not to mention the flags that would be raised if a company were to pay some policyholders more than others.

Yet there are a lot of reasons to pay a little more than is justified by valuation alone. Some consumer affairs people are more than willing to help consumers squeeze a little extra out of their insurers. And insurers are willing to be a little more generous on occasion — following a catastrophe, say, or when there's a bodily injury claim that they'd like to keep at a reasonable level.

Another source of potential problems is the fact that many auto loans start out too big and go down too slowly. Commissioner Clark cited that fact as one of the reasons behind his decision to zero in on only NADA valuations. But while consumers whose auto loans are underwater are more likely to seek higher payouts following a total loss, that doesn't seem to be the evaluators' fault.

Evaluating the evaluators

If valuation of auto claims is an issue, and if it appears to matter which vendor a particular company has chosen to handle the task, should departments be auditing third-party evaluation firms?

CCC's Chartrand says no. Unless statutes or regulations specifically authorize the department to evaluate the evaluators, they should stick to regulating insurance companies. But West Virginia's Clark says he could formally examine them if he wanted to.

"If we have a complaint, we may ask, 'How did you come up with this?' he said. "We have taken the position that I have the ability to approve it, and if you have it to approve, we could also disapprove."

If there's one thing Chartrand and Clark agree on, it's that the issue of third-party evaluators isn't worthy

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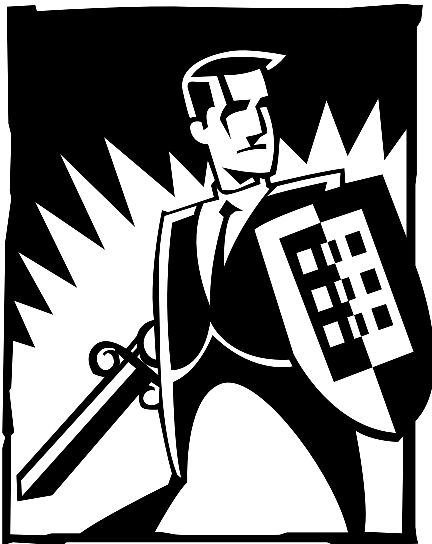

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Third-party claims evaluators *(continued from preceding page)*

of some of the ink it's gotten, if only because there's nothing at all wrong with the basic concept.

"One thing you've got to keep in mind if you're an insurance regulator," said Chartrand, "is that you don't want the insurance companies involved directly in the valuation process. You want them to shop it out. You don't want the insurance company making that decision."

Clark, for his part, said that publicity about the evaluators had no impact on his decision a year ago October to begin looking into the firms.

"I did what I think is right for West Virginians," he said.

"I've learned after the fact that this is an issue in other states, and there have actually been some lawsuits. My decision was basically made a year ago without input from any other state. This came from looking at problems we have in West Virginia, and I felt this was the best way to address them."

"The irony is we have had adjusters in the field, agents and even companies commend us on the decision." ■

California's Quackenbush scandal tarnishes industry, panelists say

Frederick L. Pilot
SENIOR EDITOR
Smart's Insurance Bulletin

On Sept. 12, 2000, a post-mortem symposium was held on the scandal that brought down California's Insurance Commissioner Chuck Quackenbush this past July. Smart's Inc., the Association of California Insurance Companies and the National Association of Independent Insurers sponsored the event. Panelists included key legislators, two former California insurance commissioners and officials of property-casualty trade groups.

The property-casualty industry added insult to injury, some panelists said, when it permitted itself to be bullied and intimidated by a commissioner it had supported. The industry supported Commissioner Quackenbush, a Republican, on the theory that he would provide a freer regulatory climate than did his Democratic predecessor, John Garamendi.

The industry was firmly linked with Quackenbush in the public's mind by repeated media stories detailing political contributions to Quackenbush's 1994 and 1998 commissioner campaigns. And because insurers believed Quackenbush was in their camp on regulatory policy, they were reluctant to publicly criticize his actions — including his demands for "contributions" from several insurers to settle allegations of mishandling claims from the 1994 Northridge earthquake. Those settlements funded nonprofit "consumer outreach" organizations aimed more at burnishing Quackenbush's political career than any ostensible public benefit.

"In retrospect, these [Northridge] companies should have told Quackenbush to go jump in the lake" instead of agreeing to the settlements, said Alister McAlister of the NAII. "If the industry is pushed beyond what they feel is ethical, it should push back." But Garamendi pointed to the several million dollars insurers gave Quackenbush in campaign cash. He said those funds hampered insurers' ability to put principle before political expediency. "You didn't take him on because you were his supporters and because you financed him," Garamendi said. "He was yours and you were his."

