THE REGULATOR™
INSURANCE REGULATORY EXAMINERS SOCIETY

Departments and AGs use varied tools to battle fraud

by Scott Hoober
Special to *The Regulator*

The idea behind financial regulation is to make sure insurers are financially sound and not playing Enron-like games with their finances. Similarly, market conduct exams are aimed at ensuring that consumers aren't harmed by market-distorting behavior. Ditto for agent licensing and all the other insurance department functions.

But sometimes all that prevention fails to produce a pound of cure.

Some companies or agents defraud their customers, some employers play games to reduce health or workers' comp premiums, and sometimes consumers themselves fake auto accidents or commit other crimes. What then?

The answer has often been a hodge-podge of remedies — everything from departments keeping track of complaints on a per-company basis, to fraud units investigating major cases, to investigations by local or state police agencies, to cases brought by the county or district attorneys or the attorney general's office, to private civil lawsuits.

A brief survey of several states finds a variety of different structures. Yet one way or another, fraud is getting investigated and criminals are being put in jail.

Putting it together

To do the job right, you need to have a few basics in place:

- A mechanism to hear allegations of fraud and pass them along to be investigated.
- Skilled, trained investigators.
- Someone with law enforcement experience who can handle

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Enron's impact on state outsourcing decisions

by J. Robert Hunter
Director of Insurance
Consumer Federation of America

Enron . . . What a mess! Employees devastated, investors ripped off . . . and what a set of questions the mess raises for insurance commissioners. The basic question is this: Just what do the Enron revelations mean to state insurance regulation?

In the past, some Congressional members have been very critical of state regulation of insurer solvency. Congress blamed state regulatory authorities for insurer "Failed Promises," as Representative John Dingell (D-MI) put it several years ago.

The states reacted by developing a very good accreditation program, which significantly upgraded the quality of state oversight of insurer

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From the President

The Half-Way Point

My term as president is more than half over. The first half was filled with planning, setting goals, meetings and hard work. The level of activity at the committees has been brisk and productive.

The Meetings and Elections committee picked a CDS site for 2006 (Chicago) and is hard at work planning the 2002 elections and officers slate. The Accreditation committee has been implementing the new healthcare path for AIEs, and investigating a possible new technology path while performing all its other duties.The Publications committee continues to refine *The Regulator* while exploring other possible publications. Meanwhile, our Financial committee worked hard to pound out a budget during uncertain times while keeping the books balanced.

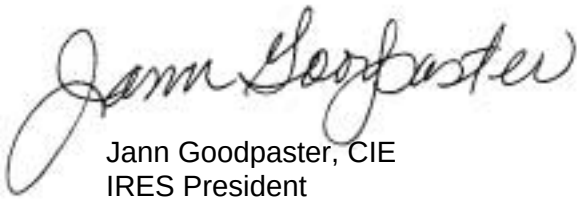
Our Membership committee has been working in high gear, especially in the state chairs sub committee. In the last *Regulator*, I wrote that Colorado had reported the first new state chapter meeting. Since then I've heard of several more states that had formed a state chapter and planned or held a meeting. Still in the works is a handbook for state chairs.

And, of course, the Education committee is responsible for our annual Career Development Seminar (CDS). The 2002 CDS committee, chaired by Doug Freeman, didn't even wait for the last CDS to be over to begin planning. With notes in hand from our 2001 CDS in Baltimore, the committee started working on the 2002 San

Antonio event even before the leaves had fallen last year. In addition to our already proven format, this year's CDS features a new "round robin event." To get the scoop, visit the website at **www.go-ires.org:/seminars/index.html.**

Many of you, by now, will have received a survey at your email address. The survey is a tool to help the IRES board determine what directions you, the members, want your organization to take in the coming months and years. If you haven't already completed it, I urge you to do so.

I hope all of you are making plans to be in San Antonio.



Jann Goodpaster, CIE
IRES President

Does one of your co-workers deserve special recognition?

The Al Greer Award annually honors an insurance regulator who not only embodies the dedication, knowledge and tenacity of a professional regulator, but exceeds those standards. If you have someone you'd like to nominate, it's easy. Contact the IRES office (913-768-4700 or ireshq@swbell.net) and request a nomination form. Or visit our web site at www.go-ires.org. Click on the MEMBERSHIP tab at top of home page, then select AL GREER FORM.

AL GREER ACHIEVEMENT AWARD

C.E. News

MOST FREQUENTLY ASKED QUESTIONS . .

What is the deadline for completing courses for this compliance period?

Courses or seminars submitted for credit must be completed during the current compliance period Sept. 1, 2001 to Sept. 1, 2002. The reporting deadline is Oct. 1, 2002.

What courses qualify for CE credit?

Qualifying courses must be more than 50% directly and substantively insurance related. Basic computer courses, even if offered by the NAIC do not qualify. For a computer training program to qualify it must be demonstrated that the course concentrates over 50% of the content on insurance specific applications.

Can I obtain a CE compliance reporting form from the IRES website?

Yes, the NICE manual is available for downloading from the IRES website @ www.go-ires.org. All continuing education forms, including the compliance reporting form are available online and may be downloaded and printed for your convenience. The hard copy may then be sent to the CE office for processing. Please include a certificate of attendance or comparable proof of your attendance when submitting your compliance reporting form.

How do I file an extension if I am unable to meet the compliance deadline?

The extension request form is on page 19 of the NICE manual (hard copy) and in the downloadable version of the manual on the IRES website. Please indicate you are requesting a one-year extension for the annual reporting period Sept. 1, 2001 to Sept. 1, 2002. Your written request must be received by the IRES CE office prior to Sept. 1, 2002.

N · I · C · E

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surveillance, serve warrants and make arrests.

- Prosecutors willing to take insurance fraud cases and bring them before a jury.

William Bradbury, a former longtime FBI agent who now serves as director of investigations for the North Carolina Department of Insurance, estimates that something like two-thirds of the states have law enforcement officers on the staff of their insurance departments.

Some of those departments also have attorneys on staff, sometimes deputy attorneys general who have been assigned to handle insurance cases, sometimes their own people. Some work with the attorney general's people to put together cases. Some investigate cases, then take them to a district attorney, U.S. attorney or other prosecutorial agency. And some rely on a combination of the above.