Garamendi added Quackenbush made a fatal error in reversing his 1994 campaign decision not to accept contributions from the industry, citing the potential for conflict of interest. "He made a mistake because he took money from the industry and ultimately it compromised him," Garamendi noted. As for the industry, the former commissioner said it is "even more dangerous to give money and have your reputation besmirched by it."

The industry also suffered at the hands of California Department of Insurance (CD) deputies who employed hardball opening negotiating tactics in which they threatened Northridge insurers with possible fines of up to $3 billion for market conduct violations. While Quackenbush deputies defended their actions in legislative oversight hearings as a standard opening negotiating gambit, that large sum was repeatedly mentioned in media accounts and fostered the impression that insurers' records in adjusting claims from the 1994 temblor were utterly deplorable.

In addition, noted Personal Insurance Federation of California President Dan Dunmoyer, there was an accompanying perception — with the proposed fines and the subsequent payment of $12 million in settlements to the CDI-created nonprofits — that insurers somehow got off paying nothing to Northridge claimants. "The industry got slammed in this process," Dunmoyer observed.

Assemblyman Tom Calderon (D-Montebello), the incoming chairman of the California Assembly Insurance Committee, agreed Northridge insurers should have paused before agreeing to contribute to the controversial nonprofits to settle preliminary findings of market misconduct.

"You shouldn't have taken the deal," Calderon said. "You should have fought it." But Sen. Jackie Speier (D-San Mateo) said the fact the insurers grumbled about (but did not go public over) what one insurer

This article was first published by Smart's Insurance Bulletin, which provides weekly reporting and analysis on regulatory, political and legal developments affecting the California property-casualty industry.

Quackenbush scandal tarnishes industry, panelists say

later described as "ham handed" CDI negotiating tactics that included the use of mock negative news stories about the carriers' handling of Northridge claims "speaks volumes about the power of that office."

Checks and balances

Speier said that the current system of checks and balances over CDI didn't adequately protect the public from abuses of power by the Quackenbush administration. That's because the Insurance Code was written in an era of gubernatorially appointed insurance commissioners and should therefore be subject to "wholesale review," Speier said. "The Department is perceived by the public as having a strong consumer protection function," Speier said. "The truth is it has a weak consumer protection function."

To check CDI's power, Speier has proposed SB 2107**,** which would require CDI to obtain legislative approval before entering into settlements with insurers that involve payments to nonprofit organizations. The measure awaits action by Gov. Gray Davis.

Ex-commissioner Quackenbush

Another measure, AB 481, by Assembly Insurance Committee member Jack Scott (D-Altadena) would also rein in CDI in the post-Quackenbush era. It would require any settlement funds earmarked for education or research to be deposited in the Insurance Fund and to be spent only when authorized by the state budget.

But Mark Webb, vice president of state affairs for the American Insurance Association, said the bill goes too far. "It's unfathomable that CDI must get legislative approval for fines citing regulation or code violations," Webb said. Webb also said the "sordid mess" of the Quackenbush scandal would help fuel the push towards federal regulation of the insurance industry.

Barry Carmody, president of the Association of California Insurance Companies, opined that the best check on CDI's power is an inquisitive news media.

News outlets played a major role in bringing about the departure of Quackenbush, whose actions in connection with the settlements involving the nonprofits were subjected to intensive media scrutiny. While insurer complaints over the handling of the Northridge settlement negotiations first surfaced in *Smart's* in the summer of 1999, lawmakers didn't pay the matter much attention until the *Los Angeles Times* began aggressively looking into the matter earlier this year, Carmody noted. But while it can be very effective, media scrutiny is a "hit and miss" form of oversight that is likely to focus on only what's politically popular, Carmody cautioned.

Friends and foes

Under an elected commissioner, political considerations can play a very large role in whether there is effective oversight of CDI. Former commissioner Garamendi noted while he was in office, insurers were quick to publicly question and criticize his actions. But because insurers thought — wrongly, it turned out — that they had a friend in Quackenbush, they were reluctant to speak out against his policies.

Elected vs. appointed commissioner

Symposium panelists offered opinions on both sides of the question whether the insurance commissioner's office should be once again made appointive rather than elected, as it became under Proposition 103. Speier, who authored a constitutional amendment that would have restored the commissioner to appointive status, called the question an "idle philosophical dispute" given the overwhelming political difficulty of taking away a high-profile office that appeals to lawmakers facing term limits. Her measure, SCA 19, died in committee earlier this year.

Richards Barger, who served as former Gov. Ronald Reagan's appointed insurance commissioner from 1968 to 1972, complained that elected commissioners have politicized the office at the expense of knowledgeable and fair regulatory oversight. "You get these political types who don't really care," Barger said. "They learn a few buzz words about the industry and that's that."

In addition, noted Barger and ACIC's Carmody, politicizing the office hinders the open dialogue between licensees and regulators that in the past aided in effective regulation of the industry. Licensees are also reluctant to criticize deputies — the political appointees of the commissioner — for fear of offending the commissioner or bringing problems they are having with these regulators to the commissioner's attention. ■

James Gardiner

The Country's Oldest Working Life Actuary

by Wayne Cotter
Editor, THE REGULATOR

It was 1929, September 11th. The stock market was continuing its unprecedented rally, President Hoover and the U.S. Senate were at loggerheads, and Connie Mack's Philadelphia Athletics were seriously challenging New York Yankee hegemony in baseball's American League. And in Manhattan, a young man was embarking on a career in the insurance industry that would span more than seven decades and bring him recognition as one of this country's foremost authorities on public pensions.

James Gardiner did not just stumble into the insurance industry. He had always loved mathematics as a child growing up in Amsterdam, New York. In 1927, as a math major at Yale, he began to explore the possibilities of forging this love for mathematics into a successful career. He recalls asking his professor of "Compound Interest & Annuities Certain" if any practical use for mathematics existed outside of engineering and teaching. The professor steered him to the Actuarial Society of America (now the Society of Actuaries).

While attempting to understand the actuary's role in the insurance marketplace, Jim became acquainted with some of the profession's harsher realities. For example, in order to become an associate actuary, a candidate had to successfully complete eight 3-hour exams. Jim noted that the first examination was based largely on the very same algebra textbook used at Yale. His familiarity with the text boosted Mr. Gardiner's confidence and prompted him to take the test cold. He failed.

On the basis of his test application, however, the Metropolitan Life Insurance Company offered him a job as a summer intern at $20 a week. During that summer, Jim met another intern – Gilbert Fitzhugh– with whom he would develop a life-long friendship. (Mr. Fitzhugh went on to become President and Chairman of the Board of Metropolitan.) The internship prompted Mr. Gardiner to more diligently pursue his actuarial credentials. During his senior year, he passed the initial two exams in the associate actuary series and was on his way.

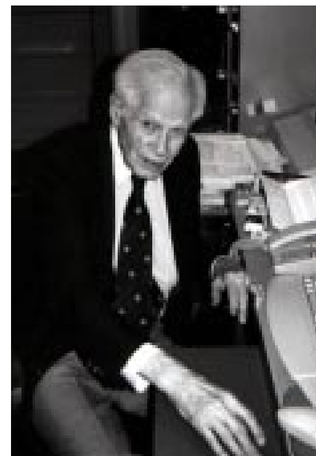
Before entering the working world, however, he and Gilbert Fitzhugh spent the summer touring the country. In a ten-week period, they visited 35 states, logging over 18,000 miles in a 1928 Model A Ford. The achievement is even more noteworthy considering the fact that nearly all roads west of Kansas City were unpaved at that time. It was during this period that Jim developed his life-long passion for mountain climbing. He and Mr. Fitzhugh conquered Mt. Whitney, California's highest peak, as well as Pike's Peak during that memorable trip.

Upon his return, Mr. Gardiner was hired by Metropolitan as a full-time actuarial clerk for $40 a week. Mr. Fitzhugh was also hired. Mr. Gardiner recalls sharing a $90-a-month furnished apartment near Central Park West with two friends during those early working years.

Mr. Gardiner began in the actuarial ordinary life section of Metropolitan doing valuation and statement work. In those days, employees worked five days and Saturday mornings. He remembers one Washington's Birthday weekend in the early 1930s when Metropolitan gave employees Saturday off. Mr. Gardiner and Mr. Fitzhugh wagered fellow employees they could drive round-trip from Manhattan to Cocoa Beach, Florida (now Cape Canaveral) over the long weekend and be back on the job

Gardiner in 1913 with his grandfather . . .

. . . In the 1940s



. . . at work today

at 9 a.m., Tuesday morning. Lots of all-night driving and coffee helped the two meet their Tuesday-morning goal, and their winnings proved more than sufficient to offset the expenses of the trip.

By the mid-1930s, Mr. Gardiner had completed the requisite examinations and become a Fellow of the Actuarial Society of America. Later in the decade he was transferred to the annuity unit of the Met's group contract bureau. At the Met, actuaries were responsible for devising the policies used in the marketplace, and Metropolitan Life was considered a pioneer in group pension contracts.

In the late 1940s, Mr. Gardiner was named manager of the group contract bureau and later became involved in the financial end of the business, *i.e.,* the valuation of liabilities, financial analysis and determination of contract rates.