In North Carolina, for instance, Bradbury's 19 investigators and five supervisors usually behave like any other law enforcement agency, taking the case to a prosecutor when it's ready for trial. But they also work with in-house counsel, such as the ones assigned to the Public Services Division of the North Carolina Department, headed by Angela Ford.

"When Public Services is looking to yank a license or do something to an unauthorized entity," Bradbury said, "eight out of ten times we'll have a fraud case going on as well. We refer them back and forth all the time. But when it comes down to actually criminally prosecuting the case, we go the traditional route — to a prosecutor.

"We work very closely with the attorney general's office, but not in criminal prosecutions," he added. "We have attorneys assigned to the Public Services group, which helps out all the time on different hearing matters, civil-type matters."

One charge that's been leveled at outside attorneys, whether they work for the state's attorney general or for state courts, is that they simply don't care to prosecute insurance fraud.

As one regulator put it, off the record, "AGs have to run for re-election, and some of these insurance fraud cases just aren't sexy enough to get their attention."

In recent years, though, it seems that insurance fraud has gotten sexier. Or perhaps it's just a case of insurance commissioners and attorneys general becoming more willing to cooperate.

In Florida, as in North Carolina, the department relies on state attorney's offices to prosecute cases. Denise Prather of the Florida Division of Insurance Fraud says lack of interest is not a problem.

"Florida is ranked No. 1 in cases presented to the prosecutor and No. 1 in convictions," said Prather.

"We're a pretty large operation for a state agency in Florida, and we've got 121 investigators and 12 field offices working pretty closely with those state attorney's offices."

Besides, she added: "Insurance fraud, criminal fraud, has been in the spotlight quite a bit. We're able to interest them. Some of our cases are large and involve a lot of dollar loss, and I think that's another incentive" for prosecutors to sit up and take notice.

Relying on outsiders

Oklahoma is one of those states with the exact opposite setup: no in-house law enforcement officers and reliance on the AG to prosecute cases.

The 1999 tornadoes encouraged the AG to take an aggressive stance on issues related to the catastrophe, for instance by preventing price gouging by contractors. But even before the storm struck, the new first-term insurance commissioner, Carroll Fisher, had already approached the AG about greater cooperation in investigating and prosecuting a wide range of insurance fraud.

"I was the one who took the initiative to establish the relationship," said Fisher. "[Attorney General] Drew Edmondson and I are real close friends, and we're both elected officials here in Oklahoma. I had been out on the campaign trail with him quite a bit, and I've known him for quite a few years."

When Fisher wanted to expand his in-house fraud unit, which then had just one investigator, he worked with the AG to get the legislation passed.

"I went to him and said, 'Drew, I'm going after some legislation that's going to give us an opportunity to establish a fraud unit, and I'm going to need your help on the prosecution side. I'll send part of the revenue over to you, and I also want to work with the

Departments and AGs use many tools to combat fraud

OSBI [Oklahoma State Bureau of Investigation] in case we need bullets and badges.'"

The bill, which passed without a dissenting vote, assesses each insurance company in Oklahoma a fee, producing about $600,000 to $700,000 a year.

"It was a sizable amount," Fisher said, "of which we were allowed to have 60% of the revenue for the Oklahoma Insurance Department, 25% for the AG's office for prosecution, and 15% to the OSBI so that if I needed bullets and badges, I wouldn't put my investigators in harm's way."

During 2001, the Oklahoma department received 387 complaints and opened 223 cases — 51 of them against agents. They referred 30 of those cases to the AG and the OSBI, and of those 30, 28 were filed for criminal prosecution. The department recovered more than $173,000 for consumers.

Though Oklahoma's investigators tend to be retired cops, just as the investigators in states where they're required to carry badges and guns, there seems to be a difference in focus. Neither Florida nor North Carolina, for instance, gets involved with civil cases.

"Our mission is to make an arrest, to put people in jail," said Florida's Prather.
"We're cops, and we work most of our cases with the state attorney's offices." Bradbury in North Carolina echoed the thought: "As the law enforcement people that we are, we don't do any civil stuff.

Green eyeshades

Larger states do go after civil as well as criminal cases, but they tend to use a separate civil division.

No matter how you divide up the workload, most insurance fraud investigation is green-eyeshade stuff: going through reams of paper, using forensic accounting techniques and making cases based on the paper trail.

Yet every fraud unit — especially those whose investigators are licensed law enforcement officers — has its stories.

In North Carolina, the biggest single source of insurance fraud is auto. That includes rings that stage accidents, and those rings often are composed of people who commit other crimes as well.

"We find ourselves, when we least expect it, being involved in ticklish situations," Bradbury said.

"We had a staged-accident ring that involved motorcycle gang members down around Charlotte. We ran upon a methadone lab, plus they were big into strip clubs and stuff like that.

"We also find ourselves doing a lot of surveillance work," Bradbury added. "Before executing a search warrant, for example, we'll have to sit up on the place and make sure it's safe to go in, or the person we want to be there is in fact there."

Fortunately, most insurance fraud investigations deal with cupidity and stupidity.

In Florida, too, following the paper trail sometimes puts investigators into the kind of situation with which streets cops are more familiar.

"All of our guys carry guns and carry badges," Prather said. "We've had a couple of Miami investigators who were in the wrong place at the wrong time and had to use their weapons, but that doesn't occur very often."

In fact, the work is usually so nonviolent that it's easy to forget about the risk.

"This is mostly white-collar crime that we deal with, and investigators get a little complacent about it," Prather said. That's why investigators' training always includes officer safety issues.

Fortunately, most insurance fraud investigations deal with cupidity and stupidity, not the kind of shoot-em-ups that prime-time police dramas like to feature.

Fisher's favorite story from Oklahoma's fraud unit is about the rancher who turned in his John Deere tractor as stolen. After collecting his insurance payment, he sold the place and moved on.

"After a rain, the new owner of the ranch saw something green growing in the pasture," said Fisher,

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"and it wasn't grass — it was the top of a John Deere tractor."

Every so often, fraud investigators will come upon a case that's too big to handle in a routine fashion. That's when they turn to the federal courts, often in cooperation with the FBI or other federal agencies.

Several years ago, the then-insurance commissioner of Vermont ran into a scam artist in Montreal who was selling insurance on boats, jet skis and snowmobiles across the U.S. It was a pure scam — the outfit was selling policies and collecting premiums, but it moved on before it had to pay any claims — and it was careful not to bilk people in the same jurisdiction where it had offices.