Jim, along with an actuarial team at Metropolitan, helped develop Immediate Participation Guarantees (IPGs) that were first introduced in the 1960s. Up to that point, banks that handled pension trust business made no guarantees and held no contingency reserves, while insurers had to cover expenses and build up reserves before paying dividends. The IPGs provided no guarantees to the policyholder and very little contingency reserve. They were, in effect, forerunners of today's ubiquitous separate accounts.

Gardiner Goes Public

In 1972, Mr. Gardiner turned 65 and on April 1 of that year fell victim to Metropolitan's mandatory retirement policy that was in place at that time. Five days later, however, he was on board as a regulator with the New York State Insurance Department.

The Department's role in supervising public pension funds was mandated in 1920 by the state legislature. Mr. Gardiner does not participate directly in the examinations, but is responsible for preparing staff prior to review as well as assessing results and recommendations.

He also works to establish standards for the public retirement systems in accordance with Section 314 of the New York Insurance Law, reviews annual statements submitted by the funds, determines the adequacy of individual plan funding and analyzes pension-related legislation. Currently, assets in the eight public pension funds regulated by New York State exceed $300 billion.

"My job," says Gardiner, "presents new challenges every day and an opportunity to promote uniformity, clarity of provisions, and actuarial soundness among New York's public retirement systems. A thorough knowledge of actuarial science is, of course, essential, but one also must know the Retirement & Social Security Law, the Education Law, the New York Administrative Code, the New York Insurance Law and certain portions of the General Municipal Law."

About 20 years ago, Jim Gardiner set a goal of climbing the highest peak in each of our 50 states. A lofty goal for a man in his 70s, but one that did not surprise a whole lot of people. Jim's friends believe he can do anything. (Before hanging up his hiking boots for good, he did manage to reach the summit of 32 states.) In fact, mountain climbing turns out to be the perfect metaphor for the man. James Gardiner has always reached for the stars; climbing mountains just brings him a bit closer.

Mr. Gardiner turns 94 in January 2001

*** Gardiner Tidbits***

- Mr. Gardiner was born during the second term of the Roosevelt Administration — Teddy's not Franklin's.
- Indian head pennies, not Lincoln cents, were still being minted in Mr. Gardiner's birth year.
- In 1903, four years before Mr. Gardiner's birth, the Wright Brothers completed their historic flight at Kitty Hawk.
- Oklahoma was not yet a state when Mr. Gardiner was born.
- Mr. Gardiner saw his first "talkie" at the age of 22.
- Mr. Gardiner's purchased his first car, a 1912 Corbin (with kerosene tail lights), for $65.
- Wyatt Earp died the year Mr. Gardiner began working for Metropolitan Life.
- Of the Society of Actuaries' 17,000 members, 13 have birth dates preceding Mr. Gardiner's. None of the 13 are currently employed. Thus, Mr. Gardiner is this country's oldest working life actuary.
- Mr. Gardiner has two children and three grandchildren. He married for the third time in 1993.

Are you ready for codification?

by Dave Christensen
Statutory Accounting Principles Manager
National Assocation of Insurance Commissioners

Editor's Note: *In 1989, the NAIC adopted a Solvency Agenda designed to enhance the ability of state regulators to protect insurance consumers from the financial trauma of insurer insolvency. In recognition of the fact that enhancement of solvency regulation is an ongoing process, the agenda was updated in 1991. The Codification Project is a direct result of the 1991 Solvency Agenda. This article provides answers to some basic questions regarding Codification, which was implemented this month (January 2001) in most states.*

What is Codification?

Codification is the replacement of the old *Accounting Practices and Procedures Manuals* for property & casualty, life, accident & gealth, HMOs, fraternals, etc. with a new, more comprehensive guide, *Accounting Practices and Procedures Manual – Effective January 1, 2001 as of March 2000* (the two-volume green manual).

What was the purpose of the Codification Project?

The objectives of the Codification project were to codify statutory accounting guidance into a single source, develop guidance where there are no statutory rules, and address areas where current statutory guidance conflicts with the three fundamental concepts of conservatism, consistency, and recognition, as summarized in the Statement of Concepts.

What is the effective date of Codification?

The NAIC effective date of Codification is January 1 2001. For information regarding the effective date of Codification and the status of its implementation by state, go to the NAIC website at: www.naic.org/finance/codific/index.htm.

What are the benefits of Codification?

For insurance departments, Codification results in more complete disclosures and more comparable financial statements, which will make analysis techniques more useful to regulators. The disclosure requirement in Appendix A-205 — *Illustrative Disclosure of Differences Between NAIC Statutory Accounting Practices and Procedures and Accounting Practices Prescribed or Permitted by the State of Domicile* will enhance comparability of financial statements domiciled in different states.