It didn't work in Vermont. The commissioner called in the postal authorities, and they got in touch with the Royal Canadian Mounted Police.

In recent years, some of the large-scale investigations have involved viatical firms. North Carolina and Florida were two of the states to be involved in a task force, along with the FBI and the Postal Inspection Service. Besides the crime itself — usually material misrepresentation on insurance or viatical applications — departments had to deal with the investment-security angle, in which investors were sold a bill of goods.

One big issue in North Carolina has been professional employer organizations (PEOs, also known as employee leasing companies).

"We have a case right now," Bradbury said, "involving workers' comp that was North Carolina assigned-risk, North Carolina-only coverage. The PEO involved marketed this to their North Carolina companies — but they also took it and marketed it to other PEOs, located in other states. They phonied up the certificates of insurance and sent them out to these other PEOs, that had their client companies in other states, and then kept the premiums."

When claims started coming, they paid the first few, then they went under and picked up again somewhere else. Meanwhile, workers and PEOs that thought they had coverage find they actually never did.

Interagency cooperation

Sometimes the division of labor seems awfully artificial. In Oklahoma, for instance, workers' comp fraud is assigned to the AG's office.

In New York, the Managed Care Consumer Bill of Rights, passed in 1996, empowers the AG to bring lawsuits against health plans that repeatedly engage in fraudulent, deceptive or illegal business activity.

In North Carolina, a recent reorganization put all fraud investigators under one roof, including the ones who investigate bail bondsmen.

Many of the differences between the way states handle fraud investigation lies in the demographics of the various states.

"We're the fourth most populous state in the country," said Florida's Prather, "and that is probably about where we stand as far as fraud."

The state's large Spanish-speaking population can be a challenge as well. Florida has plenty of bilingual investigators, though a surprising percentage of calls to the department's hotline — even in the north, where Spanish-speakers aren't as common — are from people who don't speak much English.

"We're also different from some of the other states in that we investigate all kinds of fraud," Prather said. "Not just workers' comp or claimant fraud, but insolvency fraud, medical-provider fraud . . . PIP [personal injury protection] fraud is a big issue. We do agent cases, adjuster cases, company cases — most of the company cases are some kind of insolvency fraud.

"Maybe 15% of our cases are agent cases," she said. "It's commonly called mishandling of fiduciary funds, where they're pocketing premiums and not sending them to carriers."

In North Carolina, by contract, "When it comes down to the consistent, pervasive fraud, from year to year, it's P&C and it's auto.

"We take the stance that the industry has its special investigative units, and they work a lot of that type of fraud, and we like to concentrate on certain types of situations that the industry would not be involved in, or would need some help in."

Besides fraudulent employee-leasing outfits, that involves a lot of agent embezzlements, unauthorized entities and of course workers' comp is pretty much always there. We have several big premium fraud cases, and that usually comes in conjunction with a PEO case."

Despite the differences, the states seem to have one thing in common: They know fraud is out there, and one way or another, they're working to knock it down to size. ■

An interview with State Farm's Dave Hurst

Georgia auto insurers grapple with new 'diminished value' rules

Editor's Note: Georgia auto insurers, like their counterparts in most states, paid few diminished value claims over the years. Now the courts are compelling them to take another look. *The Regulator* recently interviewed Dave Hurst, Public Affairs Liaison with State Farm Insurance Company, to find out why diminished value is back with a vengeance in Georgia.

Regulator: *What is diminished value (DV)? Are there some circumstances under which consumers should be compensated for diminished value?*

Hurst: Diminished value is the concept that a vehicle that has been in a crash loses some of its value even if it is properly repaired. This concept is sometimes called "inherent" diminished value. It is claimed that if a crash-damaged vehicle isn't properly repaired, it suffers a different type of diminished value — "repair-related." We believe that inherent diminished value is a rare occurrence and that any compensation should be considered on a case-by-case basis.

Regulator: *A Georgia Supreme Court ruling* (State Farm v. Mabry (SO1A0982)) *recently affirmed a lower court decision that compelled Georgia auto insurers to compensate first-party claimants with partial physical damage losses for the diminished value of their automobiles. Such payments are required, the court said, even if these vehicles had been returned to their pre-loss condition in terms of appearance and function. Is Georgia law regarding DV as clear cut as the* Mabry *decision indicates?*

Hurst: We were disappointed by the Georgia Supreme Court's ruling because we believe it greatly expanded insurers' obligations with regard to DV. Previous court decisions in Georgia had established that DV was payable under some circumstances; none said that an insurer was required to examine every first-party claim to determine if DV might be payable, as the recent court decision did.

Regulator: *Since the diminished value law was on the books for so long in Georgia, why did Georgia auto insurers fail to pay or consider DV claims?*

Hurst: We can't speak for other auto insurers. State Farm had considered DV claims when they were presented to us.

Regulator: *Does the Georgia law simply permit DV claims to be filed by claimants or does it require auto insurers to include a DV component when paying any first-party partial loss claim?*

Hurst: Georgia law on DV is established by court decisions. Prior to the *Mabry* ruling, we did believe that the law simply allowed the filing of DV claims. Now, under the *Mabry* decision (which we will follow as part of our settlement), insurers are required to consider DV when evaluating all first-party claims.

Regulator: *Does the ruling apply to commercial vehicles as well as private passenger vehicles.*

Hurst: The Supreme Court decision doesn't exclude commercial vehicles. The settlement does include the type of commercial vehicles State Farm insures.

Regulator: *Does the court decision address DV for third-party claims? With respect to DV, is there a distinction between first-party property damage claims and third-party property damage claims?*

Hurst: No, the *Mabry* decision doesn't address third-party claims; it covers first-party collision, comprehensive and uninsured motorist claims. Court decisions have established (and most insurers have

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accepted) that DV claims may be payable under property damage liability coverage (third-party). The reason is that under the legal concept of liability, the injured party is to be "made whole" for any losses that can be proven. Again, there must be proof that a DV loss occurred. This concept does not apply to first-party coverages because they don't involve liability. The insurer promises only to repair its own policyholder's car, or to compensate the policyholder for the car's actual cash value. Most policies don't mention any DV coverage.

Regulator: *Is it State Farm's position that first-party claimants should submit a DV claim in order to be considered for compensation. If so, how would consumers become aware of their right to file a diminished value claim?*

Hurst: This has become a moot point because of the *Mabry* decision. Prior to that, we did contend that DV should be considered on first-party claims only if the customer made such a claim. Because DV is a rare occurrence, customers seldom made such claims.

> ***"Now, under the Mabry decision. . .insurers are required to consider DV when evaluating all first-party claims."***

Regulator: *If we assume that diminished value is a legitimate concept under Georgia law, should compensation be paid, in State Farm's opinion, only when a vehicle is sold to a third party? In other words, does the concept of diminished value make any sense for insureds who never sell their vehicles.*

Hurst: We believe that DV claims should be considered on a case-by-case basis. While we are aware of the argument that DV should be paid only when the vehicle is sold to a third party, I'm not aware that we ever used this argument in evaluating claims.

Regulator: *Under the court ruling and Georgia Commissioner Oxendine's subsequent directive (Georgia Insurance Commissioner – Directive 01–P&C–1), State Farm and all other Georgia auto insurers are ordered to determine which first-party claims are eligible for DV compensation and derive a methodology to provide adequate compensation. How difficult will this be for auto insurers?*

Hurst: As part of our settlement of the *Mabry* case, we agreed to use a formula previously distributed by the Georgia Insurance Department and mentioned in a June 12, 2001 order by the trial court in this case. This formula requires us to evaluate each first-party claim, considering such factors as the vehicle's value at the time of the crash, degree of damage and age (mileage), going back to December 22, 1993. This will be time-consuming, but must be done under terms of the settlement and the court decision.

Regulator: *Will you be permitted to increase automobile insurance rates in Georgia to compensate for the unanticipated losses you will incur as a result of this ruling?*

Hurst: Any rate changes by State Farm or other auto insurers must be approved by the Georgia Insurance Department. State Farm considers its total claim experience and anticipated future premium needs in requesting rate changes.

Regulator: *What is the likely impact on Georgia consumers when DV becomes a component of the standard automobile insurance policy?*

Hurst: If the increased number of DV claims results in higher costs for State Farm, this eventually would have to be reflected in the premiums our customers pay.

Georgia grapples with 'diminished value'

Regulator: *Are there any other states with DV laws that are similar to Georgia's? Do you see a trend in the United States toward permitting DV claims?*

Hurst: There are no states other than Georgia in which courts have held that insurers must consider DV when evaluating every first-party claim. In three states —Mississippi, South Carolina and Tennessee — courts have said that DV may be considered on a first-party claim if the customer requests it. In six states - Arizona, California, Delaware, Kentucky, Pennsylvania and Virginia — courts or the statutes have said DV definitely does NOT apply to first-party claims. In the remaining states and the District of Columbia, there is no agreement on the application of DV. Contrary to the Georgia situation, the trend recently has been in the opposite direction. For example, the Delaware Supreme Court held that DV doesn't apply to first-party coverages.

Regulator: *Wouldn't the perfect solution to the DV dilemma be to allow consumers to choose whether they want to buy insurance policies with a DV component? Those choosing DV would pay a premium commensurate with the additional coverage. What's wrong with such an approach?*

Hurst: It would probably be very difficult to determine how much should be added to each driver's premium for DV coverage. We continue to believe DV is something best handled on an individual-case basis; while we are using a formula in Georgia, we don't think this is the best approach. It probably also would increase our administrative and claim-handling expenses.

Regulator: *Do you plan to appeal the* Mabry *decision?*

Hurst: We have agreed to settle the case, so we have no plans to appeal the *Mabry* decision.■

IRES State Chapter News

Nebraska — The Nebraska IRES Chapter held a continuing education meeting on February 20. The group included regular members, former regulator members, sustaining members and insurance company nonmember guests. Two Nebraska Department of Insurance attorneys gave the continuing education presentations. Christy Neighbors discussed the redomestication process and Eric Dunning discussed current insurance-related legislation. The next meeting for the Nebraska IRES Chapter will be April 17. Details will be posted on the IRES website.

Illinois — The Illinois IRES chapter recently conducted a workshop. In addition to market conduct staff, regulators from producer licensing and regulation, consumer services, and policy compliance attended. Topics included the Gramm-Leach-Bliley Act, Speed to Market and other NAIC activities, Market Conduct Examiner's Handbook, and the Department's consumer initiatives. IRES members that participated in all sessions earned four CE credits. The Illinois state chair also received seven new applications for IRES membership as a result of the workshop.

Colorado — Recent activities of the Colorado IRES Chapter have been well attended and well received. Twenty-three DOI staff members attended the IRES class on Title Insurance on Jan.10 presented by Erin Toll, Director of Consumer Affairs Compliance at the Division. Thirty-three DOI employees attended the Feb. 13 IRES class on The Impact of Terrorism on the Insurance Industry. In addition to reviewing the video of the CPCU Society President's Panel discussion from the October 2001 CPCU Society Annual Meeting in Seattle, Commissioner Kirven, Victoria Lusk, Carol O'Bryan and Tom Abel addressed the class. The next IRES-sponsored class is scheduled for March 13. That meeting will feature Kim Wells, Supervisor of Consumer Affairs, who will revisit the NAIC Consumer Complaints White Paper, including the seven points recently addressed in the Consumer Complaint Handling seminar hosted by the NAIC.■

Enron impact on state regulatory decisions

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solvency. But Enron raises concern – could Enron happen to a major insurance company?

This article is an attempt to give a consumer perspective on some of the concerns raised by the Enron collapse. The Consumer Federation of America (CFA) understands that there are many other questions and issues that need to be addressed by state insurance commissioners in the wake of this scandal, but here's an early reaction to some of the most blatant ones.

Should regulators be concerned about outsourcing examinations?

Regulators have to be alarmed by the prospect of a large insurer going the way of Enron with little or no advance notice. If an audit is not reliable, this could surely occur. Outsourcing exams holds a potential of risk – Enron shows that the relationship between the auditor and the audited may not always be arms' length and truly independent. It is extremely risky to allow accounting to be verified on behalf of a state by any firm that is not independent.

Conflicts of interest for auditors derive first from the fact that they are paid by the audit client and can be fired by the audit client. Even without consulting conflicts on the line, the auditor may fear losing a $25 million audit client. Obviously, however, adding tens of millions more in consulting fees dramatically ratchets up that conflict. Enron was paying Anderson $27 million for auditing services, but internal documents show Andersen saw Enron as potentially a $100 million client. Imagine, then, being Enron's auditor and going back to announce that your unwillingness to sign off on Enron's books has lost Enron as a client for Andersen. It would be bad enough to report losing a $25 million audit client, but losing a client the firm saw as the potential source of $100 million a year? It wasn't going to happen.