For insurers, Codification provides a comprehensive accounting guide to assist in preparing statutory statements. Prior to Codification, insurers had to look to the Accounting Practice & Procedures Manuals, Annual Statement Instructions, Model Laws, etc. and use Generally Accepted Accounting Principles (GAAP) in cases where Statutory Accounting Principles (SAP) were silent.

For CPAs, Codification provides a comprehensive accounting guide to perform audits of statutory financial statements and issue their opinions. Using current NAIC guidance, it is fairly difficult to determine SAP on a historical basis. The *Accounting Practices and Procedures Manual Effective January 1, 2001* will provide the historical reference.

In addition, Codification requires state insurance departments, insurers, and CPAs to analyze the existing state codes to identify differences between the prescribed and permitted practices of the states and the *NAIC Statutory Accounting Practices and Procedures.* Insurers will be required to disclose these differences as required by Appendix A-205.

The Codification project also created a formal maintenance process that is designed to modify or clarify existing Statements of Statutory Accounting Principles, and to handle new accounting rules created by legislation or the evolution of a new type of business transaction.

The *Accounting Practices and Procedures Manual* will be updated annually to reflect the adoption of new guidance.

Does Codification preempt state legislation or regulatory authority?

Codification does *not* preempt a state's legislative and regulatory authority. It is intended to be the *foundation* of a state's Statutory Accounting Prin-

ciples, and to establish a comprehensive basis of accounting recognized and adhered to in the absence of, conflict with, or silence of, states statutes and/or regulations. Statutory financial statements will continue to be prepared on the basis of accounting practices prescribed and permitted by the states, and auditors may continue to provide audit opinions as permitted by insurance departments of the domiciliary state.

Are the changes under Codification significant?
Codification creates numerous changes to existing NAIC statutory guidance. Some of the changes are:

- Increased disclosures in notes to the financial statements
- Disclosure of differences between accounting practices prescribed or permitted by the state of domicile and application of NAIC statutory accounting practices and procedures
- Recognition of deferred tax liabilities and deferred tax assets
- Requires premiums to be recorded and aged as of the effective date of the policy or endorsement (account current method eliminated).

Codification does not preempt a state's legislative and regulatory authority. It is intended to be the foundation of a state's Statutory Accounting Principles.

What are the guidelines when new legislation or the evolution of a new type of business transaction occurs, where there are no established statutory accounting principles for reporting a specific transaction or event?

In these instances, it may be possible to report the event or transaction on the basis of its substance by selecting a statutory accounting principle that appears appropriate when applied in a manner similar to the application of an established statutory principle to an analogous transaction or event.

The Statutory Accounting Principles Statement of Concepts contains the three fundamental concepts of conservatism, consistency and recognition. Although these three concepts have always been unwritten concepts of statutory accounting, they now exist as the basepoint in determining statutory accounting guidance and should be used to fill in the holes where no current guidance exists.

Where can I find out more information about Codification?

For information on the following, check out the NAIC websites listed below:

- Current activities of the Statutory Accounting Principles Working Group — **www.naic.org/1products/finance/codific/index.htm**
- Codification Self Study Program — **www.naic.org/1pubcat/accounting.htm**
- NAIC Publications Catalog —**www.naic.org/1pubcat**

How can I obtain educational material regarding Codification?

NAIC offers the following training and education opportunities to a wide variety of professionals with diverse needs and resources (website addresses are also listed):

• **Self-Study Program** – provides individuals with a program similar to the NAIC's 2-day seminar. As the NAIC is no longer presenting its live program, the self-study is the most efficient way to become informed on the significant accounting changes resulting from Codification **(www.naic.org/1pubcat/).**

• **Royalty Program** — allows individuals or companies to purchase the rights to reproduce and train individuals using the NAIC's copyrighted training materials for a fee of $50 per person. For more information, e-mail questions you have regarding the royalty arrangement to Robin Marcotte at rmarcott@naic.org.

Additional questions?

You may contact Dave Christensen (specializes in P&C entities) or Jane Kipper (specializes in Life & Health entities) at (816) 842-3600 or dchriste@naic.org and jkipper@naic.org. ■

Still waiting on the 'bancassurance' revolution

continued from page 1

in terms of marketing, the bank channel appears to be best suited to selling simple, commodity-like insurance products to customers with correspondingly simple needs, such as the savings bank life insurance long offered in New York and other states. It is far less effective for products and customers that require the specialized expertise of a trained and experienced agent.

Unfortunately, those simple, easily commoditized products also tend to be the ones with the lowest profit margins and the most vulnerable to online competition, so the marketing window for bancassurance products would seem to be customers with simple needs who have not yet figured out how to find what they want online. Not the most promising of outlooks.