Andersen's conflicts with Enron go further, since Andersen was serving as Enron's internal accountant while also serving as its external auditor. So, the issue is not just that Andersen had a lot of money on the line, but that Andersen auditors were reviewing books that in many cases had been prepared by their colleagues. This was one of the types of consulting/auditing arranagements the SEC had proposed to ban before they caved to political pressure. Also, there was a revolving door to end all revolving doors between Andersen and Enron, and a VERY chummy relationship. As one article said, you couldn't tell who worked for Enron and who worked for Arthur Andersen.

What dangers exist when regulators target examinations based on previously issued CPA reports? Or rely on credit agencies?

Besides the use of potentially non-independent auditors to conduct examinations for the state, another obvious concern is the reliance on third-party (*e.g.*, big five) auditors' findings to direct the work of the state in its audit priorities. It could be a fatal mistake for states to give low priority to examinations of certain insurers just because they passed muster with an outside auditor. If Enron-like conditions exist, states cannot rely on CPA audit reports to determine potential problem areas.

Likewise, regulators cannot rely on credit rating agencies when scheduling which firms to audit. According to a very illuminating Bloomberg article from last November, Moody's apparently succumbed to pressure from Enron and its investment bankers and reversed its decision to lower Enron's credit rating to junk status. In insurance, credit rating firms sell a lot of products to the insurance industry, not the least of which are copies of favorable ratings to shower on prospective clients. Grade inflation is a serious temptation for rating agencies, so regulators should be leery.

What conflict-of-interest concerns should regulators be concerned about when selecting a firm to conduct an examination? How can such potential conflicts be minimized? With only five major accounting firms, can such conflicts be avoided?

The NAIC must hold hearings and undertake research on these vital questions. Obviously, the issue of auditors also doing consulting or other work for the

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Enron impact on state regulatory decisions

company to be audited must be analyzed. The historical and current relationships between auditors and top management of the insurer must also be considered (*i.e.*, the revolving-door syndrome). Anti-conflict standards must be developed and sworn to by the auditors. Significant involvement by the states must be part of any audit that is relied upon by states in lieu of an audit done directly by state employees. It may well be that to qualify for auditing insurers, accounting firms would be subjected to audit themselves by government agencies. But whatever the resolution, there must be a way of assuring the public that the audit process is independent and reliable.

Can Requests for Proposals (RFPs) be structured in such a way as to avoid potential problems?

One of the ways to minimize problems would be for states to develop independence standards and to ensure that they are met prior to hiring an auditor. Tougher conflict-of-interest questions could be incorporated in the RFP so that significantly conflicted firms would be screened out in the early stages of the process. Term limits (*i.e.*, restricting the number of times an insurance company audit can be conducted by the same accounting firm or individuals) would also be helpful.

Regardless of whether the state or the insurer pays for the audit, states should at the very least require an auditor other than the company's existing auditor to conduct the financial examination. States should also ensure that auditing firms under consideration are free of any consulting arrangements that could hinder their independence. States should also write revolving-door restrictions into their outsourcing contracts (this might be hard for state insurance departments to do, given their own revolving-door problems, but that is a topic for another day). Clearly, ensuring that the company selected to conduct the audit is not performing consulting services for the insurer isn't going to insulate them from all potential conflicts.

Are regulators setting themselves up to be second-guessed by legislatures, the media and the public by outsourcing financial examinations in the event a major insurer fails that had been given a clean bill of health by an outside auditing firm?

It is easy to imagine that, if Enron had been a major insurance company, the domiciliary commissioner would be asked to explain it (*i.e.*, be grilled) on "Meet the Press." Would any Commissioner really welcome that kind of exposure? It's a regulator's worst nightmare.

Undoubtedly if a large insurer fails and a state has relied on outsourced audits, the state has the responsibility to explain why. This is appropriate since you cannot delegate the ultimate responsibility of government to even independent (much less conflicted) private parties. The state regulator will deserve severe criticism if an Enron occurs now – you are, by Enron, forewarned.

What about the idea being promoted by the industry to give credit for self-audit or audit by industry-controlled third parties such as the Insurance Marketplace Standards Association (IMSA)? Or the idea of a self-audit privilege whereby the insurer could keep certain information secret, even in court discovery?

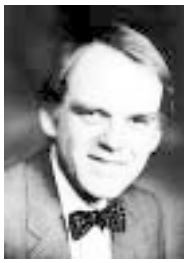
continued on next page

Enron impact

continued from previous page

The concept of relying on self-audit mechanisms to in any way reduce or replace state responsibility has always been a bad idea from a consumer perspective. Enron shows why. The NAIC should drop the idea like the hot potato it has become in the wake of the Enron mess. Consumers are particularly opposed to the idea that self-audit should, in any way, immunize the insurer from discovery by a plaintiff/insured that has been wronged by the defendant/insurer. The NAIC should kill the self-audit proposals advanced by the insurance industry at the earliest opportunity.

CFA calls upon the states, through the NAIC, to immediately undertake a process to make the audit process more reliable, and to develop standards for audit that assure the public that there is an arms' length relationship between the auditors and the audited. We particularly request that the accreditation program be revised to require that each state pass a set of standards for accountability so that independence of any audit is assured. CFA believes that states must be unambiguously involved in the management and oversight of all audits bearing the state imprimatur. This is the only way to assure the insurance-buying public that the examination process is forthright, unbiased and independent. ■



Bob Hunter is Director of Insurance for the Consumer Federation of America (CFA). Before joining CFA, Mr. Hunter was Texas Insurance Commissioner and, prior to that, President of the National Insurance Consumer Organization. He served as federal insurance administrator under presidents Ford and Carter. He is a fellow in the Casualty Actuarial Society and a member of the American Academy of Actuaries. Bob has written opinion pieces for the New York Times, the Washington Post, the Los Angeles Times and other newspapers. He also has discussed insurance issues on various television programs, including Oprah, Donahue and Larry King.

SPEs and CAT Bonds

In the wake of the Enron bankruptcy, investors and regulators in all sectors of the marketplace are taking a closer look at corporate accounting practices. Many observers have expressed amazement that Enron's accounting improprieties escaped notice until the company was already on the verge of insolvency. In part because of Enron's failure to consolidate certain special purpose entities (SPEs) into its financial statements, regulators and shareholders were largely unaware of the company's grave financial condition. Particularly alarming was the misuse of certain SPEs as vehicles for the concealment of substantial corporate debts and the personal enrichment of certain employees.

It may be tempting to view the use of all SPEs by insurance companies with suspicion in light of the Enron improprieties. However, it is important to recognize the stringent accounting rules that are already in place with respect to the use of SPEs in the reinsurance context, particularly in connection with the issuance of catastrophe bonds (CAT bonds).

The accounting rules applicable to SPEs in CAT bond transactions are designed to ensure the highest level of transparency of cash flow. The transactions are effected through traditional reinsurance contracts between the ceding insurer and the SPE. The contracts meet the standards for credit for reinsurance contained in the NAIC Credit for Reinsurance Model Law and Regulation and are reported on Schedule F of the Annual Statement.

In addition, in CAT Bond transactions the proceeds from the bond issue are deposited by the SPE in a trust for the benefit of the ceding insurer. The funds deposited in the trust are equal to the limits of coverage provided in the reinsurance contract. Indeed, the manipulation by Enron of SPEs to conceal substantial debt would never have occurred under the accounting rules applicable to CAT bonds.

In view of these regulatory restraints, we should remain confident in the continuing legitimacy of these reinsurance vehicles.

—Vincent Laurenzano, Insurance Financial Consultant, Stroock & Stroock & Lavan

"If I were overseeing an insurance company's regulatory compliance program, this is the program I would make my staff attend every year."

— Jim Fryer, Director of Continuing Education, American Institute for Chartered Property Casualty Underwriters

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Dull v. Duller

Lawyers battle over citation style

by Mark L. Gardner

Hello Reader *(Casual Greeting v. Formal Greeting).*

Can you imagine a world in which people add a string of incomprehensible gibberish after nearly every sentence *(Central Question of this Article v. Problem Facing Legal Community Today)*? Lawyers know what I'm talking about because we all have to deal with those curious little fragments that tail every sentence in countless legal documents *(Sure, I've Seen This Before v. What? You Haven't Been Sued Yet?).*

When a lawyer prepares a brief, he essentially weaves together his thoughts into sentences to make a legal point. Then, to support his argument with authority, he offers legal citations (or "cites") to help buttress his argument. In the citation, the two parties to the precedent case appear much like prizefighters on a marquee, followed by a seemingly random string of numbers and letters.

For example, a criminal defense lawyer may assert in a brief that every defendant has the right to remain silent, and follow that statement with a cite —*Miranda v. Arizona*, 384 U.S. 436 (1966). The cite tells the reader that the *Miranda v. Arizona* decision was rendered in 1966 and the details appear in Volume 384 of the *United States Reports*, the official reporter of U.S. Supreme Court cases, beginning on page 436.

Not surprisingly, the judges who write the decisions speak the same language as the attorneys that litigate the cases. Thus, the same jargon permeates every decision rendered in a U.S. court room.

A controversy is now brewing in the American legal community as to whether the time-honored system of citing should be replaced by a footnote–based system, with Black's Law Dictionary editor (and attorney) Bryan Garner leading the charge. Citations, he claims, are mind-numbing conventions that prevent lawyers and judges from writing coherently. He is currently assembling his foot soldiers, which include legal and lay people, to prepare for battle.

His opposition is the legal traditionalists who don't want to change a system that to them is not broken. They believe a citation is too important to be relegated to a mere footnote, and view as heresy any notion of dismantling the centuries-old convention.

So whom should we believe? The rebel who would have our head bouncing up and down like a bobblehead doll in an earthquake? Or the keepers of legal tradition (*Legal Luddites*) who dislike the idea of making legal opinions comprehensible to those who had the temerity not to attend law school (*And Spend a Small Fortune*)?

To me, both systems are lacking. Instead of fostering literary constipation with references that are useful to just a handful of readers, shouldn't those of us in the legal profession be focusing on content?

I suggest we develop a third system: the "Believe It Or Not" method of backing up assertions. In this system, an author would muster his or her best argument and then add the phrase "Believe It or Not" at the bottom of the final page of the brief or decision. Kind of a *caveat reader* approach, the *Believe It or Not* method would allow one to add that phrase, in italics, at the end of each legal document, and leave it at that.

Alternatively, and a bit more seriously, I would suggest "endnotes," a perfectly acceptable replacement for traditional footnotes. Under this system, one would add an endnote when necessary and the accompanying citation would appear at the close of the brief or decision — no disruptive citations, no head bobbing.

I will admit that such a system could well lead to constant page flipping, which would be equally annoying to some. But for those — like me — who couldn't care less what follows a footnote, the entire last page could be blissfully ignored. And maybe we could fully enjoy what we're reading!

Mark Gardner is an insurance attorney and former Deputy Superintendent of the New York Insurance Department.

New technology option added to AIE curriculum

The world of insurance regulation is continually changing. In an effort to keep pace with these changes, IRES has been working for several months on a new education path for earning the AIE designation. This change will recognize the growing need and demand for computer training and education for insurance regulators. It will be identified as the Information Systems Path (IS Path). Implementation will begin Sept. 1, 2002.

A number of possibilities were considered in designing a new path that emphasized computer technology. It was determined to be most practical to design the new path so as to be consistent with the new Life and Health paths that also will become effective in September. By following this approach, much confusion in regard to the various requirements and options available can be avoided.

The new IRES Information Systems accreditation path calls for the completion of the same four core courses required in the Life or Health Path — plus three Insurance Data Management Courses as well as passing the ACL Proficiency Exam administered by the NAIC. Completion of these seven courses and the exam will qualify a member for the AIE designation. The CIE designation can then be earned by completing four of five possible courses in the Property-Casualty path.

Additional details will be published in the next issue of *The Regulator.*

Scams on the Web

Looking to get on the ground floor of a great investment? Try www.mcwhortle.com, the website of a high flying firm on the verge of going public. Or is it?

The McWhortle website was devised by the Securities and Exchange Commission as an ingenious means of reaching the most gullible Americans.

What's the point of producing educational brochures, the SEC reasoned, if greedy, dim-witted investors never pay attention? The agency established a bogus website, sent out phony press releases, created fictionalized testimonials, and even concocted an audio interview with an SEC staffer who purported to be Thomas McWhortle III, the company's effervescent CEO. Potential investors are led to a link called "ready to invest." Those who continue, are confronted with the following announcement: "If you responded to an investment idea like this . . .**you could get scammed!"**

The website received more than 150,000 hits in its first three days of operation.