European Experience

Bancassurance, of course, is a French word. In France, where bancassurance has long been popular, this situation is primarily tax-driven, *i.e.,* some tax-advantaged insurance products are ***only*** available through banks.

In the United Kingdom, there is no such tax advantage, but bancassurance there has a longer history than in the U.S., dating back at least to the implementation of the European Union's Second Banking Directive in 1986. Two cases there worth looking at are Direct Line and Lloyds TSB.

Direct Line, owned by the Royal Bank of Scotland, has been a great success selling personal auto — sort of a British version of GEICO — and now, homeowners and life policies over the phone and, more recently, online. However, there is very little overlap between Direct Line customers and those of the bank, for which Direct Line has been little more than a highly successful venture capital investment. As bancassurance, it proves nothing.

Lloyds TSB (no relation to Lloyd's of London) also provides no strong evidence of the advantages of bancassurance. TSB, the old Trustee Savings Bank, was primarily a thrift institution that served a relatively down-market, blue-collar clientele before merging with Lloyds Bank in 1996. It, too, was successful in selling simple personal lines, in relatively small amounts, to customers with simple needs who were generally overlooked by the larger clearing banks and mainstream insurance companies, which tended to go after the more affluent middle class.

On the other hand, Lloyds Bank had a relatively upscale customer base. During the 1980s, Lloyds bought a controlling interest in Abbey Life, a specialist in annuity policies that was at one time owned by ITT. Along with most of the UK life insurance industry, Lloyds Abbey Life and its sister company, Black Horse Life (which marketed annuities through the Lloyds Bank branch network) were caught up in a large, ongoing controversy over government accusations of policy "mis-selling" that has so far cost the bank more than £800 million in loss provisions. Lloyds TSB has since wound down these operations and recently acquired Scottish Widows, a large, well-known life insurance company for which it had to pay a correspondingly high price.

S.900 Update

Property/Casualty Underwriting

U.S. bankers have three good reasons for not being very interested in underwriting property and casualty insurance. The risk-adjusted return on capital is not especially attractive when averaged over the cycle, the p&c cycle itself tends to be highly volatile and the risks involved are not those which bankers are experienced at managing.

While banks and insurance companies have some areas of expertise in common, such as investment management and capital markets, the core competence of banking is credit, not insurance underwriting. While it is true that the convergence of derivatives with insurance products is continuing to grow, and that some of the larger banking companies are quite expert in derivatives, there are still substantial differences between the risks covered by derivative instruments available in the market and those faced by specific insureds. Covering those risks through underwriting is the core competence of insurance companies, and again with the exception of Citigroup, few if any U.S. banking companies would claim expertise in this area.

Corporate Customers Prefer Independents

From the U.S. corporate customer's point of view, bancassurance is perceived as adding little value. A recent survey of senior-level financial executives at 444 U.S. companies, conducted by the Association for Financial Professionals, revealed that 70% of respondents reported a preference for an insurance company that has ***not*** combined with a bank or securities firm, while only 14% said that they would use a bank that has merged with an insurance company for the purchase of insurance products. In contrast, more than 50% of the survey's respondents said they would opt for a bank that has joined with a securities firm for capital markets, mergers and acquisitions, investment management, and derivatives/hedging services.

So far at least, the future of the independent U.S. insurance company seems well assured. ■

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Insurance Quotes of the Month

"When a big car crashes into a little car, the little one is going to have more damage, but the big cars . . . are not involved in as many accidents as the smaller cars."

— Gary Grant, State Farm's Chief Actuary, explaining why his company *is not* raising liability rates on SUVs and other large vehicles.

"People with standard sedans and smaller cars today are subsidizing people with sport utilities and vans and pickups."

— Kevin Kelso of Farmers Insurance Group, explaining why his company *is* raising liability rates on SUVs and other large vehicles.