Clarification

The article on business income/interruption insurance in the January 2002 issue indicated on p. 5 that a business establishment with a customer base consisting mainly of World Trade Center employees would not be covered for its loss-of-business income. Although this would be true for the standard business income insurance policy, an endorsement, called the "Business Income from Dependent Properties" is available in most states. For coverage to trigger under this endorsement, a covered cause of loss must cause physical damage to a dependent property which in turn causes an interruption to the insured's operations. One type of dependent property under this endorsement is a "leader location." A leader location is defined as an entity that attracts customers to the insured's business. For example, a major league ballpark would be a leader location to a sports memorabilia shop located near the stadium. Should the major league ballpark close temporarily as a result of a fire, the memorabilia shop owner who had purchased such coverage would be covered for his loss of business income.

REGULATORY ROUNDUP

Florida Releases Task Force Report on Use of Credit Reports. In January, the Florida Treasurer and Insurance Commissioner announced the findings of a task force that evaluated the impact of the use of credit reports in underwriting. Five of Florida's top ten homeowners' insurance writers use credit information in underwriting, and nine of the state's top ten auto insurers consider the creditworthiness of their applicants when making underwriting decisions. Many insurers also incorporate credit information into the ratemaking process. The task force, which was established in September 2001, held four public hearings around the state. A key recommendation of the task force provided that insurers should not use credit information as the *sole factor* in determining coverage and rates.

Under the federal Fair Credit Reporting Act, credit reports can be used for insurance underwriting. If credit history played a role in an insurance company's decision to deny coverage, the Act requires the insurer to inform the consumer and supply the name of the credit bureau that provided the information. Although Florida law does not specifically address insurers' use of credit reports, a Florida Insurance Department rule is currently in place that requires insurers to notify consumers when their credit report is used and to advise the consumer if an adverse decision is made based on the report. Other states are also looking at this issue. The National Association of Independent Insurers recently reported that this year 25 states, up from 18 a year ago, will be looking at the use of credit information in underwriting and ratemaking. The full report of the Florida task force is available online at **www.fldoi.com** under "Credit Report Task Force."

The New York-based Stroock & Stroock & Lavan LLP Insurance Practice Group includes Donald D. Gabay, Martin Minkowitz, William D. Latza, John R. Cashin and Vincent L. Laurenzano, an insurance finance consultant. They gratefully acknowledge the assistance of Robert T. Schmidlin, an associate in the group. This column is intended for informational purposes only and does not constitute legal advice

By Stroock & Stroock & Lavan LLP

Georgia Commissioner of Insurance Requires All Property-Casualty Insurers to Pay Diminution of Value for First-Party Automobile Physical Damage Claims. The Georgia Commissioner of Insurance issued a directive on December 7, 2001, to all property-casualty insurers licensed in Georgia, requiring them to abide by the recent decision of the Georgia Supreme Court in *State Farm Mutual Automobile Insurance Company v. Mabry* (2001 WL 1506489). The decision obligates State Farm to assess diminution of value along with the elements of physical damage to an automobile when an insured submits a first-party claim for a loss due to a covered event. The Commissioner's directive requires insurers to make assessments and payments for loss based on diminution of value to an automobile in addition to the physical damage.

The basic issue in *State Farm* addresses the scope of the insurer's contractual promise to compensate automobile insurance policyholders for their losses. Specifically, the Court determined that: (i) there is a potential for diminution of value in every event of loss and that diminution of value can occur even where the vehicle is repaired properly (*i.e.*, to its pre-loss condition); (ii) that an automobile insurance policy provision requiring State Farm to pay for loss to the insured's vehicle obligated the insurer to pay for the diminution of value of the repaired vehicle, even where the repairs returned the vehicle to its pre-loss condition; and (iii) that State Farm is obligated under its policies to assess the element of loss along with physical damage when a policyholder makes a general claim of loss to a vehicle. The Commissioner's Directive may be obtained at **www.inscomm.state.ga.us**. (See Diminished Value article, p.7.)

Illinois Anti-Fraud Legislation Becomes Effective. On January 1, 2002, Public Act 92-0233, the "Insurance Claims Fraud Prevention Act," went into

effect. The Act amends the Illinois anti-insurance fraud statutes to require property-casualty insurers writing automobile insurance in Illinois to report information related to suspected fraudulent insurance claims, applications or premium fraud to the Illinois State Attorney and Attorney General. The Illinois State Attorney may bring a civil action for violations of the Act if it does not file criminal charges. If the Illinois State Attorney does not commence a civil action, the Attorney General may do so. If a criminal proceeding is underway at the same time a civil action is pending against a defendant regarding substantially the same conduct, the civil action would be stayed until the criminal action is concluded by the trial court. Interested persons, including insurers, may also commence a civil action in the name of the State for violations of the Act. The Act makes it unlawful for any person to knowingly offer payment for procuring patients and clients and inducing patients or clients to obtain services or benefits that may be the basis of an insurance claim. Public Act 92-0233 may be obtained at **www.state.il.us/ins/**.

> ***"The [Mabry] decision obligates State Farm to assess diminution of value along with the elements of physical damage to the automobile when an insured submits a first-party claim for a loss due to a covered event."***

Michigan Enacts Legislation Giving Insurers Self-Evaluative Audit Privilege. On January 11, 2002, Senate Bill 674 was signed into law, becoming Public Act 275 of 2001. The law amends the Michigan Insurance Code to create an "insurance compliance self-evaluative audit document" privilege for certain documents prepared by an authorized insurer as the result of or in connection with an internal insurance compliance audit, and under certain circumstances, can include an internal written response to the audit findings. The privilege prevents such documents from being admitted as evidence in a civil, criminal, or administrative proceeding and could be asserted by a person involved in preparing the audit to avoid being compelled to testify about the documents and the matters to which they relate.