Regulatory Roundup

By Stroock & Stroock & Lavan LLP

ILLINOIS – U.S. Court of Appeals, Seventh Circuit, upholds Illinois HMO independent review provisions
The United States Court of Appeals, Seventh Circuit, ruled on Oct. 19, 2000, that Section 4-10 of the Illinois Health Maintenance Organization Act (the "Illinois HMO Act") was not preempted by the federal Employees Retirement Income Security Act ("ERISA"). Section 4-10 requires an HMO to submit to an independent physician the review of any disagreement between the HMO and a patient's primary care physician regarding the medical necessity of a proposed course of treatment (the "appeals provisions"). The HMO is required to honor the course of treatment if deemed necessary by the independent reviewer. In the case at issue, plaintiff sued the defendant HMO for refusing to appoint an independent physician to review plaintiff's claim. Subsequently, an independent review resulted in a determination in plaintiff's favor and plaintiff sought reimbursement on this basis. Defendant rejected plaintiff's claim for benefits, arguing that the claim, made pursuant to Section 4-10, was preempted by ERISA's civil enforcement provisions. The court declined to preempt Section 4-10, concluding that it falls within the ERISA saving clause regarding laws that regulate insurance. The court also declined to preempt Section 4-10 based on the HMO's assertion that Section 4-10 conflicts with Section 1132(a)(1)(B) of ERISA. 29 U.S.C. § 1132(a)(1)(B) permits a plan participant or beneficiary to sue to recover benefits, enforce rights or clarify rights under the plan. According to the court, the Illinois appeals provisions are not tantamount to the relief offered under Section 1132(a)(1)(B) of ERISA. The Seventh Circuit's holding is in direct conflict with a June 2000 decision (described below) rendered by the Fifth Circuit, in which that court found similar provisions enacted in Texas to be preempted by ERISA. See *Moran v. Rush Prudential HMO, Inc., 2000 U.S. App. LEXIS 26053.*

TEXAS – U.S. Court of Appeals, Fifth Circuit, invalidates Texas HMO independent review provisions as preempted by ERISA
The United States Court of Appeals, Fifth Circuit, found portions of Texas Senate Bill 386 governing the appeal of adverse determinations of the medical necessity of proposed health care services to be preempted by the federal Employees Retirement Income Security Act ("ERISA"). The court was particularly troubled by provisions that permitted a patient who has been denied coverage by an HMO to appeal to an independent review organization, the decision of which was binding on the HMO. The court held that "such an attempt to impose a state administrative regime governing coverage determinations is squarely within the ambit of ERISA's preemptive reach." While the court agreed with the State of Texas that the appeals provisions of Senate Bill 386 fell within ERISA's saving clause for laws regulating insurance, the court nonetheless invalidated the provisions, holding that they conflict with Section 1132(a)(1)(B) of ERISA. 29 U.S.C. § 1132(a)(1)(B) permits a plan participant or beneficiary to sue to recover benefits, enforce rights or clarify rights under the plan. According to the court, the appeals provisions were inconsistent with Section 1132(a)(1)(B) of ERISA by providing an alternative mechanism through which plan members may seek benefits due them under the terms of the plan. The court's opinion conflicts with an October 2000 opinion (discussed above) rendered by the Seventh Circuit, in which that court upheld similar provisions enacted in Illinois. See *Corporate Health Ins., Inc. v. Montemayor, 2000 U.S. App. LEXIS 14215.*

FLORIDA – Department of Insurance issues bulletin regarding fraud legislation affecting viatical settlement providers
The Florida Department of Insurance has issued Bulletin 2000-013 to inform viatical settlement providers and brokers of the applicability of recently enacted fraud statutes. Viatical providers, brokers, sales agents and their employees are now required to submit to the Department's Division of Fraud a report regarding their knowledge or belief that a fraudulent insurance act or practice is being or has been committed. Also, by December 1, 2000, every licensed viatical provider and broker must have adopted an anti-fraud plan and have filed it with the Division of Fraud. Such plans must contain at least the following: (1) a description of procedures for detecting possible fraudulent insurance acts and for resolving inconsistencies between medical records and insurance applications; (2) a description of procedures for the mandatory reporting to the Division of Fraud of

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The New York-based Stroock & Stroock & Lavan LLP Insurance Regulatory/Corporate Practice Group includes Donald D. Gabay, Martin Minkowitz, William D. Latza, and Vincent Laurenzano, an insurance finance consultant. They gratefully acknowledge the assistance of Todd Zornik, law clerk. This column is intended for informational purposes only and does not constitute legal advice.

possible fraudulent insurance acts; (3) a description of the plan for anti-fraud education and training of underwriters or other personnel; and (4) a written description or chart outlining the organizational arrangement of anti-fraud personnel. The Bulletin also highlights the new application of Insurance Law Section 626.989(4)(d) to viatical providers, brokers and sales agents. This section provides for a qualified immunity from civil liability in connection with the investigation of fraud. To have this qualified immunity available, a viatical provider or broker must provide the Division of Fraud with a list of designated employees who are responsible for the investigation of claims relating to fraudulent insurance acts. To view the Bulletin, visit **www.doi.state.fl.us/companies/memoranda/00-013m.htm.**