Public Act 275 also: (i) extends the privilege to internal audit documents submitted to the Commissioner of the Office of Financial and Insurance Services and requires that such documents be kept confidential; (ii) specifies that the privilege would not apply if a court required disclosure after a private hearing; (iii) establishes the burden of proof for asserting a privilege or grounds for disclosure; and (iv) exempts certain information from the privilege, including documents, communications, data, reports, or other information required to be collected, developed, maintained, or reported to a regulatory agency under the Insurance Code or other federal or state law. Public Act 275 becomes effective on March 22, 2002. It can be obtained at **www.michiganlegislature.org.**

New Jersey Enacts Legislation Mandating New Health Insurance Benefit. On Dec. 31, 2001, Assembly Bill 2313 was signed into law, becoming Chapter 295 of 2001. Chapter 295 mandates health insurers, including hospital, medical and health service corporations, individual and group health insurers, health maintenance organizations and other health benefit plans, to provide coverage for colorectal cancer screening at regular intervals for persons age 50 and older and for persons of any age who are considered to be at high risk for colorectal cancer. Chapter 295 defines "high risk for colorectal cancer" as: (i) a family history of familial adenomatous polyposis, hereditary non-polyposis colon cancer, or breast, ovarian, endometrial or colon cancer or polyps; (ii) chronic inflammatory bowel disease; or (iii) a background, ethnicity or lifestyle that a physician believes puts the person at elevated risk for colorectal cancer. The mandate requires coverage for the following methods of screening: (i) fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or (ii) the most reliable, medically recognized screening test available. The covered person's physician will determine the method and frequency of screening based upon medical necessity and in consultation with the covered person. Chapter 295 may be obtained at **www. njleg.state.nj.us.**

For experienced insurance regulators: The NAIC/IRES market regulation school

Now is the time to ask your state to enroll you in the 2002 "Regulating the Marketplace" school for experienced insurance regulators. The course is limited to about 35-40 persons, so don't delay.

WHEN: May 13-16, 2002
WHERE: NAIC offices, Kansas City
WHO TO CALL: NAIC, 816-783-8200
etrainin@naic.org

The school is cosponsored by the National Association of Insurance Commissioners and the Insurance Regulatory Examiners Society.

This is an advanced program for experienced market regulators, designed for those who work in market conduct, complaint handling, consumer services, producer licensing, rate and form review, enforcement, and compliance.

The Program

This program provides opportunities for market regulators — complaint handlers, rate and form analysts, producer licensing staff, market conduct examiners, and enforcement personnel — to review techniques that achieve integrated and effective market regulation.

Instruction is given through lecture, group discussion, and case study analysis. Presenters are experienced insurance department staff and NAIC staff.

Topics

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Model Laws and Regulations
Federal Health Insurance Regulatory Issues
Handling Consumer Complaints
Financial Regulation for Market Regulators
Issues in Rate and Form Review
Regulating Producers
Enforcement and Prosecution
Combating Fraud
NAIC Software and Databases
Market Conduct Exams & Market Conduct
Health Issues
Departmentally Coordinated Examinations
Internet and E-Commerce

Tuition for this $3^{1/2}$-day program is $450 for state insurance department staff. The program begins at 8:30 a.m. Monday and ends by noon on Thursday.

Quote of the Month

The U.S. government should be withdrawing from that market. After all, we're a taxpayer. We don't want to compete with our government for business that the commercial sector can underwrite.

— AIG Chairman and CEO Hank Greenberg explaining his opposition to the federal government underwriting war and terrorism insurance for the airline industry

IRES 2002 Career Development Seminar

JULY 28-30, 2002

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Fill out and mail to The Insurance Regulatory Examiners Society
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Yes! **Sign me up for the Year 2002 IRES Career Development Seminar. My check payable to** IRES **is enclosed.**

Name

Title First name for Badge

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Your mailing address Indicate: ☐Home ☐ Business

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$ Amount enclosed

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(includes lunch, cont. breakfast and snack breaks for both days)

Check box that applies

- ☐ IRES Member (regulator) $275
- ☐ Industry Sustaining Member ... $450
- ☐ Non-Member Regulator $400
- ☐ Retired IRES Member $100
- ☐ Industry, Non-Sustaining Member $700
- ☐ Spouse/guest meal fee $70

Spouse/Guest name

Hotel Rooms: You must book your hotel room directly with the San Antonio Hyatt. The room rate for IRES attendees is $149 per night for single-double rooms. Please call group reservations at 800-233-1234 or 210-222-1234. The IRES convention rate is available until July 8, 2002 and on a space-available basis thereafter. Our room block often is sold out by early June, so guests are advised to call early to book rooms.

CANCELLATIONS AND REFUNDS

Your registration fee minus a $25 cancellation fee, can be refunded if we receive written notice before June 30, 2002. No refunds will be given after that date. However, your registration fee may be transferred to another qualifying registrant. Refund checks will be processed after Sept. 1, 2002.

If registering after June 30, add $40.00. No registration is guaranteed until payment is received by IRES.

A $25 cancellation fee will be assessed if canceling for any reason.

SPECIAL NEEDS: If you have special needs addressed by the Americans with Disabilities Act, please notify us at 913-768-4700 at least five working days before the seminar. The hotel's facilities comply with all ADA requirements.

SPECIAL DIETS: If you have special dietary needs, please circle: Diabetic Kosher Low salt Vegetarian

Seating for all events is limited. IRES reserves the right to decline registration for late registrants due to seating limitations.

Insurance Regulatory Examiners Society

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

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Regulators and AG's: Different tools for fighting fraud
See p.1

BULLETIN BOARD

√ **CDS notes**
Certificates of attendance for full CE credit (15 hours) will not be handed out until 3 pm Tuesday, the last day of the CDS. Full 15-hour credit will only be given to those who stay for the entire CDS and pick up their certificate in person. All others must mail in a standard IRES CE reporting form requesting credit for actual class time attended, per the instructions in the IRES continuing education program manual.

√ Don't wait to book a room at the San Antonio Hyatt Riverwalk. Our CDS hotel always fills up very early. If you wait past June 1, you may not get a room or may have to pay a higher rate. Look for your CDS registration brochure in the mail this month.

√ Experienced insurance regulators: Sign up now for the IRES-NAIC "Regulating the Marketplace School" this May. See story on page 18 this issue.

√ Nominate a colleague now for the 2002 IRES Al Greer Award. This award recognizes insurance regulators for overall professional excellence. Contact the IRES office for nomination forms. The 2002 Greer Award will be announced at the Career Development Seminar and annual meeting this July in San Antonio.

Welcome, new IRES members!

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Donna Lyn M. Yasuda, HI

In next month's REGULATOR: IRES celebrates its 15th anniversary