MASSACHUSETTS – Governor signs viatical settlements legislation

On November 30, 2000, Governor Paul Cellucci signed into law House Bill 4790, the Viatical Settlements Act. House Bill 4790 requires any person seeking to act as a viatical settlement or loan provider, or as a viatical settlement or loan broker, to first obtain a license from the Insurance Commissioner. In addition, no person may use a viatical settlement or loan contract unless the contract has been filed with and approved by the Insurance Commissioner. House Bill 4790 defines "viator" to mean the owner of a life insurance policy or certificate holder under a group life insurance policy insuring the life of a person with a catastrophic, life-threatening or chronic illness or condition who enters into a viatical settlement contract. The Bill has been criticized by some groups for failing to address the regulation of viatical settlement transactions involving healthy persons, also known as "life settlements". House Bill 4790 will become effective on March 1, 2001. To view the Bill, visit **www.state.ma.us.**

MASSACHUSETTS – Division of Insurance issues bulletin regarding new genetic testing requirements

On October 23, 2000, the Massachusetts Division of Insurance issued Bulletin 00-16 regarding new genetic testing and privacy protection requirements contained in Chapter 254 of the Acts of 2000 ("Chapter 254"). Chapter 254 imposes varying restrictions, depending on the line of business, on the use of genetic information in the underwriting process. For accident and health insurance, other than disability and long-term care insurance, carriers are prohibited from canceling, refusing to issue or renew, or making any other distinction based on genetic information in the terms and conditions of any policy. Chapter 254 grants carriers of disability income, long-term care and life insurance somewhat more flexibility in the use of genetic information. For example, these carriers may consider genetic information in the underwriting process, provided that the underwriting action is based on reliable information relating to the insured's mortality or morbidity and is based on sound actuarial principles or actual or reasonably anticipated claims experience. Moreover, while disability income insurers, long-term care insurers and life insurers may not require an applicant to undergo a genetic test as a condition to the issuance or renewal of a policy, they may ask on an application whether the applicant has taken a genetic test. Subject to certain limitations, these carriers may increase a rate or deny coverage based upon the failure to answer such question. Chapter 254 became effective on November 20, 2000. To view Bulletin 00-16 or Chapter 254, visit **www.state.ma.us/doi.**

NEW YORK – Insurance Department adopts emergency financial and health information privacy regulations

The New York Insurance Department has adopted Regulation 169 (Privacy of Consumer Financial and Health Information) on an emergency basis. The Regulation is intended, in part, to implement Title V of the federal Gramm-Leach-Bliley Act ("GLBA"). The GLBA, also known as the federal Financial Services Modernization Act, was enacted in November 1999 and requires financial institutions, including insurers, to protect the privacy of consumers and customers. Accordingly, Regulation 169 sets forth conditions for the disclosure of nonpublic personal financial information to a non-affiliated third party. For example, with certain exceptions, the Regulation requires a licensee of the Insurance Department to provide the consumer an opportunity to opt out before disclosing nonpublic personal financial information about the consumer to a nonaffiliated third party. Unlike Title V of the GLBA, Regulation 169 also sets forth standards for the handling of nonpublic personal *health* information. The Regulation prohibits, with certain exceptions, the disclosure of nonpublic personal health information prior to obtaining an authorization from the consumer. Regulation 169 became effective on November 13, 2000. However, the Regulation provides for a July 1, 2001 compliance date for its provisions regarding financial information, and a December 31, 2001 compliance date for its provisions regarding health information. To view the Regulation, visit **www.ins.state.ny.us.**

Check out these specialized breakout sessions for regulators who work in:

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If registering after July 1, add $40.00. No registration is guaranteed until payment is received by IRES.

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Call for more details: 913-768-4700. Or see IRES web site: www.go-ires.org

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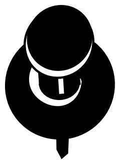
The industry's use of various third-party claim evaluators has come under scrutiny by the media, and by regulators. SEE STORY PAGE 1

NEXT ISSUE:
Elected v. appointed insurance commissioners
Viatical settlement companies: problems & pitfalls



BULLETIN BOARD

√ Do you have a regulatory colleague who deserves to be recognized? He or she could be the next receipient of the Society's Al Greer Award. See page 7.

√ The IRES Accreditation & Ethics Committee is looking into the creation of a new accreditation path for members who work in health care regulation. For comments or input on this, send an e-mail to ireshq@swbell.net and we'll forward your suggestions to the Committee.

√ If you are interested in running for a position on the IRES Board of Directors, we need to hear from you right away!! Call or e-mail IRES and ask for a board nomination form, which must be filled out and returned in order to be placed on the ballot. Any qualified regulator member of IRES is eligible for service on the IRES Board.You also may contact Angela Ford, chair, Meetings & Elections Committee, at 919-733-4935 or aford@ncdoi.net. You may nominate yourself or another person.

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